EMORY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

POLICIES AND PROCEDURES

JULY 24, 2026

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: http://www.emory.edu/irb
An equal opportunity, affirmative action university

EMORY UNIVERSITY STANDARD POLICY FORMAT COVER SHEET

POLICY: EMORY UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB)

POLICIES AND PROCEDURES (P&PS)

RESPONSIBLE OFFICIAL: INSTITUTIONAL OFFICIAL

ADMINISTERING OFFICE: IRB OFFICE

LAST REVISION: JULY 24, 2026

POLICY SECTIONS: SEE TABLE OF CONTENTS

OVERVIEW: POLICIES APPLICABLE TO HUMAN SUBJECTS RESEARCH CONDUCTED UNDER THE AUSPICES OF EMORY UNIVERSITY.

APPLICABILITY: University-Wide

POLICY DETAILS: See specific P&P Sections.

DEFINITIONS: Included within specific P&Ps and within P&Ps' Glossary.

RELATED LINKS: http://www.irb.emory.edu

CONTACT INFORMATION:

Subject	Contact	Phone
Clarification of Policy	IRB Director	404-712-0720

REVISION HISTORY: Initial draft January 25, 2007. Revised January 4, 2008, February 28, 2008, April 30, 2008, July 16, 2008, November 7, 2008, January 13, 2009, April 14, 2009, August 3, 2009, May 11, 2010, August 10, 2010, September 7, 2010, February 15, 2011, August 22, 2011, January 13, 2012, April 23, 2012, June 29, 2012, August 16, 2012, October 31, 2012, January 18, 2013, May 24, 2013, February 17, 2014, February 26, 2014, August 13, 2014, May 14, 2015, June 9, 2015, September 22, 2015, July 1, 2016, December 5, 2017, January 10, 2018, September 19, 2018, September 25, 2018, January 14, 2019, September 13, 2019, February 20, 2020, September 18, 2020, February 5, 2021, March 10, 2021, August 20, 2025, January 6, 2026, March 16, 2026, July 24, 2026

TABLE OF CONTENTS

1	EMORY UNIVERSITY HUMAN RESEARCH PROTECTION PROGRAM (HRPP) AND DEFINED TERMS	8
2	PRINCIPLES GOVERNING EMORY HRPP	11
3	INSTITUTIONAL AUTHORITY	14
4	FEDERALWIDE ASSURANCE (FWA)	16
5	ROLES AND RESPONSIBILITIES UNDER THE EMORY HRPP	18
6	NUMBER OF IRBS AND REGISTRATION	21
7	ROLES AND RESPONSIBILITIES FOR ENSURING ADEQUATE RESOURCES TO PROTECT *HUMAN SUBJECTS*	24
8	APPLICABILITY OF STATE LAW	25
9	EMORY UNIVERSITY IRB OFFICE	26
10	EMORY IRB P&PS	28
11	AUTHORITY AND RESPONSIBILITY OF THE EMORY IRB	31
12	JURISDICTION OF THE EMORY IRB	35
13	EMORY IRB RELATIONSHIPS WITH OTHER REGULATORY COMMITTEES	37
14	EMORY IRB COORDINATION WITH OTHER UNIVERSITY COMPLIANCE ENTITIES	40
15	EMORY IRB RELIANCE RELATIONSHIPS WITH OTHER INSTITUTIONS	42
16	LOCAL RESEARCH CONTEXT – RESEARCH CONDUCTED AT NON-EMORY SITES	52
17	HUMAN SUBJECTS RESEARCH AT THE ATLANTA VETERANS AFFAIRS HEALTH CARE SYSTEM (AVAHCS)/FOUNDATION FOR ATLANTA VETERANS EDUCATION AND RESEARCH (FAVER)	57
18	DEPARTMENT OF DEFENSE (DOD) SUPPORTED RESEARCH	64
19	EMORY IRB ADMINISTRATION AND OFFICIALS	70

20 SUBCOMMITTEES OF THE EMORY IRB 78

21 CONDUCT OF QUALITY ASSURANCE/QUALITY IMPROVEMENT ACTIVITIES FOR EMORY IRB OPERATIONS 80

22 IRB MEMBERSHIP 82

23 ORIENTATION AND EDUCATION FOR IRB CHAIRS, MEMBERS, AND STAFF 90

24 IRB MEMBER LIABILITY, INSURANCE, AND INDEMNIFICATION 93

25 CONSULTANTS AND AD HOC REVIEWERS 94

26 CONFIDENTIALITY OBLIGATIONS FOR IRB OFFICIALS, MEMBERS, CONSULTANTS, STAFF, AND GUESTS 96

27 DOCUMENTATION AND RECORD RETENTION 98

28 IRB PROTOCOL TRIAGE AND ASSIGNMENT OF REVIEW CATEGORY 103

29 DETERMINATIONS OF ENGAGEMENT IN HUMAN SUBJECTS RESEARCH OR CLINICAL INVESTIGATION 105

30 EXEMPT RESEARCH 109

31 EXPEDITED REVIEW 117

32 FULL COMMITTEE REVIEW 122

33 IRB MEETINGS 124

34 MINUTES OF AN IRB MEETING 129

35 CONFLICTS OF INTEREST – INVESTIGATORS 133

36 CONFLICTS OF INTEREST ON THE PART OF IRB MEMBERS AND IRB STAFF 136

37 INDEPENDENCE OF EMORY IRB WITH RESPECT TO INSTITUTIONAL AND INVESTIGATOR INFLUENCE 139

38 POSSIBLE IRB ACTIONS ON HUMAN SUBJECTS RESEARCH PROTOCOLS 141

39 CONTINUING REVIEW 149

40 PROTOCOL MODIFICATIONS (AMENDMENTS) 155

41 CLOSURE OF PROTOCOLS 159

42 CRITERIA FOR EMORY IRB APPROVAL OF RESEARCH 160

43 INFORMED CONSENT 164

44 INFORMED CONSENT OF NON-ENGLISH-SPEAKING SUBJECTS 174

45 LEGALLY AUTHORIZED REPRESENTATIVES AND SURROGATE CONSENT 178

46 WAIVER OF DOCUMENTATION OF INFORMED CONSENT 182

47 WAIVER OR ALTERATION OF INFORMED CONSENT FOR *RESEARCH* 184

48 WAIVERS OF, AND EXCEPTIONS FROM, INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH 188

49 CONSENT MONITORING 195

50 DATA AND SAFETY MONITORING PLANS 196

51 REVIEW OF RESEARCH PROTOCOLS INVOLVING VULNERABLE POPULATIONS 200

52 RESEARCH INVOLVING *CHILDREN* – ADDITIONAL PROTECTIONS 203

53 RESEARCH INVOLVING *WARDS OF THE STATE* – ADDITIONAL PROTECTIONS 211

54 RESEARCH INVOLVING *PRISONERS* – ADDITIONAL PROTECTIONS 213

55 RESEARCH INVOLVING PREGNANT WOMEN, HUMAN FETUSES, AND NEONATES – ADDITIONAL PROTECTIONS 220

56 RESEARCH INVOLVING INDIVIDUALS WITH IMPAIRED DECISION-MAKING CAPACITY, OR ECONOMICALLY OR EDUCATIONALLY DISADVANTAGED PERSONS 225

57 REQUIREMENTS FOR RESEARCH INVOLVING HUMAN EMBRYONIC STEM CELLS, GERM CELLS, STEM CELL-DERIVED TEST ARTICLES AND THE TRANSPLANTATION OF *HUMAN FETAL TISSUE* FOR THERAPEUTIC PURPOSES 229

58 COMPLAINTS 233

59 COMMUNICATION CHANNELS FOR HUMAN SUBJECTS ABOUT RESEARCH 235

60 REVIEW OF INSTANCES OF NON-COMPLIANCE FOR DETERMINATION OF SERIOUS OR CONTINUING NON-COMPLIANCE AND REPORTING 236

61 PROTOCOL OVERSIGHT AND PROCEDURES FOR HANDLING AUDITS AND VIOLATIONS 238

62 SUSPENSIONS AND TERMINATIONS OF PREVIOUSLY APPROVED RESEARCH 247

63 REPORTING TO GOVERNMENTAL REGULATORY AUTHORITIES, SPONSORS, AND INSTITUTIONAL PERSONNEL 251

64 USING FDA-REGULATED PRODUCTS 256

65 INVESTIGATIONAL MEDICAL DEVICES 258

66 EMERGENCY USE OF INVESTIGATIONAL MEDICAL DEVICES 265

67 TREATMENT USE ("COMPASSIONATE USE") OF INVESTIGATIONAL DEVICES 269

68 HUMANITARIAN USE DEVICES – EXEMPTIONS AND USES 272

69 INVESTIGATIONAL NEW DRUGS (OTHER THAN EXPANDED ACCESS) 279

70 INVESTIGATIONAL NEW DRUGS – EXPANDED ACCESS 285

71 SPONSOR-INVESTIGATOR DRUG SAFETY REPORTING OBLIGATIONS 300

72 INVESTIGATOR SAFETY INFORMATION REPORTING OBLIGATIONS TO IRB 305

73 REPORTING TO EMORY IRB OF PROTOCOL DEVIATIONS/PROTOCOL NON-COMPLIANCE; NON-COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, OR IRB POLICIES AND PROCEDURES; AND REPORTS REQUIRED BY PROTOCOL OR CONTRACT 315

74 HIPAA AND OTHER APPLICABLE PRIVACY LAWS AND POLICIES 318

75 MANDATORY REPORTING TO LAW ENFORCEMENT AGENCIES 328

76 RECRUITMENT OF SUBJECTS 335

77 PAYMENT OF SUBJECTS 339

78 EMORY UNIVERSITY AND OTHER STUDENTS AS SUBJECTS – INCLUDING DEPARTMENT OF EDUCATION REQUIREMENTS 342

79 EMORY EMPLOYEES AS SUBJECTS 348

80 INVESTIGATOR QUALIFICATIONS 350

81 RESEARCH CONDUCTED BY STUDENTS AND TRAINEES 354

82 IRB REVIEW OF ORAL HISTORY PROJECTS 356

83 GENETIC STUDIES 359

84 COLLECTION, PROCESSING, AND/OR BANKING OF HUMAN RESEARCH SUBJECT SPECIMENS 362

85 RESEARCH INVOLVING CODED PRIVATE INFORMATION OR BIOLOGICAL SPECIMENS 366

86 DEPARTMENT OF ENERGY (DOE) 369

87 DEPARTMENT OF JUSTICE (DOJ) 374

88 ENVIROMENTAL PROTECTION AGENCY (EPA) 379

89 GLOSSARY 381

1 EMORY UNIVERSITY HUMAN RESEARCH PROTECTION PROGRAM (HRPP) AND DEFINED TERMS

POLICY:

Emory University has established a Human Research Protection Program (Emory HRPP) to safeguard and promote the health and welfare of human research subjects by ensuring that their rights, safety, and well-being are protected.

DEFINED TERMS: All defined terms used in this document are capitalized and in a bold Italic typeface. Complete definitions of defined terms as well as any acronyms used herein are set forth in the Glossary at the end of this document.

PROCEDURES:

Mission of Emory University HRPP: Emory University fosters a ***Research*** environment that promotes the respect for the rights and welfare of individuals recruited for, or participating in, ***Research*** conducted by or under the auspices of Emory University. Emory University is guided by applicable laws, regulations, and principles in its review and conduct of ***Human Subjects Research.*** To fulfill this mission, Emory University has established a ***Human Research Protection Program***.

The mission of the Emory HRPP is:

- To safeguard and promote the dignity and well-being of participants in research conducted at or by Emory by assuring their rights, safety and welfare are protected;
- To provide timely and high-quality review and monitoring of human subjects research; and
- To facilitate excellence in human subjects research by providing accurate guidance and education to Emory investigators, IRB members, and research officials.
- To ensure compliance with all regulatory and ethical obligations involved in Human Subjects Research conducted at or by Emory.

The HRPP is a multi-tiered program involving the administration of the University, the ***Institutional Official,*** the ***Institutional Review Board***, other research administration and compliance offices, ***Investigators***, and research support staff.

The HRPP includes mechanisms to:

- Establish a formal process and resources to monitor, evaluate, and continually improve the protection of human research participants.
- Educate investigators and research staff about their ethical responsibility to protect research participants.
- When appropriate, intervene in research and/or respond directly to concerns of research participants.

Institutional Authority: The Emory HRPP operates under the authority of *Emory University IRB Policies & Procedures* (P&Ps), which govern the conduct and review of all human research conducted under the auspices of Emory University. These P&Ps are available to Emory

University investigators, staff, and the general public at the Emory IRB website: http://www.irb.emory.edu

Governing Laws, Regulations and Principles: The Emory HRPP is established pursuant to and in accordance with the laws, regulations, and principles listed below regarding the protection of ***Human Subjects***. Emory University will adhere to these laws, regulations, and principles with regard to ***Research*** conducted by or under its auspices:

> The ***Department of Health and Human Services (HHS)*** policy and regulations at 45 CFR Part 46, also known as the *Federal Policy for the Protection of Human Subjects* or the "***Common Rule***" (collectively referred to in this document as the "***HHS Regulations***," found at https://www.ecfr.gov/on/2018-07-19/title-45/part-46);
>
> Food and Drug Administration (FDA) regulations at 21 CFR Parts 50 and 56 (collectively referred to in this document as the "***FDA Regulations***," found at https://www.ecfr.gov/on/2018-07-19/title-21/chapter-I/subchapter-A/part-50 and https://www.ecfr.gov/on/2018-07-19/title-21/chapter-I/subchapter-A/part-56, respectively);
>
> 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* (collectively referred to in this document as the "***Belmont Report***," found at https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html);
>
> for ***Research*** involving the ***Atlanta Veterans Administration Health Care System*** (AVAHCS) or Foundation for Atlanta Veterans Education and Research (FAVER), the Department of Veterans Affairs policies for ***Human Subjects Research*** protection, including the regulations at 38 CFR Part 16 and the VHA Directive Section 1200.05(2) (collectively referred to in this document as the "***VA Regulations***," found at https://www.ecfr.gov/on/2018-07-19/title-38/chapter-I/part-16 and https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8171, respectively);
>
> for projects conducted or supported by the Department of Defense (DOD), any ***DOD Requirements***, including the regulations as 32 CFR Part 219 (collectively referred to in this document as the "***DOD Regulations***," found at https://www.ecfr.gov/on/2018-07-19/title-32/part-219); and
>
> all other applicable federal, state, and local laws and regulations.

Agreement to Abide by Principles and Regulations:
Emory University agrees to uphold the ethical principles of the Belmont Report and to abide by all requirements of the applicable ***HHS, FDA***, ***DOD*** and ***VA Regulations***. In this regard, Emory University has charged the Emory IRB with carrying out all responsibilities of a duly constituted ***Institutional Review Board*** as set forth in these governing regulations and principles. Emory University agrees to provide the Emory IRB with meeting space and sufficient staff and resources to support its review, oversight, record-keeping and other duties.

Provision of Resources: Emory University is committed to providing adequate staff, physical

space, and resources to adequately maintain and operate the Emory HRPP, including the IRB. The IO is tasked with evaluating the needs of the Emory HRPP, including the IRB and the IRB Office, and ensuring that they are provided with adequate resources, including staff, legal counsel, meeting and office space, equipment and supplies (e.g., copiers, office supplies, computers, internet access, etc.) and financial resources for conducting IRB business such as carrying out the HRPP education program, identifying and managing conflicts of interest, carrying out the HRPP quality improvement plan and community outreach activities. The resources provided for the Emory HRPP shall be reviewed and evaluated during the university's annual budget review process. Modifications to resources required to support IRB operations shall be made as necessary.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56
32 CFR Part 219
38 CFR Part 16
45 CFR Part 46
DOD Instruction 3216.02, 2022

2 PRINCIPLES GOVERNING EMORY HRPP

POLICY:

The Emory HRPP (including the Emory IRB) is guided by the ethical principles set forth in the ***Belmont Report*** regarding ***Human Subjects Research***. All institutional and non-institutional ***Research*** performance sites for Emory University will be obligated by Emory University to conform to ethical principles which are at least equivalent to those of Emory University (i.e., the ***Belmont Report*** principles) or as may be determined by the Secretary of HHS hereinafter the "***HHS Secretary***."

PROCEDURES:

Principles Considered by the Emory IRB in Reviewing *Research*: It is the duty of the Emory IRB to review and make decisions on all protocols for all ***Human Subjects Research***. The primary responsibility of the Emory IRB is the protection of ***Human Subjects*** from undue risk and from deprivation of personal rights and dignity. This protection is best assured by consideration of the three principles of the ***Belmont Report***, which are the touchstone of ethical ***Research*:**

> **Respect for Persons:** That voluntary participation by the ***Human Subjects,*** indicated by free and informed consent, is assured;
>
> **Beneficence:** That an appropriate balance exists between the potential benefits of the ***Research*** to the ***Human Subject*** or to society and the risks assumed by the ***Human Subject***; and
>
> **Justice:** That there are fair procedures and outcomes in the selection of ***Research*** subjects.

Implementation of Belmont Report Principles by the Emory IRB in its Review of *Research* – Respect for Persons:

> The Emory IRB shall implement this principle by striving to ensure voluntary informed consent of ***Human Subjects*** through careful review of the recruitment and consent process and of the consent form or information sheet to be used with ***Human Subjects***. The assurance of voluntary informed consent is one of the most important elements in any ***Research*** involving ***Human Subjects***. Any person who is to be a ***Human Subject*** in a study, whether the study is designed for their own direct benefit or for the advancement of scientific knowledge in general, must understand as completely as possible what is to be done and what the potential risks and benefits are. The person must give their consent freely without pressure or inappropriate inducement.
>
> The Emory IRB shall extend the informed consent concept to those studies in which the subjects are not able to give personal consent for themselves. In these instances, the consent document is addressed to those who have been designated responsible for the ***Human Subject's*** wellbeing (e.g., parents of ***Children***). The Emory IRB's concern is to verify that the consent process and document are likely to assist these persons to make

an informed decision, which is in the best interest of the ***Human Subject***.

The Emory IRB shall consider the nature of the study population in determining the capacity of that population for truly informed and voluntary participation in ***Research*****.** At one extreme, there may be ample understanding and manifest freedom from coercion; at the other, there may be degrees of understanding and freedom that affect the consent of potential subjects. The Emory IRB must exercise special care when considering subjects whose ability to give free and informed consent may be compromised in any way and ensure that additional safeguards are completed as appropriate.

Implementation of Belmont Principles by the Emory IRB in its Review of *Research* – Beneficence

The Emory IRB shall implement this principle by examining the risk-benefit ratio of the ***Research*** it is reviewing. The IRB is charged with deciding for any proposed activity which falls under its jurisdiction, whether, "[r]isks to subjects are reasonable in relation to anticipated benefits, if any, to subject and the importance of the knowledge that may reasonably be expected to result." [45 CFR 46.111(a)(2), 2023].

In assessing the risk-benefit relation, the Emory IRB may include consideration of the following factors: (a) risks of injury or discomfort to the individual that can be physical; psychological and/or social; and (b) potential benefits to the individual, a group to which the individual belongs and/or to society. In reviewing ***Research*** protocols, the IRB must carefully assess the types and degrees of both risks and benefits for a given subject population, as well as the investigator's communication of these risks and benefits in the consent process and form.

While the Emory IRB is not charged with reviewing the scientific design of ***Research*** *per se,* it must sometimes do so in order to assess the risk/benefit ratio. If a study's design does not seem adequate to attain the stated aim of the study, then no benefit can be anticipated from conducting the study, and there is no justification for placing any ***Human Subject*** at risk, however, minimal. Thus, the design of the study must be sound and the nature and likelihood of all risks and benefits must be made clear in any application to the IRB.

Implementation of Belmont Principles by the Emory IRB in its Review of *Research* – Justice

The Emory IRB shall implement this principle by ensuring that the ***Research*** involves a fair selection of ***Human Subjects*** through a fair (a) sharing of Research risks and (b) sharing of ***Research*** benefits. Both the risks and potential benefits of ***Research*** should be spread fairly among potential individual ***Research*** subjects and ***Research*** subject groups. Study design and selection of subjects should avoid bias for or against particular social, racial, sexual, or ethnic groups.

Sharing ***Research*** Risks: The guiding principle in the ethical selection of ***Research*** subject groups is that any risks of the ***Research*** should fall upon the groups who might benefit from the **Research**. If the results of a risky protocol might benefit the general

population, it would be unethical to focus subject recruitment on vulnerable or disadvantaged groups (e.g., institutionalized people or ***Prisoners***; or patients at free clinics primarily patronized by people unable to afford other medical care) simply because they are easily accessible or can be persuaded to participate. An undue share of ***Research*** risks also should not burden groups already burdened by other factors. Rather attempts should be made to include a fair sampling of the populations who might benefit from the study. When ***Research*** involves persons whose autonomy is compromised, it is expected that the ***Research*** bear some direct relationship to the conditions or circumstances of the ***Research*** subject population. In addition, groups fully able to consider ***Research*** risks and informed consent should be asked to face ***Research*** risks before more ***Vulnerable Populations***. For example, ***Investigational Drugs*** are usually tested in ***Adults*** before they are tested in ***Children***. Certain ***Investigational Drugs*** and procedures may be tested in healthy volunteers before being tested in patients.

Sharing ***Research*** Benefits: The Emory IRB should consider the desires of various groups to be included in ***Research***. As individuals, and through advocacy groups, many patients have come to insist on having access to experimental treatments, as these experimental treatments may potentially provide the best medical care available. In addition, ***Researchers***, ethicists and public officials have recognized that because many clinical trials focused primarily on white middle-class ***Research*** subject groups, the results of some trials were of questionable value to members of other social, racial, sexual and ethnic groups. As a result, both the National Institutes of Health (NIH) and FDA now require that study design include as broad a range of ***Research*** subjects as feasible and the data be analyzed to uncover responses that differ between groups. Whereas individuals of child-bearing potential, ***Pregnant***, and nursing individuals previously were routinely excluded from new drug trials, it is now required that whenever possible these individuals be asked to make their own choices regarding participation after being fully informed of the risks of the ***Research***.

Ethical principles from other sources (e.g., International Conference on Harmonization) may also be applied to research covered by the HRPP, for example:

- To an individual protocol because its particular circumstances raise a type of ethical issue that most other protocols do not
- When they are recognized by the federal or other funding source or the state or country where the research will occur
- When they have been developed for specific areas or types of subjects (e.g., embryos and fetal tissue, illiterate subjects)

In general, when Sponsor terms and conditions require thE6, the Emory office reviewing the contract attempts to remove the requirement, and if the terms and conditions remain, that office will alert the IRB.

Applicable Regulations, Policies, and Guidance:
45 CFR Part 46, including 46.101 and 46.111

3 INSTITUTIONAL AUTHORITY

POLICY:

The President of Emory University has the power and authority to designate the individual within the University who may serve as the ***Institutional Official (IO)*** responsible for carrying out Emory University's ***Human Research Protections Program*** (HRPP). The person designated as ***Institutional Official*** must meet the qualifications set forth in these IRB Policies & Procedures (P&Ps). The President of Emory University has designated the Emory IRB as the body within Emory University that has jurisdiction over all ***Human Subjects Research*** conducted under the auspices of Emory University.

PROCEDURES:

Appointment of the *Institutional Official* (IO): Whoever is in the role of Vice President for Research Administration (VPRA), whether interim or permanent, serves as the IO for the HRPP.

The VPRA is an employee of Emory University who holds a position within the University per which they have the legal authority to act and speak for Emory University as a whole, and per which they can ensure that Emory IRB will effectively fulfill its ***Research*** oversight functions.

Term of Appointment of the IO: The IO shall serve in this position until the earlier of the date on which:

The IO leaves Emory University;

The IO no longer has the ability or capacity to fulfill the role of IO;

The President of Emory University, or the Senior Vice President of Research (SVPR), at their discretion, requests the IO's resignation and appoints a new IO; or

Until IO tenders a resignation from the position and the SVPR or President appoints a new IO. The resignation shall be required at any time at which the IO does not meet the qualifications for holding this position.

Designation of Emory IRB: The President of Emory University has designated the Emory IRB as the body within Emory University that has jurisdiction over all ***Human Subjects Research*** conducted under the auspices of Emory University, as described in the provision immediately below entitled ***Human Subjects Research*** **Subject to Emory IRB Authority.**

Human Subjects Research **Subject to Emory IRB Authority:** The ***Human Subjects Research*** under the auspices of Emory University that is subject to the authority of the Emory IRB includes:

Human Subjects Research conducted at Emory University;

Human Subjects Research conducted by or under the direction of any employee or agent of Emory University in connection with their institutional responsibility;

Human Subjects Research conducted by students of Emory University in connection with their institutional responsibilities;

Human Subjects Research conducted by or under the direction of any employee or agent of Emory University using any property or facility of Emory University or involving Emory University non-public information to identify or contact ***Human Subjects.***

Institutions In Addition to Emory University that Rely on the Emory University IRB:

Per specific, written agreements with Emory University, other institutions may rely on the Emory University IRB and are thereby subject to these P&Ps.

The Emory IRB provides review for ***Human Subjects Research*** conducted at the AVAHCS under the ***AVAHCS Memorandum of Understanding***.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109, 56.111, and 56.112
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.103, 46.109, 46.111, and 46.112

4 FEDERALWIDE ASSURANCE (FWA)

POLICY:

Emory University holds a ***Federalwide Assurance*** (FWA) #5792, approved by the Office for Human Research Protections (OHRP). The terms of the FWA apply whenever Emory becomes engaged ***in Human Subjects Research*** that is conducted or supported by any U.S. department or agency that has adopted the requirements set forth at 45 CFR Part 46 (the "Common Rule") unless the Research is otherwise exempt from the Common Rule requirements or the federal department or agency conducting or supporting the Research determines that the Research shall be conducted under a separate assurance. All activities of the Emory IRB regarding any Human Subjects Research that is covered by the Common Rule, as set forth above, are governed by and subject to the terms and conditions of the FWA. With regard to Human Subjects Research that is not conducted or supported by any U.S. department or agency that has adopted the ***Common Rule,*** *Emory* applies the standards and requirements of its internal Human Research Protections Program.

The Emory FWA and its terms are integral to the Emory HRPP. The terms of the FWA can be found on the OHRP website at:
https://www.hhs.gov/ohrp/sites/default/files/ohrp/assurances/forms/fwatermsjun14.pdf

PROCEDURES:

Information Regarding the Emory FWA: Emory holds FWA 5792. Current information regarding the Emory FWA can be found at the following OHRP website: http://ohrp.cit.nih.gov/search

Contact Information at OHRP Regarding the FWA: Contact information for OHRP personnel responsible for processing FWAs and answering related questions can be found at the following OHRP website: https://www.hhs.gov/ohrp/about-ohrp/contact-us/index.html#go-to-fwa-irb-inquiries

Emory's Execution of the FWA: The Emory University FWA, and any modifications or amendments thereto, shall be executed by the IO.

Emory's Agreement to Terms of FWA: Emory University, including the Emory IRB, is subject to and agrees to abide by the Terms of Assurance required by the OHRP. The Emory IRB agrees to provide oversight to Human Subjects Research conducted or supported by a U.S. department or agency that has adopted the ***Common Rule*** that is carried out under its jurisdiction and it shall provide this oversight in accordance with the terms and conditions of the ***Emory FWA***

Emory University-Related Components Covered by the *Emory FWA:* The components of Emory University that are covered by the ***Emory FWA*** are as follows: Emory University and Emory Healthcare. The IO must grant approval to any additions or withdrawals of the components covered by the ***Emory FWA.***

The IRB ***Director*** shall be responsible for filing any necessary documentation with the ***Office of***

Human Research Protections (OHRP) for the addition/withdrawal of a component from the ***Emory FWA.***

Other Institutions that Rely on the *Emory FWA:* Per agreement with Emory University, all institutions that rely on the ***Emory FWA*** are subject to the terms thereof and to these P&Ps.

Emory FWA* Renewal:** The ***Emory *FWA* must be renewed every thirty-six months, even if no changes have occurred, in order to maintain an active OHRP-approved FWA. The IRB ***Director*** is responsible for ensuring that the ***Emory FWA*** is renewed in a timely fashion and is not permitted to expire. A copy of the complete current ***Emory FWA*** shall be kept in the IRB offices.

Applicable Regulations, Policies, and Guidance:

32 CFR Part 219, including 219.103
38 CFR Part 16, including 16.103 and 16.107
45 CFR Part 46, including 46.103, 46.107, and 46.501 through 46.505
56 CFR Part 56, including 56.107
DOD Instruction 3216.02, 2022

5 ROLES AND RESPONSIBILITIES UNDER THE EMORY HRPP

POLICY:

The IO is ultimately responsible for ensuring that all responsibilities are carried out under the Emory HRPP, which includes the ***Emory FWA***. The IO is responsible for ensuring that the Emory IRB upholds and carries out its responsibilities under the ***Emory FWA***. Other persons and committees within Emory University also have responsibilities in fulfilling the requirements of the HRPP. It is incumbent upon all faculty and staff who play a role in the administration of the Emory HRPP, or in the conduct or administration of ***Human Subjects Research*** subject to the jurisdiction of the Emory HRPP including the Emory FWA, to carry out all responsibilities that are assigned to those roles.

PROCEDURES:

Principal Investigator* (PI) Responsibilities:** In fulfilling Emory University's responsibilities under the ***Emory HRPP, each PI is responsible for:

Training and Knowledge: Ensuring, prior to initiating any ***Human Subjects Research***, that they, and all study staff/key personnel involved in their ***Research*** protocol, have acquired the appropriate knowledge and training regarding protections, ethical conduct of ***Research***, and applicable federal regulations, as well as the specific knowledge needed to properly conduct their specific protocol(s).

Completion of Required Training Programs: Ensuring, prior to beginning any ***Human Subjects Research*** that they, and all study staff/key personnel involved in their ***Research*** protocol, have each completed any training programs mandated by the Emory IRB or by other Emory University departments or committees that have jurisdiction over the ***Research*** in which the PI is participating (e.g., ***CITI Training Course***, HIPAA training, radiation safety training, bloodborne pathogens training), including individually, without any assistance from others, attaining a passing score on any required examinations or tests covering the training materials. See the P&P entitled "*Investigator Qualifications*" for more information.

***DOD Research*:** For protocols conducted or supported by the DOD, PIs shall insure that they, and the research personnel who work on their studies, complete the training described in the P&P entitled *Department of Defense (DOD) Supported Research.* The IRB may request written documentation of completion of any required training or certification.

Knowledge of Protocol and Related Documentation: Prior to initiating work under any ***Research*** protocol, thoroughly reading and understanding the ***Research*** protocol and any informed consent document and ***HIPAA Authorization***, and understanding and properly completing the IRB ***Protocol Application*** (including all appropriate materials) submitted to the Emory IRB for review and approval. All PIs are also responsible for ensuring that all personnel involved in carrying out the ***Research*** protocol are familiar with these documents and also abide by all of these requirements.

Regulatory Compliance: Ensuring that they and all key personnel involved in the ***Research*** protocol comply with all Emory IRB P&Ps and determinations (and those of the reviewing IRB, if not Emory IRB), which are an integral part of the University HRPP, as well as all applicable Emory University policies, and all requirements imposed by the ***FDA Regulations***, ***HHS Regulations***, ***HIPAA Regulations***, ***VA Regulations*** (for ***Human Subjects Research*** that involves the AVAHCS), ***DOD*** requirements, and any other applicable laws and regulations. Ensuring that they and all key personnel are operating within the parameters of any ***Reliance Agreements*** and cooperate with the Reviewing IRB's requirements for initial and continuing review, record keeping and reporting, and that they provide information requested by the Reviewing IRB in a timely manner.

IRB Committee **and Associated IRB** ***Chair/Vice Chair*** **Responsibilities:** In fulfilling Emory University's responsibility under the ***Emory HRPP***, each ***IRB Committee*** and its associated ***Chair/Vice Chair(s)*** is responsible for:

Review: Providing initial, modifications, and continuing review of all ***Human Subjects Research*** subject to its jurisdiction;

Documenting Review: Documenting its review and decisions regarding its review of ***Human Subjects Research*** including documentation of any findings/decisions regarding risk/benefit evaluation, ethical considerations, scientific merit, access to ***Individually Identifiable*** information regarding ***Human Subjects*** and other information, privacy considerations and compliance with the ***HHS, FDA*** and ***HIPAA Regulations*** and ***VA Regulations*** (when applicable).

Audits and Post-Approval Monitoring: The IRB may audit or monitor on-going ***Human Subjects Research*** for adherence to ***HHS, FDA*** and ***HIPAA Regulations*** and, as applicable, ***VA Regulations*** and/or ***DOD Regulations***, as well as adherence to Emory IRB P&Ps, which are an integral part of Emory's HRPP, or otherwise pursuant to ***Reliance Agreement***. The Emory IRB shall provide further monitoring, when applicable, to ensure that corrective and preventive action **(CAPA**) plans are fulfilled.

Addressing Inquiries/Complaints: Appropriately inquire into and address complaints, concerns or questions received regarding ***Human Subjects Research*** under the IRB's jurisdiction.

IRB ***Director/Associate Director*** **Responsibilities:** In fulfilling Emory University's responsibilities under the ***Emory FWA***, the IRB ***Director***, and the ***Associate Director***, as designated by the IRB ***Director***, shall be responsible for:

FWA: Updating and renewal of the ***Emory FWA***.

Registration: Updating and renewal of Emory IRB registration.

Membership Rosters: Updating of ***IRB Committee*** membership rosters.

P&Ps: Participating in review/revision and maintaining updated versions of P&Ps to

ensure compliance with ***HHS, FDA*** and ***HIPAA Regulations*** and, as applicable, ***DOD*** and ***VA Regulations.***

Agreements for Emory IRB Review: Ensuring that appropriate ***Reliance Agreements*** are executed when the Emory IRB agrees to review ***Human Subjects Research*** for researchers external to Emory***,*** as well as when Emory relies on external IRBs for review of Emory-related ***Human Subjects Research.***

(For the purposes of this document, unless noted otherwise, an ***Assistant Director*** may perform the duties of the ***Director*** or ***Associate Director***, when the latter is unavailable or has delegated that task to the former.)

IRB Staff (*Protocol Analyst, including Analyst Assistants)* Responsibilities: In fulfilling Emory University responsibilities under the ***Emory HRPP***, each Emory IRB staff member who serves as a ***Protocol Analyst*** is responsible for:

Assisting *IRB Committees*: Assisting the ***IRB Committee***s in on-going review and monitoring activities.

Assisting in Review and Monitoring: Assist in the receipt, pre-review and regulatory analysis of Research applications for review by the ***IRB Committees***.

Assisting in Review of P&Ps: Participate in the review and revision of Emory IRB P&Ps as applicable.

Applicable Regulations, Policies, and Guidance:

38 CFR Part 16, including 38.103
45 CFR Part 46, including 46.103
DOD Directive 3216.02, 2022
SECNAVINST 3900.39D, 2006
SECNAVINST 3900.39E CH-1, 2018
Emory FWA

6 NUMBER OF IRBS AND REGISTRATION

POLICY:

Emory University is committed to allocating sufficient resources, meeting space, and staff to support IRB review, education, quality assurance, and recordkeeping duties. Further, Emory University ensures that it designates and establishes sufficient numbers of IRB committees or panels to conduct a compliant review of research involving human subjects in a timely manner.

The ***Emory IRB*** holds an OHRP-approved Federalwide Assurance, FWA # 5792 and has registered its IRB committees with OHRP. The Emory IRB is composed of two separate committees: one for social-humanist-behavioral (SHB) and one for biomedical research. The biomedical committee has multiple panels. The SHB committee and each biomedical panel have meetings monthly unless there is a lack of quorum or a lack of agenda items for a particular meeting.

A ***Chair*** or ***Vice-Chair*** presides at each biomedical panel and the SHB committee meetings. Each committee or panel is referred to in these P&Ps as an ***"IRB Committee"*** and collectively they are referred to as the ***"IRB Committees***."

PROCEDURES:

Chair* and *Vice Chairs* of *IRB Committees: A single individual serves as the ***Chair*** of all of the ***IRB Committees;*** however, with the IO's approval, two Co-Chairs may share this role and its responsibilities. One or more individuals from each of the ***IRB Committees*** shall serve as ***Vice Chairs***, with one assigned to preside at each panel's convened meetings. Unless otherwise specifically indicated throughout these P&Ps, the term ***"Chair"*** shall refer to both the IRB ***Chair*** or ***Co-Chairs,*** and to any ***Vice Chair,*** when the ***Vice Chair*** is acting for or on behalf of the ***Chair.***

Appointments of Chairs and Vice Chairs of IRB Committees by the IO: The IO shall appoint the ***IRB Chair*** and any ***Vice Chairs*** in writing**.** The following specifications shall be followed with regard to appointments:

> In appointing the ***IRB Chair*** and any ***Vice Chairs*** for IRB Committees that primarily review biomedical Research, the IO shall consult with the following individuals, as appropriate: the Executive Vice President for Health Affairs; the Deans of the Schools of Medicine and Nursing (or their designees), as well as the Dean of any other School within which a candidate for Vice Chair has an appointment.
>
> In appointing any ***Vice Chairs*** for IRB Committees that primarily review social, behavioral, humanist Research, the IO shall consult with the following individuals, as appropriate, depending upon whether the IO also serves in one of these capacities: University Provost; the Dean of the College of Arts and Sciences, Dean of the School of Public Health (or their designees), as well as the Dean of any other School within which a candidate for ***Vice Chair*** has an appointment; the Executive Vice President for Health

Affairs; and the Vice President for Research Administration.

The IO also may appoint other individuals to assist the IO in overseeing the IRB and ensure that the IRB operates to uphold the ***Emory FWA***.

The term of the ***IRB Chair's*** and ***Vice Chairs'*** appointments shall be set forth in these P&Ps.

As of the effective date of this P&P, all persons currently appointed by the IO to assist the IO in carrying out the responsibilities and oversight of the ***Emory IRB***, including the IRB Chair and all Vice Chairs, are set forth by name, title, and role in Appendix 2. The ***IRB Director*** shall be responsible for keeping this list updated.

Registration of IRB Committees with OHRP and the FDA: All of the ***IRB Committees*** must be registered with OHRP and the FDA regarding the membership of each IRB Committee. Any other IRB upon which Emory may rely for review of research subject to DHHS, FDA, VA, or DOD regulations regarding human subjects, per a duly executed ***Reliance Agreement***, must also be registered with OHRP and/or the FDA (as applicable). As of the effective date of these P&Ps, OHRP administers IRB registration for both itself and the FDA.

Current IRB Registration Information: Current information regarding the Emory IRB's registration can be found at the following OHRP website: http://ohrp.cit.nih.gov/search/

OHRP Contact Information About IRB Registration: Contact information for OHRP personnel responsible for processing IRB registration and answering related questions can be found at the following OHRP website: http://www.hhs.gov/ohrp/daqi-staff.html

IRB Registration Renewal: The IRB registration must be renewed every thirty-six months, whether or not any changes to the ***IRB Committees*** have occurred, in order to maintain an active OHRP-approved registration. The IRB ***Director*** is responsible for ensuring that the IRB registration is renewed in a timely fashion and is not permitted to expire. Copies of all documentation regarding Emory IRB registration shall be kept at the IRB offices.

IRB Membership Rosters: The IRB ***Director*** shall be responsible for keeping a current roster of membership on each of the ***IRB Committees that is compliant with OHRP and (for the Biomedical Committees) FDA regulations.*** This membership roster shall list each member's name, degrees, contact information, and any specific role played on the ***IRB Committee*** (non-affiliated member, non-scientific member, ***Prisoner*** representative, etc.). The IRB ***Director*** shall be responsible for reviewing each ***IRB Committee's*** membership roster as members are added or removed.

Changes in Membership Roster: The IRB ***Director*** shall be responsible for promptly notifying OHRP and any other appropriate governmental agencies of any changes to the IRB ***Chair,*** Human Protections Administrator, or IO positions.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107
38 CFR Part 16, including 16.103 and 16.107
45 CFR Part 46, including 46.103, 46.107, 46.109, 46.111, and 46.112

7 ROLES AND RESPONSIBILITIES FOR ENSURING ADEQUATE RESOURCES TO PROTECT *HUMAN SUBJECTS*

POLICY:

The ***Emory IRB*** includes in its review of human subjects research an assessment of whether plans for scientific, clinical (including medical and psychological), technical and other necessary personnel, equipment, time, and services are appropriate and adequate to maximize the safety of human subjects, both during and after participation in a research study.

The ***Emory IRB*** also ensures that Departmental and ancillary committee approvals are issued before granting final approval for the initiation of human subjects research. Ancillary committee approvals may include, for example, radiation, biosafety, and environmental safety committee approvals. For studies for which Emory has ceded IRB review to another institution or independent IRB, the Emory IRB Office ensures that these Departmental and other appropriate ancillary committee approvals are complete prior to giving a study team institutional signoff to make a submission to the external ***Reviewing IRB*** or determines another mechanism for ensuring research does not begin until ancillary reviews are issued.

For protocols conducted or supported by the ***DOD***, the Emory IRB may ask that departmental representatives perform a scientific review of the protocol, and any substantive amendments thereto, and provide the results of that review to the IRB, prior to the IRB's review of the protocol/amendment. Alternatively, the Emory IRB may perform the scientific review.

The PI is responsible for ensuring that there are adequate resources to carry out the research in a safe manner. This includes, but it is not limited to, sufficient investigator time, adequate and qualified research personnel, equipment, supplies, infrastructure, eligible subject population, medical and psychosocial resources, and other resources are properly arranged and described in the protocol submitted to the ***Emory IRB*****.** Insofar as communication and interaction is necessary amongst the IRB and other institutional units required to protect human subjects in research at Emory (including those entities not under the control of the investigator), the PI is responsible for ensuring that those units are notified and that proper arrangements are made to maximize the safety and wellbeing of the human subjects. The PI is responsible for ensuring that the research staff is qualified and has the appropriate training, education, expertise, credentials and, when relevant, privileges, to perform procedures assigned to them during the study.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109 and 56.112
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
SECNAVINST 3900.39D, 2006
SECNAVINST 3900.39E CH-1, 2018

8 APPLICABILITY OF STATE LAW

POLICY:

The Emory HRPP is subject to the laws of the State of Georgia. The Emory IRB shall consult with Emory Office of General Counsel (OGC) for guidance on the interpretation and application of Georgia State Law. In the event of ***Human Subjects Research*** that takes place in jurisdictions other than the State of Georgia, the Emory IRB may consult with OGC for determination of applicable law and any interpretation thereof.

PROCEDURES:

Consultation with Emory OGC: The Emory IRB shall consult with attorneys in the University's Office of the General Counsel when questions arise as to:

The application of Georgia state and local laws to ***Human Subjects Research***; and

The determination of what other jurisdiction's laws may apply if the research takes place at a site outside of the Emory University campus.

As necessary, the OGC may consult with other legal experts, including attorneys in other jurisdictions in which a ***Research*** project is taking place, for advice regarding the applicability and interpretation of pertinent laws.

Applicable Regulations, Policies, and Guidance:

None

9 EMORY UNIVERSITY IRB OFFICE

POLICY:

Emory University has established and staffed the Emory University IRB Office, which is responsible for the administration of the Emory University IRB. The Emory IRB Office reports to the Vice President for Research Administration (the ***Institutional Official***), who reports to the Executive Vice Presidents, who report to the University President.

Mission Statement of IRB Staff: It is the mission of the Emory University IRB staff to protect the rights, privacy, and welfare of participants in ***Human Subjects Research*** conducted by or at Emory, primarily through support of the IRB Committees in all of their functions.

In fulfilling this objective, the IRB staff aim to further the University's research mission by:

- Protecting each human research subject's right to privacy and confidentiality
- Providing reliable analysis in pre-screening ***Human Subjects Research*** applications to help IRB members ensure that the Research possesses ethical merit and adheres to applicable laws and federal regulations.
- Maintaining operational consistency and accountability.
- Striving for continuous quality improvement and professionalism.
- Providing education and outreach to investigators.
- Providing helpful resources to former, current, and prospective Research participants.

PROCEDURES:

IRB *Director:* The IRB Office is managed in chief by the IRB ***Director***. The ***Director*** reports to the IO. The ***Director*** has expert knowledge in regulatory issues regarding ***Human Subjects Research*** and serves as the chief administrator for the University's ***HRPP*** and the primary contact at Emory University for regulatory agencies on IRB matters.

IRB *Associate Director* and ***Assistant Directors*:** The IRB Office may have an ***Associate Director(s)*** and/or ***Assistant Director(s)*** to assist the ***Director*** in carrying out their duties and to serve in the place of the ***Director*** in the ***Director's*** absence. Alternatively, other supervisory staff may fulfill similar functions as designated by the ***Director.***

IRB *Director/Associate/Assistant Director* Responsibilities: The responsibilities of the IRB Director/Associate/Assistant Director are detailed in the P&P entitled: *Roles and Responsibilities Under the Emory HRPP*.

Additional IRB Office Staff: The IRB Office also is staffed by persons appropriately chosen and trained. The duties and responsibilities for each of these positions are set forth in their

respective job descriptions and their performance is evaluated on at least an annual basis. Additionally, from time to time, the ***IRB Director*** in consultation with the ***IRB Chair*** may create and recruit personnel for additional positions to assist the Emory IRB in carrying out its responsibilities.

Selection, Supervision, and Evaluation of Staff: Staff is supervised and evaluated by the Director or designated supervisory staff. Evaluation of staff occurs on an annual basis at the end of the fiscal year using the Emory University Human Resources Policies and Procedures.

Applicable Regulations, Policies, and Guidance:

38 CFR Part 46, including 46.103
45 CFR Part 46, including 46.103
Emory FWA

10 EMORY IRB P&PS

POLICY:

The Emory IRB shall draft and maintain written ***Policies and Procedures (P&Ps)*** for the operation of the Emory HRPP including, policies and procedures for all required items set forth in the ***HHS, VA, FDA Regulations,*** and ***DOD Regulations/Requirements***. These P&Ps are an integral component of the University's HRPP. This document contains and sets forth those P&Ps. They shall be reviewed at least annually, including review for conformance with current law.

The IRB staff shall draft and maintain written administrative standard operating procedures (IRB SOPs) providing detailed guidance on the daily functions of the IRB administration. These shall be stored as a separate collection or document from the P&Ps.

PROCEDURES:

Dissemination of P&Ps: The IRB ***Director*** will keep the University community apprised of new information that may affect the ***HRPP***, including the dissemination through websites and electronic mailing lists of new and modified P&Ps; information regarding applicable laws, regulations, policies, and procedures; and information regarding emerging ethical and scientific issues.

The IRB P&Ps will always be available on the Emory IRB website, with hard copies available upon request.

P&P Requirements: Per ***HHS, FDA, VA Regulations,*** and ***DOD Regulations/Requirements***, the Emory IRB's written P&Ps must address the following items:

Review: Conduct of initial and continuing review of ***Research*** protocols.

Reporting Findings: Reporting of findings and actions to ***Investigators*** and to Emory University.

Review Frequency: Determination as to which ***Research*** protocols require review every twelve (12) months, and which require more frequent review.

Verification: Determination as to which ***Research*** protocols undergoing ***Continuing Review*** require verification from sources other than the PI that no material changes occurred within the ***Research*** protocol since the last IRB review.

Reporting Changes in *Research* Protocols: Prompt reporting of proposed changes in approved ***Research*** protocols and ensuring that changes are not initiated without prior Emory IRB review and approval, except as necessary to eliminate immediate hazards to ***Human Subjects.***

Reporting to Emory IRB and Appropriate Officials: Prompt reporting to the Emory IRB and to appropriate ***Research Sponsors;*** Emory University officials; and/or HHS/FDA/VA/DOD officials of the following:

- ***Unanticipated Problems Involving Risks to Participants or Others***;
- Any ***Serious*** or ***Continuing Non-Compliance*** with ***HHS, FDA, DOD*** and/or ***VA Regulations*** or the requirements or determinations of the Emory IRB; Any ***Suspension*** or ***Termination*** of Emory IRB approval of a ***Research*** protocol.

Adoption of P&Ps and Effective Date: In conformance with the requirements of the ***HHS, FDA, VA Regulations,*** and ***DOD Regulations/Requirement*****s** set forth above, the Emory IRB has adopted these P&Ps as of the effective date shown on the cover sheet for these P&Ps.

Maintenance of P&Ps: The current version of these P&Ps shall be maintained by the IRB ***Director*** on the Emory IRB's official website at http://www.irb.emory.edu

P&P Compliance with *HHS, FDA, VA, HIPAA Regulations,* EPA, DOJ, DOE, and the ***DOD Regulations/Requirements*****:** These P&Ps are subject to the above***,*** as well as any other applicable governmental laws and regulations. In the event of any conflict between these P&Ps and such applicable laws and regulations, the applicable laws and regulations shall control, and these P&Ps shall be conformed to such laws and regulations.

P&Ps Review and Revision Procedure: Set forth below, are the procedures to be followed for the review and adoption of new P&Ps and the review and revision of existing P&Ps:

Review of P&Ps and Appointment of *P&P Subcommittee*: three IRB members will serve on a subcommittee to participate in the review and revision of the P&Ps to ensure compliance with all applicable rules and regulations and to incorporate any new modifications to these P&Ps. This subcommittee shall be called the "***P&P Subcommittee***" and shall meet or review via email when substantive changes to the P&Ps are required. In addition to these IRB members, the following persons by virtue of their position shall serve as members of the ***P&P Subcommittee***: an IRB ***Chair***; the IRB ***Director***, a ***Protocol Analyst*** or other person involved in the administration of the Emory IRB, as designated by the IRB ***Director*** in their discretion; and a representative from the Office of Research Compliance and Regulatory Affairs (RCRA).

Initial Review of P&Ps by IRB *Director*: The IRB ***Director*** and their designee shall perform a periodic review of the P&Ps and bring forward to the ***P&P Subcommittee*** suggested or required modifications or additions to the P&Ps. This process shall occur on an as needed basis when changes in applicable laws and regulations occur or as suggestions for modifications or additions are received from interested parties. This periodic review shall occur as needed. As a part of this review process, the IRB ***Director*** shall solicit suggested additions and modifications to the P&Ps from all ***IRB Committee*** members. Any reasonable suggested modifications or additions shall be provided to the ***P&P Subcommittee*** for review and discussion.

Meeting of *P&P Subcommittee*: The IRB ***Director*** shall convene a meeting(s) of the ***P&P Subcommittee*** in order to review and consider P&P additions and modifications that are brought forward. The IRB ***Director*** shall convene meetings as necessary. The P&P Subcommittee may communicate about changes in person or by any other practical means that allows two-way

communication (e.g., telephone or e-mail). A majority of the ***P&P Subcommittee*** members must be present, or respond, in order to have an officially constituted meeting. The ***P&P Subcommittee*** members will vote on each addition/modification that has been brought forward. Each member of the ***P&P Subcommittee*** shall be entitled to a single vote on issues that come before the subcommittee, and motions voted upon shall be carried when they receive a majority of the votes of those reviewing the changes. The ***P&P Subcommittee*** shall keep records pertaining to the actions taken.

The date of the final vote submitted by the ***P&P Subcommittee*** members (or the date a vote was taken at a convened meeting, when applicable) on revised P&Ps shall become the date affixed to the P&Ps as the current version date. The P&Ps shall be posted on the IRB website in a format that cannot be changed.

Review by the IO: Proposed substantive changes to the P&Ps shall be forwarded to the IO for review and comment.

Revisions without the *P&P Subcommittee*: Minor changes may occur with the documented approval of the IRB Director, Chair, Vice Chair, or IO. These changes should not affect Emory IRB or IRB staff operations. Examples of these changes include but are not limited to:

- Correcting typographical errors;
- Updating or correcting specific information that does not alter the meaning of the text (such as an address change) or references internal to the P&Ps (such as the wrong P&P citation); and
- Indenting, bolding, or other formatting and font changes to improve the readability of the P&Ps.
- Correcting text in a chapter that may be in contradiction with a federal regulation

Making and Circulating Revisions: Upon adoption of new P&Ps or changes/modifications to existing P&Ps, the IRB ***Director*** shall update the web-based and hardcopy versions of the P&Ps accordingly. The IRB ***Director*** shall circulate the updates to all IRB members. The IRB ***Director*** also shall take such steps as are necessary to make appropriate persons within the University aware of the changes.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108
32 CFR Part 219
38 CFR Part 16, including 16.103
45 CFR Part 46, including 46.103

11 AUTHORITY AND RESPONSIBILITY OF THE EMORY IRB

POLICY:

The Emory IRB is an administrative body established to protect the rights and welfare of ***Human Subjects*** recruited to participate in ***Research*** activities conducted under the auspices of Emory University. The Emory IRB is the body at Emory University that has the authority to approve, require modifications in, or disapprove all ***Human Subjects Research*** activities conducted under the auspices of Emory University including exempt research activities under 45 CFR Part 46.104 for which limited IRB review is a condition of exemption. The Emory IRB also has the authority to ***Suspend,*** place restrictions on, or ***Terminate*** approval of ***Human Subjects Research*** activities that fall within its jurisdiction and that are not being conducted in accordance with Emory IRB requirements or that have been associated with unexpected serious harm to subjects.

PROCEDURES:

Responsibility of the Emory IRB: In order to protect the rights and welfare of persons participating in ***Research,*** the Emory IRB is responsible for the ***Initial Review*** and continuing oversight of ***Human Subjects Research*** under its jurisdiction. Through this review, which includes an initial analysis and on-going monitoring of the risks and benefits associated with the ***Research***, the Emory IRB ensures that the ***Human Subjects Research*** is being carried out in accordance with the requirements of the applicable ***HHS, FDA, VA Regulations, DOD Regulations/Requirements,*** and the ***Belmont Report*** ethical principles.

In order to ensure that appropriate safeguards exist to protect the rights and welfare of ***Research*** subjects, the IRB reviews all relevant ***Research*** documents and participant-facing materials ***,*** including, but not limited to the consent/assent forms, investigator brochures (for studies conducted under the FDA's ***Investigational New Drug*** regulations); tests; surveys; questionnaires; and recruitment materials. The Emory IRB also performs the functions of an ***Institutional Privacy Board*** under the regulations implementing the ***Health Insurance Portability and Accountability Act***.

Authority of the Emory IRB: The Emory FWA evidences the Emory IRB's commitment to protecting the rights and welfare of ***Human Subjects*** in accordance with applicable ***HHS, FDA, VA Regulations***, ***DOD Regulations/Requirements*** and the ***Belmont Report*** principles. In accordance with the FWA, the Emory IRB has the authority to perform the following tasks:

> **Risk/Benefit Evaluation:** On an initial and on-going basis, evaluate the risks and potential benefits, if any, of ***Research*** protocols and proposed amendments to ***Research*** protocols and determine whether the rights and welfare of ***Human Subjects*** are adequately protected. Before any ***Human Subject*** is involved in ***Research*** under the auspices of Emory University, the Emory IRB will give proper consideration to: (a) the risks to the subjects; (b) the anticipated benefits to the subjects and others; (c) the importance of the knowledge that may reasonably be expected to result; and (d) the informed consent process to be employed.
>
> **Approve or take other voting actions:** See P&Ps entitled *Exempt Research, Expedited*

Review, Full Committee Review, IRB Meetings, Continuing Review, Protocol Modifications, Criteria for Emory IRB Approval of Research, etc.

Research Protocol Review and Actions. As described elsewhere in these P&Ps, the IRB must ensure that each Research protocol is ethically and scientifically sound and meets all regulatory requirements for approval. The IRB provides initial and continuing review and reviews modifications to protocols. See P&Ps entitled *Exempt Research, Expedited Review, Full Committee Review, IRB Meetings, Continuing Review, Protocol Modifications, Criteria for Emory IRB Approval of Research*, etc.

Report Review: Review and accept or not accept reports regarding on-going approval for ***Research*** protocols, and based on the review of such reports, permit continuation of the ***Research*** protocol or require modifications to or discontinuation of the ***Research*** protocol.

Protocol Renewal: Require applications on at least an annual basis for the continuation of approved ***Research*** protocols, when required by regulations or IRB determinations, and review such applications.

Research* Protocol Oversight:** Oversee the conduct of ***Research protocols to assure compliance with approved protocols and applicable regulations, including the conduct of periodic reviews of ***Research*** protocols where required; the conduct of appropriate for-cause, directed, and not-for-cause audits or compliance reviews; the observation of the consent process and the ***Research*** by the IRB; or a third party retained by the IRB; obtaining verification, when appropriate, from sources other than the investigators that no material changes have occurred since the last Approval; the conduct of inquiries into issues or complaints that arise concerning ***Research*** protocols; and/or the referral of such issues or complaints, or findings regarding such, to other appropriate Emory University committees or administrative personnel.

Suspension, Termination or Restriction of Protocols: ***Suspend,*** place restrictions on, or ***Terminate*** approval of ***Research*** activities that fall within the Emory IRB's jurisdiction that are not being conducted in accordance with IRB requirements or that have been associated with serious harm to ***Human Subjects.***

Education/Assistance: Set training and educational standards for persons who desire to conduct ***Human Subjects Research*** under the Emory IRB's jurisdiction and for IRB members. The Emory IRB also shall provide education, training and assistance to ***Researchers***, research staff and students regarding the appropriate conduct of ***Research*** protocols.

Institutional Privacy Board: In accordance with the ***Emory University HIPAA Privacy Policies*** (found at: https://ethicsandcompliance.emory.edu/) the Emory IRB is authorized to carry out the functions of an ***Institutional Privacy Board*** under the ***HIPAA Regulations***. The Emory IRB shall carry out all functions and responsibilities of an ***Institutional Privacy Board***, as described in the aforesaid ***Emory University HIPAA Privacy Policies***.

Timing of IRB Review and Approval in Relation to Initiation of *Research* Protocol: No protocol for ***Human Subjects Research*** and no activities that in whole or in part involve ***Human Subjects Research*** (including, but not limited to, interacting with ***Human Subjects***, their identifiable data or protected health information, ***Human Subject*** recruitment, advertising, or screening for ***Human Subject*** eligibility) may begin unless and until the protocol has been reviewed and approved by the Emory or IRB; or a determination has been made that it is ***Exempt Research*** (see P&Ps entitled "*Determination of Human Subjects Research or Clinical investigation*" and "*Exempt Research*").

Failing to Submit a Project for Emory IRB Exemption Determination or Review: If a PI fails to submit a project/study for Emory or other formally designated IRB review and the project/study would have qualified as ***Human Subjects Research*** that is either Exempt or is subject to IRB review, then the matter will be referred to the Compliance Review (CoRe) Team or the IRB at a convened meeting. Sanctions to be imposed may include a determination that data collected for the project prior to obtaining Emory IRB review and approval may not be used for Research purposes, (In some cases, the Emory IRB may expressly give permission for Research use of the data.)

In addition, if a PI fails to submit to the Emory IRB or another designated Privacy Board for review and approval in its role as ***Institutional Privacy Board*** any ***Research*** activities that require a waiver of HIPAA authorization granted by a Privacy Board under the HIPAA Regulations, then any such data so obtained or accessed may not be used for the ***Research*** absent the express permission of the IRB Privacy Board***.***

After-the-fact Approval Prohibited: The Emory IRB cannot give after-the-fact approval to a PI who requests Emory IRB approval to continue ***Human Subjects Research*** that was initiated without designated IRB review/approval. The Emory IRB cannot give after-the-fact approval to use data for ***Research*** that was collected with the intent of being used for ***Research*** without prior appropriate IRB approval; provided, however, that if the Emory IRB determines that the Research was Exempt Research, it may consider permitting the data to be used if it appears that the PI did not attempt to circumvent the IRB review process. In addition, the Emory IRB may not approve ***Research*** protocols in which it appears that the PI attempted to circumvent IRB review or these P&Ps by collecting data as non-***Research*** data and then applying to the Emory IRB for use of the data in ***Research***. PIs should err on the side of caution and seek Emory IRB review and approval for any project/study concerning or involving ***Human Subjects*** that they believe may fall within the definition of ***Human Subjects Research,*** particularly if publication of the project/study is anticipated. Similarly, PIs should seek advance Emory IRB approval for the use of or access to any data concerning health, health care and/or payment for health care that contains identifiers and that the PI believes they may want to access/use for ***Human Subjects Research*** purposes.

Further Review of Emory IRB Decisions: ***Research*** that is reviewed and approved by the Emory IRB may be subject to further review, modification and disapproval by officials of Emory University or of any other entity that is relying upon the Emory IRB's review; provided, however, neither Emory University, nor any other entity that relies upon the Emory IRB for ***Research*** protocol review, may interfere with or override a decision of the Emory IRB to disapprove a study, nor may Emory University officials approve a ***Research*** protocol that has been ***Disapproved*** by the Emory IRB.

Officials of the organization may not modify research that has been approved by the IRB without IRB approval of the requested modifications.

Multi-site Studies **Reviewed by an External IRB:** Emory IRB has the authority to cede IRB review to another IRB, with the approval of the IO or their designee and document the reliance with a reliance agreement. The Emory IRB Office is responsible for providing local context information to the ***Reviewing IRB***; to track protocols which are being reviewed by external IRBs; to establish processes to confirm all institution-specific requirements have been met before Emory study teams receive approval from external IRBs; to conduct audits as necessary of Emory study team; and to suspend or terminate the research activities at Emory despite external IRB approval when the Emory IRB determines Emory's activities to potentially be a threat to the welfare of human subjects.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109 and 56.112
32 CFR Part 219
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.103, 46.109, 46.111, and 46.112

12 JURISDICTION OF THE EMORY IRB

POLICY:

Scope of Emory IRB Jurisdiction: The Emory IRB has jurisdiction over all ***Human Subjects Research*** (whether funded or not funded) and all ***Clinical Investigations*** that are conducted at Emory University; that are conducted at locations other than Emory University by Emory University faculty, staff and students, or that it assumes jurisdiction over per written agreement; or that uses any non-public ***Individually Identifiable Private Information*** or ***Protected Health Information*** (PHI) maintained by Emory University, or any of the components covered under the ***Emory FWA***, to identify or contact ***Human Subjects***.

Within its jurisdiction the Emory IRB is responsible for initial and continuing review and oversight of any ***Human Subjects Research, Clinical Investigations.*** For ***Research*** conducted or supported by the ***DOD, DOD*** jurisdiction includes ***Research Involving a Human Being as an Experimental Subject***.

PROCEDURES:

Emory IRB review is required when:

The ***Human Subjects Research*** is conducted by Emory University or any of the components covered by the ***Emory FWA***.

The ***Human Subjects Research*** is conducted by or under the direction or supervision of Emory University or of any employee, faculty member, staff member, student, or agent of Emory University, or of any of the components covered under the ***Emory FWA***, in connection with that person's institutional responsibilities or program of education;

The ***Human Subjects Research*** is conducted by or under the direction or supervision of any employee, faculty member, staff member, student, or agent of Emory University, or of any of the components covered under the ***Emory FWA***, using Emory University property, facilities or resources;

The ***Human Subjects Research*** is conducted by a person who, or entity that, has entered into a ***Reliance Agreement*** with Emory University per which the Emory IRB is designated under the ***Emory FWA*** as the ***Reviewing IRB*** for the ***Human Subjects Research***.

Emory IRB acting as ***Privacy Board***, or another designated ***Privacy Board***, must review when the ***Human Subjects Research*** uses any non-public ***Individually Identifiable Private Information*** or ***Protected Health Information*** (PHI) maintained by Emory University, or any of the components covered under the ***Emory FWA***, to identify or contact ***Human Subjects***;

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50

21 CFR Part 56, including 56.109 and 56.112
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.103, 46.109, 46.111, and 46.112

13 EMORY IRB RELATIONSHIPS WITH OTHER REGULATORY COMMITTEES

POLICY:

The Emory IRB functions independently of, but in coordination with other regulatory committees inside and outside of Emory University. The Emory IRB makes an independent determination whether to approve or disapprove a ***Human Subjects Research*** protocol based upon whether or not ***Human Subjects*** are adequately protected. The Emory IRB may require the approval of other institutional regulatory committees as a condition of approval of a protocol.

PROCEDURES:

Coordination with Other Committees: The Emory IRB shall coordinate its review processes with other regulatory committees both inside and outside Emory University that are charged with reviewing other aspects of ***Human Subjects Research*** protocols. The Emory IRB's approval of a ***Human Subjects Research*** protocol shall remain pending until the Emory IRB has received documentation of approval from all other regulatory-required committees, persons, or offices charged with reviewing any aspects of the protocol. When Emory has ceded IRB review to an external IRB, Emory IRB will continue to monitor these institutional requirements and will only give the Emory study team institutional signoff to begin research activities once those requirements are met.

Other Emory University and Non-Emory University Research Review Committees: The following separate Emory University and non-Emory University committees (collectively referred to in this section as the "***Other Research Review Committees***" and is not meant to be an exhaustive listing) have responsibilities with regard to the review of research, including ***Human Subjects Research***, conducted at Emory University, by Emory University faculty, staff or students, or using Emory University resources: (a) Emory University Radiation Safety Committee (RSC); (b) Emory University Institutional Biosafety Committee (IBC); (c) Emory University Research Health and Safety Committee (RHSC); (d) Research Conflict of Interest Committee(s); (e) the **Protocol Review and Monitoring Committee** (PRMC); (f) Radioactive Drug Research Committee (RDRC), and (g) National Institutes of Health (NIH) Recombinant DNA Advisory Committee (RAC).

Descriptions of *Other Research Review Committees*:

Emory University Radiation Safety Committee (RSC): The RSC reviews ***Research*** that involves the use of radioactive isotopes, x-rays or other radioactive materials. Requirements for when RSC review of a ***Research*** protocol is required can be found at the following website: https://www.ehso.emory.edu/sso/documents/guideline-for-rsc-review-of-human-research-studies.pdf. Upon issuance, documentation of RSC review and approval/disapproval or exemption shall be provided to the Emory IRB.

Emory University Institutional Biosafety Committee (IBC): The IBC reviews ***Research*** that is covered under the *NIH Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules (*referred to herein as the "***NIH Guidelines***") found at

the following website: https://osp.od.nih.gov/wp-content/uploads/NIH_Guidelines.pdf.

Emory University Research Health and Safety Committee (RHSC) reviews research that involves ***Select Agents***, and certain infectious agents and biological toxins. Requirements for when IBC or RHSC review of a ***Research*** protocol is required can be found at https://www.ehso.emory.edu/sso/documents/ehs-407-rhsc-charter.pdf. Upon issuance, documentation of IBC or RHSC review and approval/disapproval or exemption shall be provided to the Emory IRB.

NIH Recombinant DNA Advisory Committee (RAC): The RAC is the public advisory committee that advises the ***HHS Secretary***, the HHS Assistant Secretary for Health, and the NIH Director concerning recombinant DNA research. Specifications for ***Research*** that must undergo RAC review are set forth in the NIH Guidelines, as well as in the policies and procedures of the IBC found at https://www.ehso.emory.edu/guidance/programs/research-safety.html. When RAC review is required, documentation of RAC review and approval/disapproval must be provided to the IRB upon issuance.

Conflict of Interest and Commitment (COI/COC):: The Emory University Conflict of Interest and Commitment Office has its own review process for ***Research*** that involves a COI on the part of the PI or key study personnel. Resources for requirements regarding disclosure and review of COIs involving ***Research*** and contact persons for schools can be found at the following web page: http://www.coi.emory.edu. The Conflict of Interest and Commitment Office is responsible for providing the Emory IRB with documentation of review and any required management plan upon issuance.

Emory University Protocol Review and Monitoring Committee (PRMC): The PRMC provides scientific review of all oncology related protocols involving Emory researchers. Information about PRMC review requirements can be found at the following web page: https://winshipcancer.emory.edu/research/clinical-trials-office/clinical-translational-review-committee.html. Upon issuance, documentation of PRMC review and approval/disapproval or exemption shall be provided to the Emory IRB.

Radioactive Drug Research Committee (RDRC): The RDRC is a subcommittee of the Emory University Radiation Safety Committee for Human Use (RSC-I). The RDRC reviews certain research protocols involving radioactive compounds as required by FDA regulations. RSC-I reviews all other human research protocols involving administration of radioactive materials or radiation from radioactive material to subjects solely as a result of participation in a research study.

Assessment of Research Protocol by PI to Determine What Committee Review is Required: The PI is responsible for reviewing their ***Research*** protocol and the review requirements of the Emory IRB and the ***Other Research Review Committees*** in order to determine to which committees the protocol must be submitted for review. The ultimate decision as to whether review of a protocol falls within a committee's jurisdiction shall be with that committee, but any committee may send a protocol to another committee for a decision as to whether review by the recipient committee is required (e.g., the Emory IRB may send a protocol for which it believes the PI may have

a COI to the COI committee for review, even if the PI on the protocol did not initiate such review). The PI is prohibited from beginning human subjects research activities under a ***Human Subjects Research*** protocol until all required committee approvals have been obtained.

Procedure for Review of *Human Subjects Research* that Requires Submission to the Emory IRB and to the *Other Research Review Committees*:

If a protocol involves activities that must be reviewed by the Emory IRB and by one or more of the ***Other Research Review Committees***, the PI may simultaneously submit the protocol for review to the Emory IRB and the ***Other Research Review Committee(s),*** but the Emory IRB's approval shall be pending unless and until it receives notice of approval from the ***Other Research Review Committee(s).***

In addition, the Emory IRB may, on its own initiative, send a protocol to one or more of the ***Other Research Review Committees*** or direct the submitting PI to do so. The Emory IRB also may receive a protocol for review from one of the ***Other Research Review Committees.***

For new submissions in which the application indicates that RSC, IHBC, COI, or PRMC review is needed, eIRB prevents the IRB from granting full IRB approval until the applicable approval(s) or exemption(s) have been issued in the system.

Protocol Analysts shall be responsible for making an initial assessment as to which of the ***Other Research Review Committees***, if any, the protocol should be routed, and whether that routing has taken place. IRB Members and Designated Reviewers shall also make such assessments.

If a protocol is routed to one of the ***Other Research Review Committee(s)*** for review, that committee may review and approve the protocol, but it should note in any approval letters that ***Human Subjects Research*** may not be initiated until Emory IRB approval has been obtained. Upon issuance of approval/disapproval, the ***Other Research Review Committee(s)*** reviewing the protocol should documentation of its approval, as well as any modifications to or restrictions placed upon the protocol to the Emory IRB.

Applicable Regulations, Policies, and Guidance:

See policies and procedures of ***Other Research Review Committees*** at websites listed above.

14 EMORY IRB COORDINATION WITH OTHER UNIVERSITY COMPLIANCE ENTITIES

POLICY:

The Emory IRB coordinates with other University compliance entities by serving as a member on the Research Senior Leadership Compliance Team (ReSeLeCT).

PROCEDURES:

Research Senior Leadership Compliance Team (ReSeLeCT)**:** In furtherance of University ***Research*** compliance efforts, the ReSeLeCT regularly meets to provide a forum for compliance units within University research and healthcare operations to meet, communicate and coordinate compliance efforts and compliance policy development.

ReSeLeCT **Composition:** The ReSeLeCT is chaired by the AVP of Research Compliance & Regulatory Affairs (RCRA). The ReSeLeCT is composed of representatives from all University units that have day-to-day operational responsibility for University ***Research*** compliance activities. Units that are eligible to appoint a representative to the ReSeLeCT are as follows:

Office of Research Compliance & Regulatory Affairs (Chair)
Office for Clinical Research (OCR)
Emory Healthcare Compliance Office
Environmental Health and Safety Office (EHSO)
Institutional Review Board (IRB)
Research Grants and Contracts (RGC)
Representatives from additional schools/centers' compliance offices and/or other representatives as agreed upon by the ReSeLeCT.

Duties of the ReSeLeCT The ReSeLeCT meets on a regular basis to ensure that dialog and coordination is maintained among the various units at the University that have compliance responsibilities. The ReSeLeCT endorses and supports compliance with the laws, regulations and policies/procedures governing the conduct of ***Research***, including, but not limited to, those laws, regulations, policies and procedures regarding human subjects ***Research,*** animal subjects ***Research;*** biosafety and occupational health and safety in the conduct of ***Research***; the ethical and responsible conduct of ***Research;*** the appropriate stewardship of ***Research*** funds; and ***Conflict of Interest***. The ReSeLeCT provides a forum for the coordination of ***Research*** compliance efforts among the various units of the Emory community that are involved in ***Research*** compliance activities within their units. This cooperative forum will encourage efficient use of resources and provide a consistent approach to regulatory affairs and quality assurance.

In addition, the ReSeLeCT supports the fostering of a culture of compliance in the research compliance arena at Emory by supporting University units in their efforts to:

Promote education and training regarding applicable ***Research*** compliance policies and procedures; and

Ensure that University personnel are aware of their obligation to report in good faith concerns regarding ***Research*** compliance to appropriate University personnel without fear of retaliation.

Applicable Regulations, Policies, and Guidance:

None

15 EMORY IRB RELIANCE RELATIONSHIPS WITH OTHER INSTITUTIONS

POLICY:

Emory University acknowledges that each institution that is ***Engaged*** in multi-institutional, ***Collaborative Research*** is responsible for safeguarding the rights and welfare of ***Human Subjects*** and for complying with applicable federal and other regulations. With respect to such ***Collaborative Research***, Emory and the other institutions may choose to provide concurrent review within their own jurisdictions unless prohibited by applicable regulations or funding agency policy. Alternatively, the Emory IRB may enter into a written ***Reliance Agreement*** per which the Emory IRB relies on the review of another qualified IRB or vice versa. Emory may also enter into written ***Reliance Agreements*** to rely on the review of another qualified IRB for research taking place solely at Emory (e.g. a commercial IRB). When ceding review to an external IRB, Emory officials may not approve research that was disapproved by the external IRB.

In addition, when ***Multi-site Studies*** conducted or supported by the ***DOD*** is being conducted, Emory and the other Research sites shall enter into formal written agreements that specify the roles and responsibilities of each party.

PROCEDURES:

Concurrent IRB Review:
If Emory provides IRB review of Research concurrently with the IRB review of the collaborating institutions' IRBs, all of the P&Ps, rules, regulations and laws described in these P&Ps shall apply to Emory's review just as they would in non-***Collaborative Research*** IRB reviews.

Eligibility of a Study for Reliance or Single IRB Review:
With regard to any cooperative ***Research*** projects that fall within the jurisdiction of the Emory IRB, Emory may review for or rely on another appropriately constituted IRB for the review of the ***Research***, including determinations of **Exemption**.

Emory IRB will not pursue a ***Reliance Agreement*** with another institution unless a formal request is submitted to designated staff member at the Emory IRB. This is to allow Emory to ensure compliance with institutional requirements and to track and monitor human subjects research conducted under its HRPP.

Requests for Reliance
The Emory IRB maintains a record of all human subjects research conducted by Emory University, regardless of whether the research is under Emory IRB oversight or that of an external IRB. Instructions for requesting reliance are provided on the Emory IRB website. Emory researchers are required submit "external IRB" submissions to the Emory IRB for studies where Emory is being asked to rely on an external IRB. When Emory researchers are requesting Emory to serve as the ***Reviewing IRB,*** they may contact the reliance team to make the request. The Emory IRB reliance team reviews these requests on a case-by-case basis depending on factors such as the research activities involved, funding source, number of participating sites, level of engagement of Emory, and inclusion of vulnerable populations.

Assessing the Quality of Other IRBs When Emory is Asked to Cede Review:
Emory will cede review to other institutions that can meet the Emory IRB's standards based on objective information. Emory will generally only agree to cede review to other institutions that are AAHRPP-accredited, have signed the SMART IRB Master Reliance Agreement or have sufficient IRB policies in place. Emory has the discretion to make exceptions on a case-by-case basis to cede review to a ***Reviewing IRB*** depending on the risk of the Research and Emory's level of engagement. In such cases, Emory may review relevant portions of the minutes of the ***Reviewing IRB*** where the particular study is reviewed, review the IRB's records for the study, review the Policies and Procedures or monitor the ***Reviewing IRB's*** performance in other ways such as conducting not-for-cause inspections or observing a relevant IRB meeting. If the institution is not accredited, the proposed ***Reviewing IRB*** must provide an assurance it will conduct its review consistent with applicable ethical standards and regulations within the ***Reliance Agreement.*** For all federally-funded studies, the IO or delegate will ensure that the ***Reviewing IRB***'s institution has an FWA or study-specific Assurance on file with the applicable Agency (if an institutional IRB; independent IRBs are not required to hold an FWA), and that that IRB is registered with OHRP.

The authority to make decisions regarding reliance rests with the Emory IRB office and may be made via verbal or written communication to the Emory study team. The decision made by the Emory IRB is ultimately approved by the IO or the IO's designee, who has the sole authority to sign ***Reliance Agreements***.

The decision to pursue a reliance relationship is made only when Emory determines that doing so is warranted or required as a condition of an award or regulation, and that ceding oversight complies with federal and institutional requirements and does not compromise the ability of the institutions to adequately oversee the ***Human Subjects Research***. The Emory IRB provides information on the Emory website to ensure that investigators understand which studies are eligible for reliance. Once Emory agrees to a reliance request, the researcher and other institutions are notified.
The following non-exhaustive factors are taken into account when determining whether to enter into a ***Reliance Agreement***:

- Whether, by accepting the role of ***Reviewing IRB***, Emory will need to encumber other significant institutional resources to oversee the study.
- Whether the proposed ***Reviewing IRB*** has sufficient resources to adequately oversee the research in a manner that will ensure the protection of human subjects.
- Whether, by accepting the role, Emory will be jeopardizing its ability to meet regulatory requirements.
- Whether the research is federally funded.
- Whether single IRB review is required by the sponsor or regulation.
- Whether the research involves a vulnerable population.
- Whether the research poses more than minimal risk.
- Whether the research will involve procedures or activities that raise significant regulatory or ethical issues.
- Whether the project likely qualifies for exemption from the Common Rule.

- Whether the research will be conducted as part of an existing IRB reliance relationship.
- Whether the proposed ***Reviewing IRB*** has sufficient knowledge of the local context to assume IRB oversight for the research.
- Whether the proposed ***Reviewing IRB*** has sufficient expertise to review the protocol.
- Whether the investigators involved are in good standing with no recent history of noncompliance or misconduct and are qualified to conduct the research as proposed.
- Whether the other institution holds an FWA and is accredited or is otherwise able to meet Emory's standards.
- Whether previous experience with the other institution indicates the reliance process will be protracted or if concerns arise during the reliance process.
- Whether Emory's involvement warrants the proposed ***Reliance Agreement***.
- Whether the proposed ***Reviewing IRB*** is the prime awardee.
- Whether the study is a clinical trial or FDA-regulated.
- Whether there is a sponsor-investigator.
- Whether the other institution is able to indemnify Emory and provide Emory with proof of insurance.
- Whether the lead study team/coordinating center has the resources to handle all of the additional duties required by single IRB review.
- Whether the proposed ***Reviewing IRB*** makes their policies and procedures readily available.
- Whether the terms of the ***Reliance Agreement***, including procedures for communication between the two organizations, are acceptable to both Emory IRB and the Emory ***Principal Investigator***.
- Where the Human Subjects Research activities would take place.
- Which institution's facilities and personnel would be involved and in what capacities.

Reliance Agreements:

The IRB ***Director*** or designee shall ensure that reliance is appropriately documented by both institutions or independent IRB. ***Reliance Agreements*** must identify the roles and responsibilities of the ***Reviewing IRB*** and ***Relying Party***.

Emory University may document reliance on a study-by-study basis or for multiple studies at once such as those conducted by networks or cooperative groups. Reliance can be documented using the SMART IRB agreement, IRB Authorization Agreements (IAAs), Individual Investigator Agreements (IIA), Memorandums of Understanding (MOUs), or via electronic systems such as the SMART IRB Online Reliance System and IREx. Formal reliance agreements may or may not be used for ***Exempt Research***.

The ***Reliance Agreement***, specifically an ***IRB Authorization Agreement*** (IAA), must set forth Emory's FWA number and for Research subject to federal regulations, the FWA of the other party to the Agreement if applicable. The ***Reliance Agreement*** should identify the scope of the agreement, the names of the respective PIs, and clearly state which party is relying on the other for IRB review. The ***Reliance Agreement*** should also state how the ***Relying Party*** will be kept informed of the ***Reviewing IRB***'s actions. Further details should be included in an appropriate template for use by the Emory IRB and IO covering the following details:

- Statement that institutions will ensure that all faculty, staff, students, or ***Agents***

engaged in the ceded research under their purview have adequate education, training, and qualifications to perform the research and safeguard the rights and welfare of human subjects;

- Assurance that all ***Relying Party*** research personnel will comply with the determinations and requirements of the ***Reviewing IRB***, applicable federal regulations, state and local laws, and local institutional requirements related to the ceded research;
- Assurance that the ***Relying Party*** has a mechanism or access to a mechanism to conduct for-cause audits of the ceded research when the ***Reviewing IRB*** determines such infrastructure is necessary for it to serve as the ***Reviewing IRB*** for the ceded research and will conduct audits upon the ***Reviewing IRB's*** request;
- A statement that the ***Relying Party*** will notify the ***Reviewing IRB*** promptly in writing of any suspension, restriction, termination, or expiration of its FWA;
- A statement that ***Relying Party*** research personnel will not initiate any research or change of protocol (except where necessary to eliminate an apparent immediate hazard to subjects), without receiving prior approval from the ***Reviewing IRB***;
- A statement that the ***Relying Party*** study team will provide any information about the conduct of the research at the ***Relying Party*** that the ***Reviewing IRB*** requires for continuing review;
- Statement that the ***Relying Party*** will communicate to the ***Reviewing IRB*** local context information such as local language requirements for the consent form(s), conflict of interest management plans, the requirements of any applicable state or local laws, regulations, institutional policies, standards, or other local factors (including local ancillary reviews) relevant to the ceded research that would affect the conduct or approval of the research at the ***Relying Party***;
- Assurance that the ***Relying Party*** will provide the ***Reviewing IRB*** with site-specific information permitted to be customized in the study consent and HIPAA authorization documents, when such documents are required, and require the ***Relying Party*** study team to not make any changes to said documents without obtaining prior approval of the revisions from *the* ***Reviewing IRB***;
- Assurance that the ***Relying Party*** has an institutional mechanism by which complaints about the ceded research can be made by local research participants to a local contact;
- A statement that the ***Relying Party*** study team will promptly notify the ***Reviewing IRB***, in accordance with the ***Reviewing IRB*** policies and procedures, of any: unanticipated problems that may involve risks to participants or others; significant subject complaints that occurred at the ***Relying Party***; potential noncompliance with applicable human subjects protection regulations or with the requirements of the ***Reviewing IRB*** in connection with the ceded research at the ***Relying Party***;
- A statement that the ***Relying Party*** will promptly notify the ***Reviewing IRB*** of any suspension or restriction by the ***Relying Party*** or any third parties of any of its research personnel's authority to conduct human subjects research; and
- Assurance that the ***Relying Party*** will cooperate (and require its study team to cooperate) with any audit requested by the ***Reviewing IRB*** of the ceded research, which includes providing relevant research records, responding promptly to requests for information, and assisting with the development and implementation of any applicable corrective action plans.

If a ***Relying Party*** requests changes to insurance or indemnification language, the requested

changes may be escalated to the appropriate party for review and approval of the language.

When not contrary to law or a funding agency's requirements, Emory may terminate a ***Reliance Agreement*** for ceding review to another IRB when it determines termination is necessary to protect the integrity of Emory's HRPP or when the other institution has substantially breached the ***Reliance Agreement.***
The IRB ***Director***, or designee, shall ensure that any required ***Reliance Agreement*** is appropriately signed by the IOs or delegates for both institutions. Records of ***Reliance Agreements*** will be kept by the Emory IRB office.

If participating sites are added to research already approved by the Emory IRB, ***Reliance Agreements*** will be executed with those institutions if an umbrella agreement or MOU does not already exist between Emory and the ***Relying Party***. When umbrella agreements or MOUs are in place with other institutions and/or cooperative groups and cover an unspecified number of studies, the MOU does not need to be modified when new research is being added. A local context review form for the new study is all that may be needed.

Emory as a Reviewing IRB

Emory will ensure the structure and composition of the IRB is appropriate to the research reviewed and will comply with applicable laws and shall follow all of its Policies and Procedures to ensure that the IRB is properly constituted; that members are appropriately qualified; that members do not participate in the review of studies in which they have a conflict of interest; and that the IRB follows Emory policy on separating business functions from ethics review services.

Before the Emory IRB will review or approve non-Emory researchers, the Emory IRB will obtain either a completed local context review form from the ***Relying Party*** or will require those who are not affiliated with another institution to complete Emory's required CITI training and notify the Emory IRB of any financial conflicts of interest they have in the research. The Emory IRB will consider local context information provided by the ***Relying Party*** in its review of the research, including any approved conflict of interest management plans. The Emory IRB reserves the right to impose additional restrictions in addition to those outlined in the management plan.
Emory IRB may review the addition of ***Relying Parties*** to previously approved protocols as Modifications and may choose to handle such Modifications using the expedited procedure or via a convened board on a study-by-study basis. Generally, the expedited procedure will be used where the new site is operating under the same protocol document that was previously approved by Emory IRB.

Emory shall facilitate communication with the ***Relying Party*** about Emory IRB actions on the ***Human Subjects Research*** that is subject to the reliance agreement. The Emory IRB will communicate the following promptly to the ***Relying Party***, at a minimum:

- Emory IRB determinations of ***Non-Compliance*** on the part of the ***Relying Party's*** investigators
- Emory IRB determinations of ***Serious or Continuing Non-Compliance*** on the part of any investigators at Emory or the ***Relying Party***'s site
- ***Suspensions*** or ***Terminations*** of Emory IRB approval

- Emory IRB determinations of ***Unanticipated Problem Involving Risks to Subjects or Others*** (***UP***) that occur at the ***Relying Party's*** site
- Advance copies of notices that the Emory IRB or other offices plan to send to Governmental Authorities with oversight over the ***Research***, regarding determinations of ***Serious or Continuing Non-compliance*** or ***UP*** at the ***Relying Party's*** site.

Relevant minutes of IRB meetings, approval notices, approved documents, records of its membership, and other records related to review activities, in accordance with law and regulation and Emory IRB Policies and Procedures, will be made available to ***Relying Parties*** upon request to the extent not restricted under applicable law. Additional communication may be required based on specific ***Reliance Agreements***.

Emory IRB Policies and Procedures are readily available to any investigators under its purview via the Emory IRB website.

The Emory IRB website and ***Reliance Agreements*** include the name of an Emory IRB contact so that non-Emory investigators are able to obtain answers to questions, to express concerns, or to convey suggestions regarding the IRB.
The following requirements must be met by non-Emory site or investigators:

- ***Relying Party*** study members must complete the ***Relying Party's*** required human participants protection training (or in the case of individual/independent investigators, they must complete Emory's required human participants protection training); and
- ***Relying Party*** study members must make conflict of interest disclosures to the ***Relying Party*** in accordance with the ***Relying Party's*** policies and management plans must be provided to Emory IRB (or in the case of individual/independent investigators, they must make disclosures to Emory in accordance with Emory's policies). The ***Relying Party***, if applicable, must agree that, although Emory IRB will not modify the ***Relying Party***'s management plans or mandated disclosures, it may impose additional conflict of interest management requirements that are more stringent or restrictive than those included in the management plan.

The Emory IRB may serve as the ***Reviewing IRB*** for an entity that does not have its own IRB (outside of Memorandums of Understanding such as Emory has with the AVAHCS) if (a) Emory is involved in the conduct of or funding of the ***Human Subjects Research*** at the entity; or collaborating with the entity in the conduct of the Human Subjects Research, or is providing funding for the research; (b) the IO approves of the arrangement in advance; (c) the Emory IRB can develop appropriate means by which to consider the local context of the ***Research***; and (d) if the ***Research*** involved is being supported by a federal agency and the entity is ***Engaged in Research***, then the entity must have an appropriate FWA in effect. If the foregoing criteria are met, then the Emory IRB may enter into an appropriate IAA.

Reliance Agreements for Exempt Studies:

A ***Reliance Agreement*** will not automatically be required if the research is deemed exempt by all institutions considered engaged in the ***Collaborative Research***.
In cases where Emory has determined ***Collaborative Research*** to not be Exempt, instead requiring Expedited or Full Board review, but other engaged institutions have determined the research to be Exempt, Emory shall proceed with its own review.

In cases where the other engaged institution(s) have determined the ***Collaborative Research*** to

be exempt, Emory shall evaluate the exempt determinations and may decide to concur in lieu of requiring a formal review by the Emory IRB. Departmental review by alternative means (e.g. email) must still occur for exempt studies not requiring formal Emory IRB submission. A formal ***Reliance Agreement*** may not be required.

Extended Reliance Relationships:

Although Emory will generally only agree to pursue a ***Reliance Agreement*** for a protocol on a study-by-study basis, Emory IRB may agree to enter into an umbrella reliance agreement or memorandum of understanding under which multiple studies, a particular category of studies, or all studies may be reviewed by one IRB. When an umbrella reliance agreement has been entered into, Emory investigators are still required to submit a formal request to Emory IRB for each individual study in order to allow Emory to ensure compliance with institutional requirements and to track and monitor human subjects research conducted under its HRPP**Emory Conducting Research at non-Emory Site Whose Personnel Is Not Engaged:**

Occasionally, Emory may conduct ***Research*** at a non-Emory site that has an IRB and FWA, but personnel at that site are not ***Engaged in*** the ***Research***. In such cases, the Emory PI may be asked to provide the Emory IRB with documentation from the non-Emory IRB to the effect that its approval is not required. Emory IRB shall also require evidence of permission granted by the other institution to the Emory investigators to conduct the ***Research*** at their site.

Emory Personnel Conducting Federally-Funded Human Subjects Research at Non-Emory Sites that do not have a FWA:

In cases in which Emory PIs are conducting federally-funded ***Human Subjects Research*** at non-Emory sites that do not have an FWA, then all ***Human Subjects Research*** procedures and practices must be carried out by Emory personnel and Emory and the non-Emory site must not be ***Engaged in Research***, with the exception of non-Emory personnel at that site covered by a ***Reliance Agreement***, specifically an ***Individual Investigator Agreement*** (IIA) in order to conduct research under the auspices of Emory's FWA. Criteria for the extension of Emory's FWA to cover individual investigators shall follow OHRP guidance. The Emory IRB should obtain, via the PI, written permission from the Non-Emory the site at which the ***Research*** is to take place, for Emory investigators to conduct the ***Human Subjects Research*** at the site.

Emory University as Coordinating Center for a Multi-Center Protocol:

When Emory University serves as the coordinating center for a multi-center ***Human Subjects Research*** protocol, the Emory IRB will require the Emory University PI to ensure that IRB approval has been obtained from the IRB at each participating site prior to the initiation of ***Human Subjects Research*** at that site, or alternatively, that appropriate ***Reliance Agreements*** have been entered into by all sites to rely on a single IRB (not necessarily the Emory IRB). If Emory agrees to serve as the ***Reviewing IRB*** for other sites, then at the time of initial review of the protocol the Emory IRB will assess the procedures for dissemination of protocol information (e.g., ***Unanticipated Problems Involving Risks to Participants or Others,*** protocol modifications, interim findings, etc.) to all participating sites.

Emory as a Relying Party

The Emory IRB requires an **"**external IRB" submission when asked to rely on an external IRB. The Emory IRB conducts a local context review to confirm the study has received approval from the reviewing IRB, ensure all institutional requirements have been met as applicable to the research including insertion of Emory's required language into consent forms, completion of all required ancillary reviews, development of Conflict of Interest management plans and completion of

required CITI training for all study team members. Emory provides the local context information to the study teams who are responsible for submitting it to the ***Reviewing IRB.***

When Emory relies on another IRB for review, the research is included in the Emory HRPP audit and compliance program.

Emory investigators are responsible for maintaining Emory-required CITI training and comply with any Conflict of Interest management plans during the conduct of the research. Emory investigators are responsible for providing any information in a timely manner that is requested by the ***Reviewing IRB*** related to initial review, modifications, continuing review, and close out of the research.

Additionally, Emory investigators are responsible for adhering to the determinations of the ***Reviewing IRB,*** the ***Reviewing IRB's*** policies and Emory's policies and procedures. Emory investigators must follow the reporting guidelines of the ***Reviewing IRB*** *but* should ensure reporting of matters that are considered reportable per the Emory IRB guidance even if not required by the ***Reviewing IRB.***

If the reportable events represent an ***Egregious Event*** such as, but not limited to, surgery performed on the wrong-side, dispensation of the wrong drug to a participant, fabrication or falsification of data, and HIPAA privacy matters, the Emory PI should report these to the Emory IRB at the same time they are reporting these matters to the Reviewing IRB.

Emory investigators are responsible for providing the relevant Emory offices with the ***Reviewing IRB***'s approval letter and approved documents for Emory as a site prior to conducting any research activities that relate to Emory's engagement in the research. Emory investigators are responsible for obtaining, documenting and maintaining study records in accordance with Emory's record retention policies including maintaining records of informed consent.
Emory study teams cannot begin any human subjects research activities for a study ceded to an external IRB until 1) the ***Reviewing IRB*** has formally agreed to assume IRB oversight via a ***Reliance Agreement***, 2) institutional signoff has been given by the Emory IRB, and 3) the ***Reviewing IRB*** has approved the Emory study team's involvement in the research.

When Emory relies on another IRB for review, the research is included in the Emory HRPP audit and compliance program.

When ceding review to an external IRB, Emory officials may not approve research that was disapproved by the external IRB.

Transferring IRB Oversight
It is Emory policy that the same IRB retains oversight responsibility for a specific research project throughout the life of the project. However, it is sometimes appropriate to transfer the review responsibility from the Emory IRB to a non-Emory IRB, or vice versa.

Transfer shall be accomplished in an orderly way that assures continuous IRB oversight with no lapse in either IRB approval or the protection of human subjects, and with minimal disruption of research activities. All transfer decisions must be approved in advance by Emory IRB. Transfer

requests from investigators will not be considered except under justifiable circumstances.

Transfer to Emory: When a study is transferred from a non-Emory IRB to the Emory IRB, the Emory IRB shall perform a complete review of the study, or in some cases, a continuing review. The transfer is not considered to be completed until the Emory IRB has approved the transferred study and ***Reliance Agreements*** have been executed if applicable.

Transfer from Emory: Emory IRB has the authority to require the transfer of an Emory IRB-approved study to another institution when the lead researcher moves to that institution, if Emory is no longer "engaged," transfer becomes required as a condition of participation by the sponsor or lead site, and/or Emory believes IRB oversight would be best accomplished by the other institution.

IRB Shopping

The Emory IRB does not permit Emory investigators to request IRB review from another institution when Emory has previously disapproved the protocol. Requests for transfers to or from Emory IRB will not be approved if, in the judgment of Emory IRB, the request for a transfer constitutes "IRB shopping" or the practice of submitting protocols to multiple IRBs until one is found that will approve a protocol.

Multi-Site DOD Research

The Emory IRB may serve as the reviewing IRB for DoD studies. Participating sites shall enter into written agreements that include the following elements: (a) statement of work and specific assignment of responsibilities; (b) description of the research; (c) specific roles and responsibilities of each institution; (d) responsibility for scientific review and IRB review; (e) description of recruitment of subjects and provisions for obtaining informed consent; (f) provisions for oversight and monitoring, reporting requirements, document retention and compliance. Collaborators at each site must ensure compliance at their sites with all applicable requirements, and if reliance is placed upon another IRB for review and oversight, that reliance may not compromise any standards or requirements.

AVAHCS Research

For an **AVAHCS *Multi-Site Study***, not only the ***Principal Investigator,*** but also all local site Researchers, must obtain written approvals from the relevant local VA facilities' IRBs of record and all other local committees, subcommittees, and other approvals according to the respective applicable local, VA and other federal requirements. Research cannot be initiated at any given site until the local Researcher has obtained a signed agreement that addresses the responsibilities of each party, including ownership of data and re-use of data for other research and written notification that the research can be initiated from the local associate chief of staff for research and development.

Collaboration is encouraged when non-VA researchers have a substantial role in the design, conduct, or analysis of research.

The provision of services by the Emory IRB to the AVAHCS and the ***Foundation for Atlanta Veterans Education and Research*** (FAVER) is established through the ***AVAHCS Memorandum of Understanding*** that outlines the responsibilities of the AVAHCS/FAVER and Emory University

through its Emory IRB. See also the P&P *entitled Human Subjects Research at Atlanta Veterans Affairs Health Care System/Foundation for Atlanta Veterans Education and Research*.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109, 56.111, and 56.112
38 CFR Part 16, including 16.102, 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.102, 46.103, 46.109, 46.111, and 46.112
SECNAVINST 3900.9D, 2006
SECNAVINST 3900.39E CH-1, 2018

16 LOCAL RESEARCH CONTEXT – RESEARCH CONDUCTED AT NON-EMORY SITES

POLICY:

In reviewing ***Research*** protocols that will be conducted at international or other non-Emory University sites, the Emory IRB must have sufficient knowledge of the local ***Research*** context in order to fulfill its responsibilities under its FWA and to comply with all applicable required standards. In particular, the IRB must be sensitive to community attitudes and be able to ascertain the acceptability of proposed Research in terms of institutional commitments and regulations; applicable law; and standards of professional conduct and practice. All policies and procedures that are applied to research conducted domestically will be applied to research conducted in other countries, as appropriate, including oversight of the following: initial review, continuing review, and review of modifications; post-approval monitoring; and handling of complaints, noncompliance, and UPs.

For protocols conducted or supported by the ***DOD***, the Emory IRB must ensure that DOD-mandated additional safeguards are in place.

PROCEDURES:

Requirements of OHRP Regulations
In accordance with federal regulations, the Emory IRB, in reviewing ***Research*** protocols that will be conducted at a non-Emory site, must have obtained sufficient knowledge about the local research context to ensure that adequate protections are in place for the conduct of the ***Research*** in that geographic location. ***Federal Regulations*** require that IRBs be knowledgeable about the local ***Research*** context as demonstrated by fulfillment of the following criteria:

- The IRB's composition must be adequate in light of the scope of the institution's ***Research*** activities, types of subject populations, appropriateness of proposed review procedures in light of probable risks, and the size and complexity of the institution.
- The IRB's members must be sufficiently qualified through their experience and expertise and diversity, including race, gender, cultural background, and sensitivity to such issues as community attitudes to promote respect for the IRB's advice and counsel.

- The IRB must be able to evaluate ***Research*** in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice.
- The IRB must also be capable of ensuring that the selection of subjects is equitable, privacy and confidentiality of subjects is maintained, informed consent is sought in language understandable to the subject and in circumstances that minimize the possibility of coercion, and that there are appropriate safeguards protecting vulnerable subjects.

Requirements of FDA Regulations

For the purposes of ***Research*** that may be subject to regulation by the ***FDA***, the ***FDA Regulations*** contain essentially the same requirements as those set forth above in the provision entitled **Requirements of *HHS Regulations***. Both ***HHS*** and ***FDA Regulations***, as well as other Federal regulations may apply to the same ***Research*** protocol. Alternatively, either ***HHS*** or ***FDA Regulations*** may apply to a ***Research*** protocol.

Requirements of HIPAA Privacy Rule
HIPAA is a US regulation and does not apply to international research. In very rare circumstances, data brought to Emory from international sites may be covered by HIPAA.

Demonstration of Sufficient Knowledge of Local *Research* Context
In reviewing ***Research*** to be conducted at an international or other non-Emory site, the Emory IRB must demonstrate that it has obtained sufficient knowledge about the local ***Research*** context to review the ***Research*** to be conducted in that geographic location in accordance with the standards established by OHRP. The level of local knowledge required is based on the degree of risk presented by the ***Research***. The OHRP standards include the following:

> ***Minimal Risk*****:** When the ***Research*** involves ***Minimal Risk*** to the participants, the IRB should obtain the necessary information about the ***Research*** context through written materials or discussion with appropriate consultants.
>
> **Greater than *Minimal Risk*:** When the ***Research*** involves greater than ***Minimal Risk*** and the ***Investigator*** and/or study personnel will have ***Interaction*** or ***Intervention*** with the participants, the IRB should obtain the necessary information about the local ***Research*** context through one or more of the following mechanisms or through other mechanisms deemed appropriate by OHRP for the proposed ***Research*** and local ***Research*** context, before the study commences enrollment:
>
> > Personal knowledge of the local ***Research*** context on the part of one or more IRB members;
> >
> > Participation (physically or by telephone conference) by one or more appropriate consultants in a convened IRB meeting. Such consultant(s) should have personal knowledge of the local ***Research*** context;
> >
> > Prior written review of proposed ***Research*** by one or more appropriate consultant(s) with personal knowledge of the local ***Research*** context;
> >
> > Reciprocal and documented interchange between the IRB and elements of the local ***Research*** context.
> >
> > Documentation of local IRB or ethics committee approval

Other Factors that May be Considered by the Emory IRB in its Review of the Research and Consideration of Local *Research* Context

The extent of training in human subjects research ethics of study staff. Study staff includes all personnel engaged in human subjects research, including non-Emory local study staff. If local study staff are under local ethics committee oversight, then that committee's requirements take precedence.

The qualifications of the researchers and research staff for conducting research in the country or area;

Coordination and communication with local IRBs when appropriate;

The economic prosperity of the area in which the ***Research*** is to take place;

The influence of local officials on the population;

If the Research is in another country, whether the country or area allows foreign visitors;

The nature of the procedures conducted;

The literacy rate of the area;

Local laws, including the local legal rights of the population (such as legal age of adult consent, any mandatory reporting issues, and laws relevant to sub-populations such as women in general, unmarried v. married women, children, etc.);

How complaints will be reported and to whom;

The relevance of the ***Research*** to the local population's needs and interests;

The possibility of including officials from the area in the monitoring of the ***Research***;

The likelihood for the subject population to benefit from the results of the research; and

The local standards of care for relevant medical conditions.

The Emory IRB must also assure that adequate provisions are made for data and safety monitoring and take into consideration that some foreign IRBs or Ethics Committees may not require ***Continuing Review*** of approved ***Research***. The Emory IRB, however, should ascertain that the local IRB's approval period is consistent with all applicable regulations.

Consideration of Issues Associated with Informed Consent
In reviewing ***Research*** to be conducted at an international site or other non-Emory site, in addition to ensuring that the elements of ***Informed Consent*** are met, (as established in **Chapter 41**, *entitled: Informed Consent Policy*), the Emory IRB will consider the following issues:

Disclosure of information to individuals who may be unfamiliar with and distrustful of the concepts:

Differences in societal and cultural norms;

Differences in the role of women and gender minorities, compared to men, in society;

Differences in the role of family and community in the consent process;

Multiple local languages; and

Literacy level.

The informed consent documents must be in a language appropriate to the location of the ***Research***, and understandable to the proposed participants.

Informed Consent Translations – documents used with the subjects will need to be reviewed in English by Emory's IRB. For Non-***Exempt Research***, a translated version will need to be submitted to Emory's IRB as well after initial IRB approval.

The translation may be done by a ***Certified Translator*** (certification will need to be provided along with the translated documents to the IRB). If a Qualified Translator cannot be used, the following options are acceptable:

- A back translation can be done (one person translates the documents into the language and a different person translates the translation back into English
- The TRAPD team translation model may be utilized.
- Machine translation may be used with review for accuracy by a bilingual individual, when approved by the IRB.

Documentation Required from PI

Commencement of human subjects research activity will be contingent upon receipt of the following documentation for Research that takes place at an international or other non-Emory site (this contingency may be noted in a pending approval letter, or in a full approval letter for cases where the other site's IRB will not approve without documentation of full Emory IRB approval)

For an international or other non-Emory site ***Engaged in Human Subjects Research***:

A local IRB (Ethics Committee) approval letter for the proposed Research, if an IRB (or Ethics Committee) exists;

If the study is federally funded, then an OHRP-approved FWA for the international or other non-Emory institution or site is required.

For an international or other non-Emory site not ***Engaged in Human Subjects Research***:

For studies which are more than minimal risk, local IRB/IEC review or documentation of appropriate legal regulatory consultation is required for any

international sites (both may be required by Emory University for certain Clinical Trials).

For studies which are no more than minimal risk, local IRB/IEC review is recommended. When the international or other non-Emory site cannot obtain IRB/IEC review, a letter of cooperation showing that the appropriate institutional or oversight officials are permitting the research to be conducted at the site is required, along with a Cultural Context Letter. See IRB website for template language.

See also the P&P section entitled*: Emory IRB Relationships with Other Institutions; Reliance Arrangement for IRB Review*.

As appropriate, the IRB may require copies of monitoring reports of the research under review.

Type of IRB Review
The Emory IRB shall apply all relevant rules to determine whether Research conducted at non-Emory sites is eligible for Exempt or Expedited review, or if it requires ***Full Committee Review***.

Research Subject to VA Regulations
As with other research, before approving international research involving human subjects research, the IRB must ensure that human subjects outside of the U.S. who participate in research projects in which VA is a collaborator receive equivalent protections as research participants inside the U.S. if the activity involves human subjects research requiring IRB approval or limited IRB review. International research may not be initiated unless permission is obtained from the facility director.

Additional Safeguards Mandated for Protocols Conducted or Supported by the DOD
When such ***Research*** is conducted outside of the U.S. or U.S. territories or possessions and that involves subjects who are not U.S. citizens or DOD personnel must meet the following requirements:

(a) Permission of the host country to conduct the research in the form of a certification or review by host country ethics board.
(b) Compliance with laws, customs, and practices of the host country.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.111
45 CFR Part 46, including 46.103, 46.107, 46.111, and 46.116
FDA Guidance for Institutional Review Boards and Clinical Investigators: Non-Local IRB Review, January 1998
DOD Instruction 3216.02, 2022
SECNAVINST 3900.39D, 2006
SECNAVINST 3900.39E CH-1, 2018

17 HUMAN SUBJECTS RESEARCH AT THE ATLANTA VETERANS AFFAIRS HEALTH CARE SYSTEM (AVAHCS)/FOUNDATION FOR ATLANTA VETERANS EDUCATION AND RESEARCH (FAVER)

POLICY:

The provision of services by the Emory IRB to the ***Atlanta Veterans Affairs Health Care System*** (AVAHCS) and to the ***Foundation for Atlanta Veterans Education and Research*** (FAVER) is established through the ***AVAHCS Memorandum of Understanding*** that outlines the responsibilities of the AVAHCS/FAVER and Emory University through its IRB. The Emory IRB is designated as the ***Reviewing IRB*** for the AVAHCS/FAVER pursuant to these entities' respective FWAs.

Protocols reviewed by the Emory IRB on behalf of the AVAHCS/FAVER receive the same IRB review, both initial and continuing, as those conducted at Emory University; provided, however, that Emory shall assure that ***AVAHCS Research*** or other VA-supported ***Research*** shall not be assigned to a commercial or sociobehavioral IRB for review. The Emory IRB does and shall continue to meet all Department of Veterans Affairs requirements for an affiliate human studies subcommittee of the ***AVAHCS Research & Development Committee*** (hereafter referred to as "RDC").

PROCEDURES:

Relationship between Emory IRB and RDC: The AVAHCS has a Research and Development Committee that reviews ***AVAHCS Research*** protocols. Review of an ***AVAHCS Research*** protocol by the RDC is in addition to, and not in lieu of, Emory IRB review and approval.

AVAHCS Responsibilities: The AVAHCS remains responsible for ensuring compliance with the Emory IRB's determinations and with the terms of its own FWA. Specifically, the AVAHCS shall be responsible for reviewing all Emory IRB determinations for ***AVAHCS Research.*** Neither the RDC nor the AVAHCS may overrule disapprovals made by the Emory IRB regarding human subjects research protocols. In addition, the AVAHCS may defer to the Emory IRB when making determinations of non-human subjects research.

The AVAHCS shall conduct a quality assurance program for ***Human Subject Research*** protection in conjunction with the Emory IRB on an on-going basis. Findings and follow-up from any review will be shared with the Emory IRB. AVAHCS will staff the Emory IRB with a VA-IRB liaison to serve as the person responsible for processing AVAHCS studies through the IRB. The VA-IRB liaison will function as a staff member of the IRB with knowledge of VA policies pertaining to human subjects. They will serve as the subject matter expert to the IRB on VA issues.

See the end of this chapter for further responsibilities of the VA Facility Director with regards to the AVAHCS HRPP, not otherwise stated in these Policies and Procedures.

Documentation of Relationship: The AVAHCS and Emory University have entered into the following agreements regarding IRB arrangements:

Federalwide Assurance (FWA): Emory University, Atlanta Veterans Affairs Health Care System (AVAHCS), and Foundation for Atlanta Veterans Education and Research (FAVER) have entered into Federalwide Assurances (FWAs) with OHRP. Under these FWAs, Emory University operates the Emory IRB, which is the designated IRB for AVAHCS and the FAVER. Current information regarding the Emory FWA (FWA 00005792), the AVAHCS, Decatur FWA (FWA 00002551), and FAVER (FWA 00003511) can be found at the following OHRP website: https://ohrp.cit.nih.gov/search/fwasearch.aspx?styp=bsc.

Memorandum of Understanding: Emory University, AVAHCS, and the FAVER have documented their relationship through the ***AVAHCS Memorandum of Understanding.*** The Emory IRB is subject to and agrees to abide by the terms of its FWA: Number FWA00005792 (the ***Emory FWA).*** The Emory IRB agrees to provide initial review and continuing oversight of ***AVAHCS Research*** in accordance with the terms and conditions of the ***Emory FWA*** and per the requirements set forth in these P&Ps.

Adherence to VA Regulations in Review of AVAHCS Research: The Emory IRB agrees to apply and adhere to all applicable VA Regulations in reviewing AVAHCS Research and any other VA-supported Research submitted to the Emory IRB for review.

Review of AVAHCS Research by Emory IRB Committees: Emory shall ensure that submitted ***AVAHCS Research*** and other VA-supported ***Research*** is reviewed by an Emory *IRB Committee*, as required by ***VA Regulations***, any other applicable regulations and these P&Ps. This includes review of AVAHCS research and other VA-Supported research by the other regulatory committees as laid out in P&P 13 (Emory IRB Relationships with other Regulatory Committees). In accordance with ***VA Regulations*** Emory shall not assign ***AVAHCS Research*** or other VA-supported ***Research*** to a commercial or sociobehavioral IRB (e.g., WIRB or Emory's sociobehavioral IRB) for review, nor shall it assign review of a VA protocol without a prior written agreement.

Emory IRB Minutes: Emory IRB will make available to the AVAHCS Research Office complete unredacted copies of approved Emory IRB meeting minutes, as they pertain to AVAHCS studies.

Review Process -- ***AVAHCS Research*** **Protocols and Other Items Requiring both RDC Review and Approval and Emory IRB Approval:** Listed below are the AVAHCS items requiring review by both the Emory IRB and the RDC. In general, approval should first be obtained from the Emory IRB before being submitted for review and approval or acknowledgement by the RDC:

- ***AVAHCS Research*** protocols (initial and continuing review);
- Modifications/amendment to ***AVAHCS Research*** protocols;

The IRB should consider the relevance of the research to the mission of VA and the Veteran population it serves.

Initial Review Process for *AVAHCS Research* Protocols:

Review Type: The Emory IRB determines the appropriate review type for ***AVAHCS Research*** (e.g., review by ***Full Committee Review, Expedited Review,*** etc.) in accordance

with these P&Ps and VHA Directive 1200.05. ***AVAHCS Research*** protocols which undergo ***Expedited Review*** shall be reviewed by a designated IRB voting member. ***AVAHCS Research*** protocols which undergo a determination that the ***AVAHCS Research*** is exempt from IRB review shall be reviewed by either IRB administrator or IRB staff who have appropriate training and experience to make exempt determinations (in addition to the designated IRB voting members).

Communication of Approval/Concerns: Following review of an ***AVAHCS Research*** protocol, the Emory IRB will provide the RDC with a copy of the correspondence sent to the PI setting forth whether the protocol has been granted ***Approval, Approval Pending, Deferral*** or ***Disapproval,*** and the reason(s) if applicable, if other than approval. Any concerns or criteria for approval of the ***AVAHCS Research*** protocol also may be communicated to the RDC via the AVAHCS representatives sitting on the ***IRB Committee*** that reviewed the protocol at issue. The approval letter sent to the PI will indicate the effective dates of the approval.

Review by RDC: The RDC shall review the ***AVAHCS Research*** protocol with regard to ensuring that any AVAHCS requirements for the protection of ***Human Subjects*** have been met, that the study is meritorious, and the scientific objectives are valid, and that the informed consent form used in the protocol conforms to AVAHCS standards. The RDC is permitted to assign scientific review and some administrative responsibilities, including compliance issues, to more appropriate subcommittees and individuals. In its review, the RDC may take into consideration any items or concerns raised by the Emory IRB. The RDC shall provide the Emory IRB with correspondence to the PI detailing any ***Human Subject*** protection concerns that the RDC identifies during its review of the protocol by copying the Emory IRB on the approval letter as needed. In the event that the RDC restricts or limits the ability of an investigator to perform research, the RDC shall notify the Emory IRB immediately and provide the Emory IRB with copies of any minutes or other documentation pertaining to the RDC's review or oversight of a protocol that is subject to Emory IRB jurisdiction. The RDC and facility director have the authority to suspend or terminate their approval of research.

PI Response: The PI shall respond to any items or concerns regarding the ***AVAHCS Research*** protocol being reviewed directly to the committee that raised the item/concern, whether that is the RDC or the Emory IRB. The RDC and the Emory IRB shall make independent determinations based upon PI responses but shall share their respective decisions with each other as needed.

Approval by Emory IRB and RDC Required: In order to proceed with the ***AVAHCS Research*** protocol, the PI must have the final ***Approval*** of both the Emory IRB, the AVAHCS privacy officer, AVAHCS information security officer, and the RDC. In the event that the RDC overrides an ***Approval*** by the Emory IRB, the PI must not commence any part of the ***AVAHCS Research*** protocol unless and until all concerns have been addressed and each committee grants its final ***Approval***. The RDC may not approve an ***AVAHCS Research*** protocol that has been ***Disapproved*** by the Emory IRB.

HIPAA Waiver Approval: The Emory IRB must review and approve all ***Waivers of HIPAA Authorization*** for ***AVAHCS Research*** protocols and otherwise provide review for

AVAHCS Research in accordance with the ***HIPAA Regulations.*** VA HIPAA Authorizations shall be in a format that is approved by the AVAHCS.

Use of AVAHCS Approved Forms: PIs who wish to perform ***AVAHCS Research*** protocols must use the standard AVAHCS informed consent template and the AVAHCS ***HIPAA Authorization*** template and/or combined consent and HIPAA authorization template found at the Atlanta VA research website. The Emory IRB and the RDC shall review all completed informed consent templates and confirm that all Emory and VA-required elements are included in the final version of each of these forms. The VA Privacy Officer must review the ***HIPAA Authorization*** to ensure it contains all required elements and is consistent with all privacy requirements before the PI can begin to use or collect the individual's information based on an approved research protocol.

Continuing Review of AVAHCS Research Protocols: The ***AVAHCS Research Office*** maintains information on the approval periods of all AVAHCS-associated projects with information obtained from Emory IRB approval letters and from the Emory IRB database for ***AVAHCS Research.*** The Emory IRB sends PIs expiration notices for their ***AVAHCS Research*** protocols, but PIs are ultimately responsible for monitoring the approval periods for their ***AVAHCS Research*** protocols. Copies of continuation approvals and newly approved/stamped informed consent forms are sent by the VA IRB Liaison or designee directly to the ***AVAHCS Research Office.***

Review of Amendments and Modifications to *AVAHCS Research* Protocols:
Any amendment to or modification of an ***AVAHCS Research*** protocol must be approved by the Emory IRB. If the amendment addresses an issue related to biosafety or radiation safety, then the changes must be reviewed by the appropriate VA regulatory committee and approved by it before IRB approval. PIs must submit amendments/modifications directly to the Emory IRB for review. Once an amendment/modification has received approval from the Emory IRB, the RDC chair acknowledges the amendment unless the nature of the amendment/modification, as determined by the RDC chair, requires review by the full RDC. Amendments or modifications to ***AVAHCS***.

Protocol Approval Expirations: Failure on the part of the PI to submit a protocol for continuing review prior to the protocol's expiration date shall result in expiration of the protocol and immediate termination of all research-related activities, except for limited subject safety measures, as delineated by federal regulations. The AVAHCS accepts all decisions made by the Emory IRB regarding expired IRB approvals.

Protocol Closures: The AVAHCS accepts all ***Closure*** decisions made by the Emory IRB. In the event that an ***AVAHCS Research*** protocol is ***Closed*** by the Emory IRB, but the project underlying the protocol remains active (e.g., for an animal component of the project to be completed), then the project is considered to be active by the AVAHCS, but it is not considered to be an IRB-approved ***AVAHCS Research*** protocol, and no activity with ***Human Subjects*** may take place, except as otherwise authorized by the Emory IRB in accordance with ***HHS, FDA*** and ***VA Regulations.***

Protocol Suspensions and Terminations: Any termination or suspension by the IRB related to concerns about the safety, rights, or welfare of human research subjects, research staff, or others must be reported in writing to the AVAHCS Director, ACOS-R and RDC in a timely manner

after the termination or suspension occurs. The facility director must report the termination or suspension to the appropriate Office of Research Oversight research officer within five business days after receiving such notification.

Reportable Events, Protocol Deviations/Noncompliance: Reporting Serious Adverse Events and Problems Involving Risks to Subjects or Others in ***AVAHCS Research are reported to the Emory IRB and are routed to the AVAHCS Research Office and RDC.*** Please note that definitions and reporting timelines and thresholds may be different (more stringent) for **VA Research**. Please see specific guidelines for reporting found at Atlanta VA Health Care System Research Website:

https://www.atlanta.va.gov/services/research/Conducting_Human_Research.asp

Reporting Protocol Deviations and/or Noncompliance in ***AVAHCS*** Human Subjects Research to the Emory IRB and RDC is dependent upon the nature and severity of the protocol deviation and/or noncompliance. Specific guidelines for reporting Protocol Deviations and Noncompliance are found at:

https://www.atlanta.va.gov/services/research/Conducting_Human_Research.asp

Reporting to Governmental Regulatory Authorities: As described in the P&P entitled Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel The Emory IRB will rely on the AVAHCS to make any necessary reports to governmental regulatory authorities. These reports will be made by the AVAHCS Institutional Official (the AVAHCS Director), through the AVAHCS Research Compliance Office. The AVAHCS Research Compliance Office will prepare reports documenting any determinations regarding ***AVAHCS Research*** to all necessary regulatory authorities, (such as OHRP, FDA or other governmental agencies) with copies being sent to the ***AVAHCS Research*** Office, the Chair of the RDC, the VA Office of Research and Development and to the Regional VA Office of Research Oversight.

Recruitment of Volunteers for *AVAHCS Research*, including Non-Veterans: The Emory IRB shall follow the P&P entitled *Recruitment of Subjects* with regard to recruitment of subjects for ***AVAHCS Research***. To improve veterans' access to non-VA research, advertisements for research not conducted at a VA facility may be posted, provided facility director ensures there is a formal process to review and approve recruiting documents, flyers, and advertisements prior to being posted or distributed. A VA facility may not use Facebook as a method of advertising non-VA studies.

Please refer to local ***AVAHCS*** policies and guidelines for assistance at: https://www.va.gov/atlanta-health-care/.

Classified Research: Classified research involving human participants cannot be approved by a VA facility IRB or affiliate IRB or Research and Development Committee or performed at VA facilities.

RDC and *AVAHCS Research Office* Procedures: The procedures followed by the RDC and the ***AVAHCS Research Office*** with regard to review and documentation of matters involving the Emory IRB are set forth in the VHA Directive 1200.05 and VHA Directive 1200.01.

Roles and Responsibilities of the AVAHCS Facility Director in relation to the AVAHCS HRPP: The facility director serves as the IO for the medical facility and oversees the facility's research program. The IO is responsible for the creation and implementation of an HRPP for research involving human subjects. The IO's responsibilities for the facility's HRPP include, but are not limited to:

- Delegating authority in writing for respective roles and responsibilities for the HRPP. This delegation of authority must provide the organizational structure and ensure leadership for oversight activities for all human subjects research conducted at or by the facility.
- Ensuring that the institution's HRPP functions effectively and that the institution provides the resources and support necessary to comply with all requirements applicable to research involving human subjects;
- Overseeing the R&D Committee, IRB, and other applicable subcommittees of the R&D Committee, facility research office, and all VA investigators and VA research staff who conduct human subjects research at that facility;
- Ensuring independence of the IRB;
- Serving as the official representative of the institution to external agencies and oversight bodies, and providing all written communication with external departments, agencies, and oversight bodies;
- Ensuring that a documented procedure is in place for determining when a research activity approved by the IRB, prior to January 21, 2019, can transition to the 2018 Requirements, if applicable. The documented procedure must list what individuals or groups are designated to make the determinations. NOTE: Investigators may not make a determination that their studies can be transitioned to the 2018 Requirements;
- Ensuring appropriate documentation of required actions and responsibilities pertaining to review, approval, conduct, and oversight of human subjects research conducted at the AVAHCS
- Ensuring all human subjects research is reviewed and approved by an IRB and will be subject to oversight by the IRB. NOTE: Research that falls within the exempt categories required to be submitted to the IRB for a determination, but is not subject to review by an IRB member unless it is determined to meet one of the exempt categories requiring limited IRB review. All exempt research must be reviewed and approved by the R&D Committee
- The RDC, ORD, and the AVAHCS facility director are the only officers who can disapprove research studies.
- Ensuring that any IRB operated by the VA facility is established in accordance with the requirements of VHA Directive 1200.05 and registered through ORO with the HHS OHRP. NOTE: A VA facility may not use a commercial IRB as an IRB of Record;
    - When the facility engages the services of another entity's IRB as its IRB of Record, the IO is responsible for:
        - Establishing and signing a Memorandum of Understanding (MOU) or Authorizing Agreement with other VA facilities or external organization(s) providing IRB services (see VHA Handbook 1058.03 and MOU Checklist: http://www.va.gov/ORO/orochecklists.asp); Ensuring that external IRBs of Record used by the VA facility hold current IRB registrations with FDA/OHRP and provide updates to membership as required by VHA Handbook 1058.03;

Applicable Regulations, Policies, and Guidance:

38 CFR Part 16
45 CFR Part 46, including 46.103
VHA Directive 1058.01, 2020
VHA Directive 1200.01(01), 2021
VHA Directive Section 1200.05(2), 2021

18 DEPARTMENT OF DEFENSE (DOD) SUPPORTED RESEARCH

POLICY: Research conducted by or at Emory University that is conducted or supported by the Department of Defense or one of its components (i.e., Army, Navy, Marine Corps or Air Forces) requires compliance with additional regulations, directives and instructions specific to the DOD and/or the component that is involved. Research that recruits personnel from DOD or one of its components as participants also is subject to these additional requirements. Support for the research may come from a grant, contract, subcontract, cooperative agreement or other funding arrangement.

Important Note: DOD policies and requirements do *not* apply when DOD personnel incidentally participate as subjects in research that is not supported by DOD, and DOD personnel are not an intended population of the research.

DEFINED TERMS:

Department of Defense (DOD) Regulations: The rules set forth by the Office of the Secretary of Defense through Title 32 of the Code of Federal Regulations (CFR), Part 219.

Department of Defense (DOD) Requirements: All mandates set forth in the regulations set forth at 32 CFR Part 219 and any DOD unit specific mandates, i.e., mandates specific to the DOD unit (Navy, Marine Corps, etc.) that is conducting or supporting the research.

Research Involving a Human Being as an Experimental Subject: For projects conducted or supported by the DOD, this term means an activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Examples of interventions or interactions include, but are not limited to, a physical procedure, a drug, a manipulation of the subject of subject's environment, the withholding of an intervention that would have been undertaken if not for the research purpose. This term does not include:

- Activities carried out for the purposes of diagnosis, treatment or prevention of injury and disease in members of the Armed Forces and other mission essential personnel under Force Health Protection programs of the Department of Defense.

- Authorized health and medical activities as part of the reasonable practice of medicine or other health professions.

- Monitoring for compliance of individuals and organizations with requirements applicable to military, civilian or contractor personnel or to organizational units. This includes activities such as drug testing, occupational health and safety monitoring and security clearance reviews.

Minimal Risk: In Research funded or conducted by the Department of Defense, the definition of ***Minimal Risk*** based on the phrase "ordinarily encountered in daily life or during the performance of routing physical or physiological examinations or tests" is not interpreted to include the inherent risks certain categories of human subjects face in their everyday life. For example, the risks imposed in research involving human subjects focused on a special

population should not be evaluated against the inherent risks encountered in their work environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain).

PROCEDURES:

1. DOD supported Research requires compliance with additional rules, regulations, directives and instructions. Researchers must notify the Emory IRB of any DOD support for their research and provide the information requested below so that additional requirements can properly be identified and followed. These additional requirements include, but are not limited to the following:
    a. **Education**: The Researcher and all personnel who conduct the DOD supported Research must complete initial and continuing ethics education: (a) CITI training as required by the Emory IRB for the individual's role; (b) any specific education or certification required by a particular DOD funding unit. The Researcher should contact the DOD liaison for information on any such requirements and communicate them to the Emory IRB in the initial IRB submission. The IRB will verify that the specific requirements are met before issuing final approval of the research study. The DOD Component may evaluate the education policies to ensure the personnel are qualified to perform the research, based on the complexity and risk of the research.
    In addition, all personnel involved in reviewing, approving, supporting, conducting, managing, or overseeing research involving human subjects must complete initial and ongoing research ethics and human subject protections training appropriate to each individual's level of involvement, duties, and responsibilities. In addition to the basic and refresher CITI modules required of all IRB members, and the basic CITI modules and continuing education requirements for the IRB staff, the Emory IRB analyst assigned to a DOD-supported study, with assistance from the PI, will determine from the Sponsor the need for orientation and/or education of the IRB chair, members involved in the review of the research study, IRB staff, and Institutional Official per any additional education requirements of the particular DOD funding unit. The IRB will verify that the specific training requirements for these personnel are met prior to issuing final approval of the research study.
    b. **Scientific Review**: The IRB must consider the scientific merit of the research. The IRB may rely on outside experts to provide an evaluation of the scientific merit. Scientific review by another site in a multisite study may be sufficient. Evidence of this review must be provided to the Emory IRB. See IRB P&Ps entitled *Number of IRBs and Registration and IRB Policy & Procedure* and *Criteria for Emory IRB Approval of Research* for additional information regarding this review requirement.
    c. **International Research**: When the Research is to be conducted outside of the U.S. or its territories and involves participants who are not U.S. citizens or DOD personnel, it requires the written permission of the host country and compliance with the host country's laws, regulations and customs. See Emory IRB P&P *Local Research Context; Research Conducted At International Performance Sites* for additional information regarding international DOD supported research.

d. **Classified Research:** Non-exempt classified research must be conducted following the requirements of DOD Instruction 3216.02.13
e. **Reporting Requirements**: DOD supported research requires prompt to DOD HRPO of serious and continuing non-compliance, as well as other events. See Emory IRB P&P entitled *Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel* for additional information regarding these requirements.
    i. The following must also be reported promptly to the DOD HRPO. This reporting should be done by the researchers:
        1. Significant changes to the research protocol after approval by the IRB
        2. The results of IRB continuing review
        3. Change of reviewing IRB
f. When the organization is notified by any Federal department, agency or national organization that any part of an HRPP is under investigation for cause involving a DOD-supported research protocol ***Multi-Site Research***: For DOD-supported ***Multi-Site Research***, a written agreement must be in place among Emory and the other sites. In the case of an Army supported project, the Army will generate this agreement as a contract. For other DOD components, Emory will work with the researcher to generate the agreement. See also Chapter 15*, Emory IRB Relationships with Other Institutions*, for more detail.
g. **Survey or Questionnaire Research**: Research that involves such survey(s) must be separately approved by the appropriate DOD unit after the Emory IRB approves the research protocol. Surveys administered to DOD personnel must be submitted and reviewed and approved by the DOD after the research protocol is reviewed and approved by the IRB. When a survey is administered across multiple DOD Components additional review is required. See Emory IRB P&P entitled *Exempt Research* for additional information regarding DOD supported research involving surveys/questionnaires.
h. **Greater Than Minimal Risk Research**: For DOD-supported research that is greater than minimal risk, a named, independent research monitor must be appointed. See IRB Policy & Procedure -- *Data and Safety Monitoring Plans* for details regarding the types of persons who may serve as research monitors and the monitor's responsibilities.
i. **Research Related Injury**: DOD supported research requires the research site to make arrangements for the provision of treatment for research related injuries and some DOD components require that participants not bear any costs related to such treatment. Researchers should contact their DOD funding unit's liaison to determine specific requirements. See IRB Policy and Procedure – Informed Consent Policy for additional information regarding research related injury requirements.
j. **Waiver of Informed Consent**: In order for a waiver of informed consent to be permitted for DOD supported Research, the IRB must determine that the research participants for whom consent is to be waived do not fall within the category of "experimental subjects" as set forth within the term "***Research Involving a Human Being as an Experimental Subject***." The full definition of this term and other information regarding waiver of informed consent for DOD

supported research can be found in IRB Policy and Procedure – *Waiver or Alteration of Informed Consent for Research.*

k. **Planned Emergency Research** – For DOD supported research, the Secretary of Defense must waive the requirement of informed consent for planned emergency research. See IRB Policy and Procedure – *Waiver of Informed Consent for Planned Emergency Research*.

l. **Investigational Drugs, Biologics & Devices** – Certain DOD requirements may not apply when investigational drugs, biologics or devices are used for Force Health Protection in accordance with DOD Directive 6200.2 – Use of Investigational New drugs for Force Health Protection (Aug. 1, 2000). [See SECNAVINST 3900.39D Para. 4b (5)].

m. **Recruitment of Subjects** – Additional DOD requirements must be followed for Research that recruits DOD personnel or U.S. military personnel as subjects. See IRB Policy and Procedure – *Recruitment of Subjects for a description of these additional requirements.*

n. **Vulnerable Populations** – DOD supported Research that affects vulnerable classes of subjects (e.g., fetuses, pregnant persons, and human in vitro fertilization; prisoners; or children) shall meet the protections of 45 CFR Part 46, Subparts B, C, and D. See IRB Policy & Procedure – *Review of Research Protocols Involving Vulnerable Populations* and IRB Policy & Procedure - *Research Involving Pregnant Women, Human Fetuses and Neonates – Additional Protections* for more details and definitions specific to DOD supported Research.

o. **Prisoners of War** – DOD supported research prohibits the use of Prisoners of War as human subjects. See IRB Policy & Procedure – *Research Involving Prisoners – Additional Protections for details and definition of Prisoners of War*.

p. **Surrogate Consent** – The IRB must determine that a study is intended to benefit a subject before a legally authorized representative can consent on the subject's behalf. See IRB Policy and Procedure – *Legally Authorized Representatives and Surrogate Consen*t.

q. **Research Involving Human Subjects for Testing of Chemical or Biological Agents** – Research in this category is generally prohibited with narrow exceptions for research for prophylactic, protective or other peaceful purposes that is conducted in accordance with 50 U.S.C. Section 1520a. [See DOD Directive 3216.2 Para. 4.4.5].

r. **Research Misconduct** – The University's Policy on Research Misconduct (Policy 7.8) shall apply with respect to all DOD supported research. [See DOD Directive 3216.2 Para. 4.8].

s. **Competing and Conflicting Interests** – IRB Policy and Procedure – Conflict of Interest on the Part of IRB Administrators; IRB Members and Staff Members; Handling Undue Influence of Investigators shall apply to all DOD supported research. In addition, the University's Policy on Conflict of Interest (Policy 4.87) and Policy on Researchers Holding Financial Interests in Research (Policy 7.7) shall apply with respect to all DOD supported research.

t. **Subject Compensation** – If the DOD supported research includes DOD or U.S. military personnel as subjects, then dual compensation restrictions may apply. See IRB Policy and Procedure – Payment of Subjects for details regarding these restrictions.

u. **Record-Keeping** – Record keeping requirements for DOD supported research may vary among the DOD units that are providing the support. Researchers should consult with their DOD liaisons to determine the appropriate requirements. Records maintained that document compliance or non-compliance with DOD regulations must be made accessible for inspection and copying by representatives of the DOD at reasonable times and in a reasonable manner as determined by the supporting DOD component.
v. **Oversight** – The DOD component that supports the Research shall have oversight with respect thereto, including research review and site visits.
w. **Subject Incarceration while participating in a study**: For DOD-supported research, the non-DoD institution must notify the HRPO and other federal agencies, if required. Reference Prisoner chapter here.

2. Researchers who are receiving DOD support for a study must provide the Emory IRB with the following information at the time of their submission of an initial IRB application to the Emory IRB:

a. When Emory is the lead site: State whether the study involves multiple sites, and if so, list the roles and responsibilities of each party at each site participating in the research. A written agreement must be in place among Emory and the other sites (this does not refer to a ***Reliance Agreement***

b. If Emory IRB will serve as the reviewing IRB for a DoD institution: The process for serving as a reviewing IRB/EC for DoD institutions collaborating with non-DoD institutions, including who is responsible and the process they go through to obtain DoD approval for a non-DoD institution to be designated to review for DoD research, including ensuring the following conditions are met (DoDI 3216.02 section 3.5):

- Each institution engaged in non-exempt human participant research must have a current federal assurance of compliance.
- The non-DoD institution's IRB/EC is registered in accordance with Subpart E of 45 CFR 46.
- The DoD institution reviews the protocol to ensure all applicable local and DoD requirements are addressed in the protocol.
- The DoD institution, non-DoD institution, and the non-DoD institution's IRB/EC have a written agreement defining the responsibilities and authorities of each institution in complying with all legal requirements. This agreement must specify that the non-DoD IRB/EC will apply the DoD requirements specified in DoDI 3216.02, including but not limited to non-DoD institutional responsibilities defined under DoD 3216.02 section 3.6(b).
- If the research constitutes classified human participant research, the COHRP must approve the agreement to rely on the non-DoD institution's IRB/EC.

c. State whether the study involves any surveys or questionnaires that will be given to DOD personnel and/or U.S. military personnel. Research that involves such surveys must be separately approved by the appropriate DOD unit after the Emory IRB approves the research protocol.

d. State whether the study involves more than minimal risk. If so, then the appointment of a named, independent research monitor is required. The research monitor must be independent of the study team and their name and CV must be provided to the IRB. (Note: The IRB, in its discretion, also may require a medical monitor for minimal risk studies.)
e. State whether the study, or any part of the study, will be conducted outside of the United States or its territories and involve participants who are not U.S. citizens or DOD personnel. Research in other countries that involves non-U.S. citizens or persons who are not DOD personnel requires the written permission of the host country and compliance with the host country's laws, regulations, and customs. Documentation of such approval and certification of such compliance must be provided to the IRB.
f. State whether the research will include DOD personnel or U.S. Military personnel as participants. If so, the IRB application must specify how the additional requirements set forth in IRB Policy and Procedure– *Recruitment of Subjects* will be met. In addition, certification must be provided that all requirements set forth in IRB Policy and Procedure – *Payment of Subjects* will be followed.
g. State whether a waiver of informed consent is being requested, and if so, state whether participants will fall within the definition of ***Research Involving a Human Being as an Experimental Subject*** (see above). If so, any waiver of consent must be granted by the Secretary of Defense.
h. State whether the research involves prisoners of war.
i. State whether the research involves testing of chemical or biological agents.
j. State whether the research subject population is one for which it is likely that surrogate consent may have to be obtained.
k. State whether research ethics education requirements have been met by all research team members. Documentation of completing educational requirements must be provided to the IRB.

Applicable Regulations, Policies, and Guidance:

32 CFR Part 219
10 U.S.C. 980
DOD Instruction 3210.7, 2018
DOD Instruction 3216.02, 2022
DOD Instruction 6200.2, 2008
OPNAVINST 5300.8C, 2008
SECNAVINST 3900.39E CH-1, 2018

19 EMORY IRB ADMINISTRATION AND OFFICIALS

POLICY:

The President of Emory University appoints an IO who has responsibility for oversight of all IRB activities. The IO appoints an IRB ***Chair*** and ***Vice Chairs*** who are responsible for the conduct and oversight of IRB ***Human Subjects Research*** review activities.

PROCEDURES:

Institutional Official **(IO):**

Appointment, Term and Qualifications of IO: The appointment, term and qualifications of the IO are as set forth above in the P&P entitled *Institutional Authority*.

Qualifications of IO: In order to be eligible for appointment as IO, an individual must be an employee of Emory University who holds a position within the University per which they have the legal authority to act and speak for Emory University as a whole, and per which they can ensure that Emory IRB will effectively fulfill its ***Human Subjects Research*** oversight functions.

Responsibilities of IO: The IO shall have top-level oversight for all Emory IRB activities.

The IO or their delegate shall execute any agreements on behalf of the Emory IRB, including ***Reliance Agreements*** to serve as ***the Reviewing IRB*** for another entity or to rely on another IRB for review of Emory University related ***Human Subjects Research***.

The IO shall be responsible for making any required annual report to appropriate governmental agencies, and for making such other reports to these agencies as are required by law or as the IO deems appropriate or as requested by the IRB ***Chair***.

The IO shall appoint the IRB **Chair** and ***Vice Chairs.***

The IO shall appoint members to ***IRB Committees*** in consultation with the IRB ***Chair*** and ***Director***.

The IO shall provide performance reviews of the IRB ***Chair*** and ***Vice Chairs*** in consultation with IRB ***Director.***

The IO shall provide a performance review of the IRB ***Director*** in consultation with the IRB ***Chair.***

The IO shall consult with IRB ***Chair*** and ***Director*** on performance review of IRB members.

The IO shall perform any other duties assigned to them by the ***HHS, FDA*** and/or ***VA Regulations***, these P&Ps or other applicable University policies and procedures.

Delegation of IO's Duties: The IO may designate in writing additional Emory University administrators to assist them in the performance of their oversight responsibilities. The IO shall specify in writing any responsibilities being delegated.

Performance Review: The Executive Vice-Presidents of Emory University shall review the performance of the IO on an annual basis to ensure that they are acting in full accordance with all applicable policies, laws and regulations.

IRB Chair or Co-Chairs

Appointment and Term: The IO shall appoint the IRB ***Chair or Co-Chairs*** (referred to as "IRB Chair" in remainder of Chapter) in writing. Unless sooner terminated, the IRB ***Chair's*** term shall be for five (5) years from the effective date of appointment set forth in the IO's written appointment document. At the expiration of the IRB ***Chair's*** term, provided the IRB ***Chair*** is in good standing, the IO may re-appoint the IRB ***Chair*** for one or more additional consecutive term(s) without limitation.

Qualifications: The IRB ***Chair*** must be an individual from within Emory University who is fully capable of managing the Emory IRB and the matters brought before it with fairness and impartiality. The IRB ***Chair*** should have the highest educational or professional degree in their field; have extensive knowledge of the conduct of ***Human Subjects Research***; have extensive understanding of and familiarity with laws, regulations, Emory IRB P&Ps, and other applicable Emory University policies and procedures; and have been a member in good standing of the Emory IRB or another IRB for at least two (2) years.

The IRB ***Chair*** shall be a faculty member or employee of a unit of Emory University. The task of making the IRB a respected part of the institutional community will fall primarily on the shoulders of the IRB ***Chair.*** The ***Chair*** must ensure that the IRB is perceived to be fair, impartial, and immune to pressure by the institution's administration, the ***Investigators*** whose protocols are brought before the IRB, and other professional and non-professional sources.

Resignation: The IRB ***Chair*** may resign from their position at any time upon written notice to the IO. The IRB ***Chair*** shall specify an effective date in their resignation. The IO shall appoint an interim or permanent replacement IRB ***Chair*** to begin service upon the effective date of the IRB ***Chair's*** resignation. Any actions taken by the former IRB ***Chair*** after the effective date of their resignation shall be null and void. The IRB ***Chair's*** resignation and the effective date thereof, as well as the appointment of any interim or permanent successor, shall be announced by the IRB ***Director*** at each ***IRB Committee*** meeting that takes place after the resignation notice is received.

Removal: The IO may remove the IRB ***Chair*** from their position at any time that the IO determines in their discretion that the IRB ***Chair*** is not appropriately or adequately fulfilling their job responsibilities, or has violated applicable laws, regulations or Emory University policies or procedures, or has been involved in any activities or neglect of duty that would cause harm to the operations or reputation of the Emory IRB. Upon removal of the IRB ***Chair***, the IO shall appoint an interim or permanent replacement IRB ***Chair.*** The removal of the IRB ***Chair,*** the appointment of any interim or permanent successor and the effective dates of such events shall be announced by the IRB ***Director*** at each ***IRB Committee*** meeting as soon as possible after the event takes place.

Responsibilities of the IRB Chair: The IRB ***Chair*** shall perform the following responsibilities with regard to the Emory IRB:

Convene and lead regular ***IRB Committee*** meetings.

Convene and lead special ***IRB Committee*** and subcommittee meetings as necessary.

Sign correspondence for the Emory IRB.

Designate IRB ***Vice Chairs*** and/or other IRB members to perform duties, and delegate review and signature authority to such designees, as appropriate.

Make decisions in emergency situations to protect ***Human Subjects*** and remain in compliance with regulations.

Appoint any consultants to perform reviews or assist IRB members in the review process.

Make or review and confirm reviewer assignments.

Make or review and confirm decisions regarding assignment of ***Research*** protocols to ***Full Review***, ***Expedited Review*** or as being exempt from IRB review.

Review or delegate reviews of reports received by the Emory IRB and determine which reports require review by full ***IRB Committee***.

Perform ***Expedited Reviews*** of ***Research*** protocols or designate a ***Vice Chair*** or other experienced reviewer who is a member of the Emory IRB to perform an ***Expedited Review.*** Expedited Reviews shall be performed by the Chair (or Vice Chair or Designated Reviewers) as defined in the P&P entitled ***Expedited Review.*** As a general guideline, a member will be eligible for designation to conduct expedited reviews if they have been a member of the Emory IRB or another IRB in good standing for at least six months and is current with training requirements. The Chair may designate qualified members to perform expedited reviews on a term basis or as needed on a case-by-case basis, preferably in writing (letter, email, memorandum, etc.).

Review or assist in review of revisions to ***Research*** protocols and informed consent documents in order to make sure that any changes or other modifications or additions required as a condition of approval have been made.

Review or assist in review of ***Serious Adverse Event (SAE)*** reports and reports of ***Unanticipated Problems Involving Risks to Participants or Others*** and make recommendation/determinations as to any ***IRB Committee*** review/actions that should take place in light of such reports.

Assist in the development and review of Emory IRB policies, procedures, and forms.

Relate concerns of Emory IRB staff and members to Emory University administrators regarding issues concerning ***Human Subjects Research*** and the Emory IRB.

Review complaints received regarding ***Human Subjects Research*** and put in place appropriate procedures for inquiring into and making determinations and recommendations regarding such complaints.

Make any required reports to governmental regulatory agencies, sponsors, or university

officials, or refer such reports to IO for reporting by IO.

Suspend enrollment in or conduct of ***Research*** protocols in accordance with Emory HRPP P&Ps or applicable legal and regulatory requirements, pending ***IRB Committee*** review.

Report to the IO and any other appropriate Emory University or governmental officials on matters involving Serious or Continuing Non-Compliance, Unanticipated Problems Involving Risk to Subjects or Others, or any other serious concerns about the dignity, safety or welfare of Human Subjects in Research within the Emory IRB's oversight.

Review of IRB member performance and competence in consultation with IO and IRB ***Director.***

Consult with IO regarding performance review of IRB ***Director.***

Perform any other duties assigned to them by the ***HHS, FDA*** and/or ***VA Regulations***, these P&Ps or other applicable University policies and procedures.

Delegation of Responsibilities to *Vice Chairs*: For any period of absence or unavailability, the IRB ***Chair's*** duties automatically shall be delegated to the ***Vice Chair*** for each ***IRB Committee***. In addition, at any time, the ***IRB Chair*** may delegate specific responsibilities to any ***Vice Chair***, provided that the delegation of responsibility is in writing.

Delegation of Responsibilities to IRB *Director*: The IRB ***Chair*** (or any ***Vice Chair***) may delegate the following responsibilities to the IRB ***Director,*** who in turn may seek the assistance of any ***Associate or Assistant Director***, ***Protocol Analyst,*** or other Emory IRB staff member in performing such responsibilities:

Review of ***Research*** protocols received to make a preliminary assessment as to whether the ***Research*** protocol requires review by full ***IRB Committee***, ***Expedited Review***, is Exempt from review, or does not constitute Human Subjects Research.

Make initial assignments of ***Research*** protocols to IRB members for review, subject to change in consultation with IRB members, IRB staff, or the ***Chair/Vice Chair.***

Review requested revisions to ***Research*** protocols or informed consent documents to make preliminary determination as to whether requested changes were made, subject to confirmatory review by ***Chair/Vice Chair***.

Review ***HIPAA Authorizations*** and ***Applications for Waiver of HIPAA Authorization*** eligible for expedited review, for compliance with ***HIPAA Regulations***, subject to confirmatory review by IRB ***Chair/Vice Chair.***

Sign certain types of ***Reliance Agreements*** on behalf of Emory as delegated by the IO.

Perform any other duties assigned to them by the ***HHS, FDA*** and/or ***VA Regulations***, these P&Ps or other applicable University policies and procedures.

Compensation: The type and amount of compensation (if any) to the IRB ***Chair*** for the performance of IRB-related duties shall be determined by the IO and/or their designees.

IRB Vice Chairs

Appointment and Term: The IO shall appoint at least one ***Vice Chair*** for each ***IRB Committee***. The ***Vice Chair*** shall be a member of the ***IRB Committee*** to which they have been appointed ***Vice Chair***. The appointment of the ***Vice Chair*** shall be in writing signed by the IO. The term of a ***Vice Chair's*** appointment may be extended by mutual agreement.

Qualifications: The ***Vice Chair*** shall have been for at least one (1) year a member in good standing on an ***IRB Committee*** and shall have an extensive understanding of and familiarity with laws, regulations, Emory IRB P&Ps, and other applicable Emory University policies and procedures.

Resignation: A ***Vice Chair*** may resign at any time by giving written notice of their resignation specifying an effective date to the IO, with a copy to the IRB ***Chair***. The IO shall appoint an interim ***Vice Chair*** to take over upon the effective date of the ***Vice Chair's*** resignation until appointment of a permanent ***Vice Chair*** by the IO. Any resignation of a ***Vice Chair*** or appointment of an interim or permanent ***Vice Chair*** shall be announced by the IRB ***Director*** or Chair at the next meeting of the appropriate ***IRB Committee*** that takes place after the appointment is made. Any action taken by a former ***Vice Chair*** after the effective date of their resignation shall be null and void.

Removal: The IO may remove a ***Vice Chair*** at any time upon determination in the IO's discretion that the ***Vice Chair*** is not appropriately or adequately fulfilling their job responsibilities, or has violated applicable laws, regulations or Emory University policies or procedures, or has been involved in any activities or neglect of duty that would cause harm to the operations or reputation of the Emory IRB. Upon removal of the ***Vice Chair*** shall appoint a replacement ***Vice Chair***. Any removal of a ***Vice Chair*** or appointment of a replacement shall be announced by the IRB ***Director*** at the next meeting of the appropriate ***IRB Committee*** that takes place after the appointment occurs.

Vice Chair **Responsibilities**: The ***Vice Chair*** shall have the same authority and responsibility as the ***Chair*** and shall perform the IRB ***Chair's*** responsibilities for the ***IRB Committee*** to which the ***Vice Chair*** is appointed in the absence of or at the direction of the IRB ***Chair.*** The ***Vice Chair*** also shall perform such responsibilities as are delegated to them by the IRB ***Chair*** or as are specified as belonging to the ***Vice Chair*** elsewhere in the ***HHS, FDA*** or ***VA Regulations***, these P&Ps or other applicable policies and procedures of Emory University. The ***Vice Chair*** shall report any problems or instances of non-compliance to the IO, the IRB ***Chair*** or any other appropriate Emory University or governmental officials.

Compensation: The type and amount of compensation (if any) to a ***Vice Chair*** for the performance of Emory IRB-related duties shall be determined by the IO and/or their designees.

Performance Review: The performance of each IRB ***Vice Chair*** will be reviewed on an annual basis by the IO in consultation with the IRB ***Director***.

IRB *Director*:

Appointment and Term: The IRB ***Director*** shall be appointed by and report to the IO, and/or the IO's designee(s), to serve as the Emory IRB administrative official in charge of overseeing the day-to-day operations of the Emory IRB.

Qualifications: The IRB ***Director*** shall have extensive knowledge of laws, regulations, and Emory University policies and procedures bearing on Emory IRB operations and protections for ***Human Subjects*** in ***Research.***

Removal and Resignation: The IRB ***Director*** shall be an at-will employee of Emory University and shall serve at the pleasure of the IO and/or the IO's designees in accordance with all applicable Emory University human resources policies governing other Emory University employees. If the IRB ***Director*** resigns, they shall notify the IO, the IO's designees, and the IRB ***Chair*** in writing, including an effective date for the resignation. Any resignation of the IRB ***Director*** and/or the appointment of a permanent or interim IRB ***Director*** shall be announced by the IRB ***Chair*** at the soonest of each ***IRB Committee*** meeting that occurs after the resignation notice is received. Any action taken by a former IRB ***Director*** after the effective date of their resignation or removal shall be null and void.

Responsibilities: The IRB ***Director*** shall have the following responsibilities, as well as any other responsibilities assigned to the IRB ***Director*** elsewhere in these P&Ps:

Assist the IRB ***Chair, Vice Chairs,*** and IRB members in carrying out their Emory IRB-related responsibilities.

Perform any responsibilities delegated to the IRB ***Director*** by the IRB ***Chair,*** as appropriate.

Provide oversight and guidance for the ***Associate*** and ***Assistant Director*** and ***Protocol Analysts*** and other Emory IRB staff members in carrying out their Emory IRB-related responsibilities.

Develop, implement, and provide oversight for processes and procedures to be followed in the day-to-day operations of the Emory IRB.

Attend ***IRB Committee*** meetings whenever possible to provide advice and assistance.

Inform the IO and their designee on Emory IRB operations.

Assist ***Researchers*** and research personnel at Emory University in navigating Emory IRB processes and procedures and addressing questions and concerns regarding Emory IRB operations.

Carry out other duties as assigned by the IO, the IO's designee and the IRB ***Chair,*** or as are elsewhere specified as belonging to the ***Director*** in these P&Ps or other applicable Emory University policies and procedures.

Initiate review and update of Emory IRB P&Ps on at least an annual basis.

Provide oversight for all document retention and security P&Ps that the Emory IRB is required to follow.

Maintain current status of ***Emory FWA*** and Emory IRB registration and provide updated membership rosters to OHRP and other appropriate regulatory agencies.

Report any serious problems and matters involving Serious or Continuing Non-compliance or UPs to the IO and/or the IRB ***Chair*** or other appropriate Emory University or governmental officials.

Consult with IO on performance review of IRB ***Chair*** and ***Vice Chairs*** and perform performance reviews of ***Assistant Director*** and ***Protocol Analysts***.

Consult with IRB ***Chair*** and IO regarding performance review of IRB members.

Perform any other duties assigned to them by the ***HHS, FDA,*** and/or ***VA Regulations***, these P&Ps or other applicable University policies and procedures.

Delegation of Duties: The IRB ***Director*** shall have the authority to hire and fire one or more ***Associate Directors, Assistant Directors, Protocol Analysts,*** and other personnel to assist the IRB ***Director*** in carrying out their responsibilities, and the IRB ***Director*** may delegate their duties to these individuals as appropriate.

Compensation: The IRB ***Director*** shall be a salaried employee of Emory University whose compensation is established by the IO or their designee and in accordance with all applicable Emory University human resources policies.

Performance Review: The IRB ***Director's*** performance will be reviewed on an annual basis by the IO and/or their designee in consultation with the IRB ***Chair***. If the ***Director*** is not acting in accordance with the IRB's mission, following these P&Ps and/or is not fulfilling the responsibilities of the ***Director***, then they will be removed.

Supervisory Staff*:*

Hiring: The IRB ***Director*** may hire one or more supervisory staff (e.g., ***Associate*** and ***Assistant Directors,*** Team Leads, Education & Quality Assurance Consultants) to assist the IRB ***Director*** and to perform other duties and functions necessary for the day-to-day operations of the Emory IRB. All such individuals shall be at-will employees of Emory University and shall work under the direction and supervision of the IRB ***Director.*** They shall be subject to all human resources and compensation policies of Emory University.

Specific Responsibility of Supervisory Staff*:* In the event of the IRB ***Director's*** absence the supervisory staff shall assume and carry out the IRB ***Director's*** responsibilities. The IO may designate one supervisory staff member to assume the role of the IRB Director in their discretion. In addition, the supervisory staff shall, at any time, perform any of the IRB ***Director's***

job duties delegated in writing by the IRB ***Director;*** assigned by the ***HHS, FDA*** and/or ***VA Regulations***; or assigned by these P&Ps or other applicable University policies and procedures.

Compensation: Compensation for the supervisory staff shall be determined by the IRB ***Director*** in accordance with applicable Emory University human resources policies.

Performance Review: The IRB ***Director*** shall review the performance of the supervisor staff on an annual basis.

Protocol Analysts:

Hiring: The IRB ***Director*** may hire one or more ***Protocol Analysts*** to assist the IRB ***Director*** and to perform other duties and functions necessary for the day-to-day operations of the Emory IRB. All such individuals shall be at-will employees of Emory University and shall work under the direction and supervision of the IRB ***Director***. They shall be subject to all human resources and compensation policies of Emory University

Responsibilities: All such persons shall have their responsibilities determined by the IRB ***Director*** and included in appropriate job descriptions. In addition, ***Protocol Analysts*** shall perform such duties as may be assigned to them by these P&Ps or other applicable University policies and procedures.

Compensation: Compensation for the ***Protocol Analysts*** shall be determined by the IRB ***Director*** in accordance with applicable Emory University human resources policies.

Performance Review: The IRB ***Director*** shall review the performance of each ***Protocol Analyst*** on an annual basis.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.103
38 CFR Part 46, including 46.103
Emory FWA

20 SUBCOMMITTEES OF THE EMORY IRB

POLICY:

The IRB ***Chair*** in consultation with IRB ***Director*** may designate one or more IRB members to serve on a subcommittee in order to perform functions, as appropriate: (a) on behalf of the IRB; or (b) for review and adoption by the full IRB. The IRB ***Chair*** may request that non-IRB members with particular expertise serve as consultants to any such subcommittees.

PROCEDURES:

Appointment of a Subcommittee: The IRB ***Chair***, or in their absence, a ***Vice Chair*** shall appoint IRB members to serve on an IRB subcommittee and shall charge the subcommittee with its duties. All appointments and charges shall be in writing. A subcommittee may consist of one or more members.

Duties of Subcommittees and Required Composition: IRB subcommittees may perform any or all of the following duties, and as noted in some instances, have a particular composition:

Expedited Review: The IRB ***Chair*** may appoint a subcommittee of experienced IRB members to perform the ***Expedited Review*** of new or continuing protocols or modifications/amendments. The IRB ***Chair*** or a ***Vice Chair*** must serve as a member on any such subcommittee charged with performing ***Expedited Reviews***. The experience of the member(s) of the subcommittee must be matched as closely as possible with the field of expertise relevant to the study.

Review and *Approval* of Revisions Requiring Only Simple Concurrence: The IRB ***Chair*** may appoint a subcommittee of experienced IRB members to perform the review of ***Research*** protocols granted ***Approval Pending*** revisions, provided that the nature of the revisions require only simple concurrence by the PI. The IRB ***Chair*** or a ***Vice Chair*** must serve as a member on any such subcommittee charged with performing such reviews. The subcommittee may consist of one individual (i.e., the ***Chair*** or ***Vice Chair***).

Review *Serious Adverse Events* or *Unanticipated Problems Involving Risks to Participants or Others*: The IRB ***Chair*** may appoint a subcommittee to perform the review of ***Serious Adverse Events*** or ***Unanticipated Problems Involving Risks to Participants or Others*** with regard to issues of participant safety, necessity of changes to protocol and/or consent procedures, etc. The IRB ***Chair*** or a ***Vice Chair*** must serve as a member on any such subcommittee charged with performing such reviews.

Conduct of an Inquiry: The IRB ***Chair*** may appoint a subcommittee to conduct an inquiry into allegations of non-compliance that come to the attention of the IRB. The scope of the IRB's inquiry shall be established by the IRB ***Chair*** and may include any or all of the following items: (a) review of protocols in question; (b) review of any monitoring or audit reports of the ***Investigator(s)*** involved; (c) review of relevant documentation, including consent documents, case report forms, subject's ***Research*** or medical records, as they relate to the investigator(s) execution of the protocol involving

Human Subjects; (d) interviews of appropriate personnel, as necessary; (e) preparation of a written report of findings including recommended actions, as appropriate. Any subcommittee charged with the conduct of an inquiry shall report its findings and recommendations to the full IRB for review and action (e.g., approval or modifications required to secure approval.

Conduct of an On-Site Review: The IRB ***Chair*** may appoint a subcommittee to conduct an on-site review of an ***Investigator's*** work in order to assess compliance with IRB requirements; evaluate risk to subjects; evaluate consent procedures, etc.

Other Functions as Determined by the IRB: The IRB ***Chair*** may appoint a subcommittee to carry out additional functions of the IRB as determined by the full IRB. In all such cases, the IRB shall specify in writing: (a) what the charge of the subcommittee shall be; (b) whether the ***Chair*** or a ***Vice Chair*** must be a member of any such subcommittee; and (d) whether the subcommittee's actions and recommendations must be approved by the full IRB prior to adoption.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109 and 56.112
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.103, 46.109, 46.111, and 46.112

21 CONDUCT OF QUALITY ASSURANCE/QUALITY IMPROVEMENT ACTIVITIES FOR EMORY IRB OPERATIONS

POLICY:

The Emory IRB shall follow a quality assurance plan (QA Plan) to ensure that its operations are adequate and adjusted to achieve appropriate levels of quality and compliance The QA Plan shall focus on key areas of the ***Emory HRPP*** including IRB operations, investigator activities, study subject comprehension and satisfaction, IRB Member review activities, recordkeeping, etc.

PROCEDURES:

Guidelines for the Quality Assurance Plan:

The Emory IRB, in conjunction with representatives of other units of the ***Emory HRPP***, engages in a comprehensive review on a periodic basis, using the QA Plan as a guide. The IRB Director shall ensure that the QA Plan is implemented, reviewed periodically, and revised. The following issues shall serve as guidelines for the periodic review and revision of the QA Plan:

1. Have the Emory IRB P&Ps kept pace with any changes in the standards for accreditation promulgated by the Association for Accreditation of Human Research Protection Programs, Inc (AAHRPP) since Emory's most recent accreditation. Are clear steps outlined as to what changes need to be made?
2. Which metrics does the Emory IRB use to benchmark standards and measure progress?
3. Do ***Human Subjects Research*** Investigators at Emory understand their obligations under the Belmont Principles?
4. Is the IRB documentation and recordkeeping system complete, accurate, and flexible enough to provide the necessary documentation of compliance with federal regulations and to satisfactorily serve the Emory human research community?
5. Is the system sufficiently responsive so that human research investigators can plan, obtain approval, and meet reporting requirements in a timely manner that facilitates the educational, research, and clinical missions of the institution?
6. Does the IRB provide adequate support and education for its Members and staff to fulfill their responsibilities under the ***Emory HRPP***? Are the opinions of all IRB members sought and respected?
7. Are IRB Committee meetings functioning in a consistent manner across panels?
8. Is the burden of IRB membership equitably shared across the institution? Are experts outside the IRB consulted when appropriate?
9. Are IRB decisions communicated efficiently and effectively? Do letter templates require revision?
10. Are reports to federal agencies submitted and monitored for follow-up?
11. Do IRB staff members understand their duties clearly? Can they keep pace with the volume of work without losing quality?
12. How are delays in reviews monitored and handled? What difficulties does the Emory IRB face and how do they impact the Emory ***HRPP***?
13. Is there clear evidence of ongoing quality improvement? If so, in which areas?

The revised QA Plan should be reviewed by the IO, IRB Chair, Director, and qualified staff and kept at the IRB Office. Copies shall be made available upon request.

Periodic Assessment of Outreach Activities: The IRB Chair, Director, and Education and Quality Assurance staff of the Emory IRB will meet at least once a year to evaluate the IRB outreach to participants, researchers, and IRB members. Assessments may include interviews, surveys, focus groups, written evaluations, website feedback, etc.

Inquiries/Audits: The IRB shall conduct for-cause and not-for-cause reviews/audits of ***Research*** protocols subject to its jurisdiction in accordance with the P&P *entitled: Protocol Oversight and Procedures for Handling Audits and Violations*.

When Emory has relied on another entity or institution's IRB: Emory IRB will reasonably cooperate with or conduct for-cause audits upon request. The request must arise due to an issue related to the ceded research. When a for-cause audit is requested, the audit will be a focused audit based upon the event that was reported. When an audit is requested, Emory and the ***Reviewing IRB*** may discuss what type of audit might reasonably be expected based on the issue and in light of the resources available.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.109 and 56.112
38 CFR Part 16, including 16.103, 16.109, 16.111, and 16.112
45 CFR Part 46, including 46.103, 46.109, 46.111, and 46.112

22 IRB MEMBERSHIP

POLICY:

The IO shall appoint qualified members to serve on the IRB with such backgrounds and qualifications as are necessary to provide appropriate expertise for reviewing ***Research*** protocols and to satisfy all membership requirements of the ***HHS, FDA,*** and ***VA Regulations***. Members shall carry out all duties required of IRB members per the ***HHS, FDA,*** and ***VA Regulations*** and as specified in these P&Ps. The Vice President for Research Administration and any other individual responsible for business development are not permitted to serve as member or ex-officio member of the IRB or carry out day-to-day operations of the IRB review process.

PROCEDURES:

Composition of the IRB: Each ***IRB Committee*** shall have at least five members with varying backgrounds to promote complete and adequate review of ***Human Subjects Research*** activities commonly conducted by Emory University.

Qualifications of IRB Members: All IRB members shall be appropriately qualified by education and/or professional experience and expertise (professional competence) to serve in their particular IRB role and membership category on the ***IRB Committee*** to which they are appointed. One member may satisfy more than one membership category. Selection of members to the IRB shall take into account the following qualifications and requirements:

IRB members shall have knowledge of applicable law and ***HHS, FDA,*** and ***VA Regulations;***

IRB members shall have knowledge of Emory University commitments and policies;

IRB members shall be sufficiently qualified through their experience, expertise and backgrounds (e.g., representation of multiple professions, scientific and nonscientific members, nonaffiliated members) to promote respect of its advice and counsel on safeguarding the rights and welfare of ***Human Subjects.***

The IRB membership overall will possess the professional competence necessary to review specific ***Research*** activities and will include persons knowledgeable in a variety of areas such that 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.

If the IRB regularly reviews ***Research*** that involves a ***Vulnerable Population*** (e.g., ***Children***, ***Prisoners***, or individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons), consideration will be given to the inclusion of one or more individuals on the IRB who are knowledgeable about and experienced in working with these subjects. When protocols involve ***Vulnerable Populations***, the review process will include one or more individuals who are

knowledgeable about or have experience in working with these participants either as members of the IRB or as consultants.

In the case of IRB review of ***Research*** in which ***Prisoners*** are involved: at least one IRB member shall be a ***Prisoner Representative*** who has an appropriate background and experience to review protocols involving ***Prisoners,*** except that when a protocol is reviewed by more than one **IRB Committee**, only one of the ***Reviewing IRB*** **Committees** needs to meet this requirement; and

Each IRB has at least one member who represents the perspective of research participants.

The IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in non-scientific areas. Members whose training, background, and occupation would qualify them to view scientific activities from the standpoint of someone within a behavioral or biomedical research discipline are considered scientists.

The IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

> *Note*: Veterans whose only relationship with the VA facility is receiving care at a VA facility or receiving benefits from the Veterans Benefits Administration are not considered to be affiliated for the purpose of being an IRB member. Individuals who perform occasional volunteer activities without compensation (WOC) are not considered affiliated. However, those who hold a WOC appointment for volunteer activities other than IRB service are considered to be affiliated. Individuals who have retired from the VA and who are receiving VA retirement benefits are considered affiliated.

AVAHCS research and development administration officials including but not limited to the Associated Chief of Staff for Research and Development and the Administrative Officer for Research and Development are prohibited from serving as voting members of the Emory IRB.

Institutional employees responsible for human research grant or contract administration may not serve as IRB members.

Review of Membership for Compositional Requirements:

Determination that IRB Committee Compositional Requirements are Met Overall: On at least an annual basis, the IRB ***Director*** shall be responsible for the review of the membership and composition of each ***IRB Committee*** in order to determine whether they continue to meet all institutional and regulatory requirements.

Determination that IRB Committee Compositional Requirements are Met for a Particular

Meeting: The IRB ***Chair*** *and* ***Director***, with assistance from the IRB staff, shall be responsible for ensuring that compositional requirements for specific ***IRB Committee*** meetings are met depending upon the nature of the protocols to be reviewed at that ***IRB Committee*** meeting. ***Protocol Analysts*** shall note in the minutes for the ***IRB Committee*** meeting which IRB members present satisfy the compositional requirements for the meeting as a whole and for any particular protocols that require a particular compositional requirement for review.

Appointment of IRB Members: The IO shall nominate qualified individuals to serve as members on ***IRB Committees***. The IO may accept nominations of potential members from schools and departments within the University. The IO (or their designee) shall review all nominees and in consultation with the IRB ***Chair*** and ***Director*** may appoint qualified persons in writing to serve as IRB members. Each member's term shall be either determinate (such as for two or three years, to be specified in the appointment letter) or indeterminate (for as long as the member's service on the IRB is mutually agreeable, or until the member resigns or is removed from IRB membership). At the conclusion of a member's defined term, provided the member is in good standing, the IO may re-appoint the member for one or more additional consecutive term(s), without limitation.

Appointment of AVAHCS Representatives as Members: AVAHCS IRB appointees are nominated in writing for membership on the Emory IRB by the AVAHCS Associate Chief of Staff for Research, through the RDC, and are appointed for membership on the Emory IRB by the Director of the AVAHCS. Members must further have an interest in ***AVAHCS Research*** and must demonstrate competence in ***Human Subjects Research*** protections by meeting all AVAHCS and Emory IRB member educational requirements. The AVAHCS representatives shall be appointed for a period of three (3) years. At the conclusion of an AVAHCS representative's term, provided that the representative is in good standing, the Director of the AVAHCS may re-appoint the representative for one or more additional consecutive three-year term(s), without limitation. The IRB does not need a member affiliated with the AVAHCS to review studies conducted at the AVAHCS.

The facility director, administrative staff, chief of staff, other senior administrators such as associate or assistant directors, or chief nurse, may observe meetings but not serve as voting or non-voting members of the facility's IRB. Research office staff including, but not limited to, the associate chief of staff for research and development, the administrative officer for research and development, and IRB administrative staff, may not serve as voting members of the IRB. The facility director appoints the privacy officer and information security officer as non-voting members or consultants of the IRB or research and development committee. The research compliance officer may serve as a non-voting consultant, as needed, to the VA facility's IRB. The research compliance officer may not serve as a voting or non-voting member of the IRB. The research compliance officer may attend meetings of the IRB when requested by the IRB or as specified by local procedure.

Communication of Appointment to *IRB Committee:* The IRB ***Chair*** or Director will announce the appointment of a new IRB member at a meeting of the ***IRB Committee*** to which the member is being appointed.

Considerations in Making Appointments: The IO shall appoint IRB members to serve on ***IRB Committees*** in sufficient number and type to ensure that all compositional requirements of the

HHS, FDA and ***VA Regulations*** are met and to ensure that each ***IRB Committee*** can regularly achieve a ***Quorum*** at its meetings.

One Member, One Vote: Each member appointed by the IO (or designee) to serve on an ***IRB Committee*** shall be entitled to only one vote.

Voting by Proxy: Voting by proxy is prohibited.

Resignation: An IRB member may resign by submitting their written resignation indicating the effective period to the IRB ***Chair, Director,*** or IRB staff member (who must forward it promptly to the IRB Director). The IRB member may not take any action with regard to IRB-related activities after such resignation date, and any such actions are null and void. The IRB ***Chair*** *or* ***Director*** shall announce an IRB member's resignation and its effective date at the first meeting of the ***IRB Committee*** on which the IRB member serves that takes place after notice of resignation is received.

Removal: The IO, after consultation with the IRB ***Chair*** and ***Director***; may remove an IRB member at any time from participation on the IRB if the IRB member is not appropriately or adequately fulfilling their job responsibilities; has violated applicable laws, regulations or Emory University policies or procedures; or has been involved in any activities or neglect of duty that would cause harm to the Emory IRB's operations or reputation. With respect to IRB members who are faculty or staff of Emory University, the IO may remove them from participation on the Emory IRB if at any time during their term they cease to hold their faculty/staff position or fall out of good standing with Emory University. Any Emory IRB related actions taken by the former IRB member after the effective removal date are null and void. The IRB will update members on any changes in membership.

Ex officio **Attendees:** Qualified IRB staff shall attend ***IRB Committee*** meetings and participate in review and discussion activities concerning ***Research*** protocols and administrative matters, but they may not vote on such matters. *Ex officio* attendees shall not be counted toward the establishment of ***Quorum*** at ***IRB Committee*** meetings. Any ***Research*** protocols reviewed by an *ex officio* attendee also must be reviewed by at least one IRB member.

Alternate Members - Appointment and Role: The IO may appoint an alternate member to serve for one or more IRB member(s). A regular member may have more than one appointed alternate. The alternate's expertise or compositional category of membership (i.e., affiliated nonscientist, unaffiliated nonscientist, non-physician scientist, physician scientist, or prisoner representative) shall be comparable to those of the primary member. The appointment of an alternate shall be in writing; identify the type of primary member (e.g., physician scientist, unaffiliated nonscientist) for whom they are an alternate; and specify the term of appointment. Alternates must be appointed by the IO in advance of the first meeting at which they are to serve as an alternate. The IRB membership roster shall identify the type of primary IRB member(s) for whom each alternate member may substitute. A new appointment letter is not required if an alternate member is made a primary member during their tenure.

The mode of appointment and functions of alternate members shall be the same as that of the primary IRB members for whom they serve as alternates. When an alternate member substitutes for a primary member, the alternate member shall receive and review the same

materials prior the IRB meeting that the primary member received or would have received. The role of the alternate member is to serve as a voting member of the IRB when a regular member to whom the alternate is assigned is unavailable to attend a convened meeting or to be present at the review of certain protocols during a convened meeting.

Duties of IRB Members: All IRB members, both regular and alternate, shall be required to fulfill the following duties in order to remain in good standing as an IRB member:

Meeting Attendance: Other than for those who are primarily Designated Reviewers, members shall be diligent in attending the meetings of the **IRB Committee panel** to which the member is appointed (except that alternates may not be needed except upon request). If a member is unable to attend a scheduled meeting, then they should provide as much advance notice as possible to the IRB staff. If the inability to attend will be prolonged, a request for an alternate to be assigned may be submitted to the IRB ***Chair*** or ***Director.*** Members are expected to give reasonable notice of extended absences. IRB members who fail to attend multiple meetings and/or who fail to provide appropriate notice of absences may be removed from IRB membership if appropriate inquiries by the IRB Chair or staff indicate that the member is no longer interested or available in IRB membership.

Orientation, Training, and Ongoing Education: Complete any orientation training and ongoing education required by the Emory IRB, as specified in the P&P entitled *Orientation and Education for IRB Chairs & Members*. Members must demonstrate understanding of the three Belmont Report ethical principles and the ability to apply them. Members are expected to develop a solid working knowledge of the rules, policies and procedures (e.g., ***HHS, FDA,*** and ***VA Regulations)*** that apply to the types of Research they review. Further, Members should seek guidance from the IRB Chair, Director, or qualified staff whenever necessary.

Confidentiality: Sign appropriate confidentiality/non-disclosure agreements and treat confidentially all ***Research*** proposals, protocols, supporting data and other documents provided for review. In addition, members shall return copies of protocols and supporting materials submitted for review to IRB Office staff at the conclusion of review and discussion for appropriate destruction. Materials left at a Member's home or office must be promptly destroyed at the conclusion of the review.

Research Protocol Review and Meeting Preparation: Sufficiently in advance of an ***IRB Committee*** meeting at which a ***Research*** protocol is to be discussed or applicable review deadline, each IRB member shall:

Accept review assignments as primary, secondary, or tertiary reviewer.

Review the agenda, submission materials, protocols, proposed informed consent forms and other appropriate documents that are distributed to IRB members. Members shall review these materials before each meeting in order to participate fully in the review of each proposed project.

Thoroughly review all ***Research*** protocol application materials pertaining to an

assignment.

Discuss any questions about assigned reviews with the PI, other IRB members, IRB ***Chair***, IRB staff or appropriate unconflicted consultants.

Determine if any changes are required to any of the materials submitted for review and provide specific recommendations for changes.

Meeting Discussions and Protocol Review Process: At ***IRB Committee*** meetings, the IRB member shall be prepared to present the findings and recommendations for their ***Initial , Continuing Reviews ,or modification*** of ***Research*** protocols; review ***Serious Adverse Events***; or review of other IRB matters assigned. Through the protocol review process, the IRB member shall act to:

Ensure that the rights and welfare of ***Human Subjects*** are protected.

Ensure that any ***Research*** risks are minimized and that risks are reasonable in relation to anticipated benefits to subjects and the importance of the knowledge that may result from the ***Research.***

Ensure that in any evaluation of risks and benefits, those that may result from the ***Research*** are considered in distinct contrast to the risks and benefits the ***Human Subjects*** would encounter from therapies that would be administered even if they did not participate in the ***Research.*** Possible long-range effects of applying knowledge gained in the ***Research*** should not be considered.

Determine that the selection of ***Human Subjects*** is equitable taking into account the purpose of the ***Research***; setting of the ***Research***; and any special characteristic of the ***Human Subject*** population being studied (i.e., ***Minors***, ***Prisoners***, ***Pregnant Women***, students, cognitively or mentally impaired persons or educationally or economically disadvantaged persons collectively referred to herein as "***Vulnerable Populations***").

Determine if the informed consent process is adequate and contains all elements required by the ***HHS, FDA,*** and/or ***VA Regulations***, as well as any other applicable laws or regulations.

Determine that the ***Research*** protocol makes adequate provision for ensuring ***Human Subject*** safety, including the use, as appropriate or required of a data safety monitoring board or similar mechanism.

Determine that there are adequate provisions within the ***Research*** protocol to protect the privacy of ***Human Subjects*** and maintain confidentiality in full accordance with applicable ***HIPAA Regulations***.

Ensure that additional safeguards are in place to protect the rights, safety, and welfare of subjects in ***Vulnerable Populations***.

Ensure that ***Researchers*** use procedures that are consistent with sound ***Research*** design; and when appropriate, utilize accepted procedures on ***Human Subjects*** for diagnostic or treatment purposes.

Reporting: IRB members are required to report any problems or instances of non-compliance to the IRB ***Director*** or IRB ***Chair*** or other appropriate Emory University or governmental officials.

Other Responsibilities: In addition to performing the responsibilities and duties set forth above, IRB members also shall perform any other responsibilities appropriately delegated to them by the IRB ***Chair*** or set forth elsewhere in these P&Ps.

Compensation: The type and amount of compensation (if any) to an IRB member for the performance of IRB-related duties shall be determined by the IO and/or their designees.

Review of IRB Member Performance: The IRB ***Chair or Vice Chairs*** shall review each IRB member's performance periodically in consultation with the IO and the IRB ***Director.*** The performance of each Vice-Chair, Chair, and IRB Director will be reviewed on an annual basis by the IO. Members, Chairs, and Vice Chairs will be given formal feedback based on their performance evaluations. The IRB Director will fulfill this function for the IRB members, Chairs, and Vice Chairs. With respect to the Chairs, the IO shall also provide formal feedback based on their performance evaluations. Feedback shall be provided in writing and may also be provided in person.

Membership Rosters: The IRB ***Director*** or their designee shall keep a membership roster for each ***IRB Committee***. The membership roster must identify members sufficiently in terms of their experience to describe each member's chief anticipated contribution to IRB deliberations. The roster must contain the following information about each member:

1. Name.
2. Gender.
3. Earned degrees.
4. Affiliated or unaffiliated status (in the case of an unaffiliated member, neither the member nor an immediate family member of the member may be affiliated with the University), including a description of employment or other relationship with Emory University.
5. Status as scientist (physician-scientist or non-physician scientist) or non-scientist. In general, any members who are trained and have experience in the sciences (physical, life, technological/engineering, social or behavioral) will be designated as scientists. OHRP and/or SACHRP guidance will be consulted when determining if a person should be in the scientist or non-scientist category.
6. Experience, certifications, licenses, or other indicia of professional qualifications sufficient to describe each member's chief anticipated contributions to IRB deliberations, if applicable.
7. Representative capacity of each IRB member (i.e., what role, if any, the IRB member has in fulfilling ***IRB Committee*** compositional requirements, such as which member is a ***Prisoner Representative***, which is knowledgeable about or experienced in working with specific ***Vulnerable Populations***, etc.).

8. Official capacity on ***IRB Committee***, e.g., member, ***Vice Chair***, ***Chair.***
9. Alternate status, including the type of primary member(s) for whom the alternate serves.

Maintenance of IRB Membership Roster: The IRB ***Director*** or designee shall keep each membership roster up to date and report changes to the membership roster to OHRP and to any other governmental agencies as required.

AVAHCS Research Compliance Officer(s) as Consultant(s): The Emory IRB may consult the AVAHCS research compliance officer(s) as non-voting consultant(s). The research compliance officer may not serve as a member of the IRB but may attend meetings of the IRB when requested or as specified by Emory policies and procedures, including attendance to perform compliance review or audits.

IRB Staff as Members and Designated Reviewers: IRB Staff may be appointed by the ***IO*** as alternate, affiliated IRB members to serve as Designated Reviewers. When those IRB staff attend meetings, they shall not be counted as ***voting members*** unless otherwise noted in the minutes.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107, 56.111, and 56.115
38 CFR Part 16, including 16.103, 16.107, 16.111, and 16.115
45 CFR Part 46, including 46.103, 46.107, 46.111, and 46.115

23 ORIENTATION AND EDUCATION FOR IRB CHAIRS, MEMBERS, AND STAFF

POLICY:

Orientation and continuing education for the IRB ***Chair, Vice Chairs***, IRB Members and IRB Staff is a vital component of Emory University's ***HRPP***. Emory University is committed to providing orientation, training and ongoing education for all IRB members and staff regarding ***Research*** ethics, regulatory compliance, and institutional requirements for the protection of ***Human Subjects.***

PROCEDURES:

Orientation for New IRB Members: In order to ensure that new IRB members receive education in appropriate IRB principles, regulations and policies, every prospective new member (regular or alternate) will meet with the IRB Chair, Director, or supervisory IRB staff for a preliminary interview. The prospective member will also attend training in navigating the Emory IRB website and the electronic submission system in the role of IRB Member. Each member is provided resources, including the Belmont Report, HHS and FDA regulations, reviewer checklists, etc. New members are encouraged to talk with current IRB Members for candid perspectives on the time commitment and value of IRB membership. Educational resources will be made available to new Members. Finally, each new IRB member must complete the Emory-required curriculum of the CITI Training Course and observe a convened IRB Committee meeting before eligibility for appointment is complete.

Note: Emory IRB Chairs are selected from among experienced Emory IRB members and have gone through the orientation and training described above. When appointed, a new Chair/Vice-Chair also becomes a designated reviewer for expedited studies, if not already designated.

Continuing Education for IRB Members and Chairs: To ensure that oversight of ***Human Subjects Research*** is ethically grounded, and the decisions made by the IRB are consistent with current regulatory and policy requirements, training is continuous for IRB members throughout their service on the IRB. CITI certification (Biomedical for biomedical Committee members and Chairs; Sociobehavioral for sociobehavioral Committee members and Chairs) must be maintained per the same schedule required of researchers. Other educational activities include, but are not limited to the following and are made available to affiliated and unaffiliated IRB Members:

Educational segments at convened IRB Committee meetings;

Annual in-service workshops/sessions created especially for IRB Members;

Participation in interactive webinars from PRIM&R and other respected research ethics organizations;

Attendance at seminars and lectures on ethics at the Ethics Center and other academic venues at Emory;

Attendance at educational sessions given by guest speakers, the Emory IRB Chair, Vice Chair, Director, or qualified staff or Members on topics of interest in Human Subjects Research protections, regulatory compliance and research ethics.

Identification and dissemination by the IRB ***Director*** of new information that might affect the ***Human Subjects Research Protection Program***, including laws, regulations, policies, procedures and emerging ethical and scientific issues to IRB members via email, mail or during IRB meetings; and

Access to IRB Office resource library. The IRB Chair and Vice Chairs shall receive complimentary copies of selected titles on research ethics, Human Subjects protections, and IRB management.

In addition, personnel involved in the review, approval, oversight or management of protocols conducted or supported by the ***DOD*** shall complete the additional requirements as described in P&Ps entitled: *Department of Defense (DOD) Supported Research*.

Monitoring Member/Chair Training: The IRB shall maintain documentation of members' and Chairs' completion of any required training or certification, will monitor it regularly as meeting agendas and quorum are prepared, and be able to verify such training via a third party (e.g., the CITI program website). When CITI refresher training requirements for members and Chairs are checked and found not to be met, the IRB Director or the relevant IRB meeting facilitator will inform the member that they may not participate in further IRB reviews or meetings until the member recertifies.

IRB Member and Staff Attendance at Training Conferences: The Emory IRB will provide support to send selected IRB members and staff to attend the annual PRIM&R conference and/or regional OHRP and FDA conferences on ***Human Subjects Research*** protections. Unaffiliated and/or nonscientist IRB members may receive priority in selection.

Orientation and Continuing Education for IRB Staff: New IRB staff must undergo the formal Emory IRB new hire training program which involves deeper reading of the federal regulations, review of selected P&Ps, SOPs, and checklists, and mentored training on processing different types of submissions. The IRB *Director,* A*ssociate/Assistant Directors, Protocol Analysts* and all other professional staff are required to complete the basic CITI modules, biomedical as well as sociobehavioral, listed on the IRB website during the new hire training period. Regular external and on-the-job training is also provided to IRB staff.

Continuing education is required for all IRB staff. It includes but is not limited to the following:

- Education on new policies, guidance, regulations, and office procedures at required staff meetings and team meetings.
- CIP certification is required and must be maintained (via continuing education or retaking the exam) for IRB staff in the position of Research Protocol Analyst II or above, within a reasonable timeframe after basic eligibility for the certification is met.
- Screening of webinars several times per year, offered by PRIM&R and other respected research ethics organizations
- Attendance at compliance-related presentations by other Emory offices
- Provision of reading material on human subjects research ethics and related topics in

the office library
- Attendance at PRIM&R, OHRP, FDA, or other off-site training sessions or conferences on a rotating basis.
- Continued on-the-job training in the context of specific protocol reviews

The IRB shall maintain documentation of staff's completion of required training or certification, as well as continuing education activities (beyond routine staff meetings). Continuing education activities, including consistent attendance at required staff meetings, are assessed by supervisors as part of the performance review at the end of each fiscal year.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107
38 CFR Part 16, including 16.107
45 CFR Part 46, including 46.107
DOD Instruction 3216.02, 2022
SECNAVINST 3900.39D, 2006

24 IRB MEMBER LIABILITY, INSURANCE, AND INDEMNIFICATION

POLICY:

Emory University will indemnify IRB members against liability incurred while performing actions that fall within the scope of their duties as IRB members.

PROCEDURES:

Employees of Emory University: IRB members who are employed by Emory University are considered to be acting within the scope of their employment when they perform any actions that fall within the scope of their duties as IRB members and are not knowingly inconsistent with these P&Ps. As such, Emory University shall provide legal defense and insurance coverage for any claims arising out of IRB members' performance of their IRB member duties under the University's general liability insurance/self-insurance.

Unaffiliated IRB Members: Emory University agrees to defend, hold harmless and indemnify non-Emory affiliated IRB members who are not employees of Emory University from and against any claims and liabilities arising out of the non-Emory affiliated IRB members' performance of actions that fall within the scope of their duties as IRB members and are not knowingly inconsistent with these P&Ps.

Documentation of Indemnification: Upon request, Emory University's Office of the General Counsel shall provide non-Emory affiliated IRB members with a letter evidencing the defense, hold harmless and indemnification obligation specified above under the provision immediately above entitled *Unaffiliated IRB Members.*

Notification of Claims: In the event that any IRB member (including non-Emory affiliated IRB members) receives notice (whether written or verbal) of any claim being made against the IRB member concerning the IRB member's IRB activities, the IRB member shall immediately notify the IRB ***Director*** and the Emory University Office of the General Counsel.

Cooperation: In consideration of the insurance and/or indemnification provided hereunder, all IRB members agree that Emory University may select the counsel to defend any claims made against the IRB member and the Emory University IRB, and further agree to cooperate with Emory University and its counsel in the defense and/or settlement of any such claims.

Right to Settle: In exchange for the insurance and/or indemnification provided hereunder, all IRB members agree and confer upon Emory University the sole right to prosecute, defend or settle any claims or litigation concerning the Emory IRB or IRB members as Emory University deems fit within its sole discretion.

Applicable Regulations, Policies, and Guidance:

None

25 CONSULTANTS AND AD HOC REVIEWERS

POLICY:

At their discretion, the IRB ***Chair*** may invite scientists or non-scientists with special expertise and/or knowledge of local ***Research*** context from within or outside Emory University to function as Consultants and/or *ad hoc* reviewers, as may be required in order to provide appropriate review of ***Research*** protocols or to assist the Emory IRB in its review of ***Research*** protocols. (For the purposes of these P&Ps, "Consultant" shall include *ad hoc* reviewers.)

It is incumbent upon all Emory faculty and staff who may be asked to serve as a Consultant to carry out all assigned responsibilities.

PROCEDURES:

Determination of Need for Consultant: The IRB ***Chair or Vice Chair,*** in consultation with IRB ***Members and/or Staff,*** shall determine whether or not a Consultant is necessary to perform an in-depth review of a ***Research*** protocol in advance of the ***IRB Committee*** meeting at which the protocol is to be discussed, and who the Consultant should be. Consultants shall be used when the IRB is required to review issues or protocols that require scientific, scholarly, practical, or other expertise beyond or in addition to that which is available on the Emory IRB. Consultants must not be used to completely replace appropriate scientific or scholarly expertise of the IRB members attending the meeting. If there is not at least one person on the IRB with appropriate scientific or scholarly expertise or other expertise or knowledge to conduct an in-depth review of the protocol, the IRB will defer the review to another meeting.

Provision of Materials and Confidentiality/Non-Disclosure Agreements: The IRB ***Staff*** or their designee shall ensure that the Consultant receives the protocol and all other relevant materials in advance of the convened meeting at which the protocol is to be reviewed. Before providing any materials to the Consultant or discussing the protocol or issue, the IRB ***Director*** shall ensure that Consultant signs a confidentiality/non-disclosure agreement

Conflicts of Interest: The IRB ***Director*** or designee shall review the Emory IRB's ***Conflict of Interest*** policy (set forth in the P&P *entitled Conflicts of Interest – Investigators* and *Conflicts of Interest on the Part of IRB Administrators, IRB Members & Staff Members*) with any Consultant before the Consultant undertakes the review of any issue or protocol. The Consultant must verbally confirm to the IRB ***Director*** or designee that they do not have a ***Conflict of Interest*** prior to initiating review activities. Individuals who have a ***Conflict of Interest*** or whose spouse or family member has a ***Conflict of Interest*** in the ***Sponsor*** of the ***Research*** will not be eligible to serve as a Consultant to the IRB.

Participation in IRB Meetings: The Consultant shall present their findings in writing or in person (which may include by speakerphone) to the ***IRB Committee*** for consideration. If present at the meeting, the Consultant may, at request of the ***IRB Committee***, participate in any portion of the ***IRB Committee's*** discussion that is relevant to the Consultant's review activities; however, the Consultant may not vote on any matter coming before the ***IRB Committee*** or be present at such time as the vote is taken.

Documentation in IRB Files and Meeting Minutes: Written statements of consultants or summaries of their oral presentation created by the IRB Chair, Director, or staff will be kept in the relevant IRB records. In addition, key information provided by Consultants at meetings will be documented in the meeting minutes. Written reviews provided by outside reviewers shall be filed with the protocol to which the review pertains.

Compensation: Any compensation to be paid to a consultant/outside reviewer shall be as determined by the IRB ***Director.***

Consultants from *Relying Parties*: If Emory IRB is serving as the ***Reviewing IRB*** for another institution, Emory IRB may ask an unconflicted representative of the ***Relying Party's*** IRB to consult on the particular submission based on special expertise or local context considerations.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107, 56.108, and 56.110
38 CFR Part 46, including 46.103, 46.107, 46.108, and 46.110
45 CFR Part 46, including 46.103, 46.107, 46.108, and 46.110

26 CONFIDENTIALITY OBLIGATIONS FOR IRB OFFICIALS, MEMBERS, CONSULTANTS, STAFF, AND GUESTS

POLICY:

Emory IRB officials, Members, Consultants, staff, and guests at convened IRB Committee meetings are required to execute an Emory IRB confidentiality and non-disclosure agreement in order to protect sensitive, confidential and proprietary information that they may receive in carrying out their IRB duties or attending a convened meeting.

PROCEDURES:

Obligation to Maintain Confidentiality: Emory IRB administrators, IRB members, Consultants and staff members often receive sensitive information during the conduct of their Emory IRB duties. This information may concern patients or ***Research*** subjects, trade secrets or proprietary information, confidential inquiries or investigations being conducted by the Emory IRB or other institutional or governmental authorities; or matters that Emory University is required by laws, regulations, contractual obligations or its policies to protect against disclosure to unauthorized individuals.

To protect this information, IRB members, and consultants (when appropriate) are required to sign a Confidentiality and Non-Disclosure Agreement and to abide by the requirements thereof. The execution of this Confidentiality and Non-Disclosure Agreement is a condition required in order to be an IRB member or Consultant Any guest observing a convened IRB meeting must sign a Confidentiality and Non-Disclosure Agreement; however, this does not apply to investigators attending an IRB meeting to answer questions about a Research protocol under review.

Protected Health Information: In addition to complying with the confidentiality and non-disclosure obligations set forth herein, each Emory IRB Member and staff member, as well as any Consultant, is obligated to comply with all ***HIPAA Regulations*** and ***HIPAA Privacy*** and/or ***Security Policies*** with regard to the use and disclosure of ***Protected Health Information*** (PHI).

Electronic Protected Health Information or ePHI: Following Emory policies on HIPAA Privacy Policies and Emory HIPAA Security Policies, which can be found at: www.ethicsandcompliance.emory.edu. Emory IRB staff and members should comply with the confidentiality and non-disclosure obligations set in these policies and in the federal regulations, including HHS Regulations.

Individually Identifiable Health Information: For health information that does not constitute PHI, the Emory IRB staff and members will follow the requirements to comply with the confidentiality and non-disclosure obligations set in Emory Policy 5.23, Identifiable Health Information Policy, and in the federal regulations, including HHS Regulations.

Reporting Breaches of Confidentiality and Non-Disclosure Obligations: Emory IRB officials, IRB members and staff members are required to report to the IRB ***Director*** and/or the IRB ***Chair*** any instances of which they are aware that involve a use or disclosure of information in violation of

the confidentiality obligations set forth in the Confidentiality and Non-Disclosure Agreement, these P&Ps, ***HIPAA Regulations*** or ***HIPAA Privacy*** and/or ***Security Policies.*** The IRB ***Director*** and IRB ***Chair*** shall, in turn, report the breach to the Emory University HIPAA Privacy Officer within the Office of Ethics and Compliance. The Emory IRB shall take such steps as are appropriate to mitigate any damage that may have been caused by the breach and to take corrective action as necessary to ensure that a similar breach does not occur in the future.

Sanctions for Failure to Abide by Obligations: IRB members, Consultants, officials, and staff who intentionally or repeatedly fail to comply with confidentiality and non-disclosure obligations may be removed from service on the Emory IRB. In addition, if an Emory University employee fails to comply with these obligations in connection with their responsibilities concerning the Emory IRB, they may receive sanctions from their employing unit, up to and including the possibility of termination of employment.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.103 and 46.111
45 CFR Part 162, including 162.103
45 CFR Part 164, including 164.501, 164.504, and 164.530

27 DOCUMENTATION AND RECORD RETENTION

POLICY:

The Emory IRB shall maintain appropriate written and/or electronic documents that pertain to its initial and on-going review of ***Human Subjects Research.*** Records shall be kept for the longer of three years from the time of their creation or receipt by the Emory IRB, or longer as required by any other applicable record retention period. Records relating to Human Subjects Research that is performed shall be kept for at least three (3) years after the completion of the Human Subjects Research. Emory IRB shall maintain records regarding all VA Research that it has reviewed in compliance with VA Records Control Schedule (RCS 10-1) and provide VA and ORO access to the records. Contractual provisions for contract-supported Human Subjects Research may specify longer retention periods. The longer provision should apply in case applicable requirements conflict.

PROCEDURES:

Emory IRB to Maintain Documentation: The Emory IRB shall maintain documentation of all ***Human Subject Research*** protocols and related materials received for review and documentation of determinations required by laws, regulations, codes, and guidance, and actions taken with regard to the oversight of ***Human Subjects Research*** within its jurisdiction. Documentation of study reviews by expedited procedures shall include records showing the basis for expediting (permissible category, minimal risk), any regulatory required findings, and description of action taken by the member-reviewer. For exempt research, the documentation of review shall include the basis for exemption (specific category).

Physical Documents Received by the Emory IRB: All physical documents received by the Emory IRB that pertain to its review or oversight of ***Human Subjects Research*** shall be stamped with the date received. The IRB ***Director*** shall implement processes governing the tracking of documents that are sent to the Emory IRB and the routing of documents received to appropriate IRB or HRPP personnel.

Document Security: The following requirements shall be observed with regard to document security practices:

> **Access to Documents:** Access to hardcopy and electronic documents maintained by the Emory IRB shall be limited to HRPP personnel, ***IRB Committee*** members, officials, and staff who need such access in order to perform their job duties, to comply with regulatory requirements or to report any compliance issues. Access to Emory IRB documents by other persons must be approved by the IRB ***Director*** or ***Chair*** and shall be documented.
>
> For ***DOD*** supported ***Research***: Records maintained that document compliance or non-compliance with DOD regulations must be made accessible for inspection and copying by representatives of the DOD at reasonable times and in a reasonable manner as determined by the supporting DOD component.

Removal of Original Documents: No original IRB File materials shall be removed from the IRB Offices except as approved by the IRB ***Director*** or the IRB ***Chair*** in certain limited circumstances (e.g., for copying or scanning by an approved service; for use in an Emory University inquiry or investigation; for production in accordance with a subpoena or request for production of documents; or pursuant to an appropriate request from a governmental agency with regulatory authority over the Emory IRB).

Removal of Copies: Copies of File materials shall only be removed from the IRB Offices with the consent of the IRB ***Chair*** or IRB ***Director*** upon request of University and/or governmental regulatory officials, or to report compliance concerns to appropriate Emory University or governmental officials.

Electronic Records: The IRB ***Director*** shall implement processes and procedures concerning access to electronic records kept on computer systems that comply with all ***HIPAA Security Policies*** requirements, as well as with any FDA or OHRP mandated requirements. These processes and procedures shall comply with all requirements set forth by the ***HIPAA Security Rule Policies,*** and shall at a minimum:

Require all persons to have unique user IDs and passwords to access their computers.

Require passwords to be changed on a regular basis.

Require all computers to have automatic log-off.

Require all computer systems to be backed up on a regular basis.

Require a data recovery and disaster management plan.

Require a logging system for tracking and auditing user actions with respect to users and user actions to creating, modifying and deleting data.

Require reporting of, and inquiry into, any unauthorized access to electronic records or breach of security procedures.

Reporting of Security Breaches: Persons who discover any security breaches or instances of missing or damaged documents or electronic information shall immediately report such event to the IRB ***Director*** or the IRB ***Chair.*** The IRB ***Director*** or IRB ***Chair*** will make further reports of such events as necessary (e.g., reporting to HIPAA Privacy Officer and/or HIPAA Security Officer), as well as inquire into any such events and implement appropriate corrective measures.

Types of Documents to be Maintained by the Emory IRB: The Emory IRB shall maintain the following types of documentation at the IRB Offices for studies under its jurisdiction:

Copies of all original ***Research*** protocol proposals for review, including any accompanying documents.

Copies of approved consent and HIPAA authorization documents.

Copies of investigator brochures

Copies of recruitment materials

Copies of data and safety monitoring reports

Copies of applications for protocol ***Approval/Continuing Review*** including the rationale for conducting continuing review of research that otherwise would not require continuing review as described in the ***Revised Common Rule***.

Copies of protocol modifications or amendments including rationale for an expedited reviewer's determination under §46.110(b)(1)(i) that research appearing on the expedited review list described in §46.110(a) is more than minimal risk.

Documentation specifying the responsibilities that an institution and an organization operating an IRB each will undertake to ensure compliance with the requirements of the policy described in the ***Revised Common Rule***.

Copies of reports received regarding ***Research*** protocols, e.g., progress reports, significant new findings, ***Serious Adverse Event*** reports (both internal and external), reports concerning ***Unanticipated Problems Involving Risks to Participants or Others,*** and any other reports submitted concerning ***Research*** protocols

Documentation of noncompliance

Documentation of all determinations made by the IRB as required by laws, regulations, codes, and guidance

Minutes of each meeting of an ***IRB Committee*** and of any Emory IRB subcommittee

Copies of all audit logs, audit reports or other documents of continuing protocol review activity conducted by or on behalf of the Emory IRB

Copies of all Emory IRB correspondence

Copies of all current and past ***IRB Committee*** membership rosters

Official copy of the P&Ps

Official copies of the ***Emory FWA*** and the Emory IRB registration

Copies of any statements or correspondence provided or received from ***Human Subjects,*** including any statements provided to ***Human Subjects*** of new findings developed during the course of a ***Research*** protocol that may relate to a ***Human Subject's*** willingness to continue participating in a ***Research*** protocol

Copies of any complaints/questions regarding ***Human Subjects Research*** and any

documentation concerning inquiry into and response to such complaints/questions

Copies of documentation of approval from other Emory University committees with jurisdiction over ***Human Subjects Research,*** e.g., approval by Radiation Safety Committee, Institutional Health & Biosafety Committee, and/or Research Conflict of Interest committees

Copies of training documentation for ***IRB Committee*** members and IRB staff

Copies of resumes/CVs and letters of appointment or employment for ***IRB Committee*** members, and staff

Copies of DHHS-approved sample consent documents and protocol, when they exist

Copies of scientific evaluations, if any

Copies of ***Reliance Agreements***, if applicable

Local context worksheets for ***Relying Parties***, if applicable

Any other records related to ***Relying Parties***, when applicable

Any other records required by applicable laws, regulations, or Emory IRB or other Emory University policies and procedures

For AVAHCS or VA-Supported Research the following records must also be maintained:

- The required records, including the Researcher's research records, must be retained for a minimum of six years
- Codes or keys linking participant data to identifiers must be retained as part of the research record for at least six years (researcher files only).
- If a protocol is cancelled without participant enrollment, IRB records are maintained for at least five years after cancellation.
- Correspondence between the IRB and the Research and Development Committee.
- Correspondence between the IRB and Researchers.
- Internal serious adverse events.
- Documentation of protocol deviations.
- A resume for each IRB member.
- All previous membership rosters

Records Retention: At a minimum, the above records are required to be kept by the Emory IRB for at least three (3) years from date of creation or receipt by IRB, and records relating to ***Human Subjects Research*** that is performed will be kept for a minimum of three (3) years after completion of the ***Human Subjects Research*** at the site or sites over which the Emory IRB has jurisdiction of the ***Human Subjects Research.*** If a protocol is cancelled without subject enrollment, then IRB records will be maintained for at least three (3) years after cancellation. Records will be kept longer if required by applicable governmental laws or regulations or

contractual obligations with ***Research*** sponsors. Emory IRB shall maintain records regarding all VA Research that it has reviewed in compliance with VA Records Control Schedule (RCS 10-1), and provide VA and ORO access to the records. In the event that the Emory IRB needs to dispose of records prior to the VA time frame, it will work with VA to transfer the appropriate documents relating to VA research to the VA.

Destruction of Records: After any applicable records retention period has expired, the IRB shall dispose of any records that need no longer be maintained via cross-cut shredding or other method of disposal permitted under the ***HIPAA Privacy Policies.*** Appropriate documentation of destruction shall be maintained.

Availability of Records: Records shall be accessible for inspection and copying by authorized representatives of OHRP, FDA, VA and/or other appropriate governmental entities.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.115
38 CFR Part 16, including 16.115
45 CFR Part 46, including 46.103, 46.109, 46.110, and 46.115
45 CFR Part 164, including 164.308, 164.310, 164.312, and 164.530

28 IRB PROTOCOL TRIAGE AND ASSIGNMENT OF REVIEW CATEGORY

POLICY:

The Emory IRB is committed to the rigorous and accurate application of regulations and guidance to the triaging of Protocols submitted for its review.

PROCEDURES:

The Emory IRB shall use the following materials in determining the IRB review category to assign to a protocol: the definitions set forth within these P&Ps, applicable federal regulations, other applicable Emory University policies, guidance documents on the IRB website, and the Human Subjects Research Decision Chart set forth at the OHRP website, OHRP guidance on Coded Private Information or Specimens Use in Research, Guidance (2008), and/or other authoritative analytical tools. A copy of all submitted materials and official determination correspondence will be kept on file at the IRB Office.

Ensuring Adequate Time for IRB Member Review: Generally, there are four IRB meetings for biomedical research per month; one meeting per month for review of noncompliance matters, UPs, and Conflict of Interest management plans for ongoing studies; and one meeting per month for sociobehavioral and public health research. Holiday schedules and the IRB workload fluctuations may require more or less frequent meetings. The Emory IRB website shall publish the meeting schedule. The IRB staff will, in general, forward materials to IRB members one week in advance of an IRB meeting. If a submission that does not meet this guideline requires review, it shall be sent to the IRB members at the discretion of the ***Chair*** or ***Vice-Chair***.

Protocol Submissions for Triage Process and *Initial Review*: Qualified IRB staff will initially determine, in accordance with federal regulations and guidance, that a new submission fits one of the following categories: Not ***Human Subjects Research***; Emory not ***Engaged in Human Subjects Research***; ***Exempt*** Human Subjects Research; eligible for ***Expedited Review***; or requires Full Committee Review.

Determinations of Not ***Human Subjects Research,*** not ***Engaged in Human Subjects Research,*** and Exemption made by qualified IRB staff do not need further review by the Chair/Vice Chair. The **IRB Director** shall decide when IRB staff are qualified to make these determinations based on length of experience and demonstrated expertise. Determinations made by IRB staff in training should be reviewed by senior or supervisory staff or the Chair/Vice Chair. All other determinations are subject to confirmation or change by the IRB ***Chair/Vice Chair*** before they are finalized. Each type of review and the materials used in performing the review are described in the P&Ps entitled *Possible IRB Committee Actions on Research Protocols*, *Continuing Review, Protocol Modifications,* and *Closure of Protocols*.

Protocol Submission for *Continuing Review*: Upon receipt of a protocol for ***Continuing Review***, qualified IRB staff will make an initial determination in accordance with federal regulations, whether the submission is eligible for ***Expedited Review*** or requires ***Full Committee Review.***

Expedited Initial Review/Continuing Review: The ***Protocol Analyst*** will route those protocols

that they have initially determined qualify for ***Expedited Review*** to the ***Chair/Vice Chairs*** or staff designated IRB members for review. The ***Chair/Vice Chair*** will make the final determination of ***Expedited Review*** status and provide a written review of the protocol. Alternatively, the ***Chair/Vice Chair*** may determine that the protocol requires ***Full Committee Review.***

Full Committee Initial Review/Continuing Review: The ***Protocol Analyst*** will route those protocols requiring continuing review that they have determined require ***Full Committee Review*** to an appropriate full ***IRB Committees*** for review.

Failure of the PI to submit a ***Continuing Review*** prior to the protocol's expiration date shall result in expiration of the protocol and immediate termination of all research-related activities, except for limited subject safety measures, as delineated by federal regulations.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
45 CFR Part 46

29 DETERMINATIONS OF ENGAGEMENT IN HUMAN SUBJECTS RESEARCH OR CLINICAL INVESTIGATION

POLICY:

A PI may make an unofficial determination that they are not ***Engaged*** in ***Human Subjects Research***, or a project ***Does Not Constitute Human Subjects Research*** and/or does not constitute a ***Clinical Investigation*** under these P&Ps and applicable regulations, but the University will hold the PI responsible if the determination is not correct.

The Emory IRB Office is the only body that can issue an official determination, or confirm an unofficial determination, under these P&Ps and/or applicable regulations, as to whether a project (or Emory personnel's involvement in a ***Multi-site/Collaborative Study***) falls into one or more of the following categories: (a) is not a Clinical Investigation; (b) is not ***Human Subjects Research;*** and/or (c) is not otherwise subject to the jurisdiction of the Emory IRB as an ***Institutional Review Board*** or ***Institutional Privacy Board*** under HIPAA.

DEFINITIONS:

See Glossary for the definitions of the following relevant terms:

- Research
- Clinical Investigation
- Systematic Investigation
- Generalizable Knowledge
- Clinical trial (HHS Definition)
- Human Subjects Research (DOD Definition*)*
- Human Subject (FDA Definition)
- Human Subject (HHS Definition)
- Engaged in Human Subjects Research
- Employees or Agents

PROCEDURES:

Unofficial Determinations (by PI) Using these P&Ps and the definitions contained herein, guidance information on the IRB website, and applicable ***FDA Regulations*** and formal guidance, a PI may make an unofficial determination as to whether or not a project constitutes a ***Clinical Investigation*** that is subject to IRB review under applicable ***FDA Regulations***.

Using these P&Ps and the definitions contained herein, guidance information on the IRB website, applicable federal regulations and formal guidance, and the Human Subjects Research Decision Charts set forth at the OHRP website, a PI may make an unofficial determination as to whether or not a project constitutes engagement in ***Human Subjects Research*** or is otherwise subject to the jurisdiction of the Emory IRB as an ***Institutional Review Board*** or as an ***Institutional Privacy Board.***

Responsibility for Unofficial Decisions: The University will hold the PI responsible for any

incorrect determination. Specifically, if the University later determines that a PI initiated a project that constituted a ***Clinical Investigation***; or engagement in ***Human Subjects Research;*** or was otherwise subject to IRB jurisdiction per these P&Ps and/or applicable regulations, and the PI did not submit the project to the Emory IRB Office for review, then the University may prohibit the PI from publishing or otherwise making use of the data from the project, as well as imposing other appropriate sanctions upon the PI.

Official Determination (by IRB): In order to receive an official written decision from the Emory IRB Office as to a project's IRB status, the PI must submit a proposal with sufficient information to enable the Emory IRB to make its determination if it (a) is not a Clinical Investigation; and/or (b) does not constitute engagement in ***Human Subjects Research;*** and/or (c) does not otherwise fall within the Emory IRB's jurisdiction. The Emory IRB staff may use the information in these P&Ps, applicable federal regulations and formal guidance, internal guidance documents, guidance on the IRB website, and/or the the Human Subjects Research Decision Charts set forth at the OHRP website, in order to make the official determination. IRB staff deemed qualified by training and expertise by the ***IRB Director*** do not need further review by supervisory staff or the Chair/Vice Chair. Determinations made by IRB staff in training should be reviewed by senior or supervisory staff, or the Chair/Vice Chair. The Emory IRB Office will notify the PI of its determination via email and/or, upon request, provide a letter to this effect.

Timing of IRB Review and Approval in Relation to Initiation of *Research*
Protocol: No protocol for a ***Clinical Investigation*** or for ***Human Subjects Research*** and no activities that in whole or in part involve a ***Clinical Investigation*** or ***Human Subjects Research*** (including, but not limited to, interacting with ***Human Subjects, Human Subject*** recruitment, advertising, or screening for ***Human Subject*** eligibility) may begin before the protocol has been reviewed and approved by the Emory IRB; or a determination has been made that it does not require IRB review.

A protocol determined not to be ***Human Subjects Research*** or to be ***Exempt*** may nonetheless require review and approvals of a waiver of HIPAA authorization. Therefore, no ***Research*** activities that involve investigators' access to or use of PHI from a ***Covered Entity*** or ***Covered Component*** of a ***Hybrid Covered Entity*** prior to or without HIPAA authorization for the ***Research***, may take place before review and approval by the Emory IRB, acting in its capacity as the ***Institutional Privacy Board***.

Change Requiring Clarification by IRB: If a PI initially gathers data for purposes that would not constitute a ***Clinical Investigation*** or ***Research*** or begins a project that is not a ***Clinical Investigation*** and/or not ***Research***, but later determines the they would like to use the data for a ***Clinical Investigation*** for ***Research*** or convert the project to a ***Clinical Investigation*** or ***Research*** project, then the Emory IRB must review and approve the project prior to the PI beginning the project or accessing and using the data for ***Research*** or ***Clinical Investigation*** purposes. Likewise, any change to the project previously determined to be not Human Subjects Research, or not a Clinical Investigation that could change the determination should be brought to the IRB for clarification.

Failing to Submit a Project for Emory IRB Review: If a PI fails to submit a project/study for Emory IRB review and the project/study is one that would have qualified as a ***Clinical Investigation*** or ***Human Subjects Research*** that should have been subject to Emory IRB review,

then the IRB will consider it an incidence of noncompliance and shall follow the P&Ps for handling noncompliance investigations. Sanctions that the IRB may impose include but are not limited to the prohibition on the use of any data collected for the project/study prior to obtaining Emory IRB review/approval for research purposes; and publication of retractions or corrections. Findings or results generated prior to obtaining Emory IRB review/approval may not be published, presented or used to satisfy any educational program requirements for a thesis or dissertation, unless otherwise authorized by other applicable academic Emory policies.

The same policies as stated immediately above shall also apply to cases where a PI fails to submit to the Emory IRB for review and approval in its role as ***Institutional Privacy Board*** any ***Research*** activities that involve access to or use of data from a ***Covered Entity/Covered Component*** of a ***Hybrid Covered Entity*** regarding ***Human Subjects*** that concerns health, health care and/or payment for health care and contains identifiers***.***

After-the-fact Approval Prohibited: The Emory IRB cannot give after-the-fact approval to a PI who requests Emory IRB approval to continue a ***Clinical Investigation*** or ***Human Subjects Research*** that was initiated without Emory IRB review/approval, nor can it give after-the-fact approval to use data for a ***Clinical Investigation*** or ***Research*** that was collected with the intent of being used for a ***Clinical Investigation*** or ***Research*** without prior Emory IRB approval.

In addition, the Emory IRB may not approve protocols in which it appears that the PI attempted to circumvent IRB review or these P&Ps by collecting data as non-***Research/***non-***Clinical Investigation*** data and then applying to the Emory IRB for use of the data in **Research and/or a *Clinical Investigation*.** PIs should err on the side of caution and seek Emory IRB review and approval for any project/study concerning or involving humans***,*** particularly if publication of the project/study is anticipated.

Similarly, PIs should seek Emory IRB approval for the use of or access to any data from a ***Covered Entity*** or ***Covered Component*** of a ***Hybrid Covered Entity*** concerning health, health care and/or payment for health care that contains identifiers and that the PI believes they may want to access/use for ***Human Subjects Research*** purposes.

Engagement as it relates to *Multi-site/Collaborative Research*: When an agent of Emory is performing research activities on-site at another institution that constitute engagement or when Emory is participating as a site in a multi-site protocol, Emory IRB Review is required for Emory investigators. Alternatively, Emory may choose to cede IRB review to another institution via a ***Reliance Agreement***. If Emory determines that the Emory personnel's involvement in the protocol does not constitute "engagement" or determines that the Emory personnel is not acting as an agent of Emory for the purpose of the research, Emory IRB Review (or a ***Reliance Agreement***) is not required.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.101 through 56.105
45 CFR Part 46, including 46.101 and 46.102
45 CFR Part 162, including 162.103
45 CFR Part 164, including 164.501, 164.504, and 164.530

DOD Instruction 3216.02, 2022

30 EXEMPT RESEARCH

POLICY:

Certain categories of ***Human Subjects*** **Research** are ***Exempt*** under the federal regulations. Prior to its initiation, the ***Research*** must be determined to be ***Exempt*** by qualified personnel at the IRB Office or members of the IRB (such as experienced team leads, the IRB Director, a qualified IRB member, ***Chair*** or a ***Vice Chair***), or by a designated IRB of a collaborating institution***.*** Investigators and those with any other conflict of interest in the research are not permitted to make a determination that ***Research*** is Exempt.

Prior to initiation of research, all ***Exempt Research*** protocols must be reviewed by qualified IRB staff or an IRB member to ensure that the study meets the principles embodied in the Belmont Report and exempt criteria under the Common Rule. All Exempt Research protocols must also be reviewed and approved by the University via the PI's department chair or authorized approver before determination of Exempt Research by the Emory IRB.

For ***AVAHCS Research*** or other VA-supported ***Research*** that is not otherwise subject to ***FDA Regulations,*** only the minimal risk categories of ***Research*** set forth in VHA Directive 1200.05(02), Appendix A may be classified as ***Exempt Research***. In addition to an experienced member of the IRB making an exempt determination for VA Research, IRB administrators or IRB staff who have appropriate training and experience may make these determinations also.

For ***DOE Research***, when conducting classified research, the use of exemptions is prohibited. The fact that research meets a particular exemption category may be noted, but review by a convened IRB is required.

PROCEDURES:

Categories of Research that may be determined to be *Exempt Research:*
DHHS or Agency heads retain final judgment as to whether a particular activity is covered by the federal ***HHS Regulations***.

DHHS or Agency heads may require that specific research activities or classes of research activities conducted, supported, or otherwise subject to regulation by the Department or Agency but not otherwise covered by ***HHS Regulations***, comply with some or all of the requirements of this policy.

Additionally, other pertinent international, federal, state or local laws may require IRB review or other additional protections for human subject for specific research projects that might otherwise be categorized as exempt.

For studies determined to be exempt on or after the compliance date of the ***Revised Common Rule:***

Categories of Research that may be determined to be *Exempt Research:*
Pursuant to applicable ***HHS*** and ***VA Regulations,*** University approval via appropriate

department chair and/or ***AVAHCS*** approval via the RDC, but not convened or expedited IRB review and approval is required for ***Human Subjects Research*** that involves no more than minimal risk and falls solely in one or more of the following categories.

Limited IRB review may be required for certain categories. These ***Exempt*** categories do not apply to ***Research*** involving prisoners/detainees as subjects except for research aimed at involving a broader subject population that only incidentally includes prisoners, or to ***Research*** that involves FDA-regulated products or is otherwise regulated under the ***FDA Regulations:***

> ***(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 the use of 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) information obtained is recorded in a manner that ***Human Subjects*** cannot be identified, directly or through identifiers linked to the ***Human Subjects;*** and (ii) any disclosure of the ***Human Subjects'*** responses outside the ***Research*** would not reasonably place the ***Human Subjects*** at risk of criminal or civil liability or be damaging to the ***Human Subjects'*** financial standing, employability, educational advancement or reputation; or if (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, then an IRB conducts a limited IRB review.
>
> NOTE (a): The Department of Veterans Affairs (VA) also includes loss of insurability in this category.
>
> NOTE (b): Survey Research that is conducted or supported by the ***DOD*** and that constitutes ***Research Involving Human Subjects*** will require IRB review. In addition, such ***Research*** also may require approval by an appropriate DOD Office (e.g., survey Research supported by Department of the Navy must be approved by the Navy Survey Approval Manager), typically after IRB approval has been granted.
>
> NOTE (c): In accordance with ***HHS Regulations***, Institutions with HHS-approved assurances on file will abide by provisions of Subparts A-D. Some of the other departments and agencies have incorporated all provisions of Title 45 CFR part 46 into their policies and procedures as well. However, the exemptions at 45 CFR 46.10 (2023) do not apply to research involving prisoners (i.e., Subpart C). The exemption at 45 CFR 46.104(d)(2) (i.e., for research involving survey or interview procedures or observation of public behavior) does not apply to research with children (i.e., Subpart D), except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

(3) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:

(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 research subject's responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or damaging to the subject's 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 ***HHS Regulations***.

Note (a): 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.

Note (b): If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that they 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, 2023, or for "public health activities and purposes" as described under 45 CFR 164.512(b), 2023; 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 (i) procedures for obtaining benefits or services under those programs; (ii) possible changes in or alternatives to those programs or procedures; or (iii) 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.

NOTE: For ***AVAHCS Research,*** the determination of exempt status for these research and demonstration projects must be made by the Under Secretary for Health on behalf of the Secretary of Veterans Affairs, after consultation with Office of Research and Development, the Office of Research Oversight, the Office of General Counsel, and other experts, as appropriate.

(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 U.S. Environmental Protection Agency (EPA) or the Food Safety and Inspection Service of the U.S. Department of Agriculture (USDA).

(7) Storage or maintenance for secondary research for which ***Broad Consent*** is required (see chapter 43, "*Informed Consent*," for more information about ***Broad Consent***): Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by **HHS Regulations**.

(8) Secondary research for which broad consent is required (see chapter 43, "*Informed Consent*," for more information about ***Broad Consent***): Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met:

(i) ***Broad Consent*** for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with ***HHS Regulations***;

(ii) Documentation of informed consent or waiver of documentation of consent was obtained in accordance with ***HHS Regulations***;

(iii) An IRB conducts a limited IRB review and makes the determination required by §46.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section; and

(iv) The investigator does not include returning individual research results to subjects as part of the study plan. This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

Subpart B (pregnant women, neonates, fetuses): Each of the exemptions at this section may be applied to research subject to subpart B if the conditions of the exemption are met.

Subpart C (prisoners): The exemptions at this section do not apply to research subject to subpart C, except for research aimed at involving a broader subject population that only incidentally includes prisoners.

Subpart D (children): The exemptions at paragraphs (d)(1), (4), (5), (6), (7), and (8) above may be applied to research subject to subpart D if the conditions of the exemption are met. Paragraphs (d)(2)(i) and (ii) of this section only may apply to research subject to subpart D involving educational tests or the observation of public behavior when the investigator(s) do not participate in the activities being observed. Paragraph (d)(2)(iii) of this section may not be applied to research subject to subpart D.

*For studies determined to be exempt before compliance date for the **Revised Common Rule:***

Unless otherwise required by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

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

(2) ***Research*** involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human research subject's responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, or reputation.

(3) ***Research*** involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if:

(i) the human subjects are elected or appointed public officials or candidates for public office; or

(ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

(4) ***Research*** involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

(5) ***Research*** and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine:

(i) Public benefit or service programs;

(ii) procedures for obtaining benefits or services under those programs;

(iii) possible changes in or alternatives to those programs or procedures; or

(iv) possible changes in methods or levels of payment for benefits or services under those programs.

(6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or

environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Right to Review *Research* that may Qualify as *Exempt Research:* Based on the nature of the ***Research*** and of the ***Human Subject*** populations to be involved, the Emory IRB reserves the right to require initial and continuing review and oversight of ***Human Subjects Research*** that may otherwise qualify as ***Exempt Research*** per the ***HHS,*** and/or ***VA Regulations*** and/or of protocols that may not otherwise require prior IRB ***Full Committee*** or ***Expedited*** review per ***FDA Regulations.***

Procedure for Evaluation of *Research* Protocols to Determine if they Qualify as *Exempt Research*
The following procedure applies when the Emory IRB is the IRB of record (see chapter 15 entitled "*Emory IRB Relationships with Other Institutions; Reliance Arrangement for IRB Review*")***.***

For any protocol that a PI believes constitutes ***Exempt Research,*** they must submit to the Emory IRB an IRB application, ***Research*** protocol, consent document, and all other documentation that the IRB office requests as relevant to the proper review of the project,

Upon initial receipt of this documentation, qualified IRB staff shall conduct a preliminary review in order to determine whether the ***Research*** protocol may be ***Exempt Research,*** using applicable P&Ps, federal regulations and guidance. As needed, the ***Protocol Analysts*** shall forward their recommendations in this regard to a ***Senior Reviewer***. ***The Senior Reviewer*** shall make the final determination as to whether the ***Research*** protocol is ***Exempt*** and record the category(ies) under ***HHS Regulations*** and/or VA Directive 1200.05, Appendix A, per which the protocol is ***Exempt.*** Alternatively, the ***Senior Reviewer*** may determine that the protocol is not exempt and requires review and approval. A ***Senior Reviewer*** may, at their discretion, skip the preliminary review of the Protocol Analyst, conduct the preliminary review, and make the final determination. A ***Senior Reviewer*** may not disapprove the ***Research*** protocol.

If a protocol is determined to be ***Exempt Research*** and the Emory IRB does not otherwise elect to review it, then the Emory IRB shall send a written notice of this decision to the PI; otherwise, the protocol shall be reviewed per ***Expedited Review*** or ***Full Committee Review.***

Exempt determinations for AVAHCS research: The VA Directive require that the IRB Chair, or an IRB member designated by the Chair, must review all exempt determinations. In addition to an experienced member of the IRB or Chair making an exempt determination for VA Research, IRB administrators or IRB staff who have appropriate training and experience may make these determinations also. Determinations must be recorded. VA research that is determined to be exempt will be communicated by the VA IRB liaison in the same way to the IRB (reporting to convened meetings via the meeting agenda or attachment).

Designation of *Research* as *Exempt* Does Not Preclude Emory IRB Review for HIPAA Purposes: The Emory IRB performs the functions of an ***Institutional Privacy Board*** under the ***HIPAA Privacy Rule.*** Accordingly, even though a ***Research*** protocol may not require prior IRB ***Full Committee*** or ***Expedited*** review pursuant to the ***HHS, FDA*** or ***VA Regulations,*** it may require

review and approval by the Emory IRB for HIPAA purposes.

Effective period for *Exempt Research* Determination: A determination of ***Exempt Research*** made pursuant to these policies and procedures shall be effective indefinitely; but the ***Principal Investigator*** is responsible for notifying the Emory IRB if the project changes in a way that might alter the exempt status. The Emory IRB shall review such changes to assess whether the project is still ***Exempt Research*** or requires review.

Additional Protections: The ***Senior Reviewer*** making the ***Exempt Research*** determination also shall determine whether to require additional protections for subjects (including specific informed consent procedures) in keeping with the ***Belmont Report*** guidelines. The ***Senior Reviewer*** shall include a description of these additional protections in the notice to the PI that grants ***Exempt Research*** status and assigns an appropriate category.

AVAHCS Research **that is** ***Exempt: AVAHCS Research*** protocols that receive an ***Exempt Research*** determination from the Emory IRB must be reviewed by the AVAHCS RDC prior to initiation and they must be included in the RDC's annual review of ***Research*** projects.

FDA-Regulated Protocols that May Not Require Prior IRB Committee Review: For ***Research*** regulated under the ***FDA Regulations,*** prior IRB ***Full Committee*** or ***Expedited*** review is not required for:

> A non-research, non-Clinical Investigation ***Emergency Use*** of a FDA- regulated ***Investigational Device,*** provided that the use is reported to the Emory IRB within five business days after it occurred and further provided that any subsequent use of the ***Investigational Device*** at Emory University is subject to Emory IRB review.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.102 through 56.104
38 CFR Part 16, including 16.102 and 16.119
45 CFR Part 46, including 46.101 through 46.104, 46.111, and 46.119
45 CFR Part 164, including 164.508 and 164.512
5 U.S.C. 552a (Privacy Act of 1974)
44 U.S.C. 3501 (Paperwork Reduction Act of 1995 and E-Government Act of 2002)
Social Security Act, sections 1115 and 1115A
OPNAVINST 5300.8C, 2008
SECNAVINST 3900.39D CH-1, 2018
VHA Directive 1200.05(2), 2021

31 EXPEDITED REVIEW

POLICY:

The Emory IRB may employ an ***Expedited Review*** process for the ***Initial*** or ***Continuing Review*** of ***Research*** that is no more than ***Minimal Risk*** (except as noted) and falls within a category approved for Expedited Review under the HHS Regulations or for minor changes in previously approved ***Research*** during the period (of one year or less) for which approval is authorized.

PROCEDURES:

Research **Eligible for** ***Expedited Review*****:** The Emory IRB may use ***Expedited Review*** for ***Research*** under its jurisdiction that satisfies either or both of the following criteria:

The ***Research*** protocol falls into one of the categories set forth in the provision below entitled *Categories of Research Eligible for Expedited Review* and is found by the IRB reviewer to involve no more than ***Minimal Risk*** (except as noted); and/or

The ***Research*** protocol involves ***Minor Changes*** to previously approved ***Research*** during the period of one year or less for which approval is authorized.

Categories of ***Research*** **Eligible for** ***Expedited Review***: The activities listed below should not be deemed to be of ***Minimal Risk*** simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the ***Expedited Review*** procedure when the specific circumstances of the proposed ***Research*** involve no more than ***Minimal Risk*** to ***Human Subjects***.

- The categories in this list apply regardless of the age of subjects, except as noted.
- The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.
- The ***Expedited Review*** procedure may not be used for classified ***Research*** involving ***Human Subjects***.
- The standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of IRB review (***Expedited*** or ***Full Committee Review).***

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

Category 1: Clinical Studies of drugs and medical devices when: (a) the study involves

only ***Research*** on drugs for which an ***Investigational New Drug*** application is not required (provided, however that ***Research*** on marketed drugs that significantly increases the risks or decreases the acceptability of the risk associated with the use of the product is not eligible for ***Expedited Review***) OR (b) the study involves only ***Research*** on ***Medical Devices*** for which an ***Investigational Device Exemption*** application is not required, or the ***Medical Device*** is approved for marketing and the ***Medical Device*** is being used in accordance with its approved labeling. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review.***

Category 2: Collection of blood samples by finger stick, heel, stick, ear stick or venipuncture when: (a) the samples are taken from healthy, non-pregnant adults who weigh at least 110 pounds and amounts drawn do not exceed 550 ml. in an eight week period and collection does not occur more frequently than two times per week OR (b) the samples are taken 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, and 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 two times per week. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review***.

Category 3: Prospective collection of biological specimens for ***Research*** purposes by noninvasive means such as collection of: (a) hair and nail clippings in a non-disfiguring manner; (b) deciduous teeth at time of exfoliation, or if permanent teeth, if routine patient care indicates a need for extraction; (c) excreta or external secretions (including sweat); (d) uncannulated saliva collected either in an un-stimulated fashion or stimulated by chewing gumbase or wax or by applying a citric solution to the tongue; (e) placenta removed at delivery; (f) amniotic fluid obtained at the time rupture of the membrane prior to or during labor; (g) supra and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with acceptable prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab or mouth washings; (k) sputum collected after saline mist nebulization. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review***.

Category 4: Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice excluding procedures involving x-rays or microwaves; provided, however, that when ***Medical Devices*** are employed, they must be 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 approved ***Medical Devices*** for new indications. Examples of data collection falling into this category include collection carried out by the following methods: (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 participant or an invasion of the participant's privacy; (b) weighing or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment and

flexibility testing where appropriate, given the age, weight and health of the individual. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review***.

Category 5: ***Research*** involving materials (data, documents, records or specimens) that have been collected, or will be collected solely for non-***Research*** purposes such as medical treatment or diagnosis. NOTE: Some ***Research*** in this category may be ***Exempt Research*** under the ***HHS Regulations*** as discussed in **Section 29** (*entitled: Exempt Research*). This category refers only to ***Research*** that is not otherwise ***Exempt Research***. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review.***

Category 6: Collection of data from voice, video, digital or image recordings made for ***Research*** purposes. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review***.

Category 7: ***Research*** on individual or group characteristics or behavior (including but not limited to, ***Research*** on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or **Research** employing survey, interview, oral history, focus group, program evaluation, human factors evaluation or quality assurance methodologies. NOTE: Some ***Research*** in this category may be ***Exempt Research*** under the ***HHS Regulations*** as discussed in **Section 29** (*entitled: Exempt Research*). This category refers only to ***Research*** that is not otherwise ***Exempt Research***. This category may be applied to protocols undergoing either ***Initial*** or ***Continuing Review.***

Category 8: ***Continuing Review*** of ***Research*** previously approved by the convened IRB as follows:

(a) where (i) the ***Research*** is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all ***Research***-related interventions; and (iii) the *Research* remains active only for long-term follow-up of subjects; *or*

(b) where no subjects have been enrolled and no additional risks have been identified; *or*

(c) where the remaining ***Research*** activities are limited to data analysis.

NOTE: for categories 8a and 8c the following applicability criteria apply: (1) the remaining activities must be ***Minimal Risk;*** (2) if identification of the research subjects or their responses will reasonably place them at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, insurability, reputation, or be stigmatizing, reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal; and (3) the ***Research*** may not be classified ***Research***. For category 8b the only applicability criterion is that the ***Research*** may not be classified ***Research.***

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 ever been enrolled at a particular site, the criterion that "no additional risks have been identified" is interpreted to mean that neither the investigator nor the IRB at a particular site has identified any additional risks from any site or other relevant source.

Category 9: ***Continuing Review*** of ***Research***, not conducted under an ***Investigational New Drug*** application or an ***Investigational Device Exemption,*** when the second through the eighth categories above do not apply, but the IRB has determined and documented at a convened meeting that the ***Research*** involves no greater than ***Minimal Risk***; and no additional risks have been identified (provided, however, that this determination regarding "no additional risks" does not need to be made by the convened IRB.)

NOTE: If a ***Research*** protocol has been initially approved by ***Full Committee Review***, then continuing review may **NOT** be done by ***Expedited Review*** unless the protocol falls within Categories 8 or 9 above, or if subsequent modifications have resulted in the Research meeting the criteria for categories 1-7.

IRB Process for Conducting *Expedited Review*: Triaging shall be conducted per the P&P entitled *IRB Protocol Triage & Assignment of Review Category*.

Materials for Submission: Pis shall submit all documentation that they normally submit for ***Initial*** or ***Continuing Full Committee Review,*** including the appropriate application for ***Initial*** or ***Continuing Review*** and status report for continuing ***Research***.

Assignment to *Expedited Review*: The ***Protocol Analyst*** will make an initial determination as to whether the protocol qualifies for ***Expedited Review*** using the Expedited Review Checklist. The ***Protocol Analyst*** will route those new protocols that they, have initially determined to be eligible for ***Expedited Review*** to the IRB ***Chair***, ***Vice Chair,*** or Designated Reviewer for review after verifying that the reviewer is not listed as study personnel.

Review by *Chair/Vice Chair/*Designated Reviewer: The ***Chair/Vice Chair/***Designated Reviewer, unless conflicted (see P&P entitled *Conflicts of Interest on the Part of IRB Members and IRB Staff*), will confirm or alter the determination that a protocol is eligible for ***Expedited Review*** and (when applicable) reroute it accordingly. The reviewer is expected to review all information that the convened IRB would have received had the submission gone to a convened IRB meeting. In reviewing a protocol under ***Expedited Review***, the IRB ***Chair/Vice Chair/*** Designated Reviewer shall follow the review procedures described in the P&P entitled *Possible IRB Committee Actions on Research Protocols*.

If the review of a protocol requires special expertise, the ***Chair/Vice Chair/*** Designated Reviewer and another IRB member or consultant with appropriate expertise shall review the protocol.

If the study does not meet criteria for approval, then the IRB office will inform the PI in writing

what modifications are required. The PI's modifications will be sent to back to the ***Chair/Vice Chair/*** Designated Reviewer for review and approval. In the event that ***Expedited Review*** is carried out by more than one IRB member and the reviewers disagree, the IRB ***Chair*** shall make the final determination, or if one of the reviewers is the ***Chair***, or the ***Chair*** otherwise determines in their discretion, the protocol will be submitted for ***Full Committee Review***.

No Disapprovals by Expedited Review: The ***Chair/Vice Chair/***Designated Reviewer may not ***Disapprove*** a protocol under the ***Expedited Review*** procedure; rather, the protocol must be referred for ***Full Committee Review*** if the reviewer believes that it should be ***Disapproved.***

Informing the IRB of the Results of *Expedited Review*: Any member can request to receive and review the full protocol and all supporting materials for any protocol that is to receive ***Expedited Review*** from the IRB Office. The IRB members will be apprised of all ***Expedited Review*** approvals granted by a member of their assigned IRB ***Committee*** through publication of such approvals in the agenda for the next scheduled ***IRB Committee*** meeting. Copies of any ***Expedited Review*** approval shall be made available for any optional review at the request of any IRB member.

Appeals: If the IRB makes a decision by ***Expedited Review*** that the PI believes to be unduly restrictive, the PI may request a re-review by the full IRB Committee. Any such request should be sent by the PI in writing to the IRB Chair.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.110
21 CFR Part 312
21 CFR Part 812
45 CFR Part 46, including 46.101, 46.110, and 46.402
Categories of Research that may be Reviewed by the Institutional Review Board (IRB) through an Expedited Procedure, 63 FR 60364-60367, November 1998

32 FULL COMMITTEE REVIEW

POLICY:

The Emory IRB shall refer for ***Full Committee Review*** those protocols that (a) do not otherwise qualify for a designation of ***Does Not Constitute Human Subjects Research***, ***Exempt Research***, or ***Expedited Review***; and/or (b) are being referred for ***Full Committee Review*** at the discretion of the IRB in accordance with applicable policies and regulations.

PROCEDURES:

Full Committee Review: Assignment of submissions to ***IRB Committees*** for ***Full Committee Review*** will be made based upon the expertise of the members on the ***IRB Committee*** and workload.

Primary and Secondary Reviewers:

Selection: Qualified IRB staff will assign each protocol to a primary and secondary reviewer from the members of the ***IRB Committee.*** All ***IRB Committee*** members will be able to view the assignments. All submissions that require ***Full Committee Review*** will be assigned to primary and secondary reviewers regardless of whether they are initial studies, continuing reviews, or modifications.

Assignment to primary and secondary reviewers shall be made based on scientific and scholarly expertise of reviewers; any ***Vulnerable Populations*** involved in the ***Research*** and the experience of the reviewers with those populations; absence of conflict of interest on the part of the members; and/or workload. At least one reviewer who has appropriate scientific or scholarly expertise and/or experience with any ***Vulnerable Population*** involved shall be assigned to conduct an in-depth review of the protocol. If the IRB staff cannot identify an IRB Member who has the necessary experience, then the IRB ***Chair*** or ***Director*** may solicit Consultants from the University or the community with the necessary expertise to assist. Each submission must be reviewed by at least one IRB member.

Written Review: The primary and secondary reviewers will in general provide written reviews of each protocol assigned to them, using the IRB reviewer worksheets to guide their review. Each reviewer's written comments should be submitted to the IRB office at least one business day prior to the scheduled meeting to allow time for the primary reviewer to view the comments and for relaying questions to the study team, if applicable. Written comments cannot substitute for review of the submission at a convened ***IRB Committee*** meeting.

Presentation: At the convened ***IRB Committee*** meeting, the primary reviewer will present the protocol to the IRB including an overview of the aims, design, study procedures, safety monitoring, and qualifications of the ***Investigators.*** And shall lead the ***IRB Committee*** through the completion of the regulatory criteria for approval, as set forth in the IRB checklist appropriate to the type of review (i.e., ***Initial Review***, ***Continuing Review***, ***Modification***). The primary reviewer shall present or allow the presentation of any review comments from the secondary reviewer.

Recommendations: The primary reviewer shall make a recommendation to the ***Chair/Vice Chair*** regarding the action to be taken with regard to the protocol (e.g., ***Approval, Approval Pending, Deferral, Tabled*** or ***Disapproval***), as well as any necessary subpart determinations for vulnerable populations (e.g., ***Prisoner***, ***Pregnant Women, Minors***, **Ward of State**); risk status (***Minimal Risk*** or ***Greater than Minimal Risk***); approval period; risk of device (as applicable) and granting of a partial or complete ***Waiver of HIPAA Authorization*** or of ***Informed Consent*** (as applicable).

Absence of Primary Reviewer at a Meeting: If the primary reviewer is not present at the ***IRB Committee*** meeting, the secondary reviewer shall assume their duties. If neither the primary nor secondary reviewers are present at the ***IRB Committee***, any tertiary reviewer or presiding ***Chair*** shall assume the presentation duties. If none of the reviewers assigned to review a ***Research*** protocol is present at the ***IRB Committee*** meeting, and no other IRB member present has conducted a thorough review, the ***Research*** protocol shall be ***Tabled*** and rescheduled for presentation at the next meeting of the same ***IRB Committee***, or alternatively provided to other reviewers on another ***IRB Committee*** for review.

IRB Committee* Action**: After hearing primary and secondary reviewers, the ***IRB Committee shall discuss the protocol and entertain a motion and vote on the action that should be taken with regard to the protocol in accordance with the P&P *entitled Possible IRB Committee Actions on Research Protocols*. The IRB office shall notify the PI in writing of the action of the full Committee with regard to the PI's protocol.

For Full Committee review of Reportable Events and Noncompliance, the IRB uses the following Standard Operating Procedure: *Process for reviewing NC/UP cases*

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.50 through 50.54
21 CFR Part 56, including 56.107 through 56.109, 56.111. 56.115
38 CFR Part 16, including 38.107 through 38.109, 38.111, and 38.115
45 CFR Part 46, including 46.107 through 46.109, 46.111. 46.115, and 46.403 through 46.407

33 IRB MEETINGS

POLICY:

Each ***IRB Committee*** will hold regularly scheduled meetings for the purpose of providing initial and continuing review for ***Research*** protocols and modifications that come before the Emory IRB and for conducting IRB business. A ***Quorum*** must be present in order to conduct an official ***IRB Committee*** meeting.

See Glossary **for the definitions of the following relevant terms:**

- Full Committee Review
- Full Committee
- Full Review
- Quorum

PROCEDURES:

Convened IRB Meetings: Except when an ***Exempt Research*** or ***Expedited*** **Research** review procedure is used, the IRB must review proposed Research at convened meetings at which a ***Quorum*** is present.

Meeting Schedule and Location for IRB Committees: The IRB staff, in consultation with the ***Chair or relevant Vice Chair***, shall schedule any meeting of an ***IRB Committee***. In general, each biomedical IRB panel meetings once per month. The sociobehavioral IRB meets monthly only as needed when there are sociobehavioral studies requiring full board review; otherwise, the meetings are not held. The IRB staff shall be responsible for providing written notice to all IRB members of the date, starting time and location of each ***IRB Committee*** meeting, as well as of any changes to or cancellation of meetings. The staff shall also publish the meeting schedule for the benefit of the researchers. The schedule for ***IRB Committee*** meetings may vary due to holidays, lack of a ***Quorum***, emergency circumstances, or other events (e.g., inclement weather). In addition, special meetings may be called at any time at the request of the ***Chair*** or ***Director.***

Attendance at Meetings: All IRB members shall be diligent in attending ***IRB Committee*** meetings and arriving at the meetings at their designated start time. IRB members in attendance shall be recorded in the minutes for each ***IRB Committee*** meeting. IRB members who will not be able to attend a scheduled meeting should notify the IRB ***staff*** of this fact as far in advance as possible of the ***IRB Committee*** meeting. Repeated attendance problems may be cause for removal of an IRB member.

Guests at Meetings: Individuals not associated with the HRPP administration such as researchers, fellows, prospective members, and students, may observe an IRB meeting with the permission of the Chair, relevant Vice Chair or IRB Director for purposes related to the mission of the University. In general, guests should not speak unless first recognized by the IRB ***Chair/Vice Chair*** but are encouraged to seek the permission of the presiding Chair/Vice Chair to

contribute nonbinding comments to the discussion in good faith.

All persons, whether regular attendees or guests, who attend the ***IRB Committee*** meeting must sign an appropriate ***Confidentiality and Non-Disclosure Agreement*** (see the P&P *entitled Confidentiality Obligations for IRB Administrators, Members, Consultants/Outside Reviewers & Staff***)**, with the exception of PIs who may be present at the during the discussion of their ***Research*** (see provision below entitled *Presence of PIs at IRB Committee Meetings*).

Attendance by Telephonic Means: An IRB member may attend an ***IRB Committee*** meeting by telephonic means if the following requirements are met: (a) the IRB member receives all materials for review ahead of the meeting; (b) the IRB member has the materials with them during the call; (c) the IRB member uses a telephone in a private area where the conversation cannot be overheard by others; and (d) the IRB member communicates using a speaker phone present at the meeting place per which the IRB member may speak to and be heard by all other IRB members present at the meeting place. An IRB member present by telephonic means may be counted toward ***Quorum.***

Leadership of IRB Meetings: An IRB ***Chair*** or ***Vice Chair*** (or designated voting member or IRB Director, if the IRB Chair or Vice Chair is not able to be present at the start of the meeting) shall call the meeting to order. An IRB Chair or Vice Chair must be present during each ***IRB Committee*** meeting. In case the presiding Chair or Vice Chair must recuse themself, before leaving the meeting room, they shall designate a voting member to preside *pro tem*.

IRB Staff at Meetings: Designated IRB staff will be in attendance at each ***IRB Committee*** meeting to take minutes and to provide information and support. Whenever possible, the IRB Director should attend to educate and advise as needed.

Distribution of Materials for Meetings: Prior to placing a protocol on the ***IRB Committee*** meeting agenda, the ***Protocol Analyst*** shall review each application received for completeness and regulatory compliance using the relevant checklist. The IRB ***Director****, or designee,* shall oversee the ***Protocol Analyst's*** preparation of an agenda for each ***IRB Committee*** meeting. The agenda will set forth the place and time of the meeting and include review assignments and all items of business for the meeting.

The IRB office will distribute to each IRB member the agenda and access to the studies on the agenda via the IRB's electronic submission system approximately one week prior to the meeting, along with other materials via email if applicable (items may be added later than this to the agenda if necessary and if the Chair determines that the members have ample time to thoroughly review the submission before the meeting). Depending on the type of submission (new study, modification, continuing review, reportable event) documents may include:

> Complete IRB application form for the agenda item. This will include the full protocol, application, or a protocol summary containing the relevant information to determine whether the proposed research fulfills the criteria for approval;
>
> Proposed consent;
>
> Parental permission/assent form(s) and revocation letters (if applicable);

Proposed HIPAA authorization materials;

Recruitment materials/subject information;

Data collection instruments (including all surveys and questionnaires);

Any relevant grant application(s);

Any investigator's brochure;

Any HHS approved sample informed consent document; and

Any HHS approved protocol.

If any IRB member requires additional information to complete their review, they may contact the PI directly, or contact the IRB office to request additional information.

Meeting Procedures: The following procedures shall be followed with regard to the conduct of each ***IRB Committee*** meeting:

Quorum: The IRB ***Chair or Vice Chair*** (or designated voting member or IRB ***Director***) shall call the ***IRB Committee*** meeting to order when a ***Quorum*** is in attendance. A current membership roster reflecting compositional requirements shall be available for reference. Quorum is documented in the minutes.

No official Emory IRB business may be conducted unless a ***Quorum*** is present, The IRB ***Chair or Vice Chair***, with the assistance of the IRB staff***,*** will be responsible for ensuring that an appropriate ***Quorum*** is present prior to calling the meeting to order and throughout the conduct of the meeting.

At least one member who represents the general perspective of subjects must be present at meetings of the convened IRB. This role will be fulfilled by an unaffiliated (also known as "community"), non-scientist member. The attendance of an unaffiliated non-scientist shall be recorded in the meeting minutes. Without such a member in attendance, the meeting may not proceed with business.

Votes may only occur when a ***Quorum*** is present. In order for a protocol to be approved it must receive the approval of a majority of all voting members present at the time the protocol is reviewed. IRB staff present at the meeting will take note of arrivals and departures of all members and notify the IRB ***Chair*** if ***Quorum*** is lost. If at any time during an IRB ***Committee*** meeting ***Quorum*** is lost, then the protocol must be tabled until ***Quorum*** is restored. If ***Quorum*** cannot be recovered, the meeting must be adjourned.

IRB members who have conflicts of interest with regard to ***Research*** protocols or other matters that are being reviewed by the IRB ***Committee*** must recuse themselves and leave the room/teleconference during discussion and voting on such matters and

cannot be counted toward ***Quorum*** for such matters. The ***Chair*** should remind members at the start of the meeting about the need to identify and disclose such conflicts of interest.

Department of Energy-Supported *Research*: The DOE requires:
(a) When conducting classified research, the IRB must have a voting quorum of at least five members, which must include both a non-scientist and a non-affiliated member.
(b) The non-affiliated member must be a non-governmental member with the appropriate security clearances. This individual cannot be a current federal employee or contractor.
(c) Any IRB member can appeal a vote to approve research to the Institutional Official, Secretary of Energy, and Director of the Office of Science and Technology, in that order

Technology: In general IRB members are provided with laptop computers to review materials during the meeting, and documents may also be displayed on a projector. In cases where meetings are conducted using remote technologies (e.g. Zoom), documents will be displayed for IRB members whenever possible.

Length of Meeting: IRB members shall be permitted time during the ***IRB Committee*** meeting for thorough discussion of all items on the agenda. IRB Staff will work with the IRB Team Lead, Director, and Chair to ensure that the number of items to review on an agenda is feasible and does not unduly burden the reviewers. Meetings are generally not given a predetermined end time. The ***IRB Committee*** meeting shall continue from the time ***Quorum*** is established until the earlier of the time that ***Quorum*** is lost, or all items of business shown on the agenda have been discussed or the ***Chair*** adjourns the meeting. In general, IRB members shall refrain from leaving ***IRB Committee*** meetings before all items of business are discussed and shall advise the IRB staff or IRB ***Chair*** in advance of any need to leave before the ***IRB Committee*** meeting's conclusion.

Reviewers: Reviews are routed and assigned in accordance with these P&Ps (see P&P entitled *Full Committee Review*). Reviewers shall thoroughly review all ***Research*** protocols assigned to them in advance of the ***IRB Committe*****e** meeting and make presentations at the meeting as described in the P&P entitled *Full Committee Review*.

Discussion: After each reviewer's presentation is complete, the ***IRB Committee*** will discuss any issues concerning the review of the ***Research*** protocol and then vote on the ***Research*** protocol. The primary reviewer shall include in their presentation a recommendation as to Committee action, risk level, etc., as discussed in the P&P entitled *Full Committee Review*).

Voting: Voting shall generally be done by voice vote; however, the ***Chair/Vice Chair*** in their opinion, may permit voting by other methods, e.g., hand vote, written ballot. Each voting member receives one vote (no vote is counted for members who are present but not eligible to vote on a given item, for example who are serving solely as consultants on specific studies, or as alternates available to vote if quorum would be lost due to recusal of other members. Voting by proxy is not permitted. For each ***Research*** protocol, any member may make a motion for a vote. In addition, in the case of ***Research*** protocols involving ***Minors***, the appropriate ***Pediatrics***

Designation for the ***Research*** protocol shall be expressly included in the motion brought to a vote. Motions shall carry by a majority of the persons voting, and in the event of a tie, the recommendation/motion will not carry, and the matter will be deferred to another ***IRB Committee*** meeting. Votes for the following categories shall be sought and recorded in the minutes: Total votes, Yes (or in favor), No (or opposed), and Abstained.

Voting on Matters Other than *Research* Protocols: Other matters to be voted on by the ***IRB Committee*** shall be placed before the ***IRB Committee*** in terms of a motion and votes on the motion shall be taken and recorded in the same manner as set forth above in the provision entitled *Voting***.**

Presence of PIs at IRB Committee Meetings: The ***IRB Committee*** may request a PI to come to/call in for the ***IRB Committee*** meeting to address questions concerning their ***Research*** protocol. Similarly, a PI may request to come to the IRB Committee to make a presentation regarding their ***Research*** protocol. Any such request should be made with reasonable notice in advance of the ***IRB Committee*** meeting at which the PI's protocol is to be discussed, and the IRB ***Chair or Vice Chair*** shall review and grant or deny the request, as determined in their reasonable discretion. The IRB should notify the PI of the decision in writing.

The IRB staff shall notify each PI whose ***Research*** protocol is being reviewed at an ***IRB Committee*** meeting that their ***Research*** protocol is being considered, and may request from the PI a telephone number at which the PI may be contacted during the time of the meeting for questions from the ***IRB Committee***.

If a PI attends an ***IRB Committee*** meeting regarding their ***Research*** protocol, then the PI should be present only for the discussion of their ***Research*** protocol and not for the discussion or voting on another PI's ***Research***. The PI should be excused and leave the room/teleconference for any sensitive discussion and the vote on their ***Research***.

At the request of the ***IRB Committee,*** telephone or videoconferencing software shall be used to contact the PI for information during the meeting.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.51 through 50.54
21 CFR Part 56, including 56.107 through 56.109, 56.111. 56.115
38 CFR Part 16, including 38.107 through 38.109, 38.111, and 38.115
45 CFR Part 46, including 46.107 through 46.109, 46.115, and 46.403 through 46.407

34 MINUTES OF AN IRB MEETING

POLICY:

Written minutes must be taken of all IRB meetings and be available for review by IRB members by the next regularly scheduled meeting date. Minutes must meet all requirements set forth in ***HHS, FDA*** and ***VA Regulations***, as well as all institutional requirements.

PROCEDURES:

Procedure for Recording Voting in Minutes: IRB staff who are present at the ***IRB Committee*** meeting and the IRB ***Director/Associate/Assistant Director*** who is present at the ***IRB Committee*** meeting shall be responsible for counting and confirming the votes on each matter brought to a vote. All votes shall be recorded in the minutes as the total number, number in favor (or yes), number opposed (or no), and number abstaining.

Contents of Minutes: Minutes of each ***IRB Committee*** meeting shall at a minimum contain the following elements:

Attendance: A record of attendance of members, noting the key compositional requirements for ***Quorum*** and noting which members are eligible to vote, and a record of attendance of guests at the ***IRB Committee*** meeting.

Attendance by Alternate Means: A record of those members or alternate members who participated in the meeting through videoconference or teleconference (speakerphone) and documentation that those attending via such means received all pertinent material prior to the meeting and were able to actively and equally participate in all discussions.

Quorum*:** A record of ***Quorum and/or loss of ***Quorum*** at each Emory IRB meeting, including presence of one member whose primary concern is in a non-scientific area. Minutes shall specifically note changes in the voting members present during voting on each item throughout the meeting, in order to document the maintenance of ***Quorum***. The minutes shall also note when departing members are replaced by other members during the meeting in order to maintain quorum.

Actions taken by the IRB: A record of actions in sufficient detail to show the actions taken by the IRB at the convened meeting. The minutes shall reflect separate deliberations, actions and votes for each protocol undergoing initial review, continuing review or review of modifications by the convened IRB.

The IRB shall use the minutes, the meeting agenda, an appendix thereto, or the eIRB system to notify IRB members of actions taken through ***Expedited Review***.

Votes*:* A record of votes taken by the ***IRB Committee*** on all actions, including the total number of votes, the number of votes for, against and abstaining. The vote on each action will reflect those members eligible to vote on that item.

Basis for Action: A description of the ***IRB Committee's*** rationale for requiring changes in or disapproving a protocol.

Discussion of Controverted Issues and their resolution: A written summary of ***IRB Committee*** discussion of issues, including those involving opposing views, and their resolution.

Justification for Changes to HHS Approved Consent Documents: A record of the justification for any deletion or substantive modification of information concerning risks or alternative procedures contained in HHS-approved sample consent documents.
Conflict of Interest: For any ***IRB Committee*** meeting in which an IRB ***Chair***, ***Vice Chair*** or IRB member recuses themself due to a conflicting interest with the research under review, the minutes reflect that a conflicting interest has been disclosed and that the individual with the conflicting interest left the meeting and was not involved in any discussion of or voting on the protocol in question and was not counted towards ***Quorum*** for the discussion.

Vulnerable Populations: A record that reflects that the IRB reviewed additional safeguards to protect ***Vulnerable Populations*** (as described in the P&P entitled *Review of Research Protocols Involving Vulnerable Populations*) if entered as study subjects, if this information is not otherwise documented in IRB records.

Review Period: For ***Initial*** and ***Continuing Review***, a record of the duration of the approval granted to each protocol, as determined by the IRB.

Risk Level: The risk categories to be used are minimal risk or greater than minimal risk.

HIPAA: A record indicating the approval of a waiver or alteration of the ***HIPAA Authorization*** requirement. The presence of a HIPAA waiver/alteration worksheet within the electronic study submission, which describes how each criterion for a waiver/alteration is met, will suffice for a record of why the waiver/alteration was granted. Any additional discussion of how the study does or does not satisfy those criteria will be recorded in the minutes.

Consultants (and *ad hoc* Reviewers): A record of key information provided by Consultants if any.

Required Findings: Description of any required findings that IRB must make with regard to particular protocols along with the protocol-specific information justifying each IRB finding. In particular, documentation shall be included that:

> Establishes that the ***Research*** meets each of the required criteria of 45 CFR Section 116 (f) along with protocol-specific information to justify why the IRB considers the ***Research*** to meet each criterion 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 informed consent.

Establishes that the ***Research*** meets each of the required criterion in ***HHS Regulations*** along with protocol specific information justifying why the IRB considers the ***Research*** to meet each criterion when the requirements for written documentation of consent are waived;

When approving ***Research*** that involves populations covered by ***HHS Regulations*** Subparts B, C, or D, the minutes shall set forth the protocol specific justifications and findings regarding the determination stated in the Subparts, or the IRB's agreement with the findings and justifications as presented by the ***Investigator*** on IRB forms

When applicable under the FDA Regulations: rationale for significant risk/non-significant risk device determinations.

Accuracy of Minutes: ***IRB Committee*** meeting minutes must accurately reflect the discussion and voting that took place at the meeting. ***Protocol Analysts*** who attend the IRB Committee meeting and take notes during attendance are responsible for preparing the minutes.

Finalizing Minutes: After a draft of the minutes is complete, it shall be distributed to the IRB Committee members of the relevant panel for review. If no comments are received within the timeframe noted in the distribution correspondence, the minutes are determined to be finalized.

Alteration of Minutes: Modifying the minutes of an ***IRB Committee*** meeting by any IRB member, administrator, staff member or other party to reflect events that did not occur at the meeting is strictly prohibited. In addition, it is prohibited to add to or correct finalized minutes, to align with factual events and discussion, without distribution to the IRB Committee for review and acceptance with the exception of minor administrative (non-substantive revisions such as correction of typos) can be made following final approval without rerouting. Violation of either of these prohibitions may be grounds for removal from the Emory IRB or dismissal from an administrative or staff position with the Emory IRB.

Availability of Minutes: All IRB minutes shall be available for inspection and copying by OHRP or the FDA upon request. Minutes concerning the review of ***AVAHCS Research*** will also be available to the RDC in a timely fashion after their approval. The RDC, ORO, the local VA research office staff, and the RCO shall have access to all non-redacted records of the IRB concerning the review of ***AVAHCS Research*** within two days of a request A copy of the IRB approved minutes for each IRB meeting shall be distributed to the IO, leaders of the Offices of Compliance and University Counsel upon request. For ***Multi-site Research*** for which Emory is serving as the ***Reviewing IRB***, the study-specific portion of the minutes shall be available to IRB representatives and study team members from the ***Relying Parties*** for inspection and copying upon request.

Retention of Minutes: IRB minutes shall be kept according to the document retention specifications set forth in Section 26 (*entitled: Documentation and Records Retention*).

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.50 through 50.54
21 CFR Part 56, including 56.107 through 56.109, and 56.115
38 CFR Part 16, including 38.107 through 38.109, and 38.115
45 CFR Part 46, including 46.107 through 46.109, 46.115, and 46.403 through 46.407
45 CFR Part 164, including 164.308, 164.310, 164.312, 164.512, and 164.530

35 CONFLICTS OF INTEREST – INVESTIGATORS

POLICY:

Participation by academic or staff members in external activities that enhance their professional skills or constitute public service can be beneficial to the University as well as to the individual. However, such activities can lead to conflicts of interest regarding an Investigator's responsibility to the University. Accordingly, Emory University has adopted a policy regarding Financial Interests in Research, with which Investigators are expected to comply.

Please note that, for ***Conflict of Interest*** purposes, the term **Investigator** is defined as follows:

> The Project Directors, ***Principal Investigators***, members of the research team identified as senior/key personnel on the grant or contract application, progress report, or any other report, and individuals identified by the ***Principal Investigator*** or Project Director who are responsible for and have substantial independent decision making in respect to the design, conduct or reporting of the research, such as Collaborators or Consultants named on the grant.

PROCEDURES:

General Conflict Management:
With regard to Research protocols submitted for IRB review, all Investigators who are PIs, Project Directors, Senior Key Research personnel, and individuals having responsibility for and substantial independence in decision making with respect to the design, conduct or reporting of the research, must follow all applicable Emory University Policy for Investigators Holding a Financial Interest in Research, Emory Policy 7.7.

Researchers involved in VA Research must disclose conflicts of interest. This means disclosing to the IRB any potential, actual, or perceived conflict of interest of a financial, professional, or personal nature that may affect any aspect of the research and complying with all applicable VA and other federal requirements regarding conflict of interest. All VA Research, even research reviewed by an affiliate IRB, must have the OGE Form 450 Alternative VA for the investigators reviewed by the Financial Conflict of Interest (FCOI) administrator or Office of General Counsel (OGC). The AVAHCS is in charge of obtaining this form for all researchers per this requirement.

The following procedures apply when the Emory IRB is responsible for reviewing management plans for investigators. In cases where the Emory IRB has ceded review to an external IRB, the applicable IRB ***Reliance Agreement*** may stipulate other procedures for review of Conflict of Interest management plans. The terms of such ***Reliance Agreements*** are subject to prior review by the Conflict of Interest Office and the Office for Research Compliance in addition to the ***IRB Director*** and ***Institutional Official***.

IRB Subcommittee Review of the COI Management Plan: When the Emory Conflict of Interest and Conflict of Commitment (COI/COC) Office identifies a ***Significant Financial Interest*** Requiring Disclosure (SFI), the COI/COC office must provide the IRB with documentation

establishing theCOI Review Committee decision (pending final approval of the management plan) regarding the ***Significant Financial Interest***, as well as a copy of any management plan. The Compliance Review (CoRe) team will review any management plan to determine if the SFI will adversely affect the protection of Human Subjects and if the management plan is adequate.

Referral to ***Full Committee Review***: If the CoRe team requests additions to the plan that the PI does not agree with, the recommended additions are referred to the convened meeting of the Emory IRB for further review. The full board's decision will apply. If the CoRe team is unable to make a determination, they will also refer the review (along with any recommendations) to a convened meeting of the Emory IRB.

Based on the significance of the SFI and potential for adverse effects on the protection of subjects, management plans may include:

- disclosure to subjects through the consent process,
- modifications in the Research plan,
- monitoring by independent reviewers,
- divestiture of financial interests,
- appointment of a non-interested PI, or
- prohibition of the conduct of the Research at the University.

For PHS and NSF funded activities, the COI Review Committee will determine whether an FCOI, as defined by 42 CFR Part 50, exists. The IRB Chair/Vice Chair, ***CoRe team***, or IRB Committee may require additional management tools than those required by the COI Review Committee. The IRB Chair/Vice Chair, ***CoRe team***, and IRB Committee cannot reverse the COI Review Committee's finding that a Financial Conflict of Interest exists.

VA facilities are not required to follow PHS requirements, even when research is funded by a PHS agency.

A copy of the final management plan will be filed with the IRB. A copy of the revised, IRB-approved management plan will be sent via email or hard copy to the COI Review Committee if the IRB requires substantial changes.

Alternate Paths for Identification of Potential SFI: Protocol-Specific Conflict Management
Alternatively, the IRB can be alerted to potential SFI through the IRB application, which asks protocol-specific questions regarding Financial Interests of the investigators and key personnel. Key Research personnel are those individuals who:

> 1) are identified as senior/key personnel on the grant or contract application, progress report, or any other report; or
> 2) are identified by the ***Principal Investigator*** or Project Director as having responsibility for and substantial independence in decision-making with respect to the design, conduct or reporting of the research.

If a potential SFI is disclosed in an initial IRB study submission, the IRB will refer the matter to the COI/COC Office, and the review process described in the immediately preceding section will be employed.

Change in Conflict of Interest Status and Continuing Review
If the SFI status of an Investigator changes during the course of a study, the individual is required to notify the COI/COC Office within thirty (30) working days of the change.

If the change removes an existing SFI and the COI Review Committee or Office determines that a management plan is no longer required, the IRB will accept that determination and review any modifications needed to eliminate the management plan.

If a new SFI arises, or an existing SFI changes such that the management plan requires revision by the Research Conflict if Interest Committee, any resulting management plan will be forwarded to the IRB by the COI/COC Office and will be handled per the section "Protocol-Specific Conflict Management" above. The IRB will review the change in status, along with any disclosures or protocol modifications required by an IRB-approved management plan, as a modification to the protocol. In addition, at the time of ***Continuing Review***, the Investigator will be asked whether there has been any change in the financial interest status relating to the Research. Any new disclosures will be handled as per the process directly above.

Conflicts of Interest and *Multi-Site Research* for which Emory is the *Reviewing IRB*: the following shall be true of ***Significant Financial Conflicts of Interest***:

- Individual investigators (not affiliated with any institution) or investigators affiliated with an institution that do not have a COI management process are subject to Emory University's policies and processes.
- Individuals affiliated with an institution that has a COI process are subject to their institution's COI policies and must submit their management plan to the Emory IRB. While Emory IRB will not modify the management plan, Emory may add more restrictive elements to the management plan if it is determined that more restrictive provisions are needed to protect the rights and welfare of human subjects, including not permitting the individual to be engaged in the research as investigator or key personnel.

Applicable Regulations, Policies, and Guidance:

21 CFR Parts 54, 312, 314, 320, 330, 601, 807, 812, 814, and 860
38 CFR Part 16, including 16.107
42 CFR Part 50, including 50.603
45 CFR Part 46, including 46.107
VHA Directive Section 1200.05(02)
VHA Policy and Guidance FAQ: Financial Conflict of Interest (FCOI), February 2013

36 CONFLICTS OF INTEREST ON THE PART OF IRB MEMBERS AND IRB STAFF

Any **IRB member** (or consultant), **IRB Director**, IRB staff, or must disclose a ***conflicting interest*** in a project to the **IRB Chair** or Director before the project is reviewed by the ***Full Committee***. The conflicted individual may not participate in the review of such project by any means. For studies reviewed by the ***Full Committee,*** the conflicted individual must leave the room during the discussion of and vote on such a project, except when providing information at the IRB's request. The conflicted individual will be present to provide the information but must leave the meeting for the remainder of the discussion and vote on the item.

DEFINED TERMS:

A "conflicting interest" of an IRB member (or consultant), ***IRB Director***, or IRB staff generally includes the following:

1) Participation of themself or their spouse or dependent children in a project, including serving as an investigator on the project, a member of the research team or involvement in the design, conduct, or reporting of the research;

2) Supervisory relationship between themself and the ***Principal Investigator*** of the research.

3) Financial Interest. Financial interest is defined as:

   - Receiving payments of $5,000 or more including salary; consulting fees; honoraria; and/or gifts received within the past 12 months or anticipated for the next 12 months (excluding salary, grant support, and other payments for services received from Emory University)
   - Equity or ownership interest (including stock options) valued at $5,000 or more as determined by reference to the entity's publicly listed price (excluding mutual funds)
   - Any equity or ownership interest in an entity if the entity's value cannot be determined by reference to publicly listed prices (e.g., privately held companies, such as start-up companies)
   - A position as director, officer, partner, trustee, employee, or any other position of management
   - Receipt of licensing fees or royalties from intellectual property rights (patent, copyright, trademark, trade secrets, etc.) that are more than $5,000 annually from an entity or for a technology related to an Investigator's teaching, research, administrative, or clinical duties at Emory
   - Any compensation whose value could be affected by the outcome of the research

4) Personal relationship with investigator (has an immediate family relationship or other close personal relationship with the investigator);

5) Fiduciary relationship to sponsor or the product or service being studied (serves as an executive to a company sponsoring the research or the product or service being studied

or serves on such a company's board of directors);

6) Other non-financial interests that may be conflicting interests, such as having an interest that they believe conflicts with the ability to review a project objectively;

7) Any other reason for which the individual believes they have a conflicting interest with the research;

Institutional employees responsible for human research grant or contract administration may not serve as IRB members.

PROCEDURES:

Submissions reviewed by the *Full Committee*:

The IRB meeting facilitators will compare the list of members expected to attend the meeting with the study personnel listed in the electronic submission system. If a conflict is found, the facilitators will (1) note the conflict in their facilitator materials, and (2) ensure that the conflicted member is not assigned as a reviewer for the submission.

The **IRB Chair** presiding over the meeting shall remind the members to disclose any conflicts of interest prior to discussion of the relevant item and to recuse themselves.

IRB members (or consultants), **IRB Director**, or **IRB Associate/Assistant Director**, must review the list of projects for an upcoming meeting with the conflicts issue in mind and disclose a conflicting interest as soon as possible to the IRB Chair, meeting facilitator, or Director. An **IRB member, Consultant**, **IRB Director**, or IRB staff member with a conflicting interest in a project will not accept that project for review, and the item will be reassigned to another IRB reviewer. If the only attending non-scientist or unaffiliated member has a conflicting interest, the meeting facilitator will reassign the project to another panel for review.

If an **IRB member** (or consultant), **IRB Director**, or IRB staff member recognizes a conflicting interest in a project during the IRB meeting, the individual must inform the IRB Chair of the conflicting interest and leave the meeting during the discussion of and vote on the project.

An **IRB Member** may abstain from the review, deliberation, and vote on any project if the member's own judgment warrants abstaining from the review, deliberation, and vote on a project.

If other IRB members need to request information about the project from the **IRB member** (or consultant), **IRB Director**, or IRB staff member with the conflicting interest, the conflicted person may remain in the meeting during the presentation of the project. The conflicted person must then leave the meeting during the IRB's discussion and vote.

IRB staff will record in the minutes a recusal of an **IRB member** based on a conflicting interest.

The **IRB member** will not be counted as part of the quorum for the project. Should the quorum fail in this case, the IRB may not take further action or vote on the project.

Submissions reviewed by expedited procedures:

The IRB analyst processing the submission reviews the list of study personnel in the electronic submission system and does not assign the submission to a designated reviewer who is clearly conflicted. If a designated reviewer is assigned a submission for review and is conflicted, the reviewer will not complete the review, will notify the analyst, and the analyst will reassign the submission to an unconflicted reviewer.

Applicable Regulations, Policies, and Guidance:

None

37 INDEPENDENCE OF EMORY IRB WITH RESPECT TO INSTITUTIONAL AND INVESTIGATOR INFLUENCE

POLICY

In order to fulfill its ethical obligations to protect human subjects in research, the Emory IRB must exercise autonomy and judiciousness in its thinking and decision-making. The Emory IRB should treat all human subjects with the same level of respect across protocol submissions and must refrain from showing bias toward or against any investigators based on factors such as scoring by funding agencies or the relative power and influence amongst investigators submitting protocols for review.

A request by an investigator to hasten the review of a submission is not presumed to be an attempt at undue influence.

Any offers of special monetary incentives, favors in kind, or other rewards by investigators to IRB members or staff for the guaranteed approval of a submission is presumed to be an attempt at undue influence and must be reported to the appropriate IRB or institutional officials.

PROCEDURES FOR ASSESSING UNDUE INFLUENCE

The Emory IRB shall first determine whether an inappropriate and unethical inducement was presented by an investigator to an IRB member or staff such as special monetary incentives, favors in kind, or other rewards for the guaranteed approval of a submission.

If the action by the investigator is determined not to presumptively constitute undue influence, the Emory IRB shall then determine whether the action in question is reasonable or justified. The IRB shall take into consideration its own possible responsibility in creating delays in the review process in determining whether the actions of the investigator are reasonable or justified.

The Emory IRB shall make all attempts not to obstruct the conduct of ethical research involving human subjects at Emory and shall consider requests from investigators to put a submission on the agenda of a certain scheduled IRB meeting on a case-by-case basis.

To evaluate such requests, the IRB Director (or designee such as the Chair or a Vice Chair) shall consider the interests of the prospective human subjects for the submission at issue, the size of the agenda with respect to meeting time, the availability of appropriately qualified reviewers, and whether the request constitutes undue influence or a reasonable and justifiable request. The IRB Director (or designee) will ensure that proper pre-review is conducted and on the merits of the pre-review, shall not agree to place the submission on the requested agenda unless the submission is deemed reasonably likely not to be deferred.

PROCEDURES FOR REPORTING UNDUE INFLUENCE

Emory IRB staff, who may be vulnerable to attempts by investigators to unduly influence their prioritization of assignments or the actions of IRB members, should report any such attempts

promptly to the IRB Director. In cases where the IRB Director, Chair, or Vice Chair is perceived as acting as an agent of an investigator attempting to unduly influence IRB staff or members, such attempts should be reported to the IO. The Director and/or the IO, either singly or in consultation with each other, will investigate the situation carefully and make reasonable and good faith efforts to protect the autonomy of the IRB members and staff in fulfilling their responsibilities and to mitigate any damage caused by attempts at undue influence. The person(s) investigating and managing allegations of undue influence may consult other qualified officials, such as the Director of Research Compliance.

In addition, Emory employees and students may call the confidential, vendor-serviced Trustline to discuss or report concerns about inappropriate or unethical conduct of the IRB.

AVAHCS-appointed IRB members may directly contact the AVAHCS Facility Director if they experience undue influence or if they have concerns about the IRB.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107
38 CFR Part 16, including 16.107
45 CFR Part 46, including 46.107

38 POSSIBLE IRB ACTIONS ON HUMAN SUBJECTS RESEARCH PROTOCOLS

POLICY:

In order to provide initial and/or continuing review and review of modifications related to nonexempt Human Subjects ***Research*** protocols that come before it, the Emory IRB, depending on the type of protocol involved, shall provide ***Full Committee Review*** (at a convened meeting with proper quorum) or ***Expedited Review.***

For ***Full Committee Review*** the IRB shall take one of the following actions by a separate vote for each submission (i.e., may not batch protocols together under a "block vote"): ***Approval; Approval Pending Modifications*** *(i.e., specific minor revisions);* ***Deferral; Disapproval; or Table***. For studies reviewed by the Full Committee: if substantive and complex additional information is needed to assess that required criteria for approval are met per 45 CFR 46.111/21 CFR 56.111, responsive information requires review by the convened IRB, thus the submissions must be ***Deferred*** or ***Tabled***. ***Deferred*** and ***Tabled*** studies must return to ***Full Board*** for review, unless changes are made such that the study meets the criteria for expedited review.

For ***Expedited Review***, since voting does not take place, the IRB is authorized to ***Approve***, but may not ***Disapprove*** human subjects research. If the reviewer(s) conducting the review require revisions in order to approve, the IRB may consider this a state of ***Expedited Approval Pending***, but this term has no bearing on the effective date of the final approval. If the preliminary review leads to sufficient doubt as to the potential for eventual approval, the IRB must refer the application to ***Full Committee*** Review unless the PI withdraws the application, at their discretion. Only at ***Full Committee*** may the IRB ***Disapprove*** a protocol.

The IRB shall determine the period for which ***Continuing Review*** shall be required based on the ***Revised Common Rule*** requirement, risk level, risk-benefit ratio, etc.; provided, however, that every protocol requiring ***Continuing Review*** shall receive ***Continuing Review*** from the IRB not less than once per year. No non-***Exempt Human Subjects Research*** activities may be performed on any protocol that does not have current IRB approval.

PROCEDURES:

Actions for nonexempt ***Human Subjects Research*** **Protocols**: The Emory IRB may take any of the following actions specified in the following table with regard to a protocol that is presented to the Emory IRB for initial or continuing review.

ACTION	ACTION DATE	EFFECTIVE DATE OF APPROVAL	DESCRIPTION	TAKEN BY (*Expedited Review*)	TAKEN BY (*Full Committee Review*)
Approval	***Full Committee:*** Date of meeting	***Full Committee:*** Date of meeting or*	Action taken if ***Research*** protocol can be approved AS IS without the	***Chair, Vice Chair*** or qualified member	Majority of voting IRB members present if

	***Expedited**:* Date of decision by reviewer. **Admin (for Minor Admin. Revisions):** Date of decision by reviewer	***Expedited and Admin:*** Date of decision or: *__BOTH:__ may assign a prospective date (i.e., for continuing review period to begin after expiration of previous approval period if it is within 30 days of approval)	need for any changes or corrections.	designated to review. ***IRB Staff, Chair, Vice Chair*** for Minor Admin. Revisions	***Quorum*** is present.
Approval Pending Modification (specific minor revisions)	***Full Committee***: Date of meeting	***Full Committee***: Date of meeting *as to the vote*; *as to activation of the approval* upon receipt and acceptance of responsive materials, approval activates as of the date the reviewer decides the response is adequate (see paragraph directly below re: final approval of protocols granted approval pending modifications).	Action taken by full Committee if ***Research*** protocol requires only specific minor revisions (i.e., specified by the IRB in notice to PI), with activation of approval to follow upon acceptance of responses per process described further below	***In follow up to meeting,*** PI's responsive material is reviewed on ***Expedited*** basis it confirms if it satisfies the Committee's requests. If yes, **activation** of protocol may begin; if no, refer to ***Full Committee***	Majority of voting IRB members present if ***Quorum*** is present. ***In follow up to meeting, If*** PI's responsive material does not satisfy the Committee's requests, refer back to ***Full Committee***
Deferral	***Full Committee Review*:** Date of meeting at which vote takes place.	N/A (study must return to full board for review where it may be disapproved, deferred again, approved, or approved pending modifications; see those other categories in this table)	Action taken if substantive and complex additional information is needed to assess that required criteria for approval are met per 45 CFR 46.111/21 CFR 56.111	N/A	Majority of voting members if quorum is present
Disapproval	Date of ***Full Committee*** meeting	***ONLY Full Committee Review*: *Research*** protocol cannot begin and cannot be resubmitted for review.	Action taken if ***Research*** protocol cannot be approved because required criteria per 45 CFR 46.111/21 CFR 56.111 are not met	N/A	Majority of voting IRB members if quorum is present

Tabled	***Full Committee Review*****:** Date of meeting at which vote takes place.	N/A (study must return to full board for review where it may be disapproved, deferred, approved, or approved pending modifications; see those other categories in this table)	Action is taken if ***IRB Committee*** postpones discussion and vote on a ***Research*** protocol until another meeting (e.g., due to loss of ***Quorum***).	N/A.	

Final *Approval* for *Research* Protocols that are Granted *Approval Pending*: When a ***Research*** protocol is granted ***Approval Pending***, it means that the PI must provide the ***IRB*** with documentation that they have made the specific minor revisions requested by the ***IRB Committee***. The PI may not begin any human subjects research activities under the protocol until the IRB ***Chair/Vice Chair*** or a designated reviewer accepts the responsive material as satisfying the IRB's requests (or, ***Protocol Analyst*** in the case of minor administrative pending issues). The date on which the information/changes are accepted is the approval activation date (sometimes called the "final approval" or "effective" date). The Emory IRB shall send a written notice that sets forth the effective date and dates of the approval period.

Special Rule for Protocols Granted *Approval Pending* by the ***Full Committee*:** As permitted by ***OHRP Guidance***, for protocols granted ***Approval Pending,*** the **Emory IRB** calculates the expiration date for the ***Research*** protocol based on the date that ***Approval Pending*** was granted and NOT on the final activation date.

NOTE: Approval Pending is not applicable under ***Expedited Review***.

Determination of Risk: At the time of initial review, review of modifications, and continuing review when applicable, the IRB will make a determination regarding the risks associated with the ***Research***. The risk categories to be used are ***Minimal Risk*** or ***Greater than Minimal Risk***. The *d*efinition of ***Minimal Risk*** is set forth in the HHS and ***FDA Regulations***. The meeting minutes will reflect the ***IRB Committee*** determination regarding risk levels and the IRB records will document the risk determination for studies approved by ***Expedited Review***.

Determination of Approval Period: At the time of ***Initial Review*** and at ***Continuing Review*** each protocol is assigned an expiration date, when required by the applicable ***Common Rule*** version. For protocols reviewed by ***Full Committee Review***, this expiration date will be the earlier of (a) one year from the date of the ***IRB Committee*** meeting at which the ***Approved*** or ***Approval Pending*** action was taken; or (b) any shorter period prescribed by the ***IRB Committee***.

For ***Research*** protocols reviewed by ***Expedited Review***, the expiration date, when applicable, will be the earlier of (a) one year from the date on which the reviewer granted ***Approval***; or (b) any shorter period prescribed by the reviewer.

The IRB shall consider the following factors when determining which studies require review more frequently than once a year:

The likely medical condition of the proposed subjects;

The overall qualifications of the PI and other members of the ***Research*** team;

The specific experience of the PI and other members of the ***Research*** term in conducting similar ***Research;***

The IRB's previous experience with that researcher or sponsor (e.g., compliance history, previous problems with the researcher obtaining informed consent, prior complaints from participants about the research);

The nature, uncertainty and frequency of adverse events observed in similar ***Research*** at this and other institutions;

The vulnerability of the study participants;

The novelty of the ***Research*** and the likelihood of unanticipated events;

The expected rate of subject accrual; and

Any other factors that the IRB deems relevant.

In specifying an approval period of less than annually, 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 and that the number of subjects studied or enrolled determine the approval period only when the number of subjects is studied or enrolled in less than one year. The meeting minutes will reflect the approval period specified.

Independent Verification Regarding Material Changes: Protecting the rights and welfare of ***Human Subjects*** sometimes requires that the IRB verify independently, using sources other than the PI, information about various aspects of the study including, but not limited to, adverse event reporting information in the scientific literature, reports of drug toxicity, drug approval status, eligibility, and informed consent procedures, and verification that no material changes occurred during the IRB-designated approval period.

Criteria Employed in Determining When Verification is Required: The IRB will determine the need for verification from outside sources on a case-by-case basis using criteria including, but not limited to, the following:

Information provided in a ***Continuing Review*** report or by other credible sources suggesting that material changes have occurred since previous IRB review;

The experience of the PI in conducting clinical research;

The IRB's previous experience with that researcher or sponsor (e.g., compliance history, previous problems with the PI obtaining informed consent, prior complaints from

participants about the PI);

Probability and magnitude of anticipated risks to subjects;

Likely medical condition or vulnerable condition of the proposed subjects;

The projected rate of enrollment;

Whether the study involves novel therapies;

Probable nature and frequency of changes that may ordinarily be expected in the type of ***Research*** proposed.

In addition, the IRB may randomly select protocols for audit and verification.

Timing of Verification: In making determinations about independent verification, the IRB may prospectively require that such verification take place at predetermined intervals during the approval period; may retrospectively require such verification at the time of ***Continuing Review***; or may require such verification at any time during the approval period in the light of new information.

Continuing Review: Per ***HHS, FDA*** and ***VA Regulations***, each ***Research*** protocol that is reviewed by the Emory IRB must receive ***Continuing Review*** and ***Approval*** from the Emory IRB, unless not required per the ***Revised Common Rule***. The PI must submit a protocol to the ***IRB Committee*** for ***Continuing Review*** sufficiently in advance of the protocol's expiration date to permit review and ***Approval*** by the ***IRB Committee***.

IRB ***Approval*** is considered to have lapsed at midnight on the expiration date of the ***Approval***.

The P&P chapter entitled *Continuing Review* sets forth more information.

Modifications (Amendments): The ***IRB*** may review modifications to protocols by ***Full Committee Review*** or ***Expedited Review*** in accordance with the procedures set forth in the P&Ps entitled *Expedited Review* and entitled *Full Committee Review* respectively. As appropriate, the ***IRB Committee*** or reviewer may take any of the actions described in this chapter with regard to modifications. See the P&P chapter "Protocol Modifications (Amendments)" for more detail about the criteria for type of review for Modifications.

The date on which a modification is considered approved and can be implemented is the date of activation of ***Approval.*** In the case of modifications granted Pending Approval, the date of Approval is the date of the decision to accept responsive material as adequate to address the ***IRB Committee's*** requests.

The IRB shall state the approval period in a written notice to the PI.

Approval in Principle **or Approval of Programs and Projects Lacking Specific Human Subjects Research Plans**: 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.

1. The study procedures are to be developed during the course of the ***Research***, but ***Human Subjects*** approval is required by the sponsoring agency.
2. The involvement of ***Human Subjects*** depends on the outcomes of work with animal subjects.

The IRB may then grant ***Approval in Principle*** without having reviewed the as yet undeveloped recruitment, consent and intervention materials. IRB approval of the final materials via a modification needs to be in place 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***.

Reporting of IRB Actions to PIs: All IRB actions are communicated to the PI in writing via a letter, which may be sent electronically and/or by interoffice mail, regular mail, or express mail. The signature of the appropriate IRB Chair, Vice Chair, member or staff may be recorded in the letter digitally or manually; or, the communication may have no signature. Staff can sign letters which report on the actions of the IRB. The IRB staff will not sign on behalf of any Chair/Vice Chair except with express written permission. No signature stamps may be used. The IRB may also send a certification form conforming to the DHHS standards along with the letter. In absence of a certification form per se, the letter notice of Committee action shall be presumed to provide required certification. Copies of all notices reports and other correspondence to and from ***Investigators*** shall be kept in the IRB records. The following information shall be contained in the IRB's written reports of actions:

Notices of Approval by *Full Committee Review* or *Expedited Review*: The written notice sent by the Emory IRB to a PI stating that Approval has been granted to the PI's protocol shall contain the following information:

Date of ***IRB Committee*** meeting at which ***Approval*** was granted and the expiration date of the approval period.

Copy of the approved consent documents showing the affixed approval with the dates of the approval.

Notices Regarding Protocols Granted *Approval Pending* by *Full Committee Review*: The written notice sent by the Emory IRB to a PI stating that ***Approval Pending*** has been granted to the PI's protocol shall contain the following information:

Description of the specific minor revisions to be made by PI, including replacement language.

Date of **IRB Committee** meeting at which ***Approval Pending*** was granted.

Notices Regarding Protocols Granted *Deferral* by *Full Committee Review*: The written notice sent by the Emory IRB to a PI stating that ***Deferral*** has been granted to the PI's protocol shall contain the following information:

Description of modifications or additional information or material required to facilitate review, to be submitted by the PI;

Notices Regarding Protocols Granted *Disapproval* by *Full Committee* Review: The written notice sent by the Emory IRB to a PI stating that ***Disapproval*** has been granted to the PI's protocol shall contain the following information:

Description of the reasons for the ***Disapproval.***

Invitation to the PI to respond in writing or in person to the Full Committee.

Any response from the PI is reviewed by the IRB panel that made the determination of Disapproval. When necessary, the IRB will seek consultation from qualified experts, other IRBs, the Office of Human Research Protections (OHRP) or the Food and Drug Administration (FDA). Every attempt will be made to resolve the identified problem(s). The IRB, however, retains final authority over whether or not a proposal can be approved; institutional officials may not approve research if it has not been first approved by the IRB.

Notices Regarding Suspension or Termination of Approval by the IRB: The written notice sent by the Emory IRB to a PI stating that its approval of a protocol has been ***Suspended*** or ***Terminated*** shall contain the following information:

Basis for the ***Suspension*** or ***Termination***.

Notice that No Human Subjects Research Activity may take place under the protocol until the IRB has lifted the ***Suspension***.

An explanation that if it would adversely affect the health and safety of individual human subjects to discontinue research interventions or follow up, the PI should act in the best interests of the subject and notify the IRB of the individual subject identification numbers and the circumstances of continuing the interventions or follow up. The data generated under such circumstances may not be used for research purposes, absent a decision by the ***Full Committee.***

Description of action that the IRB will take in follow-up to ***Suspension*** or ***Termination,*** along with any action required on the part of the PI.

With respect to a Termination, an explanation that approval cannot be reactivated but that the PI may consult with the IRB Chair or Vice Chair about whether they may resubmit the protocol as a new submission in the future.

Reporting of IRB Actions to Institution: The IRB reports its findings and actions to the institution in the form of its minutes which are stored permanently and securely in the IRB office and available upon request. The IRB may also distribute copies of certifications and/or notice letters to other institutional offices (such as the Office of Sponsored Programs). The IRB may

also make its findings and actions available to the other institutional offices by arranging for access to the IRB database.

Reporting of IRB Actions to AVAHCS: The IRB shall notify in writing the PI on any ***AVAHCS Research***, as well as the RDC, of its decision to grant ***Approval*** or ***Disapproval*** to a proposed ***Research*** activity, or of revisions required to secure IRB ***Approval.*** An IRB approved ***Research*** activity may be disapproved by the AVAHCS RDC, the Director of the AVAHCS, or the VA Office of Research and Development. If a ***Research*** activity is ***Disapproved*** by the IRB, the decision cannot be overruled by the RDC or any higher authority. The RDC and higher authority within the AVAHCS may strengthen requirements and/or conditions or add other modifications to secure RDC approval or approval by a higher authority. Previously approved ***Research*** proposals and/or consent forms must be re-approved by the IRB before initiating any changes or modification.

Reporting of IRB Actions to the Grady Research Oversight Committee (GROC): Research conducted in the Grady Health System must also be approved by the Grady Research Oversight Committee before research activities begin. The PI is responsible for submitting a GROC application form along with a copy of the IRB approval letter and other supporting documents. If a ***Research*** activity is ***Disapproved*** by the IRB, the decision cannot be overruled by the GROC or any higher authority. The GROC and higher authority within the Grady Health System may strengthen requirements and/or conditions or add modifications to secure GROC approval or approval by a higher authority. Previously approved **Research** proposals and/or consent forms must be re-approved by the IRB before initiating any changes or modification.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.112
45 CFR Part 46, including 46.108 and 46.112
VHA Directive 1200.05(2)

39 CONTINUING REVIEW

POLICY:

The Emory IRB will conduct a ***Continuing Review*** of on-going ***Research***, when Emory is the ***Reviewing IRB*** at intervals that are appropriate to the level of risk for each ***Research*** protocol, and not less than once per year when Continuing Review is required by applicable regulations. ***Continuing Review*** shall occur for as long as the ***Research*** remains active for long-term follow-up of participants, even when the ***Research*** is permanently closed to the enrollment of new participants and all participants have completed all ***Research***-related interventions. ***Continuing Review*** must occur even when the remaining ***Research*** activities are limited to the analysis of private identifiable information.

The Emory IRB uses the required regulatory criteria for approval for continuing review of research (see the P&P entitled *Criteria for Emory IRB Approval of Research*). Per FDA and OHRP guidance, when conducting continuing review, the IRB should start with the working presumption that the research, as previously approved, does satisfy all of the above criteria (provided, however, that the foregoing presumption may not apply if the IRB determines that its initial approval was granted based on incorrect information or the IRB determines that the initial review was flawed). The IRB makes its continuing review determination by considering whether any new information is available that would affect the IRB's prior finding that the research meets the federal regulatory criteria for approval.

Unless the IRB determines otherwise, continuing review of research is not required in the following circumstances for studies under ***the Revised Common Rule***:

Continuing Review is not required by any agency with jurisdiction over the Research, and:

Research eligible for ***expedited review*** in accordance with ***HHS Regulations***;

Research reviewed by the IRB in accordance with the limited IRB review described in the ***HHS Regulations***;

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.

The IRB must justify the decision to conduct continuing review of research originally reviewed using the expedited procedure.

For studies that do not require continuing review, the IRB may perform periodic record reviews

of these studies to ensure that the research is conducted per the protocol.

PROCEDURES:

Determination of Approval Period: The IRB shall make a determination of the approval period, as well as a determination of the need for additional supervision or oversight on a protocol-by-protocol basis, taking into consideration factors such as the nature of the protocol; nature of risks involved; past history of the investigator; number of participants; and health and background of participants.

Indication of Approval Period: For each initial or continuing ***Approval,*** the Emory IRB will indicate an approval period with an ***Approval*** expiration date specified unless ***Continuing Review*** is not required. IRB ***Approval*** is considered to have lapsed at midnight on the expiration date of the ***Approval***. The ***Approval*** date and ***Approval*** expiration date are clearly noted on all IRB certifications sent to the PI, and the PI must strictly adhere to these dates. Review of a change in a protocol ordinarily does not alter the date by which continuing review must occur.

No Grace Periods: Investigators must allow sufficient time for development and review of renewal submissions. 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 the IRB ***Approval*** expires to avoid a lapse in approval. If the IRB performs ***Continuing Review*** within 30 days before the IRB approval period expires, the IRB may retain the anniversary data as the date by which the ***Continuing Review*** must occur.

Continuing Review **Process:**

Renewal Notices: To assist PIs, the IRB office staff will endeavor to send out renewal notices to PIs 60 days in advance of the expiration date. Nevertheless, it is the PI's responsibility to ensure that the ***Continuing Review*** of on-going ***Research*** is approved prior to the expiration date, whether or not the PI receives a renewal notice. By federal regulation, no extension to that date can be granted.

Materials Submitted for *Continuing Review*: PIs must submit the following materials to the Emory IRB for ***Continuing Review*** of their protocols: (a) ***Continuing Review*** application; (b) current consent document(s) (if applicable); (c) any newly proposed consent document(s) (if applicable) via a modification; and any other relevant materials. Per OHRP and FDA, when conducting continuing review of the research the IRB must be provided with a status report on the progress of the research since the last IRB review, which includes the following information:

The number of participants enrolled at Emory site and overall study-wide

A summary of adverse events and any unanticipated problems involving risks to participants

The number of participants that have withdrawn including the reasons

A summary of any complaints about the research

A summary of any recent literature, interim findings, and modifications to the research since the last review, including any relevant multicenter trial reports

The PI's revised risk/benefit assessment based on the existing study results (if applicable)

Any other relevant information, especially information about risks associated with the research, e.g. Data and Safety Monitoring Board Reports/Letters, IND/IDE safety reports

A copy of the current informed consent document

NOTE: A summary of amendments since the last IRB review is available within the eIRB system, thus does not need to be provided by the PI

Conduct of *Continuing Review* -- *Full Committee Review*: In conducting ***Continuing Review*** of ***Research*** that is not eligible for ***Expedited Review***, all IRB members are provided with and shall review all of the materials submitted by the PI for ***Continuing Review*** including the current protocol. Primary and secondary reviewers shall be appointed and shall review in depth the complete current protocol and proposed amendments for the current approval period. Primary and secondary reviewers shall lead the IRB through the completion of the regulatory criteria for approval specified in the IRB Continuing Review checklist**.**

	Primary reviewers are expected to review these materials in depth in advance of the IRB meeting.	All IRB members are expected to review these materials in advance of the meeting in enough depth to be familiar with them and able to discuss them at the IRB meeting.
Materials to be Reviewed at Continuing Review	• The Initial IRB Application form (with all information in the above Study Outline) updated with any changes • The Continuing Review IRB Application form • The current consent documents. • Any newly proposed consent documents. • The complete protocol including any protocol modifications previously approved by the IRB.	• The Initial IRB Application form (with all information in the above Study Outline) updated with any changes • The Continuing Review IRB Application form • The current consent documents. • Any newly proposed consent documents.

Conduct of *Continuing Review* – *Expedited Review*: In the case of ***Continuing Review*** conducted by ***Expedited Review***, reviewers shall be provided with the same materials that the IRB members would have received for ***Full Committee Review***, and they may request the IRB office staff to provide them with any additional related materials. The reviewer shall use worksheets and IRB guidance documents to determine whether the protocol meets the criteria allowing ***Continuing Review*** via the ***Expedited Review***

procedure, and if so, whether the protocol continues to meet regulatory criteria for approval.

Generally, if ***Research*** did not qualify for ***Expedited Review*** at the time of initial review, it will not qualify for ***Expedited Review*** at the time of continuing review, except in limited circumstances described in ***Expedited Review*** Categories 8 and 9 in the P&P entitled *Expedited Review*. It also is possible that ***Research*** that previously qualified for ***Expedited Review*** may have changed or will change such that ***Expedited Review*** would no longer be permitted for ***Continuing Review***.

Lapse in Approval: If the IRB has not reviewed and approved a ***Research*** protocol by the end of the approval period (if any) specified by the IRB, all ***Research*** activities must stop, including recruitment (e.g., media advertisements must be stopped); enrollment of new subjects; consent; interventions; interactions, data collection, and data analysis with identifiable information unless the IRB finds that it is in the best interests of individual subjects to continue participating in the ***Research*** interventions or interactions. In addition, if the IRB has approved the ***Research*** protocol with contingencies, but those contingencies have not been satisfactorily addressed by the end of the prior approval period, then all Research activities must likewise stop, unless the convened IRB determined that certain activities not affected by the contingencies could proceed. Specifically, the following steps will be taken in the case of a lapse in ***Continuing Review***:

A PI's failure to submit ***Continuing Review*** information on time may be considered to be ***Non-Compliance*** and handled in accordance with the P&P entitled *Handling of Allegations of Non-Compliance – General Procedures.*

The continuation of ***Research*** after expiration of IRB ***Approval*** is a violation of the ***HHS, FDA*** and ***VA Regulations*** and generally will be considered to be ***Serious Non-Compliance*** and handled in accordance with the P&P entitled *Handling of Allegations of Non-Compliance – General Procedures*)

Written notice of expiration will be sent to the PI by the last date of the approval period and the PI will be advised that all ***Research*** activities must stop even if the PI submitted ***Continuing Review*** information before the expiration date.

The PI should immediately provide the IRB with a summary regarding subjects who could be harmed by the cessation of study procedures, with rationale. If possible, this list should be prepared and delivered prior to the lapse. An IRB ***Chair*** with appropriate expertise shall review the list and determine which subjects, if any, may continue and what procedures may be performed because stopping those ***Research*** procedures could cause harm. In the case of any ***Research*** that is stopped, the IRB must review and re-approve the ***Research*** prior to its re-initiation. This continuing review shall further include a determination as to what and how data collected during the lapse may be used. If the study is FDA regulated, then the Board or Designated Reviewer conducting the continuing review (and the AVAHCS Chief of Staff in the case of ***AVAHCS***

Research) must follow the requirements set forth in ***FDA Regulations*** when making this decision.

For ***AVAHCS Research***, if ***Continuing Review*** does not occur within the timeframe set by the IRB, then the ***AVAHCS Research*** is automatically stopped and the Emory IRB shall promptly notify the PI of the lapse in approval. For ***Research*** for which the approval has lapsed, enrollment for new subjects cannot occur, and continuation of ***Research*** interventions or interactions for already enrolled subjects should only continue when the IRB, in consultation with the AVAHCS Chief of Staff, finds that it is in the best interests of the individual subjects to do so.

Review of Consent Documents: For continuing review of research the IRB determines that the current consent document is still accurate and complete. Review of currently approved or newly proposed consent documents must occur during the scheduled ***Continuing Review*** of ***Research*** by the IRB. Any significant new findings that arise from the continuing review process and that may relate to a subject's willingness to participate (or continue to participate) in the study must be reflected in the most current consent document and communicated to all subjects (i.e., prospective new subjects and those already enrolled in the study). In addition, informed consent documents should be reviewed whenever new information becomes available that would require modification of information in the informed consent documents.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56, including 56.108
45 CFR Part 16, including 16.108
45 CFR PART 46, including 46.108

40 PROTOCOL MODIFICATIONS (AMENDMENTS)

POLICY:

Investigators must seek and obtain IRB ***Approval*** before making any changes in approved ***Research***, unless the change is needed to eliminate an immediate hazard to subjects, in which case the IRB must be notified promptly. The Emory IRB shall review proposed modifications to protocols by ***Expedited Review*** or ***Full Committee Review*** as appropriate, in accordance with applicable regulations and policies.

PROCEDURES:

Request for Approval of a Modification: Investigators must submit documentation to request approval of proposed changes in the ***Research***, including, but not limited to changes in: submission form questions, investigator's or ***Sponsor's*** protocol, investigators brochure, informed consent/parental permission/assent documents, other participant facing materials or any other relevant documents.

IRB Office staff will make an initial determination as to whether the proposed modification is minor (see below) and may be approved via ***Expedited Review,*** or whether the modification requires ***Full Committee Review***. The reviewer using the ***Expedited Review*** procedure has the ultimate responsibility to determine whether the proposed modification can be reviewed via ***Expedited Review***, or if it requires ***Full Committee Review.***

Minor Changes in General

Minor Change: A minor change is one which, in the judgment of the IRB Reviewer, makes no substantial alteration in (i) the level of risks to subjects; (ii) the ***Research*** design or methodology (e.g., an addition of a procedure which would not increase risk to subjects); (iii) the number of subjects enrolled in the ***Research*** (depending on the risk level of the study and other factors; see specific examples below); (iv) the qualifications of the ***Research*** team; or (v) the facilities available to support safe conduct of the ***Research***.

A minor change does NOT include the addition of any procedure that involves more than minimal risk.

Examples of minor changes are:

1. Change in PI or deletion of Co-Investigator on more than minimal risk studies

2. Scientific and/or therapeutic changes that do not pose an increase in risk to subjects from what is already approved; updates to risk information that indicate subjects are at the same or lower risk than previously known

3. Changes in the consent form that reflect scientific/therapeutic changes noted above

4. Addition of new procedures that, independent of the rest of the study, are minimal risk and would qualify for one or more of the expedited categories of research as defined in the federal regulations

5. Changes to surveys/interviews/focus group instruments that do not significantly impact the overall risk of the study, for which specific expertise is not required, and that are consistent with the approved study aims.

6. Minor clarifications or new data related to experience with the study intervention that does not impact the risk level of the study, and/or has no material impact on participants at sites under the IRBs review (e.g. enrollment closed and no participants remain on study)

7. Decrease in the overall sample size (a) by 25% or less than the currently approved number, or by five or fewer individuals above the currently approved sample size, whichever is larger, on more-than-minimal-risk studies; or (b) by any amount on minimal risk studies.

8. Increase in the sample size (a) by 25% or less than the currently approved number, or by five or fewer individuals above the currently approved sample size, whichever is larger, on more-than-minimal-risk studies; or (b) any size increase in sample size when using the same type of population indicated in the original protocol on studies that are no more than minimal risk; or (c) to accommodate the definition of "enrolled" to include all subjects who signed a consent form, not merely those who completed screening and began the study intervention; or (d) increasing sample size by any amount at Emory sites when change does not reflect an overall study-wide increase in sample size

Minor Administrative Changes: Some minor administrative changes may be approved by qualified IRB staff who do not serve as Designated Reviewers (a larger scope of modifications can be approved by IRB staff who are also Designated Reviewers and IRB Members; this scope is documented in a separate Standard Operating Procedure). These changes are exclusively limited to the following:

1. Change in contact information or names change/relocation of research sites

2. Addition or deletion of junior level personnel (not co-investigators or ***Principal Investigators***)

3. Addition of co-investigator

4. Addition or removal of co-investigator for minimal risk studies (including studies originally reviewed at ***Full Committee*** that are now no greater than minimal risk)

5. Title change, if not accompanied by a change in the study

6. Corrections of typographical errors

7. Reformatting of unchanged text

8. Errors in completion of the IRB application, as confirmed with study staff as appropriate (as long as the study was initially reviewed with the correct impression)

9. Removal of study sites that were never activated

10. Change of funding status from "pending" to "approved" (however, addition of a new grant application should be sent to Designated Reviewer)

11. Amendments submitted only to transition a study to the Revised Common Rule, when changes to informed consent are not required.

12. Other changes that involve only logistical or administrative aspects of the study (e.g., change of monitor), after consultation with IRB staff Designated Reviewer(s).

Non-minor Changes in General

Definition: For studies that undergo ***Full Committee*** review, any change that is not minor or that is not limited to the addition of procedures that qualify for expedited review must be reviewed by the ***Full Committee***. Non-minor changes to a study that are eligible for ***Expedited*** review must be assessed to determine if the changes require ***Full Committee*** review or may be reviewed on an ***Expedited*** basis. Non-minor changes that increase the risk level above minimal require full board review.

Examples of non-Minor Changes are:

1. Adding a new subject population that could have a different risk/benefit ratio from those already approved

2. Information about a significant new or significantly increased risk

3. Significantly changing the aims of a study

4. Adding questions or instruments that create a new risk of stigmatization if confidentiality were breached

5. Changing the location of the research from that which has already been approved, if that change has a potential impact on the ability to safely conduct the study or if location adds new local context considerations

6. Substantively changing the design of a clinical trial protocol.

7. Significantly increasing compensation for participation in research, or substantively changing the way compensation is provided, based on the reviewer's assessment.

Expedited Review* of Protocol Modifications**: The IRB may use ***Expedited Review procedures to

review minor changes in on-going previously approved ***Research*** during the period for which approval is authorized. ***Expedited Review*** may be carried out by the IRB ***Chair*** or ***Vice Chairs***, or other ***Designated Reviewers.*** The reviewer will use the Expedited Category list from OHRP/FDA, and this P&P Chapter to determine whether the modifications meet the criteria for use of an ***Expedited Review*** procedure, and if so, whether the ***Research*** with the proposed modifications meets the regulatory criteria for approval. Modifications that add new procedures that involve more than minimal risk, or do not fall into categories for which expedited review is permissible, may not undergo expedited review and must be reviewed by the convened IRB.

Full Committee Review **of Protocol Modifications**: When a proposed change in a ***Research*** protocol is not minor, then the IRB must review and approve the proposed modification at a convened meeting before the modification can be implemented. The only exception is a modification necessary to eliminate apparent immediate hazards to the research subjects. In such a case, the IRB should be promptly (no longer than within 30 days) informed of the modification following its implementation and should review each modification to determine if it is consistent with ensuring continued safety and welfare of research subjects.

When the IRB reviews modifications to previously approved ***Research***, the IRB shall 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.

Applicable Regulations, Policies, and Guidance:

See P&Ps entitled *Expedited Review* and *Full Committee Review*

41 CLOSURE OF PROTOCOLS

POLICY:

The completion or closure of a study by a PI is a change in activity that must be reported to the Emory IRB at the time that it occurs. The IRB may administratively close a study in appropriate circumstances (e.g., investigator leaves institution).

PROCEDURES:

Submission of Closure Information: Study closure must be reported promptly via the electronic submission system. PIs should follow the specific instructions provided on the Emory IRB website and/or within the electronic submission system.

Closure Reporting for Sponsors (including Emory faculty Sponsors or Sponsor-Investigators) of device studies: In the case of a significant risk device, the Sponsor or Sponsor-Investigator shall notify FDA within 30 working days of the completion or termination of the investigation and shall submit a final report to FDA, all reviewing IRBs, and participating investigators within 6 months after completion or termination. In the case of a device that is not a significant risk device, the Sponsor or Sponsor-Investigator shall submit a final report to all reviewing IRBs within 6 months after termination or completion.

Review of Closure Information: ***Protocol Analysts*** will review the closure information for completeness and assign a closure date. If the ***Protocol Analyst*** is unable to make the determination as to whether the study can be closed out, they will consult with a senior staff member or any IRB member.

Premature Completion: The Researchers shall report, and explain, to the IRB any premature completion or closure of a study.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 812, including 812.150
21 CFR Part 312

42 CRITERIA FOR EMORY IRB APPROVAL OF RESEARCH

POLICY:

In order for the Emory IRB to approve non-***Exempt Human Subjects Research***, it must determine that the study complies with the approval criteria set by ***HHS Regulations***.

PROCEDURES:

Procedure to be Followed in Evaluating *Research* Protocols: For each ***Research*** protocol that it evaluates, the Emory IRB shall perform the following analysis:

(a) identify the risks associated with the ***Research***, as distinguished from the risks of therapies the subject would receive even if not participating in the ***Research***;
(b) determine whether the risks are minimized to the extent possible;
(c) determine that the study employs sound ***Research*** design;
(d) identify the probable benefits, if any, to be derived from the ***Research***;
(e) determine whether the risks are reasonable in relation to the benefits, if any, to subjects, and to the importance of the knowledge to be gained from the ***Research;***
(f) ensure that potential subjects will be provided with an accurate and fair description of the risks or discomforts and the anticipated benefits, if any; of the ***Research***; and
(g) determine if there are any subjects from any ***Vulnerable Populations*** to be involved in the ***Research,*** and if so, ensure that appropriate safeguards are included to protect the rights and welfare of these subjects.

The ***Emory IRB*** includes in its review of human subjects research an assessment of whether plans for scientific, clinical (including medical and psychological), technical and other necessary personnel, equipment, time, and services are appropriate and adequate to maximize the safety of human subjects, both during and after participation in a research study. The IRB also identifies potential issues enrolling an adequate number of subjects to achieve the study's goals.

The ***Emory IRB*** also ensures that Departmental approval is in place before it will review a protocol and that other appropriate, ancillary committee approvals are complete before granting final approval for the initiation of human subjects research. Ancillary committee approvals may include, for example, radiation, biosafety, and environmental safety committee approvals.

Criteria that the IRB Must Consider in its Review of Protocols: In reviewing ***Research*** protocols for approval, the Emory IRB shall consider the following criteria. These criteria apply to both the Full Board and Expedited Review procedure for all reviews of research including initial review, continuing review, and review of a modification to previously approved research when the modification affects a criterion for approval:

Risks to Subjects are Minimized: The Emory IRB shall evaluate whether risks to subjects are minimized by the use in the protocol of procedures that (a) are consistent with sound ***Research*** design; (b) do not unnecessarily expose subjects to risk; and (c) when

appropriate, are procedures that are already being performed on the subjects for diagnostic or treatment purposes.

Sound *Research* Design/Scientific Merit: The Emory IRB must evaluate whether the protocol employs sound ***Research*** design that can reasonably be expected to result in an answer to the proposed ***Research*** question, and that the procedures employed in the ***Research*** are consistent with such sound design. As part of this evaluation, the IRB requires prior review and approval by the PI's departmental reviewer or faculty advisor for new studies; these reviews are conducted via the electronic submission system where the final approval is required before the IRB can issue final study approval. For cancer-related research, the Protocol Review and Monitoring Committee (PRMC) provides scientific review and IRB approval cannot be granted until any PRMC concerns are addressed. The IRB also recognizes that the following other entities provide scientific review during the preparation of a human subject's research protocol and may require changes:

- the sponsoring agency, via the peer review process, for federally-funded research;
- the FDA, for IND or IDE applications, and IRB approval is pending until that feedback is received and addressed by the PI, or until the 30 day period has passed after IND or IDE submission, indicating that the study may proceed;
- the VA Research and Development Committee for VA Research (post-IRB review, with RDC-required changes requiring review by the Emory IRB via modifications submitted in eIRB).

For protocols conducted or supported by the ***DOD***, the Emory IRB shall ensure that scientific merit review has taken place. The scientific review may be the review provided by the funding agency (including DOD), by an established internal review mechanism in the researcher's academic unit, or in the form of an ad-hoc review by the researcher's Chair or Dean or committee of uninvolved faculty. It may also be provided by the IRB in the course of its review. Documentation of any external scientific review must be provided to the IRB before IRB review takes place.

Risks to Subjects are Reasonable in Relation to Anticipated Benefits: The Emory IRB shall evaluate whether risks to the subjects posed by participation in the ***Research*** are justified by the anticipated benefits to the subjects, if any, and the importance of any knowledge that may reasonable be expected to result from the ***Research***. In undertaking this evaluation, the Emory IRB shall judge whether either the anticipated benefit to the subjects from participating in the ***Research,*** or the new knowledge to be gained from the ***Research***, justifies asking a person to undertake the risks of participation in 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 risks and benefits of therapies subjects would receive even if not participating in the ***Research.*** In addition, the IRB should not consider possible long-range effects of applying knowledge gained in the ***Research***. The IRB should disapprove ***Research*** in which the risks are judged unreasonable in relation to the anticipated benefits.

Selection of Subjects is Equitable: The IRB will review the inclusion/exclusion criteria for the protocol to ensure equitable selection of subjects. In making this assessment the

IRB shall take into account the purposes of the ***Research*** and the setting in which the ***Research*** will be conducted. The IRB shall be particularly cognizant of the special problems of research involving ***Vulnerable Populations***. See the P&P entitled "*Recruitment of Subjects*" for more on what information is used in this evaluation.

Informed Consent: The IRB will review the informed consent procedures and documentation to ensure that informed consent will be appropriately obtained and documented from each prospective subject or the subject's legally authorized representative, or alternatively that all criteria are met for the waiver or alteration of informed consent or documentation thereof, as more specifically set forth in the P&Ps entitled *Informed Consent,* and *Research Involving Children – Additional Protections*.

Data and Safety Monitoring: The IRB will review and evaluate the ***Data and Safety Monitoring Plan,*** if present***,*** for each protocol at the time of ***Initial Review.*** The IRB will review the progress of the ***Data and Safety Monitoring Plan***, if present, at ***Continuing Review*** as more specifically set forth in the P&P entitled *Data and Safety Monitoring Plans*.

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

Privacy: The IRB shall determine whether the activities in the ***Research*** constitute an invasion of privacy by obtaining and evaluating the manner in which ***Investigators*** are gaining access to subjects or their information, as well as assessing subjects' expectations of privacy in the ***Research*** situation. The IRB also shall ensure that ***Investigators*** have appropriate ***HIPAA Authorization*** and/or consent to access subjects or their information. In the case of ***Research*** that falls within the scope of the ***HIPAA Regulations***, the IRB shall perform the duties of an ***Institutional Privacy Board***, as set forth in the P&P entitled *HIPAA).*

Confidentiality: The IRB shall ensure that the protocol includes appropriate provisions to protect the data collected from inappropriate disclosure and unauthorized access. The IRB shall ensure that the level of protections in place for data confidentiality are commensurate with the potential harm that could result from inappropriate disclosure.

ICH-GCP: If a study is under the requirements of ICH-GCP, the Emory IRB will make additional relevant findings including requirements to informed consent. The study team will be directed to use a formal ICH-GCP checklist, which will be updated as needed.

Limited IRB Review**:** For purposes of conducting the limited IRB review required by ***HHS Regulations***, the IRB need not make the determinations at paragraphs (a)(1) through (7) of this section, and shall make the following determinations:

(i) Broad consent for storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens is obtained in accordance with the requirements of ***HHS Regulations***;

(ii) Broad consent is appropriately documented, or waiver of documentation is appropriate, in accordance with ***HHS Regulations***; and

(iii) If there is a change made for research purposes in the way the identifiable private information or identifiable biospecimens are stored or maintained, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

Vulnerable Populations: The IRB shall review each protocol to determine if the protocol is likely to involve member of a ***Vulnerable Population***, and if so, that additional safeguards are in place. See the P&P entitled *Review of Research Protocols Involving Vulnerable Populations*.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, 50.25, 50.27, and 50.55
21 CFR Part 56, including 56.111
38 CFR Part 16, including 16.116 and 16.117
45 CFR Part 46, including 46.111, 46.116, 46.117, 46.203 through 46.207, 46.303 through 46.306, and 46.403 through 46.408
OCGA 31 Chapter 9, including 31-9-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 37 Chapter 7, including 37-7-8
E6(R2) Good Clinical Practice: Integrated Addendum to ICH E6(R1), March 2018, No. 0910-0843
SECNAVINST 3900.39D, 2006

43 INFORMED CONSENT

POLICY:

Prior to the conduct of any Research involving a ***Human Subject,*** the PI (or designee) must obtain legally effective informed consent from the ***Human Subject*** or the ***Human Subject's Legally Authorized Representative*** (or ***Permission*** from a ***Parent*** or other ***Legal Guardian*** in the case of a minor ***Human Subject);*** unless the conditions for a waiver or alteration of informed consent are met as determined by the Emory IRB after review and approval. Informed consent (or an IRB approved waiver thereof) must be obtained before entering a subject into a **Research** protocol and/or conducting any procedures required by the protocol. ***Broad Consent*** may be obtained in lieu of informed consent obtained in accordance with required and additional elements of this section only with respect to the storage, maintenance, and secondary research uses of identifiable private information and identifiable biospecimens, provided institutional approval was also obtained.

PROCEDURES:

The IRB shall evaluate the description of the Informed Consent Process provided by the PI based on the following:

Enrollment: A subject is considered to be enrolled in a study when they give informed consent to participate. The PI should consider attrition, including screen failures and withdrawals from study participation that may occur throughout the study when they estimate the number of subjects to be enrolled.

Informed Consent Prior to Screening Procedures for pre-*Revised Common Rule studies*: Screening procedures (beyond reviewing existing data) used strictly to assess whether prospective subjects are appropriate candidates for inclusion in studies require informed consent prior to research procedures, or a waiver granted by the IRB. Procedures that are to be performed as part of the practice of medicine and which would be done whether or not study entry was contemplated, such as for diagnosis or treatment of a disease or medical condition, may be performed and the results subsequently used for determining study eligibility without first obtaining informed consent only if a waiver of HIPAA authorization was granted by the IRB.

Screening, recruiting, or determining eligibility for studies that fall under the *Revised Common Rule*: Procedures that are to be performed as part of the practice of medicine and which would be done whether or not study entry was contemplated, such as for diagnosis or treatment of a disease or medical condition, may be performed and the results subsequently used for determining study eligibility without first obtaining informed consent.

The Emory 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:

the investigator will obtain information through oral or written (including electronic)

communication with the prospective subject or legally authorized representative, or

the investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

Posting of clinical trial consent form: 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 website 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 website (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 website after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

Required Basic Elements of Informed Consent: The PI is responsible for ensuring that the following elements of consent are incorporated into the consent document:

I. A clear statement that the study involves ***Research.***

II. An explanation of the purposes of the ***Research.***

III. The expected duration of the ***Human Subject's*** participation in the ***Research.***

IV. A complete description of the procedures to be followed; differentiating procedures that are considered standard of care (i.e., would normally be provided to the ***Human Subject*** as standard treatment for the condition involved) from those that are performed solely for the purposes of ***Research.***

V. A description of the reasonably foreseeable risks or discomforts to the ***Human Subject.***

VI. A description of any benefits to the ***Human Subject*** or to others that may reasonably be expected from the ***Research.***

VII. A disclosure of appropriate alternative procedures or courses of treatment that might be advantageous to the ***Human Subject.***

VIII. A statement describing the extent to which confidentiality of records identifying the ***Human Subject*** and privacy will be maintained, including a statement as to what information will or will not be included in the ***Human Subject's*** medical record, if any.

IX. For ***Research*** involving more than ***Minimal Risk,*** an explanation as to whether any compensation is available and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained.

X. For ***Research*** conducted or supported by the ***DOD***, the Emory IRB shall require that:

(i) for studies of greater than minimal risk (and in the IRB's discretion, for minimal risk studies), the study includes an arrangement to provide emergency treatment and necessary follow-up for subjects who suffer from a research-related injury. Further, if the Department of Defense has "primary involvement" in the research, then procedures must be in place to protect subjects from unpaid or unreimbursed costs resulting from such research related injury. "Primary involvement" shall be determined based on consideration of the DOD portion of total involvement (i.e., funding, personnel, facilities and all other resources) in the research. In addition, any DOD-unit specific requirements regarding research-related injury shall be followed.

(ii) in addition to the basic and required consent disclosures, consent documents include:
- a statement that the DOD or a DOD organization is funding the study.
- a statement that representatives of the DOD are authorized to review research records.

XI. An explanation of whom to contact for answers to pertinent questions about the Research; Research-related injury to the ***Human Subject;*** and complaints or concerns about the ***Research.***

XII. An explanation of whom to contact at the Emory IRB (as an alternative to or in lieu of contacting the ***Research*** staff) in order to obtain answers about the ***Research;*** voice concerns or complaints about the ***Research;*** and obtain information about ***Research*** participant rights.

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

XIV. One of the following statements about any research that involves the collection of identifiable private information or identifiable biospecimens:

(i) 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

(ii) 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.

For ***FDA-regulated studies,*** a statement that the FDA may inspect the **Research**-related records.

For ***FDA-regulated Research***, the following requirements pertaining to subject withdrawal must be followed:

> When a participant withdraws from a study, the data collected on the participant to the point of withdrawal remains part of the study database and may not be removed. The consent document cannot give the subject the option of having data removed.
>
> A researcher may 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 participant would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review and address the maintenance of privacy and confidentiality of the subject's information.
>
> > The researcher 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 document). The IRB must approve the consent document.
>
> If a participant withdraws from the interventional portion of the study and does not consent to continued follow-up of associated clinical outcome information, the researcher must not access for research purposes the subject's medical record or other confidential records requiring the subject's consent. However, a researcher may review study data related to the subject collected prior to the subject's withdrawal, and may consult public records, such as those establishing survival status.

For ***Research*** that is covered by ICH-GCP, the following elements must be included:

- Discussion of trial-related treatment and probability of random assignment
- Subject responsibilities
- When applicable, the reasonably foreseeable risks or inconvenience to the participant, the participant's partner (when applicable), an embryo, fetus, or nursing infant.
- Anticipated payment if any
- Important potential risks and benefits of alternative treatment
- Authorization to access medical records by regulatory authorities
- ICH requires the subject receive a SIGNED and DATED copy of the written ICF

For ***AVAHCS Research***, the following elements also must be included in the Informed Consent to provide to the subject or LAR:

- A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or becomes pregnant) that are currently unforeseeable

- Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's or the LAR's consent
- A statement that VA will provide treatment for research related injury in accordance with applicable federal regulations.
- Any payments the subject is to receive for participating in the study
- Any real or apparent conflict of interest by investigators where the research will be performed
- Any additional costs to the subject that may result from participation in the research
- When appropriate, a statement that informs VA research subjects that they or their insurance will not be charged for any costs related to the research. NOTE: Some Veterans are required to pay copayments for medical care and services specifically related to their medical care provided by VA. These co-payment requirements will continue to apply to medical care and services that are not part of the research procedures or interventions
- The consequences of a subject's decision to withdraw from the research and procedures for orderly and safe termination of participation by the subject
- A statement that any significant new findings developed during the course of the research that may relate to the subject's willingness to continue participation will be provided to the subject
- The approximate number of subjects to be entered in the study
- For studies subject to the 2018 Requirements, 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
- For studies subject to the 2018 Requirements, a statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions
- For studies subject to the 2018 Requirements and 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);
- The informed consent for research must include information describing any photographs, video, and/or audio recordings to be taken or obtained for research purposes, how the photographs, video, and/or audio recordings will be used for the research, and whether the photographs, video, and/or audio recordings will be disclosed outside VA.
    - An informed consent to take a photograph, video and/or audio recording cannot be waived by the IRB.
    - The consent for research does not give legal authority to disclose the photographs, video, and/or audio recordings outside VA. A HIPAA authorization is needed to make such disclosures.

Additional Elements of Informed Consent: The PI is also responsible for ensuring that the following additional elements of informed consent are included in the consent document when appropriate:

i. A statement that the particular treatment or procedure may involve risks to the ***Human Subject*** (or to the embryo or ***Fetus,*** if the ***Human Subject*** is or may become ***Pregnant)***

which are currently unforeseeable.

ii. Anticipated circumstances under which the ***Human Subject's*** participation may be terminated by the PI without regard to the ***Human Subject's*** *or the* ***legally authorized representative*** consent.

iii. Any additional costs to the ***Human Subject*** that may result from participation in the ***Research.***

iv. The consequences of a ***Human Subject's*** decision to withdraw from the ***Research*** and procedures for orderly termination of participation by the ***Human Subject.***

v. A statement that significant new findings developed during the course of the Research which may relate to the Human Subject's willingness to continue participation will be provided to the Human Subject.

vi. The approximate number of Human Subjects involved in the Research protocol.

i. 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;

ii. A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions; and 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).

iii. The Emory IRB may require that information, in addition to that required in ***HHS, FDA*** and ***VA Regulations,*** be given to the ***Human Subjects*** when in its judgment the information would meaningfully add to the protection of the rights and welfare of the ***Human Subjects.***

Elements of Broad Consent: if the study has been approved for the use of ***Broad Consent*** for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens, the study PI must ensure that the following elements are included in the informed consent document. Use of Broad Consent requires institutional approval.

i. The information required under required elements of informed consent section in this chapter, specifically paragraphs, V, VI, VIII and XIII when appropriate. In addition, additional elements of informed consent, specifically paragraphs vi and vii.

ii. A general description of the types of research that may be conducted with the identifiable private information or identifiable biospecimens. This description must include sufficient information such that a reasonable person would expect that the broad consent would permit the types of research conducted;

iii. A description of the identifiable private information or identifiable biospecimens that

might be used in research, whether sharing of identifiable private information or identifiable biospecimens might occur, and the types of institutions or researchers that might conduct research with the identifiable private information or identifiable biospecimens;

iv. A description of the period of time that the identifiable private information or identifiable biospecimens may be stored and maintained (which period of time could be indefinite), and a description of the period of time that the identifiable private information or identifiable biospecimens may be used for research purposes (which period of time could be indefinite);

v. Unless the subject or legally authorized representative will be provided details about specific research studies, a statement that they will not be informed of the details of any specific research studies that might be conducted using the subject's identifiable private information or identifiable biospecimens, including the purposes of the research, and that they might have chosen not to consent to some of those specific research studies;

vi. Unless it is known that clinically relevant research results, including individual research results, will be disclosed to the subject in all circumstances, a statement that such results may not be disclosed to the subject; and

vii. An explanation of whom to contact for answers to questions about the subject's rights and about storage and use of the subject's identifiable private information or identifiable biospecimens, and whom to contact in the event of a research-related harm.

Process of Informed Consent

Informed consent consists of more than obtaining a signature on the consent document; it involves a discussion of the elements of the consent document in a manner and in a language that is understandable to the ***Human Subject.***

In evaluating the appropriateness of the informed consent process, the IRB will consider where the consent process will take place and whether the setting and process is designed to minimize the possibility of undue influence or coercion.

Informed consent must be conducted by someone who is familiar with the informed consent process and who has undergone the required human subjects research training (see P&P entitled *Investigator Qualifications).* If someone other than the PI will be obtaining the informed consent, then the PI must formally delegate this responsibility and that person should sign the consent form as the "person who obtained consent."
In evaluating the consent process, the IRB also will consider the individual who will be providing informed consent (e.g., subject, legally-authorized representative, etc.). The IRB also will evaluate the process to ensure that the ***Human Subject*** has adequate time to consider participation in ***Research,*** and that someone is available to answer all of the ***Human Subject's*** questions prior to enrolling the ***Human Subject*** in the ***Research*** protocol. The Emory IRB may require the PI to obtain informed consent for certain studies.

Concise and focused presentation (not applicable to *Broad Consent*): In Federally funded ***Research***, informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research. This part of the informed consent must be organized and presented in a way that facilitates comprehension. Informed consent as a whole must present information in sufficient detail relating to the research and must be organized and presented in a way that does not merely provide lists of isolated facts, but rather facilitates the prospective subject's or legally authorized representative's understanding of the reasons why one might or might not want to participate.

No Exculpatory Language: No informed consent, whether oral or written, may include any exculpatory language by which the ***Human Subject*** or their ***Legally Authorized Representative is*** made to waive or appear to waive any of the ***Human Subject's*** legal rights, or which releases or appears to release the PI, the ***Sponsor,*** Emory University, or any of their ***Employees or Agents*** from liability for negligence.

Documentation of Informed Consent: Informed consent must be appropriately documented in accordance with and the extent required by ***HHS*** and ***FDA Regulations***. Informed consent must be documented by the use of a written informed consent form that is approved by the IRB and signed (including in an legally effective electronic format) and dated at the time of consent by the subject or the subject's ***Legally Authorized Representative.*** The PI is responsible for obtaining a signed and dated consent document prior to enrolling any person in a ***Research*** protocol, except in circumstances in which the IRB has granted waiver of informed consent or a waiver of the documentation of informed consent (see the P&P chapters on *Waiver of Documentation of Informed Consent* and *Waiver or Alteration of Informed Consent for Research).*

If the ***Human Subject*** cannot sign the Informed Consent Document (due to physical impairment): Emory IRB does not require a Legally Authorized Representative to provide consent for subjects who are cognitively capable of consenting, but physically unable (for example, due to paralysis). In those cases, obtaining consent from the subject with the assistance of a witness is usually sufficient. Emory IRB can provide additional guidance for these situations upon request.

> For FDA-regulated studies, the person must be physically able to indicate approval or disapproval for participation in the clinical investigation. The informed consent document must set forth the method used for communication with the prospective subject; the specific means by which the subject indicated they wanted to participate; and be signed by an impartial third party who witnessed the entire consent process.

The PI is responsible for maintaining a copy of each signed consent document and must be able to provide a copy of these to the Emory IRB upon request. A copy of the consent document (or ***Permission*** document signed by a ***Parent*** or ***Legal Guardian*** in the case of the enrollment of a Child) must be provided to the ***Human Subject*** or their ***Legally Authorized Representative.***

A written copy (may be paper or electronic) shall be given to the person signing the informed consent form.

Form of Informed Consent Document: The informed consent form may be either: (a) a written informed consent form that meets ***HHS Regulation*** requirements which the investigator shall give the subject or the subject's ***Legally Authorized Representative*** adequate opportunity to read the informed consent form before it is signed***;*** or (b) a ***Short Form*** written informed consent form stating that elements of informed consent have been presented orally to the subject or the subject's ***Legally Authorized Representative***. For federally funded research, that the key information required by ***HHS Regulations*** is to be presented first to the subject, before other information, if any, was provided. The IRB shall approve a written summary of what is to be said to the subject or the ***Legally Authorized Representative*** in accordance with the provision below entitled *Use of the Short Form.*

> **Informed Consent Template:** A template for the informed consent document can be found on the Emory IRB website.

Review and Approval of the Informed Consent Form: The IRB is responsible for the review and approval of the informed consent form prepared by the PI. The wording on the informed consent form must contain all of the required elements, any additional elements (listed above) deemed necessary by the IRB, and meet all other requirements as described in this section, if no waivers are issued. If the wording of the informed consent form has been initially prepared by an external entity (e.g., a pharmaceutical company or a cooperative study group, including National Cancer Institute groups), the IRB needs to ensure that the wording of the informed consent document meets all the requirements of or has been reviewed by all ***Other Research Review Committees,*** as appropriate. IRB approval of the wording of the informed consent document must be evidenced through the use of a certification stamp on each page that indicates the date of the most recent IRB approval of the document. If the consent form is modified during the protocol approval period the form must bear the approval date of the modification, rather than the date of the approved protocol.

Obtaining Consent or Assent from Individuals who Cannot Read (such as those who are temporarily or legally blind or illiterate): In cases where the potential ***Human Subject*** cannot read, the PI (or person authorized to obtain consent) is responsible for reading aloud the entire consent or assent document with the ***Human Subject*** and for documenting that the ***Human Subject*** cannot read. Adequate opportunity for discussing questions and concerns of the subject must be offered (including repeating and explaining portions of the Informed Consent/Assent and HIPAA Document[s]). An impartial individual should witness the consent or assent process and document for the ***Research*** records that the process took place, that the subject understands the ***Research*** and consent/assent process, and that the subject consented to participate. In the case of subjects who cannot write, "making their mark" is sufficient. The ***Human Subject*** should be provided with names and telephone contact numbers for the study PI and the IRB Office.

Parental Permission and Assent. In accordance with applicable HHS and FDA Regulations, the Emory IRB must determine that adequate provisions have been made for soliciting the ***Permission*** of the parents or ***Legally Authorized Representatives*** of any ***Children*** who are participating in a ***Research*** protocol. In addition, prior to participation in ***Research,*** the Emory IRB must determine whether it is necessary to obtain ***Assent*** from the ***Children*** participating in the ***Research.*** Detailed requirements for permission and assent are found in the P&P chapter

Research Involving Children - Additional Protections.

Preemption: The informed consent requirements in this policy 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 require additional information to be disclosed in order for informed consent to be legally effective.

Emergency medical care: Nothing in this policy is intended to limit the authority of a physician to provide emergency medical care, to the extent the physician is permitted to do so under applicable federal, state, or local law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe).

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, 50.25, 50.27, and 50.55
38 CFR Part 16, including 16.116 and 16.117
45 CFR Part 46, including 46.116, 46.117, and 46.403 through 46.408
OCGA 31 Chapter 9, including 31-9-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 37 Chapter 7, including 37-7-8
DOD Directive 3216.2, 2022
E6(R2) Good Clinical Practice: Integrated Addendum to ICH E6(R1), March 2018, No. 0910-0843
FDA Information Sheet: A Guide to Informed Consent Guidance for Institutional Review Boards and Clinical Investigators, January 1998 updated June 2019
SECNAVINST 3900.39D, 2006
VHA DIRECTIVE 1200.05(2)

44 INFORMED CONSENT OF NON-ENGLISH-SPEAKING SUBJECTS

POLICY:

Investigators in human subjects research studies have an obligation under the federal regulations and institutional policies to inform potential subjects, or their legally authorized representative(s), of certain information regarding ***Human Subjects Research***. In order to ensure the subject, or their representative(s), are sufficiently informed to make a decision regarding their rights and the risks and benefits of participation, this information shall be in a language understandable to the subject or representative(s).

The IRB strongly encourages all investigators to maximize the principle of justice by seeking to enroll a diverse population into their research studies, consistent with the objectives of the research. These populations might include populations with limited English proficiency

PROCEDURES:

Obtaining Consent from Individuals who do not Speak English: The Investigator is responsible for providing a description of the ***Research*** protocol in a language that is understandable to the potential ***Human Subject.*** A ***Qualified Interpreter*** should be present to assist the PI as needed, and the fact of the interpretation, interpreter's name and a statement that the interpreter believes the subject understands the description of the research should be documented in the Research records.

In healthcare settings, under the Patient Protection and Affordable Care Act (ACA), family members can only be used as interpreters in cases of emergency or when specifically requested by the LEP individual. At EHC, if family member is used a Waiver must be signed. In general, the IRB does not allow the use of family members as interpreters, unless in very specific circumstances, such as a socio-behavioral or public health study where the consent form or script and study instruments (e.g., surveys) are fully translated into the participant's language. In this scenario, an adult family member or other non-professional interpreter is allowed to help with administrative/logistical conversations during study visit(s), after the consent discussion has taken place with a qualified interpreter. In these circumstances, prior IRB approval is required. Minors should never be used as interpreters. Under the ACA, members of the study or treating team cannot serve as interpreters unless deemed qualified by Emory Healthcare or another applicable Healthcare entity.

A certified translated copy of the complete consent document (or back translation; see paragraph below) is required to be submitted to the Emory IRB, unless an Emory IRB approved ***Short Form*** is used (refer to provision below entitled *Use of the Short* Form). For more information about certified translation, please refer to Chapter 16, under *Consideration of Issues Associated with Informed Consent*. If a certified translation service is used, the information should be submitted to the IRB with a certificate of translation.

If a ***Qualified Translator*** cannot be obtained for translation of the informed consent document, then a "back translation" should be performed, in most cases. This requires the PI have one individual translate the documents from English to the other language and then have a second

individual translate the translated version back to English. A statement from the translator attesting to the translator's proficiency in English and the other language (e.g., they are a native-born speaker of the other language and has completed 4 or 5 years of education in English or other evidence that they speak and read both languages fluently) meets this requirement. The IRB may also allow for use of alternative methods of translation, on a case-by-case basis.

Note: In cases where the full informed consent document is in the language preferred by the potential participant, use and signature of a **witness** is not required (other than the statement of the ***Qualified Interpreter***, mentioned above, when one is present to assist the researcher with the consent discussion*).*

Non-English Speaking Subject Population: In general, in studies for which it is expected that study recruitment will include a significant number of persons who do not speak English, Investigators will be expected to translate the informed consent documents into the prevalent language(s) of potential research subjects. Investigators may submit the translated form(s) for approval at initial review or later during the study.

The ***HHS, FDA*** and ***VA Regulations*** permit the use of a ***Short Form*** written informed consent document in situations in which a non-English speaking subject is unexpectedly enrolled, as this facilitates enrollment of a diverse study population. The short form is used to document that the elements of informed consent, as required by ***HHS*** and ***FDA Regulations***, have been presented to and are understood by the participant or the participant's legally authorized representative. The IRB will consider the use of **Short Forms** on a study-by-study basis.

IRB Approval of the Use of Short Form and Short Form Documents: For the short form to be used in a study, the IRB must review and approve the potential enrollment of non-English speakers. This should be reflected in the study protocol. The IRB will consider the study complexity and the amount and duration of participant involvement when determining if using the short form consent process is appropriate and can be approved. The IRB will also consider whether a significant number of people who speak the language in question would be expected to enroll and may request a translation of the full consent (and HIPAA form, if separate) instead.

Investigators may use the translated Short Form(s) provided by the IRB without submitting them to the IRB for approval. However, if investigators wish to create and translate their own Short Form(s), those, including the English version, must be reviewed and approved by the IRB prior to use.

The IRB will determine if the full English consent, as well as other study-related documents, must be translated into a participant's language after a participant is initially consented for a study through the approved short form process. The IRB's determination may be based on the features of the study, including whether the study includes ongoing interventions or interactions with the participant.

Procedures to be Followed When Use of *Short Form* is Permitted: In studies in which the Emory IRB has approved the use of the ***Short Form,*** the following procedures must be used:

> There must be *a* ***Short Form*** written consent document stating that the required, as well as any appropriate additional, elements of informed consent have been presented orally

to the ***Human Subject*** or their ***Legally Authorized Representative,*** and for federally funded research, that the key information was presented first to the subject, before other information, if any, was provided. The oral presentation and the written ***Short Form*** must be in a language that is understandable to the ***Human Subject***.

There must be a witness to the oral presentation. If the presentation is in a language other than English, the witness must be fluent in both English and the language of the presentation. If the person obtaining consent is being assisted by a ***Qualified Interpreter***; the ***Qualified Interpreter*** may serve as the witness.

A written summary of what is to be said to the ***Human Subject*** or their ***Legally Authorized Representative*** must be presented to and approved by the Emory IRB. In cases in which a ***Short Form*** is being used only for ***Human Subjects*** who do not speak English, the English language informed consent document may serve as this written summary. The Emory IRB, however, reserves the right to require the PI to provide the ***Human Subject*** with an additional document that describes the ***Research*** protocol translated into the ***Human Subject's*** primary language.

Who Must Sign the Short Form and Written Summary:

The ***Human Subject*** or their ***Legally Authorized Representative*** (or in the case of *a* ***Child,*** their ***Parent*** or ***Legal Guardian)*** must sign and date the ***Short*** **Form**.

The witness shall sign and date both the ***Short Form*** and copy of the written summary (and any additional documentation describing the ***Research*** protocol that is required by the Emory IRB).

The person obtaining consent shall sign and date a copy of the written summary (and any additional documentation describing the ***Research*** protocol that *is* required by the Emory IRB).

A **copy** of the written summary (and of any additional documentation describing the ***Research*** protocol that is required by the Emory IRB) shall be given to the ***Human Subject*** or their representative, in addition to a **copy** of the ***Short Form.***

Additional requirements for studies involving FDA-regulated products The Human Subject or their Legally Authorized Representative shall sign and date *only* the short form (not the written summary). Both the witness and person obtaining consent must sign and date the short form and a copy of the summary.

The **original** short form and summary must be retained in the study files. A copy of the summary and of the **signed** short form must be given to the subject or to their legally-authorized representative.

Optional Consent Items for Short Form: If the English consent has optional consent items (e.g., extra blood for research, permission for central imaging review), the ***Qualified Interpreter*** or investigator must write a comment on the last page of the short form to indicate the subject

made specific choices on the English consent. The ***Qualified Interpreter or investigator*** should indicate the subject's choice (e.g., checks/circles Yes or No) and include their initials for each choice on the English consent.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, 50.25, 50.27, and 50.55
38 CFR Part 16, including 16.116 and 16.117
45 CFR Part 46, including 46.116, 46.117, and 46.403 through 46.408
86 FR 27984, 2021
OCGA 31 Chapter 9, including 31-9-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 37 Chapter 7, including 37-7-8
Patient Protection and Affordable Care Act (Section 1557)
Emory Policy: Language Skills Assessment for Qualified Dual Role Interpreters and Bilingual/Multilingual Employees

45 LEGALLY AUTHORIZED REPRESENTATIVES AND SURROGATE CONSENT

POLICY:

Unless otherwise approved by the IRB, informed consent must be obtained directly from the individual subject. Under appropriate conditions, however, PIs also may obtain informed consent from a ***Legally Authorized Representative*** of the subject.

PROCEDURES:

NOTE: Special requirements for **AVAMC** and DOD**-funded *Research*** are at the end of this Chapter.

Description in *Research* Submission to the IRB: Justification for the potential use of a Legally-Authorized Representative to obtain informed consent should be described in the IRB protocol or elsewhere in the IRB submission. The IRB will then determine if the procedure is approvable based on the criteria below.

Determining if the *Human Subject* May Give Informed Consent: The ***Human Subject*** who is enrolling in the ***Research*** protocol should normally be capable of giving informed consent if they are **Adult** or are an ***Emancipated Minor*** (as described in the provision entitled ***Emancipated Minor*** below); are of sound mind and body; are conscious, mentally unimpaired, and physically able to read and/or hear and understand the elements of informed consent; and have not otherwise been declared to be legally incompetent. In cases in which a judicial determination of incompetence has not been rendered, the PI shall conduct an assessment in a prospective subject whenever there is a possibility that the prospective subject has an inability to consult for themself, such as from the result of impaired physical or mental status or decision-making capacity. As part of such an assessment, the PI shall perform, or cause to be performed the medical evaluations described and resulting information described below:

An appropriate medical evaluation that reveals the prospective subject lacks decision-making capacity and is unlikely to re-gain it soon

Consultation with a licensed psychiatrist or psychologist if determination regarding decision-making capacity is based on a diagnosis of mental illness.

Determination in a medical record by a licensed physician after personal examination of the Adult prospective subject that the prospective subject lacks sufficient understanding or capacity to make significant responsible decisions regarding their medical treatment or the ability to communicate such decisions by any means.

Emancipated Minors* in Georgia:** In Georgia, a person who is under 18 years of age may be considered to be an ***Emancipated Minor if they are married; in the armed services; or is self-supporting and has been declared to be emancipated by court order. An ***Emancipated Minor*** in Georgia may give informed consent for ***Research.***

Determining if Another Person/Entity May Give Informed Consent on Behalf of a *Human*

Subject*:** If the ***Human Subject does not meet the requirements set forth in the immediately foregoing section, then legal counsel for the University has stated that the following guidance should be used to determine if a ***Legally Authorized Representative*** can give informed consent on behalf of a ***Research*** subject in the State of Georgia.

Note: If the ***Research*** takes place outside the State of Georgia, then a determination as to who may provide informed consent must be made under the law of the site at which the ***Research*** takes place, and PIs must consult with University legal counsel in order to make this determination.

Non-Emancipated Minors/ Children: If a ***Child*** is not an ***Emancipated Minor***, then the provisions for parental permission and assent found in the P&P entitled *Research Involving Children – Additional Protections* apply.

Legally Incompetent *Adult Human Subjects* and *Research* Involving Medical Treatment (i.e., ***Research*** that involves lawful surgical or medical treatment which may be recommended, prescribed, or directed by a duly licensed physician):

The following persons may give informed consent on the Subject's behalf:

(a) Any Adult may delegate to another Adult the authority to give consent for themself by a lawful Advanced Directive for Health Care or durable power of attorney for healthcare.

(b) In the absence of a person under section (a) above, then any married person, whether an ***Adult*** or ***Minor,*** may give consent for themself and for their spouse.

In the absence of any person to consent under the provisions set forth in subsections (a) and (b) immediately above, then for **non-AVAHCS research**, the following persons may sign informed consent documents in the following order of priority (i.e., an unsuccessful attempt to contact the person at a higher level of priority must be made and documented before attempting to contact a person at a lower level of priority):

(i) Any **Adult** offspring for their ***Parents***,

(ii) Any ***Parent*** for their ***Adult*** offspring,

(iii) Any ***Adult*** for their siblings,

(iv) Any grandparent for their grandchild,

(v) Any ***Adult*** grandchild for their grandparent, or

(vi) Any ***Adult*** niece, nephew, aunt, or uncle of the patient who is related to the patient in the first degree.

Upon the inability of any ***Adult*** to consent for themself, the absence of

any persons to consent under subsections (a) and (b) above, and the absence of any person to consent under the provisions (i) – (vi) above, then an ***Adult*** friend of the ***Human Subject*** may provide consent. For purposes of this paragraph, "Adult Friend" means an adult who has exhibited special care and concern for the prospective Human Subject and a patient, who is generally familiar with the prospective Human Subject's health care views and desires, and who is willing and able to become involved in the prospective Human Subject's health care decisions and to act in their best interest. The adult friend shall sign and date an acknowledgment form provided by the hospital or other health care facility in which the prospective ***Human Subject*** is located for placement in the ***Human Subject's*** records certifying that they meet such criteria.

Legally Incompetent Adult *Human Subjects* and *Research* that Does Not Involve Medical Treatment

The category of persons who may sign informed consent documents on the Subject's behalf depends on the risk level of the ***Research*** (as determined by an IRB):

Research involving **no more than *Minimal Risk***, as determined by an IRB:

- Any person who may give informed consent on behalf of the subject in ***Research*** *involving Medical Treatment*, above

Research involving **more than *Minimal Risk,*** as determined by an IRB:

- Any person who is authorized to give consent for the Adult to participate in ***Research*** pursuant to the terms of an appropriate power of attorney or other appropriate legal document.
- On a case-by-case basis, when the risk level is only a minor increase above minimal risk, the convened IRB may allow the use of the same criteria as in ***Research*** *involving Medical Treatment*, above.

When non-therapeutic *Research* is under the requirements of ICH-GCP:

- When a non-therapeutic trial is to be carried out with the consent of the subject's legally acceptable representative, the IRB should determine that the proposed protocol and/or other document(s) adequately addresses relevant ethical concerns and meets applicable regulatory requirements for such trials.
- Where the protocol indicates that prior consent of the trial subject or the subject's legally acceptable representative is not possible, the IRB should determine that the proposed protocol and/or other document(s) adequately addresses relevant ethical concerns and meets applicable regulatory requirements for such trials (i.e., in emergency situations).

Requirements for the Execution of Informed Consent Documents in States Other than Georgia: The provisions set forth in this section apply only to ***Human Subjects*** in the State of Georgia. If the ***Human Subject*** is somewhere other than Georgia, the laws of that jurisdiction should be

consulted in determining whether the ***Human Subject*** is legally competent to give informed consent and in determining if/when a ***Minor*** is an ***Emancipated Minor;*** if/when a ***Minor*** may give informed consent; and who may give informed consent on behalf of a ***Minor*** or a legally incompetent Adult. PIs should consult with University legal counsel with regard to making such a determination.

Responsibilities of LARs: LARs are acting on behalf of the potential subjects, therefore:

- LARs must be told that their obligation is to try to determine what the subjects would do if able to make an informed decision.
- If the potential subjects wishes cannot be determined, the LARs must be told they are responsible for determining what is in the subject's best interest.

Explanation of *Research*: If feasible, the PI must explain the proposed ***Research*** to the prospective subject, even if a surrogate gives consent for the subject to participate. Under no circumstances may a subject be forced or coerced to participate in ***Research.***

AVAHCS Research:

> For ***AVAHCS Research*** surrogate consent may be obtained from: a health care agent appointed by the person in an Advanced Directive for Health Care or other appropriate legal document; a court appointed guardian; or from next-of-kin in the following order of priority, unless otherwise specified by applicable state law: spouse; ***Adult*** offspring; ***Parent; Adult*** sibling; grandparent; ***Adult*** grandchild.
>
> *NOTE*: The persons authorized to consent on behalf of persons who lack decision-making capacity for participation in the research may not necessarily be the same as the persons authorized to provide permission for the use and disclosure of information on a HIPAA authorization on behalf of persons who lack decision-making capacity

Research conducted or supported by the DOD*:* The IRB must determine that the research is intended to be beneficial to the subject before a legally authorized representative can consent to the research on behalf of an incompetent subject.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, 50.25, 50.27, and 50.55
38 CFR Part 16, including 16.116 and 16.117
45 CFR Part 46, including 46.116, 46.117, and 46.403 through 46.408
OCGA 31 Chapter 9, including 31-9-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 37 Chapter 7, including 37-7-8
DOD Instruction 3216.02, 2022
VHA Directive 1200.05(2), 2021
VHA Directive 1605.01, 2016

46 WAIVER OF DOCUMENTATION OF INFORMED CONSENT

POLICY:

The IRB may waive the requirement for the PI to obtain a signed consent form for some or all subjects if it finds that the applicable criteria set forth in applicable ***HHS, FDA,*** and/or ***VA Regulations*** are satisfied.

PROCEDURES:

Waiver of Documentation of Informed Consent for Studies that do NOT Involve Drugs, Devices or other Items Regulated by the FDA: For studies that do not involve items regulated under the ***FDA Regulations***, the Emory IRB, at its discretion, may waive the requirement for the PI to obtain a signed consent document in either of the following two situations:

The only record linking the ***Human Subject*** and the ***Research*** is the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality. In such cases, the ***Human Subject*** or ***Legally Authorized Representative*** will be asked whether they want documentation linking themselves with the ***Research***, and the ***Human Subject's*** wishes will govern;

The ***Research*** presents no more than ***Minimal Risk*** of harm to ***Human Subjects*** and involves no procedures for which consent is normally required outside of the ***Research*** context; or

If the subjects or legally authorized representatives 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.

Statement Regarding *Research*: In cases in which the Emory IRB waives the requirement for a signed consent document, the Emory IRB may require the PI to provide ***Human Subjects*** or ***Legally Authorized Representative*** with a written statement regarding the ***Research.*** In addition, the PI must provide in the IRB application a written summary of the information that is to be communicated to the subject regarding the study.

Waiver of Documentation of Informed Consent for Studies that Involve Drugs, Devices or other Items Regulated by the FDA: For studies that involve items regulated under the ***FDA Regulations***, the Emory IRB, at its discretion, may waive the requirement for the PI to obtain a signed consent document if:

The clinical investigation involves no more than ***Minimal Risk***, as defined in **FDA Regulations**, to the ***Human Subjects***;

The waiver or alteration will not adversely affect the rights and welfare of the ***Human Subjects***;

The clinical investigation could not practicably be carried out without the waiver or alteration;

Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

The requirements for an exception from informed consent for ***Planned Emergency Research***, as set forth in the P&P entitled *Waiver of Informed Consent for Planned Emergency Research* are met.

Statement Regarding *Research*: In situations in which the Emory IRB waives the requirement for documentation of informed consent, the Emory IRB may require the PI to provide subjects with a written statement regarding the ***Research***. In addition, the PI must provide in the IRB application a written summary of the information that is to be communicated to the subject regarding the study.

Waiver or Alteration of Elements of Informed Consent: A waiver or alteration of some or all of the elements of informed consent for participation in ***Research*** may only be approved by the IRB in the limited circumstances situations described in the P&P entitled *Waiver or Alteration of Informed Consent for Research***.**

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, 50.25, 50.27, and 50.55
38 CFR Part 16, including 16.116 and 16.117
45 CFR Part 46, including 46.116 through 46.117, and 46.403 through 46.408
OCGA 31 Chapter 9, including 31-9-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 37 Chapter 7, including 37-7-8
FDA Guidance Document: IRB Waiver or Alteration of Informed Consent for Clinical Investigations Involving No More Than Minimal Risk to Human Subjects Guidance for Sponsors, Investigators, and Institutional Review Boards (FDA-2017-D-3235), July 2017

47 WAIVER OR ALTERATION OF INFORMED CONSENT FOR *RESEARCH*

POLICY:

The Emory IRB may waive or alter some or all the elements of informed consent (as those elements are set forth in the P&P entitled *Informed Consent Policy)* in accordance with applicable ***HHS or FDA Regulations***. If an individual was asked to provide ***Broad Consent,*** as defined by Common Rule, for the storage, maintenance, secondary research use identifiable private information or identifiable biospecimens, and refused to, an IRB cannot waive for the storage, maintenance, or secondary research use of the identifiable private information or identifiable biospecimens.

Family Member: Any of the following legally competent persons: spouses, parents, children, brothers, sisters and spouses of brothers and sisters; and any individual related by blood or affinity whose close association with a ***Human Subject*** is the equivalent of a family relationship.

PROCEDURES:

Alteration or Waiver of Elements of Informed Consent for *Research* Protocols Involving State or Local Government Officials: The Emory IRB may waive or alter some or all elements of informed consent, or waive the requirement to obtain informed consent, for ***Research*** protocols that are conducted by or subject to the approval of state or local government officials, if the IRB Designated Reviewer determines, or the IRB Committee determines by majority vote, and documents in the IRB Committee meeting minutes, that the following elements are met after:

The ***Research*** protocol is designed to study, evaluate, or otherwise examine:

Public benefit or service programs,

Procedures for obtaining benefits or services under public benefit or service programs,

Possible changes in or alternatives to public benefit or service programs or procedures, or

Possible changes in the methods or levels of payment for benefits or service under public benefit or service programs;

and

the **Research** protocol could not practicably be carried out without a waiver or alteration of some or all of the elements of informed consent.

Alteration or Waiver of Elements of Informed Consent for Other *Research* Protocols: The Emory IRB may waive or alter some or all elements of informed consent, or waive the requirement to obtain informed consent, for a ***Research*** protocol if the IRB Designated Reviewer determines, or the IRB Committee determines by majority vote, and documents in the IRB

Committee meeting minutes, that the following elements are met:

The ***Research*** protocol involves no more than ***Minimal Risk*** to ***Human Subjects;***

could not practicably be carried out without the requested waiver or alteration;

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;

The waiver of informed consent or the waiver or alteration of some or all of the elements of informed consent will not adversely affect the rights and welfare of the ***Human Subjects;***

and

Whenever appropriate, the ***Human Subjects*** or ***Legally Authorized Representative*** will be provided with additional pertinent information after their participation in the ***Research*** protocol.

If a ***Broad Consent*** procedure (as defined by the ***Revised Common Rule***) is used, an IRB may not omit or alter any of the required elements of informed consent.

For ***Research*** conducted or supported by the ***DOD***, the IRB also must determine that the research participants for whom consent is to be waived do not fall within the category of "experimental subjects" as set forth within the term "***Research Involving a Human Being as an Experimental Subject***." If the participants do meet this definition, then informed consent cannot be waived unless approval of such waiver is obtained from the Assistant Secretary of Defense for Research and Engineering. The Assistant Secretary for Defense for Research and Engineering may waive the requirements for consent when all of the following are met:

The research is necessary to advance the development of a medical product for the Military Services.

The research may directly benefit the individual experimental subject.

The research is conducted in compliance with all other applicable laws and regulations.

For classified research, waivers of consent are prohibited

Alteration or Waiver of Elements of Informed Consent for *Clinical Investigation* Regulated by the FDA: The Emory IRB may waive or alter some or all elements of informed consent set forth in 21 CFR §50.25, or waive the requirement to obtain informed consent, for a ***Clinical Investigation*** if the IRB finds and documents that the following elements are met:

The ***Clinical Investigation*** involves no more than ***Minimal Risk*** to ***Human Subjects;***

The waiver of informed consent or the waiver or alteration of some or all of the

elements of informed consent will not adversely affect the rights and welfare of the ***Human Subjects;***

The ***Clinical Investigation*** could not practicably be carried out without the waiver of informed consent or the waiver or alteration of some or all of the elements of informed consent; and

Whenever appropriate, the ***Human Subjects*** will be provided with additional pertinent information after their participation in the ***Research*** protocol.

Additional Requirements for Waiver of *Permission* from *Parents/Legal Guardian* for *Research* Protocols involving *Children* that do NOT Involve *FDA Regulated* Products: In order to waive the requirement of obtaining ***Permission*** from ***Parents/Legal Guardian*** for ***Research*** protocols in which ***Children*** are participating as ***Human Subjects***, the IRB Committee must determine that the elements set forth in the P&P entitled *Research Involving Children – Additional Protections* are met. This determination may be made by ***Expedited*** or ***Full Committee Review***, depending on the criteria for eligibility of the Protocol, including the proposed waiver, for ***Expedited Review***.

Emergency Medical Care Exception – Exception to Requirement to Obtain Informed Consent for the Use of an FDA-Regulated Item in Emergency Medical Care Situations: In certain emergency medical care situations, informed consent for the use of an item regulated by the FDA in a ***Human Subject*** does not need to be obtained by the ***Investigator*** who needs to use the FDA-regulated item, nor approved in advance by the Emory IRB, if the following criteria are met:

Certification: The ***Investigator*** and a licensed physician who is not participating in the ***Research*** protocol certify in writing that:

The ***Human Subject*** in which the FDA-regulated item is to be used is confronted by a life-threatening situation that necessitates the use of the item.

Informed consent cannot be obtained from the ***Human Subject*** because of an inability to communicate with or obtain legally effective informed consent from the ***Human Subject***.

There is not sufficient time to obtain informed consent from the ***Human Subject's Legally Authorized Representative.***

There is no available alternative method of FDA-approved or generally recognized therapy that provides an equal or greater likelihood of saving the ***Human Subject's*** life.

If the ***Investigator*** determines that the immediate use of the FDA-regulated item is necessary to preserve the ***Human Subject's*** life, and there is not enough time to obtain the written certification of the non-participating physician before the item must be used, then the ***Investigator*** may make their written certification and provide it to a non-participating physician for the completion of

that physician's written review and evaluation within five (5) working days after the item is used.

Documentation Provided to Emory IRB: The written certification and/or review/evaluation by the ***Investigator*** and the non-participating physician must be provided to the Emory IRB ***Chair*** within five (5) working days after the use of the item/process. The IRB ***Chair*** shall review the documentation provided for compliance with applicable regulatory requirements.

NOTE: ***HHS Regulations*** do not permit the initiation of ***Research*** activities involving ***Human Subjects*** without prior IRB review and approval, even in emergency situations. If emergency medical care is initiated without prior IRB review and approval, the care may not be considered to be ***Research***; the patient may not be considered to be a ***Human Subject***; and no data regarding the care may be included in any report of a prospective ***Research*** study.

Applicable Regulations:

45 CFR Part 46, including 46.116m 46.117, and 46.408
38 CFR Part 16, including 16.116 and 16.117
DOD Instruction 3210.7, 2018
DOD Instruction 3216.02, 2022
DOD Instruction 6200.02, 2008
OPNAVINST 5300.8C, 2008
SECNAVINST 3900.39D, 2006
10 U.S.C. 980
FDA Guidance Document: IRB Waiver or Alteration of Informed Consent for Clinical Investigations Involving No More Than Minimal Risk to Human Subjects Guidance for Sponsors, Investigators, and Institutional Review Boards (FDA-2017-D-3235), July 2017
OPHR Letter Informed Consent Requirements in Emergency Research (Number 97-01), October 1996

48 WAIVERS OF, AND EXCEPTIONS FROM, INFORMED CONSENT FOR PLANNED EMERGENCY RESEARCH

POLICY:

FDA and HHS Regulations provide for a waiver of/exception to the requirements for informed consent for Research that may be carried out in Human Subjects who are in need of emergency therapy and for whom, because of the subject's medical condition and the unavailability of legally authorized representatives of the subjects, no legally effective informed consent can be obtained. The Emory IRB may approve Research under this provision provided that the Research meet the criteria in the federal regulations.

PROCEDURES:

Investigator Responsibilities: Investigators should consult with the IRB ***Director*** or ***Chair*** prior to submitting a protocol requesting a waiver for planned emergency ***Research.***

Investigators must submit to the IRB materials describing the plan for community consultation and public disclosure.

Investigators must submit a summary of efforts to contact legally authorized representatives at ***Continuing Review***.

Emergency Research **Exception – Exception from Informed Consent (EFIC) Requirements for Emergency Research Involving an FDA-Regulated Item**: The Emory IRB may approve an EFIC for a ***Research*** protocol involving the use of a FDA-regulated item/process for ***Human Subjects***, if the Emory IRB, with the concurrence of a licensed physician who is a member of or consultant to the ***IRB Committee***, and who is not participating in the ***Research*** protocol determines by majority vote and documents in the ***IRB Committee*** meeting minutes that the following requirements are met after ***Full Committee Review:***

The ***Human Subjects*** that are to be enrolled in the ***Research*** protocol are in a life-threatening situation that necessitates urgent intervention;

Available treatments for the ***Human Subjects*** are unproven or unsatisfactory;

The collection of valid scientific evidence, which may include evidence obtain through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of the FDA-regulated item that is to be used in the ***Research*** protocol;

The ***Research*** protocol sets forth informed consent procedures and documentation that meet the requirements of **Section 41** (entitled *Informed Consent Policy*), and are approved by the ***IRB Committee***, for use with those ***Human Subjects*** for whom it is feasible to obtain informed consent from the ***Human Subject*** or their ***Legally Authorized Representative.***

The ***Research*** protocol defines the length of the potential therapeutic window for the

proposed intervention based on scientific evidence, and the ***Investigator*** commits to attempting to obtain informed consent within that window of time from a ***Legally Authorized Representative*** of the ***Human Subject***, rather than proceeding without informed consent. The ***Investigator*** will summarize their efforts to contact each ***Human Subject's Legally Authorized Representative*** and will provide this summary to the ***IRB Committee*** at the time that the ***Research*** protocol is subject to ***Continuing Review***.

Further, the ***IRB Committee*** must find that informed consent may not be feasible to obtain in all situations under the ***Research*** protocol because:

Human Subjects won't be able to give informed consent as a result of their medical condition;

The FDA-regulated item under investigation must be administered before it is feasible to obtain consent from the ***Human Subjects' Legally Authorized Representative***; and

There is no reasonable way to prospectively identify the ***Human Subjects*** who are likely to become eligible for participation in the ***Research*** Protocol.

That participation in the ***Research*** protocol has the prospect of direct benefit to the ***Human Subjects*** because:

Human Subjects are facing a life-threatening situation that requires intervention;

Appropriate animal and other pre-clinical studies using the FDA-regulated item have been conducted and the information from those studies and related evidence support the premise that the intervention will provide a direct benefit to the ***Human Subjects***.

Risks that are associated with the use of the FDA-regulated product are reasonable in relation to what is known about the medical condition of the potential class of ***Human Subjects***; the risks and benefits of any standard therapy; and the known risks and benefits of the proposed intervention.

The ***Research*** protocol could not practicably be carried out without a waiver of informed consent.
That the ***Research*** protocol provides for at least the following additional protections of ***Human Subjects'*** rights and welfare:

Consultation, including consultation by the IRB Committee where appropriate, with representatives of the communities in which the ***Research*** protocol will be conducted and from which ***Human Subjects*** will be drawn;

Prior to the initiation of the protocol, public disclosure to the communities in which the protocol is to be conducted and from which the ***Human Subjects*** will be drawn, of plans for the protocol and its risks and benefits; and

Establishment of an independent data monitoring committee to exercise oversight of the ***Research*** protocol;

That after the conclusion of the ***Research*** protocol, public disclosure will include sufficient information to apprise the community of the ***Research*** results, including the demographic characteristics of the ***Human Subjects*** population involved in the ***Research*** protocol;

That the ***Research*** protocol sets forth procedures to ensure that the ***Human Subject***; or if they are incapacitated, then the ***Human Subject's Legally Authorized Representative;*** or if a ***Legally Authorized Representative*** is not reasonably available, then a ***Family Member*** of the **Human Subject** is informed as soon as possible of: the ***Human Subject's*** inclusion in the protocol; the details of the protocol; the right to discontinue the ***Human Subject's*** participation in the ***Research*** at any time without penalty or loss of benefits to which the ***Human Subject*** may otherwise be entitled; and any other information that is contained in the informed consent documentation;

That the ***Research*** protocol sets forth procedures to tell the **Human Subject** about the subject's participation in the ***Research*** protocol if the ***Human Subject's*** condition improves, even if a ***Legally Authorized Representative*** was previously provided with this information;

That the ***Research*** protocol sets forth procedures to be followed in the event that the ***Human Subject*** is enrolled in the ***Research*** protocol under a waiver of informed consent or EFIC, and the ***Human Subject*** dies before their ***Legally Authorized Representative*** or family member can be contacted whereby information about the ***Research*** protocol is made available to the ***Legally Authorized Representative*** or family member, if feasible;

That if the ***Research*** protocol involves an ***Investigational Drug,*** then it is performed under a separate ***Investigational New Drug*** application (IND), even if an IND for the drug under study already exists;

That if the ***Research*** protocol involves an ***Investigational*** **Device,** then it is performed under a separate ***Investigational Device Exemption*** (IDE), even if an IDE for the device under study already exists;

Disapproval **of** ***Emergency Research*** **Involving an FDA-Regulated Item/Process:** If the Emory IRB disapproves of ***Emergency Research*** for which a waiver of informed consent or EFIC is requested, it must document its reasons for disapproval in writing and provide them to the Investigator, as well as to the ***Sponsor*** of the ***Research*** protocol. The ***Research Sponsor*** is then responsible for disclosing this information to the following individuals/entities: the FDA; other of the ***Sponsor's Investigators*** who are participating in or are asked to participate in the same ***Research*** protocol or a substantially similar ***Research*** protocol; and other IRBs that have reviewed or are asked to review the same or a substantially similar ***Research*** protocol.

Emergency Research **Consent Waiver/EFIC**: HHS permits IRBs to grant a waiver/EFIC of the requirement to obtain informed consent for the following classes of ***Research*** activities:

Research Subject to *FDA Regulations*: ***Research*** for which the IRB has:

Approved the activity;

Approved a waiver of informed consent; and

Found and documented that:

The ***Research*** is subject to the regulations codified by the FDA at 21 CFR Part 50 and will be carried out under an IND or an IDE, the application for which has clearly identified the protocols that would include subjects who are unable to consent; and

The requirements set forth in 21 CFR Section 50.24 for EFIC for ***Emergency Research*** have been met for those protocols.

Research **Not Subject to *FDA Regulations***: ***Research*** for which the IRB has approved the ***Research*** and a waiver of informed consent and has found and documented that:

The ***Human Subjects*** are in a life-threatening situation;

Available treatments are unproven or unsatisfactory;

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;

Obtaining informed consent is not feasible because:

The ***Human Subjects*** will not be able to give informed consent as a result of their medical condition;

The intervention involved in the ***Research*** must be administered before consent from the ***Human Subjects' Legally Authorized Representatives*** is feasible; and

There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the ***Research.***

Participation in the ***Research*** holds out the prospect of direct benefit to the ***Human Subjects*** because:

Subjects are facing a life-threatening situation that requires intervention.

Appropriate animal and other preclinical studies have been conducted and the information derived from those studies and related evidence

support the potential for the intervention to provide a direct benefit to the individual ***Human Subjects.***

Risks associated with the ***Research*** are reasonable in relation to what is known about the medical condition of the potential class of ***Human 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.

The ***Research*** could not practicably be carried out without the waiver.

The proposed ***Research*** protocol defines the length of the potential therapeutic window based on scientific evidence, and that the PI has committed to attempt to contact a ***Legally Authorized Representative*** for each subject within that window of time, and, if feasible, to asking the ***Legally Authorized Representative*** contacted for consent within that window, rather than proceeding without consent. The PI must summarize efforts made to contact such ***Legally Authorized Representatives*** and make this information available to the IRB at the time of continuing review.

The IRB has reviewed and approved informed consent procedures and an informed consent document in accordance with applicable ***HHS Regulations***, and these procedures and the informed consent document will to be used with ***Human Subjects*** or their ***Legally Authorized Representatives*** in situations in which their use is feasible.

The IRB has reviewed and approved procedures and information to be used for providing an opportunity for a ***Family Member*** of the ***Human Subject*** to object to a ***Human Subject's*** participation in the ***Research.***

The IRB shall provide for the additional protection of the rights and welfare of the ***Human Subjects*** will be provided including at least:

Consultation, including, where appropriate, consultation carried out by the IRB with representatives of the communities in which the research will be conducted and from which the subjects will be drawn.

Public disclosure to the communities in which the ***Research*** will be conducted and from which the ***Human Subjects*** will be drawn, prior to the initiation of the Research, of plans for the ***Research*** and its risks and expected benefits;

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.

Establishment of an independent data monitoring committee to

exercise oversight of the ***Research.***

The PI commits that if obtaining informed consent is not feasible and a ***Legally Authorized Representative*** is not reasonably available, then the PI will attempt to contact within the therapeutic window the subject's ***Family Member*** who is not a ***Legally Authorized Representative*** and ask whether they object to the subject's participation in the ***Research***. The PI must summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.

The Emory IRB also shall ensure that:

Procedures are in place to inform, at the earliest feasible opportunity, each ***Human Subject***, or if the ***Human Subject*** remains incapacitated, the ***Human Subject's Legally Authorized Representative*** or ***Family Member***, of the ***Human Subject's*** inclusion in the ***Research,*** the details of the ***Research*** and other information contained in the informed consent document.

There is a procedure to inform the ***Human Subject***, or if they remain incapacitated, then their ***Legally Authorized Representative*** or ***Family Member*** that the ***Human Subject*** may discontinue participation at any time without penalty or loss of benefits to which the ***Human Subject*** is otherwise entitled.

If a ***Legally Authorized Representative*** or ***Family Member*** is told about the ***Research,*** and the ***Human Subject's*** condition improves, then the ***Human Subject*** also shall be informed about the ***Research*** as soon as feasible.

If the ***Human Subject*** is entered into the ***Research*** with waived consent and the ***Human Subject*** dies before a ***Legally Authorized Representative*** or ***Family Member*** can be contacted, information about the ***Research*** is to be provided to the subject's ***Legally Authorized Representative*** or ***Family Member,*** if feasible.

VA Research: No waiver of consent for planned emergency research may be granted to VA research because the VA has no provisions for waiver of consent for planned emergency research.

Research conducted or supported by the **DOD**: The head of the DOD unit that is conducting or supporting the ***Research*** must waive the requirement of informed consent for planned emergency research. In order to grant such a waiver, the research project must advance the development of a medical product necessary to the Armed Forces, and the DOD unit must determine that the research may directly benefit the research subject and is being carried out in accordance with all other applicable laws and regulations, including 21 CFR Section 50.24.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.20, 50.23, and 50.24
45 CFR Part 46, including 46.116 and 46.117
10 U.S.C. 980
DOD Instruction 3216.02, 2022
HHS Waiver of Informed Consent, October 1996, 61 FR 51531
OPHR Letter Informed Consent Requirements in Emergency Research, October 1996, No. 97-01
SECNAV Instruction 3900.39D, 2006
SECNAV Instruction 3900.39E CH-1, 2018

49 CONSENT MONITORING

POLICY:

The Emory IRB may monitor the informed consent process employed for ***Research*** studies in order to ensure that the consent process is carried out in accordance with all protocol, IRB and regulatory requirements and to reduce the possibility of any coercion or undue influence.

PROCEDURES:

Use of Consent Monitoring: In reviewing the adequacy of informed consent procedures for proposed ***Research***, the IRB may, in its discretion, determine that special monitoring of the consent process by an impartial observer (consent monitor) is required in order to ensure that the consent process is being carried out in accordance with protocol, IRB and regulatory requirements. 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 to be provided. Monitoring also may be appropriate as a corrective action when the IRB has identified problems associated with a particular ***Investigator*** or a ***Research*** project.

Performance of Consent Monitoring: When the IRB requires consent monitoring to be performed, it will assign an appropriate IRB staff member, IRB member, another appropriate individual from the University, or an outside consultant to perform the monitoring. The person who is assigned shall be thoroughly familiar with the informed consent process for ***Research*** and applicable regulations, as well as with the specific consent for the protocol(s) for which monitoring will occur. The monitor shall observe the consent process as directed by the IRB and provide constructive feedback to the PI and study team within five business days.

In addition, the monitor shall provide a report on their observations to the IRB ***Chair***, along with any recommended corrective actions. The IRB ***Chair*** will review the report and decide if it shall be reviewed by the convened IRB, in which case the ***IRB Committee*** shall vote on whether to accept the report and any recommended corrective actions. The Chair may review the report in an expedited manner if there are no concerns.

Following review of the report by the IRB ***Chair*** or ***IRB Committee,*** the IRB shall notify the PI of the results of the monitoring and any corrective action that should be employed.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.109 and 56.111
45 CFR Part 46, including 46.109 and 46.111

50 DATA AND SAFETY MONITORING PLANS

POLICY:

It is the policy of the Emory ***IRB*** that each research application, excluding ***Exempt*** research, submitted to the ***IRB*** for review must include a plan to assure the safety and welfare of its ***Subjects*** as appropriate for the study design.

PROCEDURES:

Appointment of a *Data Safety Monitor (DSM)* or *Data Safety Monitoring Board (DSMB)*: The ***Principal Investigator*** should appoint a DSM or ***DSMB*** for their study as appropriate for the size, complexity, and level of risk involved in the ***Research.*** ***Research*** activities should consider including a ***DSM*** or ***DSMB*** if:

The study is intended to provide definitive information about the effectiveness and/or safety of a medical intervention;

Prior data suggests that the intervention under study has the potential to induce a potentially unacceptable toxicity; and/or

The study is evaluating mortality or another major endpoint, such that inferiority of one treatment arm has safety as well as effectiveness implications; or It would be ethically important for the study to stop early if the primary question addressed has been definitively answered, even if secondary questions or complete safety information were not yet fully addressed.

More than minimal risk studies involving blinded intervention assignment.

***DSMB* Composition:**

The ***DSMB*** should have multidisciplinary representation, including physicians from relevant medical specialties and biostatisticians. Such representation may include other experts such as bioethicists, epidemiologists, and basic scientists.

The ***DSMB*** should have membership limited to individuals free of apparent significant ***Conflicts of Interest,*** whether they are financial, familial, intellectual, professional, or regulatory in nature.

The appropriate size of a ***DSMB*** will depend upon the particular study and types of expertise needed.

DSM or *DSMB* Responsibilities: The primary responsibility of the DSM or ***DSMB*** is to safeguard the interests of study subjects. Therefore, the DSM or DSMB must approve the safety measures in the protocol in order to: (a) preserve the study integrity and credibility and (b) facilitate the availability of timely and reliable findings to the broader clinical community. In addition, the DSM or DSMB should:

Provide written documentation confirming review of the protocol and agreement with the study design and the ***Data Safety Monitoring Plan (DSMP***).

Review the progress of the study carefully and diligently. The DSM or ***DSMB*** should assure that all significant ***Adverse Events*** are reported to the IRB according to policies and procedures.

The DSM or ***DSMB*** should be available to the ***Investigator*** for consultation concerning any untoward study events or any questions regarding consent issues.

The ***DSM*** or ***DSMB*** should provide a letter to the ***IRB*** at predefined frequency***,*** through the ***Investigator,*** which summarizes the oversight activities and recommendations of the ***DSM*** or ***DSMB*** and any concerns regarding subject safety identified during the monitoring period.

DSM or *DSMB* Charter: Each DSM or ***DSMB*** should have a written charter or charge that sets forth its mission and responsibilities. The DSM or DSMB charter should include the following:

A detailed presentation of the membership composition, including qualifications and experience;

Roles and responsibilities of the DSM or DSMB and if relevant, of Steering Committee members;

The authority of the DSM/DSMB (e.g., advisory to the ***Sponsor***, PI);

The timing and purpose of ***DSMB*** meetings;

The procedures for maintaining confidentiality;

The format, content, and frequency of DSM or DSMB reports;

Statistical procedures including monitoring guidelines, which will be used to monitor the identified primary, secondary, and safety outcome variables; and

Plans for changing frequency of interim analysis as well as procedures for recommending protocol changes.

A copy of the relevant DSM ***or DSMB*** Charter should be maintained with the related research study files.

DSM *or DSMB* Tasks: DSM or DSMB tasks may include, but need not be limited to, the following:

Conducting initial review of the proposed ***Research*** to assure quality study conduct;

Reviewing procedures to assure quality of study conduct including data management and quality control procedures;

Evaluating the quality of ongoing study conduct by reviewing the study accrual, compliance with eligibility, subject adherence to study requirements, and accuracy and completeness of data;

Consideration of factors external to the study when relevant information becomes available, such as scientific or therapeutic developments that may have an impact on the safety of the subjects or the ethics of the study;

Recommending early termination based on efficacy results;

Recommending termination due to unfavorable benefit-to-risk or inability to answer study questions;

Recommending continuation of ongoing studies;

Consideration of overall picture; primary and secondary analysis;

Modification of sample sizes based on ongoing assessment of event rates; and

Review of final results.

Note: For blinded studies, the DSMB must be able to be unblinded as needed to evaluate differential benefits and harms across treatment groups.

Data and Safety Monitoring Plan: Some studies do not require a DSM or a DSMB; however, a detailed ***Data and Safety Monitoring Plan*** (***DSMP***) is required for all ***Research*** that involves more than Minimal Risk and may be required in ***Minimal Risk*** studies at the discretion of the IRB. The level of detail in the plan should be based upon the degree of risk to the subjects. At a minimum, all DSMP's must contain the following:

A description of how risks are minimized;

A description of how risks are reasonable in relation to anticipated benefits;

Identification of a DSM or DSMB, if applicable;

A description of the general ***Data and Safety Monitoring Plan***;

A description of the plan to monitor progress and safety. Such descriptions may include:

A plan for safety review either by an assigned board, committee, or ***Data Safety Monitor (DSM)*** at predetermined intervals relevant to the complexity of the ***Research***; and

Depending on the complexity of the ***Research,*** assessments of data quality, timeliness, subject recruitment, accrual, and retention.

A description of the plan to assure compliance with reporting **of Adverse Events (serious or not)** and/or ***Unanticipated Problems Involving Risks to Participants or Others***. This may include:

A description of the process for detecting and reporting **Serious** and **Unexpected Adverse Events** and/or ***Unanticipated Problems Involving Risks to Participants or Others;***

Specification of who will be conducting monitoring visits (***DSM*** information) and who will be collecting and trending the ***Adverse Events*** (e.g., PI, research nurse, etc.);

Specification of who will be notified of an **Adverse Event** (e.g., IRB, NIH, FDA, PI, etc.);

A reporting plan indicating the timing of reports;

A plan for annual reporting of **Adverse Events** if the study will continue beyond one year;

A description of the plan to assure ***Suspensions*** of funded trials are reported to the grants program director; and

A description of the plan to assure data accuracy and protocol compliance.

Applicable Regulations, Policies, and Guidance:

NIH Policy for Data and Safety Monitoring, June 1998, Notice NOT-98-084
Further Guidance on a Data and Safety for Phase I and Phase II Trials, June 2000, Notice NOT-OD-00-038

51 REVIEW OF RESEARCH PROTOCOLS INVOLVING VULNERABLE POPULATIONS

POLICY:

In ***Research*** protocols that are likely to include ***Human Subjects*** who are likely to be vulnerable to coercion or undue influence, the Emory IRB must ensure that appropriate additional safeguards are employed to protect the ***Human Subjects'*** rights and welfare.

PROCEDURES:

Types of *Vulnerable Populations*: The following types of ***Human Subjects*** populations are considered to be ***Vulnerable Populations***: (a) ***Pregnant Women***; (b) human ***Fetuses*** and ***Neonates***; (c) ***Prisoners***; (d) ***Children***; (d) ***Wards of the State***; (e) individuals with impaired decision-making capacity; and (f) economically or educationally disadvantaged persons. In certain ***Research*** protocols, special classes of ***Human Subjects*** also may be considered ***Vulnerable Populations*** that require additional protections (e.g., comatose subjects, terminally ill subjects, elderly and aged persons, minorities, students, employees, and international ***Research*** subjects).

Review by Emory IRB: When the IRB reviews ***Research*** that involves categories of participants who are considered to be ***Vulnerable Populations***, the review process will include one or more individuals who are knowledgeable about or experienced in working with these participants.

General Additional Safeguards: In considering ***Research*** protocols that involve ***Vulnerable Populations***, the Emory IRB, in addition to employing its typical standards for review of ***Research*** protocols, also shall determine, and document its determinations in appropriate meeting minutes or review documents, whether the involvement of the ***Vulnerable Populations*** in the ***Research*** protocol is justified and whether the ***Research*** protocol minimizes risks to ***Human Subjects*** who are in these ***Vulnerable Populations***. In making these determinations, the Emory IRB shall consider the following factors:

Whether the PI provided sufficient justification for the inclusion of members from a ***Vulnerable Population*** as ***Human Subjects***;

Whether the PI provided a plan for protecting the rights of the ***Vulnerable Population*** from possible coercion or undue influence;

The nature and degree of risk to the ***Vulnerable Population***;

The condition of the particular ***Vulnerable Population*** involved;

The nature and level of anticipated benefits to the ***Vulnerable Population***;

The thoroughness of the presentation through the informed consent process of relevant risk and benefits to the ***Vulnerable Population***;

The nature and level of any monetary payments or other incentives to the ***Vulnerable Population***, and whether such payments/incentives may constitute an undue inducement;

The nature of the proposed safeguards to be employed in the ***Research*** protocol and whether these safeguards are adequate to protect the ***Vulnerable Population***;

Whether minorities receive an equal share of the benefits of the ***Research*** protocol and do not bear a disproportionate share of the burden; and

Whether the possibility of exploitation of the ***Vulnerable Population*** exists, and the steps that have been taken to reduce or eliminate it.

Additional Safeguards Specific to Certain *Vulnerable Populations*: 45 CFR Part 46, Subparts B, C and D provide extra protections for the following specific ***Vulnerable Populations***:

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

Subpart C: *Additional Protections pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects*

Subpart D: *Additional Protections for Children Involved as Subjects in Research*

The specific additional protections that are required for each of these specific ***Vulnerable Populations*** are set forth below in the following P&Ps. The Emory IRB will require the additional protections described in the P&Ps named below for all research reviewed by the Emory IRB, provided, however, that for research which is not federally funded or which is not subject to FDA regulations, then review by consultants selected by the IRB, shall be substituted for any review by a federal agency or official required in those P&Ps.

Research Involving Children – Additional Protections

Research Involving Wards of the State – Additional Protections

Research Involving Prisoners – Additional Protections

Research Involving Pregnant Women, Human Fetuses & Neonates – Additional Protections

Research Involving Individuals with Impaired Decision-Making Capacity, or Economically or Educationally Disadvantaged Persons

Research conducted or supported by the ***DOD*****:** When such ***Research*** affects vulnerable classes of subjects (e.g., fetuses, pregnant persons, human in vitro fertilization, prisoners, or children) shall meet the protections of 45 CFR Part 46, Subparts B, C, and D. Actions authorizing or requiring any action by an official of the Department of Health and Human Services (HHS) shall

instead require action by the Director, Defense Research and Engineering.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.50 through 50.56
45 CFR Part 46, including 46.201 through 46.207, 46.301 through 46.306, and 46.401 through 46.409
42 U.S.C. 289g-1 and 289g-2
DOD Instruction 3216.02, 2022

52 RESEARCH INVOLVING *CHILDREN* – ADDITIONAL PROTECTIONS

POLICY:

In reviewing ***Research*** that involves ***Children*** the Emory IRB shall ensure that the ***Research*** complies with the applicable requirements of Subpart D in ***HHS and FDA Regulations***.

PROCEDURES:

Additional Protections for Specific *Vulnerable Populations* – *Children*. The additional protections set forth in this section must be followed for ***Research*** protocols that include ***Children*** as ***Human Subjects.***

Limits on Exemption and Exempt Review for studies approved before the compliance date for the *Revised Common Rule*: ***Research*** protocols involving ***Children*** shall not be eligible for exemption from IRB review pursuant to ***HHS Regulations*** concerning ***Research*** involving survey or interview procedures or observations of public behavior, except for ***Research*** involving the observation of public behavior when the investigators do not participate in the activities being observed.

Limits on Exemption and Exempt Review for studies approved after the compliance date for the *Revised Common Rule*: The exemptions in the Chapter entitled "Exempt Research" may be applied to research subject to Subpart D if the conditions of the exemption are met, excluding the following categories:

- Exempt categories 2 (i) and (ii) apply to research subject to Subpart D involving educational tests or the observation of public behavior only when the investigator(s) do not participate in the activities being observed.
- Exempt category 2 (iii) may not be applied to research subject to Subpart D.

IRB Determination of Applicable Category Required: In addition to other responsibilities assigned to the IRBs for Research Protocol review, in conducting review of proposed Research involving Children, the IRB may approve only Research involving Children that fits all of the requirements set forth below for four permissible categories. Depending on the type of ***Research*** being reviewed, the Emory IRB, in addition to performing its standard review, shall be required to make the following additional findings:

1) ***Minimal Risk Research***: ***Minimal Risk Research*** is ***Research*** that does not involve physical or emotional risk greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests. To approve a ***Research*** protocol of this type, the Emory IRB must determine and document in its meeting minutes and/or review documents that the protocol:

Is being reviewed pursuant to 45 CFR Section 46.404, and pursuant to 21 CFR Section 50.51 if an FDA-regulated product is involved;

Presents only ***Minimal Risk*** to the ***Children*** who are enrolled; and

Provides adequately for obtaining the ***Assent*** of the ***Children*** and the ***Permission*** of their ***Parents*** or ***Legal Guardians***, as set forth in this P&P entitled *Research Involving Children – Additional Protections* and P&P entitled *Legally Authorized Representatives & Surrogate Consent.* The IRB shall determine if adequate provisions attaining ***Assent*** are included and shall decide if the ***Permission*** of one ***Parent*** or ***Legal Guardian*** is sufficient to safeguard the ***Child*** or if the ***Permission*** of both ***Parents*** is required.

2) ***Research*** **with more than** ***Minimal Risk*** **that Presents Prospect of Direct Benefit to Participants:** To approve a protocol of this type, the Emory IRB must determine and document in its meeting minutes and/or review documents that the protocol:

Is being reviewed pursuant to 45 CFR Section 46.405 and pursuant to 21 CFR Section 50.52 if an ***FDA regulated*** product is involved;

Poses risk to the subjects that is justified by the anticipated benefit to the subject (by an intervention or procedure, or by a monitoring procedure that is likely to contribute to the participant's well-being);

Presents anticipated benefit in relation to the risk that is at least as favorable to the subject as that provided by available alternative approaches; and

Provides for obtaining the ***Assent*** of the ***Children*** and the permission of their ***Parents*** or ***Legal Guardians***, as set forth in this P&P entitled *Research Involving Children – Additional Protections* and P&P entitled *Legally Authorized Representatives & Surrogate Consent.* The IRB shall determine if adequate provisions for attaining ***Assent*** are included and shall decide if the ***Permission*** of one ***Parent*** or ***Legal Guardian*** is sufficient to safeguard the ***Child*** or if the ***Permission*** of both ***Parents*** is required.

3) ***Research*** **Involving More than** ***Minimal Risk*** **and No Prospect of Direct Benefit to Individual Subjects, but Likely to Yield Generalizable Knowledge about the Subject's Disorder or Condition:** To approve this type of ***Research*** protocol, the Emory IRB must determine, and document in its meeting minutes and/or review documents, that:

The ***Research*** protocol is being reviewed pursuant to 45 CFR Section 46.406 and pursuant to 21 CFR 50.53 if an FDA-regulated product is involved;

That the risk of the ***Research*** protocol represents a minor increase over ***Minimal Risk***;

That the intervention or procedure presents experiences to the subject that are reasonably commensurate with those inherent in their actual, or expected medical, dental, psychological, social or educational situations;

That the intervention or procedure is likely to yield generalizable knowledge

about the subject's disorder or condition which is of vital importance for the understanding or amelioration of the disorder or conditions; and

That the ***Research*** protocol provides adequately for obtaining the assent of the children and the ***Permission*** of their ***Parents*** or ***Legal Guardians***, as set forth in P&Ps *Research Involving Children – Additional Protections* and *Legally Authorized Representatives & Surrogate Consent.* Both ***Parents*** must give their ***Permission*** unless one ***Parent*** is deceased, unknown, incompetent or not reasonably available, or when only one ***Parent*** has legal responsibility for the care and custody of the ***Child.***

4) Research* that Cannot be Approved under 45 CFR Sections 46.404, 46.405 or 46.406, or 21 CFR Sections 50.51, 50.52, or 50.53 if an FDA-regulated product is involved, but that Presents a Reasonable Opportunity to Further the Understanding, Prevention or Alleviation of a Serious Problem Affecting the Health or Welfare of *Children: This type of ***Research*** protocol requires approval by both the IRB and OHRP if the protocol is subject to DHHS regulation, and by the FDA, if the ***Research*** protocol involves an item regulated by the FDA.

IRB Approval: Before an IRB can submit a ***Research*** protocol in this category to OHRP and/or to the FDA for review, it must make and document in meeting minutes and/or review documents the following findings:

That the ***Research*** protocol is appropriately being reviewed pursuant to 45 CFR Section 46.407 and pursuant to 21 CFR Section 50.54 if an ***FDA regulated*** product is involved.

That the ***Research*** protocol does *not* meet the conditions for approval under 45 CFR Sections 46.404, 46.405 or 46.406, or under 21 CFR Sections 50.51, 50.52 or 50.53 if an ***FDA regulated*** product is involved.

That the ***Research*** protocol provides adequately for obtaining the assent of the ***Children*** and the ***Permission*** of their ***Parents*** or ***Legal Guardians***, as set forth in this P&P entitled *Research Involving Children – Additional Protections* and P&P entitled *Legally Authorized Representatives & Surrogate Consent.* Both ***Parents*** must give their ***Permission*** unless one ***Parent*** is deceased, unknown, incompetent, or not reasonably available; or when only one ***Parent*** has legal responsibility for the care and custody of the ***Child.***

That the ***Research*** protocol, including all ***Assent*** and informed consent forms, comply with all with all other applicable regulatory requirements set forth in 45 CFR Sections 46.111, 46.408 and 46.409, and in 21 CFR Sections 50.55, 50.56 and 56.111, and any changes to the protocol and consent/***Assent*** documents requested by the IRB are incorporated.

OHRP Submission for 407 Research Subject to HHS Regulation: In order for OHRP to determine whether review under Section 46.407 may proceed, the IRB in conjunction with the PI shall submit a determination request to OHRP through the

instructions provided on the OHRP website:

OHRP and FDA Approval of 407 Research that is Federally Supported: Expert panels established by OHRP and FDA (if an ***FDA regulated*** item is involved) must review and approve ***Research*** in this category after seeking public comments on the research through the federal register and holding a meeting of the panel.

Non-Federally Supported 407 Research and Does Not Involve *FDA Regulated* Products: If the IRB finds that Research that is not subject to HHS jurisdiction *c*annot be approved under 45 CFR Section 46.404, 46.405, or 46.406 (or Research subject to 21 CFR 50.51, 50.52, or 50.53) but presents a reasonable opportunity to further the understanding, prevention or alleviation of a serious problem affecting the health or welfare of *Children,* the IRB shall seek the opinion of Consultants before making its final decision whether to approve the project.

Parental or *Legal Guardian Permission*: The Emory IRB must determine that adequate provision have been made for soliciting the permission of each ***Child's Parents*** or ***Legal Guardians.*** ***Parents*** or ***Legal Guardians*** must be provided with the basic elements of consent, as well as any additional elements of informed consent as the IRB deems necessary, as set forth in P&P entitled ***I****nformed Consent*). Permission by ***Parents*** or ***Legal Guardians*** must be documented in accordance with 45 CFR Section 46.117, and 21 CFR 50.27 if an ***FDA regulated*** product is involved.

Research **Requiring Only One Parent's Permission**: If the ***Research*** into which the ***Child*** is to be enrolled involves no more than ***Minimal Risk*** or if the ***Research*** involves greater than ***Minimal Risk*** but presents the prospect of direct benefit to the individual ***Human Subject*** participants, then, if the ***Child*** is in the legal care/custody of their ***Parents***, the IRB may find that the ***Permission*** of only one of the ***Child's Parents*** is sufficient to safeguard the interests of the ***Child***.

If the ***Child*** is not in the legal care/custody of their ***Parents***, then the ***Child's Legal Guardian*** may sign the informed consent/***Permission*** documentation; provided, however, that if the ***Child*** is a ***Ward of the State***, then the procedures set forth in the P&P entitled *Research Involving Wards of the State – Additional Protections* must be followed. A signed statement should be obtained from the ***Legally Authorized Representative*** certifying that they are the ***Legally Authorized Representative*** and copies of appropriate supporting documentation (e.g., copy of court order) also should be obtained and kept with the certification.

Research **Requiring Both Parents' Permission**: If the ***Research*** into which the ***Child*** is to be enrolled is presents greater than ***Minimal Risk*** and offers no prospect of direct benefit to the individual ***Human Subject*** participants, or if the ***Research*** meets the requirements of 45 CFR §46.407 (i.e., ***Research*** not otherwise approvable, which presents an opportunity to understand, prevent or alleviate a serious problem affecting the health or welfare of ***Children***), then if the ***Child*** is in the legal care/custody of their ***Parents,*** the informed consent/***Permission*** documents should be signed by both ***Parents*** unless one ***Parent*** is deceased, unknown, legally incompetent or not reasonably available, or when only one ***Parent*** has legal responsibility for the care and custody of the ***Child***.

If the ***Child*** is not in the legal care/custody of their ***Parents,*** then the ***Child's Legal Guardian***

should sign the informed consent/***Permission*** documents; provided, however, that if the ***Child*** is a ***Ward of the State***, then the procedures set forth in the P&P entitled *Research Involving Wards of the State – Additional Protections* must be followed. A signed statement should be obtained from the ***Legal Guardian*** certifying that they are the ***Legal Guardian*** and copies of appropriate supporting documentation (e.g., copy of court order) also should be obtained and kept with the certification.

Research Involving Medical Treatment for *Pregnancy*, Childbirth, *Pregnancy* Prevention: If the ***Research*** into which a ***Child*** who is not an ***Emancipated Minor*** is enrolling involves lawful surgical or medical treatment which may be recommended, prescribed or directed by a duly licensed physician, then a ***Child*** assigned female at birth***,*** regardless of age or marital status, may sign informed consent documents for themself in connection with ***Pregnancy***, or the prevention thereof, or childbirth; provided, however, that certain notice requirements may apply with regard to any ***Research*** concerning abortion procedures.

Research **Involving Treatment for Drug Abuse, or Certain Venereal Disease, or HIV**: If the ***Research*** into which the ***Child*** who is not an ***Emancipated Minor*** is enrolling involves lawful treatment for drug abuse, or for the diagnosis and/or treatment of syphilis, gonorrhea and/or chancroid, or HIV (hereafter "Venereal Disease") then the ***Child*** may sign informed consent documents for themself, provided that any such treatment shall involve procedures and therapy related to conditions or illnesses arising out of the Venereal Disease or HIV diagnosis which gave rise to the consent.

Research **Involving Medical Treatment**: If the ***Research*** into which the ***Child*** who is not an ***Emancipated Minor*** is enrolling involves lawful surgical or medical treatment which may be recommended, prescribed, or directed by a duly licensed physician, then the following persons may give consent/permission:

> Any ***Parent***, whether an ***Adult*** or a ***Minor*** for their non-***Emancipated Minor Child.***
>
> Any person temporarily standing in the place of a ***Parent,*** whether formally serving or not, for a non-***Emancipated Minor*** under their care; provided, however, that if the non-***Emancipated Minor*** is a ***Ward of the State***, then the provisions of the P&P *entitled: Research Involving Wards of the State – Additional Protections* must be followed.

Research **Not Involving Medical Treatment**: If the ***Research*** into which a ***Child*** who is not an ***Emancipated Minor*** is enrolling does not involve lawful surgical or medical treatment recommended, prescribed or directed by a duly licensed physician, then the following persons may give permission:

> Any ***Parent***, whether an ***Adult*** or a ***Minor***, for their non-***Emancipated Minor*** offspring;
>
> Any ***Legal Guardian*** of the ***Child;*** provided, however, that if the ***Child*** offspring is a ***Ward of the State***, then the provisions of the P&P entitled *Research Involving Wards of the State – Additional Protections* must be followed. A signed statement should be obtained from the ***Legal Guardian*** certifying that they are the ***Legal Guardian*** and copies of appropriate supporting documentation (e.g., copy of court order) also should be obtained and kept with the certification.

Documentation in IRB Records of Parental Permission Requirements*:* The IRB shall document its determination of whether ***Permission*** must be obtained from one or both ***Parents*** in the IRB meeting minutes (for Full Committee Review), specific study records (for Expedited Review), and in the approval letter to the PI.

Waiver of Parental Permission: The IRB may waive the requirement for obtaining the ***Permission*** of a ***Parent/Legal Guardian*** if:

The Research is not ***FDA Regulated;*** and

The ***Research*** meets the requirements for waiver set forth in ***HHS Regulations***; and

The IRB determines that the protocol is designed for conditions or a subject population for which ***Permission*** from a ***Parent*** or ***Legal Guardian*** is not a reasonable requirement to protect the subjects (e.g., neglected or abused ***Children***) AND an appropriate mechanism for protecting the ***Children*** who participate is substituted, and further provided that the waiver is not inconsistent with federal, state or local law. (NOTE: The choice of an appropriate substitute mechanism will depend upon the nature and the purpose of the ***Research*** activities, the risk and anticipated benefit to the subjects, and the subject's age, maturity, status, and condition.)

Assent* from *Children: In general, a ***Minor*** who is participating in ***Research*** should actively show their willingness to participate in the ***Research***, rather than just complying with directions to participate without resistance. When judging whether ***Children*** are capable of ***Assent*** and evaluating the ***Assent*** process to be used, the IRB shall take into account the ages, maturity and psychological state of the ***Children*** who are involved. The Emory IRB has the discretion to judge ***Children's*** capacity to ***Assent*** on the basis of the characteristics of the group of ***Children*** who will be participating in the ***Research***, or on an individual basis. The Emory IRB also may determine whether, for a particular ***Research*** protocol, the decision as to whether assent should be obtained should be made on a child-by-child basis; for example, a therapeutic study for which some ***Children*** may be too sick on a given day to focus on the information presented by the Researchers. In such cases, the Emory IRB shall provide the criteria for ***Children*** from whom assent should be obtained and the criteria for ***Children*** from whom assent need not be obtained. The PI or other qualified study team members will apply these criteria to each individual child.

If the IRB determines (a) that the capability of some or all of the ***Children*** who will be enrolled is so limited that they cannot reasonably be consulted; or (b) that the intervention or the procedures involved in the ***Research*** hold out a prospect of direct benefit that is important to the health or well-being of the ***Children*** and is available only in the context of the ***Research***, then the IRB may determine that the ***Assent*** of the ***Children*** is not a necessary condition for proceeding with the ***Research***.

The IRB, as appropriate, shall document the following in meeting minutes for protocols reviewed by ***Full Committee Review*** or the specific study record for protocols reviewed by ***Expedited Review,*** whether subjects, as a group, are capable of ***Assenting***; whether ***Assent*** is or is not required for the ***Research*** to proceed; if ***Assent*** is required, whether and how ***Assent*** must

be documented; or if subjects are not capable of ***Assenting***, whether ***Assent*** may be waived and how the protocol meets the requirements for waiver.

Waiver of *Assent*: Even though the IRB determines that subjects are capable of giving ***Assent***, the IRB may waive the requirement that ***Assent*** be obtained under circumstances in which informed consent may be waived under 45 CFR Section 46.116. If the IRB after ***Full Committee Review*** determines by majority vote that ***Assent*** may be waived, then it will document how the protocol meets all requirements for waiver in the meeting minutes***.***

Process for Obtaining Assent from *Children*: The Emory IRB presumes that ***Children*** below the age of 6 years and any ***Children*** with a cognitive impairment will not be required to provide ***Assent*** prior to participation in ***Research*** provided that their ***Parent(s)*** or ***Legally Guardian*** provide(s) **Permission** for the ***Children*** to participate in the ***Research***. Subject to the specific circumstances of an individual Child, as described above, the Emory IRB uses the general principles below regarding Assent:

The Emory IRB requires that ***Children*** between the ages of 6 to 11 years be provided with an explanation of the ***Research*** protocol and that their verbal ***Assent*** to participate is obtained. The verbal assent must be documented in the research records.

Children from 12 up to and until 18 years of age must be provided with a written ***Assent*** document and their signed ***Assent*** obtained prior to enrollment in any ***Research*** (unless documentation of Assent is waived by the IRB). If research will take place outside Georgia, the age of majority in that state will determine whether the subject gives assent or consent.

Assent* Template**: A template of the Emory IRB ***Assent document is available from the Emory IRB Website

PIs should ensure that the ***Assent*** form is age appropriate and study specific, taking into account the typical ***Child's*** experience and level of understanding. The ***Assent*** form should include essential information about the ***Research*** protocol including: (a) a description of why the ***Research*** is being conducted; (b) a description of what will happen and for how long or how often it will happen; (c) an explanation that it is up to the ***Child*** to participate and that the ***Child*** may refuse to participate; (d) an explanation of whether the procedures in the ***Research*** will hurt and if so for how long and how often; (e) a description of what other choices the ***Child*** may have instead of participating in the ***Research***; (f) a description of any good things that might happen from the ***Research***; (g) a description of any compensation that the study participant will receive; and (h) a description of how and of whom the ***Child*** may ask questions regarding the ***Research***. The form should be drafted in a format that takes into consideration the age(s) of the ***Child*** who may participate in the ***Research.***

Inconsistency Between *Parent/Legal Guardian* Permission and Child *Assent*: In general, a ***Child's*** refusal to ***Assent*** to participate in a ***Research*** protocol will override ***Permission*** granted by the ***Parent/Legal Guardian*** for participation. However, the IRB may consider a request to waive ***Assent*** on an individual subject basis in situations in the ***Parent/Legal Guardian*** has given permission for participation, but the ***Child*** has refused ***Assent.*** In cases where the IRB has determined 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, assent is not a necessary condition for proceeding with the research, but assent should be obtained when possible.

When a Child Subject Becomes an Adult: When a child who was enrolled in research with parental or ***Legal Guardian's*** permission subsequently reaches the legal age of consent to the procedures involved in ongoing research, the investigator should seek and obtain informed consent from the now-adult subject for any ongoing interactions or interventions.

Compensation: In some instances, it is appropriate for researchers to offer remuneration to ***Children*** or their legal guardians to compensate them for their time or costs incurred through participation. When remuneration is to be offered to any individual other than the participant, the IRB will approve the amount offered and the mechanism by which it is to be distributed.

For remuneration intended to displace costs associated with participation, the PI should be able to justify the amount and explain why recipients are likely to incur the costs for which they are compensated. For remuneration intended to compensate ***Human Subjects*** for their time, the PI should only deliver monetary payments to the ***Human Subject*** or to an individual who regularly manages the ***Human Subject's*** finances, if they do not manage expenses on their own. It must be clear in the informed consent who is going to receive the compensation.

For *AVAHCS Research,* research involving children must not be conducted by VA investigators while on official duty, or at VA-approved off-site facilities unless a waiver has been granted by the Chief Research and Development Officer. Research involving children may not pose greater than minimal risk to the child. Biological specimens and data obtained from children is considered research involving children even if de-identified.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.3 and 50.50 through 50.56
21 CFR Part 56, including 56.111
45 CFR Part 46, including 46.101 through 46.102, 46.111, 46.201 through 46.207, 46.301 through 46.306, and 46.401 through 46.409
42 U.S.C. 289g-1 and 289g-2
OCGA 31 Chapter 17, including 31-17-7
OCGA 31 Chapter 24, including 24-12-21
OHRP Guidance: Children as Research Subjects and the HHS "407" Process, May 2005

53 RESEARCH INVOLVING *WARDS OF THE STATE* – ADDITIONAL PROTECTIONS

POLICY:

In reviewing ***Research*** that involves ***Wards of the State*** the Emory IRB shall ensure that the ***Research*** complies with the applicable requirements of ***HHS Regulations***, Subpart D.

DEFINED TERMS:

Wards of the State: ***Children*** who are under the care of a governmental agency either directly or through placement in an individual or institutional foster care setting.

PROCEDURES:

Additional Protections for Specific *Vulnerable Populations – Wards of the State*: In addition to the specific protections set forth in the P&P entitled *Research Involving Children – Additional Protections* regarding ***Research*** involving ***Children*** as ***Human Subjects***, the following additional protections also must be followed for ***Research*** protocols that include ***Children*** who are ***Wards of the State*** as ***Human Subjects:***

The governmental agency that has control of the ***Child*** provides written documentation evidencing its legal authority to give permission for the ***Child's*** participation in the ***Research*** protocol and authorizing a named agency representative to sign appropriate ***Permission*** and ***HIPAA Authorization*** forms on behalf of the child; and

If the ***Research*** protocol either (a) involves greater than ***Minimal Risk*** with no prospect of direct benefit to individual subjects but is likely to yield generalizable knowledge about research subjects' disorder or condition; or (b) is ***Research*** that must be approved under 45 CFR Section 46.406 or 46.407, or 21 CFR Section 50.53 or 50.54, then in order for ***Wards of the State*** to be considered for enrollment, the IRB must:

Determine that the ***Research*** protocol is related to the subject's status as ***Wards of the State***; or it must be conducted in schools, camps, hospitals, institutions or similar setting in which the majority of ***Children*** involved as subjects are not ***Wards of the State;***

Appoint an advocate for each ***Child*** who is a ***Ward of the State***, and the advocate shall meet the following qualifications and have the following responsibilities:

The advocate will serve in addition to any other individual acting on behalf of the ***Child*** as ***Legal Guardian*** or in *loco parentis.*

A single person may serve as advocate for more than one ***Child;***

The advocate must be an individual who has the background and experience to act in and agrees to act in the best interest of the child for

the duration of the ***Child's*** participation in the ***Research*** protocol.

The advocate must not be associated in any way with the clinical investigation, the ***Investigators*** or the guardian organization.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.50 through 50.56
45 CFR Part 46, including 46.102, 46.201 through 46.207, 46.301 through 46.306, and 46.401 through 46.409
42 U.S.C. 289g-1 and 289g-2

54 RESEARCH INVOLVING *PRISONERS* – ADDITIONAL PROTECTIONS

POLICY:

In reviewing ***Research*** that involves ***Prisoners*** the Emory IRB shall ensure that the ***Research*** complies with the applicable requirements of ***HHS Regulations***, Subpart C.

For ***Research*** conducted or supported by the ***DOD***, neither ***Prisoners of War*** nor ***Captured or Detained Personnel*** may be ***Research*** subjects. This prohibition does not apply to research involving investigational drugs and devices when the same products would be offered to US military personnel in the same location for the same condition.

PROCEDURES:

Additional Protections for Specific *Vulnerable Populations – Prisoners:* The additional protections set forth in this section must be followed for ***Research*** protocols that include ***Prisoners*** as ***Human Subjects.***

Composition of the IRB: When reviewing any ***Research*** protocol involving ***Prisoners*** as ***Human Subjects***, the Emory IRB shall ensure that in addition to the composition requirements set forth in the P&P entitled *IRB Membership*, the following composition requirements are met:

A majority of the Emory IRB members, excluding members who are ***Prisoners*** or ***Prisoner Representatives,*** will not be associated with the prisons involved.

One member of the Emory IRB shall be a ***Prisoner*** or a ***Prisoner Representative.*** A ***Prisoner Representative*** is an IRB member who has appropriate background and experience that includes a close working knowledge, understanding and appreciation of prison conditions from the ***Prisoner's*** perspective.

The Prisoner or Prisoner Representative must be present, either in-person or by speakerphone, at any meeting of the Emory IRB for full board review of new Research protocols involving Prisoners and modifications adding Prisoners. For Continuing Reviews at full board, the IRB must document the participation of the Prisoner Representative in the review, but the Prisoner Representative does not have to be present or attending by speakerphone. For expedited reviews of Research involving Prisoners, the participation of the Prisoner Representative must be obtained and documented.

The fact that the Emory IRB meets the compositional requirements for the review of a ***Research*** protocol involving ***Prisoners*** will be documented in the meeting minutes at which the ***Research*** protocol is reviewed.

The Emory IRB staff shall notify OHRP of any change in the Emory IRB Committee rosters that result from the addition of a ***Prisoner*** or ***Prisoner Representative*** as a member of an Emory ***IRB Committee***. IRB staff shall also keep on file a copy of the ***Prisoner*** or ***Prisoner Representative's*** *curriculum vitae* or other documentation that they possess

the necessary qualifications to serve in this capacity.

The Prisoner Representative must be a member of the IRB. The Prisoner Representative may be listed as an alternate member who serves as a voting member when needed. The Prisoner Representative must review research involving prisoners, focusing on the requirements of Subpart C. They must receive all review materials pertaining to the research, just as the primary reviewer does. 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 speakerphone, video conference, or webinar, as long as they are able to participate in the meeting as if they were present in person at the meeting.

The Prisoner Representative must present their review either orally or in writing at the convened meeting of the IRB when the research involving prisoners is reviewed.

Type of Review:

Minor modifications to research may be reviewed using the expedited procedure. 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.

Continuing review must use the same procedures as for initial review, including the responsibility of the Prisoner Representative to review the continuing review materials and to participate in the meeting as described above. If no participants have been enrolled, the research may receive continuing review using the expedited procedure under expedited category #8.

Research involving interaction with prisoners may be reviewed by the expedited procedure (except for DOD supported Research involving Prisoners of War), 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 as a 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.

For research that does not involve interaction with prisoners (e.g., existing data, record reviews) reviewed by the expedited procedure: this research 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.

Exempt review procedures may not be used for research involving prisoners.

If a participant becomes a prisoner while enrolled in a research study that was not reviewed according to Subpart C *(see section below on Research* conducted or supported by the *DOD for specific requirements for those studies)*

The PI shall:

Submit a Modification to add Prisoners as a population, if the following are true:

- The participant will still be incarcerated at the time of planned upcoming study procedures (including secondary data collection)
- The study team does not wish to withdraw the participant from the study

- Immediately cease all ***Research*** interactions and interventions with the participant, including obtaining private information, until the ***Modification*** has been reviewed by the IRB, UNLESS:
  - the PI provides written documentation to IRB Chair describing special circumstances that justify why it is in the Human Subject's best interest to continue to remain in the Research protocol while the IRB undertakes the review process set forth in the aforesaid provision.

The IRB shall:

- Confirm that the participant meets the definition of a "***Prisoner;***"
- Determine if the incarceration is temporary and will end before the participant would undergo any further procedures for the research, including secondary data collection.
  - If so, no further determinations or action must be taken.
- Review the ***Modification*** per the procedures in the section above, and make one of the following findings:
  - The study is neither DHHS-funded nor considered VA Research, and the "Non-DHHS" criteria below are met, OR
  - The research meets the criteria set forth in Subpart C of the Common Rule.

Non-DHHS Criteria:

- The research is NOT conducted or funded by DHHS or Veterans Administration (VA).
- The subject was not incarcerated at the time of enrollment, and subsequent incarceration was unexpected.
- The incarceration does not put the rights and wellbeing of the subject in jeopardy with respect to the study.
- The prisoner representative has been consulted.
- The terms of the subject's confinement do not inhibit the ethical conduct of the research.
- There are no other significant issues preventing the research from continuing as approved.
- This approval is limited to the individual subject and does not allow recruitment of prisoners.
- One of the following is true: (Check all that are true)
  - The subject will be at increased risk of harm if withdrawn from the research
  - The research presents no more than Minimal Risk and no more than inconvenience to the subjects.

For DHHS-Regulated Research:

- The research shall be reviewed per Subpart C
- If some requirements of Subpart C cannot be met:
    - If it is in the best interests of the subject to remain in the study, the subject shall remain enrolled and the IRB shall inform OHRP of the decision along with the justification.
    - Otherwise, the IRB shall advise the PI to remove the participant from the study and to keep the participant on the study intervention under an alternate mechanism as necessary.

Approvable Categories of *Research* Involving Prisoners as Subjects (from Subpart C)*:* For any biomedical or behavioral ***Research*** protocols involving ***Prisoners*** that the Emory IRB must determine and document within its meeting minutes or study records that the ***Research*** meets the criteria for approval of research, and protocol falls into one of the categories of ***Research*** listed below. In addition, if the ***Research*** protocol is receiving HHS funding then the ***HHS Secretary*** also must determine that the proposed ***Research*** fits one of the following four categories of permissible Research or is eligible for the epidemiological waiver described below**:**

1) Study of possible causes, effects, and processes of incarceration and of criminal behavior, provided the that study presents no more than ***Minimal Risk*** for ***Research*** involving ***Prisoners***, and no more than inconvenience to the ***Human Subject.***

2) Study of prisons as institutional structures or of ***Prisoners*** as incarcerated persons provided that the study presents no more than ***Minimal Risk*** for ***Research*** involving ***Prisoners*** and no more than inconvenience to the ***Human Subjects***.

3) Study of conditions particularly affecting ***Prisoners*** as a class (e.g., ***Research*** on a health problem that is more prevalent in prisons than elsewhere) provided that with regard to HHS-funded ***Research*** the ***HHS Secretary*** approves the study after consulting with experts in penology medicine and ethics and publishes a notice of the intent to approve the study in the Federal Register.

4) Study of practices, whether innovative or accepted, that have the intent and reasonable probability of improving the health or well-being of the ***Human Subject***; provided however, that if the ***Research*** is HHS-funded and is of a type that requires that ***Prisoners*** be assigned to control groups that may not benefit from the ***Research***, then the study may proceed only after the ***HHS Secretary*** approves the study after consulting with appropriate experts, including experts in penology medicine and ethics and publishing a notice of intent to approve the study in the Federal Register.

Prisoners should receive a copy of their signed consent form at the time of signing, unless the possession of the consent form might create a risk of breach of confidentiality for the subject that could result in indignity, stigmatization, or physical harm. Provisions should be made to allow the prisoner access to review a copy of their signed consent form at a later date (e.g., by keeping a copy at the research office and giving the subject the contact information they can use to request it later).

Epidemiology Waiver: The IRB does not have to make the finding that the Research fits one of the four categories described above if all of the criteria for the Epidemiology Waiver apply.

> The ***HHS Secretary*** has waived the applicability of 45 CFR Section 46.305(a)(1) and 46.306(a)(2) for certain ***Research*** conducted or supported by HHS that involves epidemiologic studies that involve no more than ***Minimal Risk*** and no more than inconvenience to the participants that meet the following criteria:
>
> - The sole purpose of the ***Research*** *is* (a) to describe the prevalence or incidence of a disease by identifying all cases; or (b) to study potential risk factor associations for a disease; and
> - The IRB has approved the ***Research*** and fulfilled its duties under 45 CFR 46.305(a)(2)-(7) and determined and documented that: (a) the *Research* presents no more than ***Minimal Risk*** and no more than inconvenience to the ***Prisoner***-subjects and; (b) ***Prisoners*** are not a particular focus of the ***Research***.
> - The waiver permits the conduct of ***Minimal Risk Research*** that does not otherwise fall within the categories set forth in 45 CFR Section 46.302(a)(2) and applies to research that uses epidemiologic methods such as interviews and collection of biological specimens.

Findings that the Emory IRB Must Make Regarding the *Research*: In addition to determining which of the permissible categories the Research fits, or invoking the epidemiology waiver, the Emory IRB must make the following determinations with regard to its review of any ***Research*** protocol involving ***Prisoners*** as ***Human Subjects*** and document justification for each of these findings within its meeting minutes or in the record of expedited review findings:

> Any possible advantages accruing to the ***Prisoner*** by participating in the ***Research***, when compared to general living conditions, medical care, quality of food, amenities and opportunity for earning in prison, are not of such a magnitude that they would impair the ***Prisoner's*** ability in the prison environment to weigh the risks of the ***Research*** against the value of the advantages;
>
> The risks involved in the ***Research*** are commensurate with risks that would be accepted by non-***Prisoner Human Subject*** volunteers;
>
> The procedures for the selection of subjects within the prison are fair to all ***Prisoners*** and are not subject to arbitrary intervention by prison authorities or ***Prisoners***;
>
> Any control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for the ***Research Protocol*** unless the PI provide the IRB with written justification for following some other selection procedure.
>
> The information regarding the ***Research*** protocol is presented in language that is understandable to the subject population.
>
> The Emory IRB receives adequate assurance that parole boards will not take into account a prisoner's participation in the ***Research*** protocol in making decisions

regarding parole, and each **Prisoner** is clearly informed in advance that participation in the ***Research*** protocol will have no effect on their parole;

If the Emory IRB determines that there may be a need for follow-up examination or care of participants in the ***Research*** protocol after the end of participation, then the ***Research*** protocol must make adequate provision for such examination or care, taking into account the varying lengths of individual ***Prisoners'*** sentences, and for informing participants of this fact.

Additional Federal Approval Requirements for *Research* Protocols Funded by HHS: If the ***Research*** that involves ***Prisoners*** is being funded by HHS, then in addition to the requirements for such ***Research*** specified above, the Emory IRB must certify to the ***HHS Secretary*** that it has carried out all of its required functions with regard to the review and oversight of ***Research*** involving ***Prisoners.*** To effect this certification, Emory University, through the IRB Chair, Director, or the IO, must send a certification letter to OHRP that meets the following requirements:

Contains the name and address of institution at which study is being conducted.

Contains the name of ***Research*** protocol.

Contains the name of any associated HHS grant application or proposal.

Contains a certification that the Emory IRB has reviewed the ***Research*** protocol and made the findings set forth in the provision above entitled *Findings that the Emory IRB Must Make Regarding the Research.*

Contains as an attachment a copy of the ***Research*** protocol approved by the Emory IRB; any associated HHS grant application or proposal; any Emory IRB application forms; any other information required or requested by the Emory IRB during the Emory IRB's initial review.

The foregoing materials should be sent to OHRP at the following address: Attention: OHRP Prisoner Research Contact Person, Office for Human Research Protections, Dept of Health and Human Services, The Tower Bldg., 1101 Wootton Prkwy., Suite 200, Rockville, MD 20852. Upon receipt and review of materials listed above, OHRP will make a determination as to whether ***Research*** falls within an appropriate category, and if so, which category. OHRP also shall publish any notices regarding the ***Research*** in the Federal Register, as may be necessary.

NOTE: ***AVAHCS Research*** involving ***Prisoners*** must not be conducted by VA investigators while on official duty, or at VA-approved off-site facilities unless a waiver has been granted by the Chief Research and Development Officer. If the waiver is granted, the ***Research*** must be in accordance with applicable federal regulations pertaining to ***Prisoners*** as ***Research*** subjects (see 45 CFR Part 46, Subpart C, *Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects*).

Research conducted or supported by the **DOD:**

Neither ***Prisoners of War***, nor ***Captured or Detained Personnel*** may be subjects in Research conducted or supported by the ***DOD***. This prohibition does not apply to research involving investigational drugs and devices when the same products would be offered to US military personnel in the same location for the same condition. In reviewing ***Research*** conducted or supported by the ***DOD*** that may involve ***Prisoners of War*** or ***Captured or Detained Personnel***, the Emory IRB shall be apprised of the definition of the terms ***Prisoners of War*** and/or ***Captured or Detained Personnel*** that is used by the DOD unit supporting the Research, so that this definition may be correctly applied in evaluating the project.

When a participant becomes a prisoner on a Research study that is conducted or supported by the ***DOD***: if the researcher asserts to the IRB that it is in the best interest of the prisoner-participant to continue to participate in the research while a prisoner, the IRB chair may determine that the prisoner-participant may continue to participate until the convened IRB can review this request to approve a change in the research protocol and until the organizational official and DOD Component office review the IRB's approval to change the research protocol. Otherwise, the IRB chair must require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol. The convened IRB, upon receipt of notification that a previously enrolled human participant has become a prisoner, must promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. The IRB should consult with a subject matter expert having the expertise of a prisoner representative if the IRB reviewing the research protocol does not have a prisoner representative. If the prisoner-participant can continue to consent to participate and is capable of meeting the research protocol requirements, the terms of the prisoner-participant's confinement does not inhibit the ethical conduct of the research, and there are no other significant issues preventing the research involving human participants from continuing as approved, the convened IRB may approve a change in the study to allow this prisoner-participant to continue to participate in the research. This approval is limited to the individual prisoner-participant and does not allow recruitment of prisoners as participants. Such a change in research must be reported to the relevant DOD HRPO.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.101, 46.107, 46.201 through 46.207, 46.301 through 46.306, and 46.401 through 46.409
10 U.S.C. 980
DOD Instruction 3216.2, 2022
SECNAVINST 3900.39(D), 2006
VHA Directive Section Handbook 1200.05(2), 2021

55 RESEARCH INVOLVING PREGNANT WOMEN, HUMAN FETUSES, AND NEONATES – ADDITIONAL PROTECTIONS

POLICY:

In reviewing ***Research*** that involves ***Pregnant Women***, human ***Fetuses*** or ***Neonates***, the Emory IRB shall ensure that the ***Research*** complies with the applicable requirements of ***HHS Regulations***, Subpart B.

Note: Subpart A, under the ***Revised Common Rule***, removed ***Pregnant Women*** from the list of vulnerable populations. Subpart B was unchanged, so the same protections stand.

PROCEDURES:

Additional Protections for Specific *Vulnerable Population – Pregnant Women:* The criteria for review will depend on the risk level (as determined by the IRB) and the applicability of federal regulations, as follows:

Non-Federally Regulated Minimal Risk Research: The research must meet the following criteria, and no other determinations are necessary in terms of *Pregnant Women and Fetuses*.

The research is NOT conducted, funded, or otherwise subject to regulation by DHHS, Environmental Protection Agency (EPA), or Veterans Administration (VA).
The research involves no more than Minimal Risk to pregnant persons and fetuses.
The research is not funded by Department of Defense, or does not involve interventions/invasive procedures to the pregnant person or fetus and does not involve fetuses or neonates as subjects.

More than Minimal Risk Studies, and Federally Regulated Research: The research must meet the following additional protection requirements:

Where scientifically appropriate, preclinical studies have been conducted, including studies on ***Pregnant*** animals, that provide data for assessing potential risks to ***Pregnant Women*** and ***Fetuses.***

Where scientifically appropriate, clinical studies have been conducted, including clinical studies on non-***Pregnant Women*** that provide data for assessing potential risks to ***Pregnant Women*** and ***Fetuses.***

Any risk in the ***Research*** is the least possible risk for achieving the objectives of the ***Research.***

Any risk to the ***Fetus*** from the ***Research*** is caused solely by interventions or procedures that hold the prospect of direct benefit for the ***Pregnant Woman*** or the ***Fetus***, or if there is no prospect of such direct benefit, then the ***Research*** poses only ***Minimal Risk*** to the ***Fetus*** and the ***Research's*** purpose is the development of

important biomedical knowledge that cannot be obtained by any other means.

Only the ***Pregnant Woman's*** informed consent (and not the informed consent of the ***Pregnant Woman*** and the father of the ***Fetus***) must be obtained in accordance with these P&Ps if the ***Research*** meets the following criteria:

It holds the prospect of direct benefit to the ***Pregnant Woman*** or to both the ***Pregnant Woman*** and the ***Fetus***; or

It does not hold the prospect of direct benefit for the ***Pregnant Woman*** or the ***Fetus***, but the risk to the ***Fetus*** is no greater than minimal; and the purpose of the ***Research*** is the development of important biomedical knowledge that cannot be obtained by any other means.

Informed consent of both the ***Pregnant Woman*** and the ***Fetus'*** father must be obtained in accordance with these P&Ps if the ***Research*** holds out the prospect of direct benefit solely to the ***Fetus***; provided, however, that the father's consent does not have to be obtained if he is unable to consent because he is unavailable; incompetent; temporarily incapacitated; or if the ***Pregnancy*** resulted from rape or incest.

If the ***Pregnant Woman*** is a minor, then, as applicable, informed consent/assent/permission must be obtained in accordance with the P&Ps entitled *Research Involving Children – Additional Protections* and *Legally Authorized Representatives & Surrogate Consent.*

Any person from whom informed consent is required under this section must be fully informed regarding the reasonably foreseeable impact of the ***Research*** on the ***Fetus*** or ***Neonate.***

Individuals who are engaged in the ***Research*** protocol will play no part in any decision regarding: (a) the timing, method and procedures used to terminate the ***Pregnancy***; and/or (b) determining the viability of a ***Neonate.***

No monetary or other inducements or incentives may be offered to terminate the ***Pregnancy*** for purposes of the ***Research*** protocol.

Research Involving *Pregnant Women* or *Fetuses* that Does not Meet the Requirements Set Forth Immediately Above: If the IRB determines that a ***Research*** protocol does not meet the requirements of the provision above entitled **Additional Protections for Specific *Vulnerable Population – Pregnant Women***, then the ***Research*** protocol will be eligible for conduct or funding by HHS only if the IRB determines 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*** or ***Fetuses***; and

The ***HHS Secretary***, in consultation with a panel of experts, makes the findings set

forth at 45 CFR § 46.207(b).

Additional Protections for Specific *Vulnerable Populations – Neonates*: The following additional protections must be followed for ***Research*** protocols that include ***Neonates***:

Nonviable Neonates: ***Nonviable Neonates*** may be involved in ***Research*** if the IRB, either through ***Full Committee*** or ***Expedited*** Review, determines and documents that all of the following conditions are met:

Each individual engaged in the ***Research*** will have no part in determining the ***Viability*** of a ***Neonate***;

Vital functions of the ***Neonate*** will not be artificially maintained (e.g., for the purpose of the research);

The ***Research*** will not terminate the heartbeat or respiration of the ***Neonate;***

There will be no added risk to the ***Neonate*** resulting from the ***Research;***

The purpose of the ***Research*** is the development of important biomedical knowledge that cannot be obtained by other means;

Where scientifically appropriate, preclinical and clinical studies have been conducted that provide data for assessing potential risk of the ***Research*** to ***Neonates;***

Each individual providing informed consent for the ***Research*** is fully informed about the reasonably foreseeable impact of the ***Research*** on the ***Neonate***; and

The following requirements concerning informed consent are met:

Informed consent is obtained from both ***Parents*** of the ***Neonate***; provided, however, that if either ***Parent*** is unable to consent because they are unavailable, incompetent, or temporarily incapacitated, then the informed consent of one parent of a ***Nonviable Neonate*** will suffice, and further provided that the father's consent does not need to be obtained if the ***Pregnancy*** resulted from rape or incest;

No waiver or alternation of the elements of informed consent may be granted by the IRB; and

The consent of ***Legally Authorized Representatives*** of either or both ***Parents*** of the ***Neonate*** is not sufficient to provide informed consent.

Neonates* of Uncertain *Viability: ***Neonates*** of uncertain ***Viability*** may not be involved in ***Research*** unless the IRB determines that the following requirements are met:

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 the purpose of the ***Research*** is the development of important biomedical knowledge that cannot be obtained by other means and there will be no added risk to the ***Neonate*** resulting from the ***Research***; and

Where scientifically appropriate, preclinical and clinical studies have been conducted that provide data for assessing potential risk of the ***Research*** to ***Neonates;***

The ***Neonate*** has been determined to be of uncertain ***Viability;*** provided, however, that individuals engaged in the ***Research*** have no part in determining the ***Viability*** of a ***Neonate;***

Each individual providing informed consent for the ***Research*** is fully informed about the reasonably foreseeable impact of the ***Research*** on the ***Neonate***; and

The following informed consent requirements are met:

The legally effective informed consent of either ***Parent*** of the ***Neonate*** is obtained; provided, however, that if neither ***Parent*** is able to consent because of unavailability, incompetence or temporary incapacity, then legally effective informed consent of either ***Parent's Legally Authorized Representative*** may be obtained, except that the consent of the father or their ***Legally Authorized Representative*** need not be obtained if the ***Pregnancy*** resulted from rape or incest.

Viable Neonates: A ***Neonate***, after ***Delivery***, that has been determined to be ***Viable*** may be included in ***Research*** only to the extent permitted under the general P&Ps concerning the involvement of ***Children*** in ***Human Subjects Research.***

Additional Protections for Specific *Vulnerable Population* – *Research* Involving the *Dead Fetus* or *Fetal Material* after *Delivery*: *Research* protocols that involve the ***Dead Fetus*** or ***Fetal Material*** after ***Delivery*** must meet the following additional protection requirements:

The ***Research*** must be conducted in accordance with any applicable federal, state or local laws and regulations governing such activities.

If information associated with the dead ***Fetus*** or ***Fetal Material*** is recorded for ***Research*** purposes in a manner by which living individuals can be identified (either directly or through identifiers linked to the individuals), then those living individuals shall be considered to be ***Human Subjects*** and all laws, regulations and P&Ps that regularly apply to ***Research*** involving ***Human Subjects*** shall apply.

See also the P&Ps entitled *Requirements for Research Involving Human Embryonic Stem Cell, Germ Cells, Stem Cells Derived Test Articles & the Transplantation of Human Fetal Tissue for Therapeutic Purposes* for additional restrictions that apply to ***Research*** involving ***Human Fetal Tissue*** used in federally funded ***Research*** involving the transplantation of such tissue for therapeutic purposes.

For *AVAHCS Research* Involving Pregnant Persons, Human Fetuses, and Neonates as Subjects:

Research that involves provision of in vitro fertilization services can be conducted by VA investigators while on official duty, or at VA facilities, or at VA-approved off-site facilities. (NOTE: Prospective and retrospective studies that enroll or include pregnant subjects who conceived through in vitro fertilization or other artificial reproductive technologies are permitted).

Use of stem cells shall be governed by the policy set by NIH for recipients of NIH research funding.

VA investigators cannot conduct interventions in research that enroll neonates while on official duty, or at VA facilities, or at VA-approved off-site facilities. Prospective observational and retrospective record review studies that involve neonates or neonatal outcomes are permitted.

Individuals who are known to be pregnant and/or their fetuses may be involved in research if all of the requirements of 45 CFR 46.204 are met along with the following criterion, which is verified by the VA RDC:

- The VA medical facility Director certifies that the medical facility has sufficient expertise in women's health to conduct the proposed research

For DOD supported Research: For purposes of applying Subpart B, the phrase "biomedical knowledge" must be replaced with "generalizable knowledge." The applicability of Subpart B is limited to research involving pregnant persons as participants in research that is more than minimal risk and included interventions or invasive procedures to the pregnant person or the fetus or involving fetuses or neonates as participants. Fetal research must comply with the US Code Title 42.

For human subjects research (HSR) that would not otherwise be approved but presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant persons, fetuses, or neonates, DOD institutions must demonstrate to the senior defense official (SDO) that the IRB has fulfilled its duties in accordance with Subpart B of ***HHS Regulations***. Before HSR activities may begin, the SDO must receive explicit written approval from the Directorate of Human Research Protections.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.50 through 50.56
45 CFR Part 46, including 46.201 through 46.207, 46.301 through 46.306, and 46.401 through 46.409
10 U.S.C. 980
42 U.S.C. 289g-1 and 289g-2
DOD Instruction 3216.2, 2022
SECNAVINST 3900.39D, 2006
VHA Directive Section 1200.05(2), 2021

56 RESEARCH INVOLVING INDIVIDUALS WITH IMPAIRED DECISION-MAKING CAPACITY, OR ECONOMICALLY OR EDUCATIONALLY DISADVANTAGED PERSONS

POLICY:

Research that involves persons with individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons warrants special attention because this population is considered vulnerable to coercion and undue influence and ***Research*** involving these subjects often presents greater than ***Minimal Risk*** and may not offer any direct benefit to the subjects. Accordingly, the Emory IRB shall ensure that the ***Research*** incorporates the additional safeguards set forth in this section.

PROCEDURES:

IRB Composition: When reviewing ***Research*** that purposefully requires inclusion of ***Human Subjects*** with disabilities or impaired decision-making capacity, or economically or educationally disadvantaged persons, the IRB membership shall include at least one member who is primarily concerned with the welfare of these research participants. In addition, consideration may be given to seeking review by a consultant who has experience with the subject population, such as a family member of such a person or a representative of an advocacy group for that population.

Approval Criteria: In addition to employing its typical standard for review of ***Research*** protocols, the Emory IRB shall also determine, and document in appropriate meeting minutes or review documents, whether the involvement of the impaired decision-making capacity, or economically or educationally disadvantaged persons in the ***Research*** protocol is justified and whether the ***Research*** protocol minimizes risks to these ***Human Subjects***. In making these determinations, the Emory IRB shall consider the following factors:

- Whether the PI provided sufficient justification for the inclusion of impaired decision-making capacity, or economically or educationally disadvantaged persons as a **Human Subject.** In this regard, the PI must demonstrate to the IRB that there is a compelling reason to include individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons in the ***Research;*** and that the ***Research*** cannot reasonably be conducted without their participation
- Whether the PI provided sufficient information about the cause and predicted degree of decisional incapacity and any anticipated variations in the decisional capacity of the ***Human Subject***, and whether the PI provided a plan for the assessment of the decisional incapacity of the ***Human Subject***,
- Whether the PI has provided sufficient information about the nature and degree of potential limitations on the ability of the ***Human Subject*** impaired decision-making capacities to provide sufficient interaction to satisfy the requirements of the ***Research*** protocol
  - When the recruitment plan includes individuals who are likely to have severe impairment to their functional abilities, the capacity of such prospective ***Human Subjects*** to consent to enroll in the study in question should be assessed on an individual basis prior to their enrollment.
- Whether the PI has provided sufficient information about the nature and degree of

risk to the ***Human Subject*** with impaired decision-making capacities. The ***Research*** should not entail any risk of injury to the subject unless the ***Research*** is intended to benefit the subject and the probability of benefit is greater than the probability of harm, or is likely to yield generalizable knowledge that is of vital importance to understanding the subject's disorder or condition;

- Whether the PI provided a plan for protecting the individuals impaired decision-making capacity, or economically or educationally disadvantaged persons from coercion;
- The nature of the proposed safeguards to be employed in the ***Research*** protocol and whether these safeguards are adequate to protect the ***Human Subject*** with impaired decision-making capacity, or economically or educationally disadvantaged persons;
- The nature of the proposed plan to assure adequate protections for the privacy of the ***Human Subject*** and the confidentiality of the information gathered;
- The nature and level of any monetary payments or other incentives to the ***Human Subject*** with impaired decision-making capacity, or economically or educationally disadvantaged persons, and whether such payments/incentives may constitute an undue inducement;
- Whether the possibility of exploitation of the ***Human Subject*** with impaired decision-making capacity, or economically or educationally disadvantaged persons exists, and the steps that have been taken to reduce or eliminate it;
- The nature and level of anticipated benefits to the ***Human Subject*** with impaired decision-making capacity, or economically or educationally disadvantaged persons;
- The thoroughness of the presentation through the informed consent process of relevant risk and benefits to the ***Human Subject*** with impaired decision-making capacity, or economically or educationally disadvantaged persons.
- The incorporation into the ***Research*** of procedures to ensure that the participant's representatives are well informed regarding their roles and obligations to protect impaired decision-making capacity, or economically or educationally disadvantaged persons. In this regard, the subject's ***Legally Authorized Representatives*** must be provided with description of the proposed ***Research*** and any obligations that the ***Legally Authorized Representative*** would have with regard to the subject's participation.
- Whether the elements of informed consent for a legally incompetent adult, as set forth in **Section 41** (*entitled: Informed Consent Policy*), are met. Consent from the ***Legally Authorized Representatives*** of the subjects must be obtained in accordance with the requirements set forth in the P&P entitled: *Legally Authorized Representatives & Surrogate Consent* with regard to determining whether to consent for the enrollment of the subject in the study, the ***Legally Authorized Representative*** should be informed that they are to act in the subject's best interests. Even if the consent of a ***Legally Authorized Representative*** is obtained, if a subject resists participation in a ***Research*** protocol, under no circumstances may they be forced or coerced to participate.
- Whether plans, if any, for obtaining written or verbal assent from the subject are appropriate.

Informed Consent Process: Functional abilities exist along a continuum, and prospective participants can have greater or lesser ability because of various physical and psychological conditions. The extent and nature of impairment will vary based on the nature of the condition

and on factors specific to individual participants. However, prospective ***Human Subjects*** with impairments to functional abilities are presumed to be capable of providing consent to enroll and participate in a research study unless there is substantial evidence that they are not capable. The PI will provide the IRB with information of how they plan to assess the ***Human Subjects***' cognitive functions (such as attention, comprehension, memory, and intellect), communication abilities, and other abilities that affect prospective participants' ability to make and express decisions regarding participation in research.

Fluctuating Decision-Making Capacity: For studies that involve subjects whose decision-making capacity may fluctuate or decrease, the PI may need to employ a re-consenting process using surrogate consent as set forth in the P&P entitled *Legally Authorized Representatives & Surrogate Consent***.** It is the responsibility of the PI to monitor the decision-making capacity of subjects enrolled in ***Research*** studies and to determine if surrogate consent must be re-obtained. The study team should document their efforts when asking a ***Human Subject*** with impaired capacity their wishes to participate in ***Research*** studies. The IRB will require PIs to conduct periodic competency assessment when there is a possibility of either decreased mental functioning or fluctuating decision-making capacity in prospective subjects.

Subject Compensation

In some instances, it is appropriate for researchers to offer remuneration to ***Human Subjects*** with diminished functional abilities to compensate them for their time or for costs incurred through participation. When remuneration is to be offered to any individual other than the participant, the convened IRB will and approve the amount offered and the mechanism by which it is to be distributed.

For remuneration intended to displace costs associated with participation, the PI should be able to justify the amount and explain why recipients are likely to incur the costs for which they are compensated. For remuneration intended to compensate ***Human Subjects*** for their time, the PI should only deliver monetary payments to the ***Human Subject*** or to an individual who regularly manages the ***Human Subject's*** finances, if they do not manage expenses on their own. It must be clear in the informed consent who is going to receive the compensation.

For AVAHCS research with human subjects, the following criteria must be met in order for impaired decision-making capacity persons to be enrolled as subjects:

- The IRB determines that the proposed research entails no greater than minimal risk to the subject; or
- Presents a greater probability of direct benefit to the subject than harm to the subject; or
- Greater than minimal risk and no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition that is of vital importance for the understanding or amelioration of the subject's disorder or condition.

In addition to satisfying the conditions above, the IRB determines that:

- The research cannot be performed solely with persons who possess decision-making-capacity and the focus of the research is the disorder leading to subjects' lack of decision-making capacity, whether or not the lack of decision-making itself is being evaluated (e.g., an individual who lacks decision-making capacity as the result of a stroke can participate in a study of cardiovascular effects of a stroke);

- Or the subject of the research is not directly related to subjects' lack of decision-making-capacity but the investigator has presented a compelling argument for including such subjects (e.g., transmission of methicillin-resistant staphylococcus aureus infections in a nursing home where both individuals with and without decision-making capacity are affected).

The investigator must also address in the protocol how they will determine when surrogate consent will be required. Please see P&P entitled *Legally Authorized Representatives and Surrogate Consent.*

If feasible, the investigator must explain the proposed research to the prospective research subject even when the surrogate gives consent. Although unable to provide informed consent, some persons may resist participating in a research protocol approved by their representatives. Under no circumstances may a subject be forced or coerced to participate in a research study even if the LAR has provided consent.

LARs are acting on behalf of the potential subjects, therefore:
(1) LARs must be told that their obligation is to try to determine what the subjects would do if able to make an informed decision.
(2) If the potential research subject's wishes cannot be determined, the LARs must be told they are responsible for determining what is in the subject's best interest

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.107
45 CFR Part 46, including 46.107
VHA Directive Section 1200.05(2), 2021
The Belmont Report

57 REQUIREMENTS FOR RESEARCH INVOLVING HUMAN EMBRYONIC STEM CELLS, GERM CELLS, STEM CELL-DERIVED TEST ARTICLES AND THE TRANSPLANTATION OF *HUMAN FETAL TISSUE* FOR THERAPEUTIC PURPOSES

POLICY:

Any proposed ***Research*** that involves human embryonic stem cells, germ cells, stem cell-derived test articles and/ or ***Human Fetal Tissue*** shall be reviewed by the Emory IRB to determine the applicability of: (a) ***HHS Regulations***; (b) ***FDA Regulations***; and (c) other state, federal or local regulatory requirements, depending on the type and location of ***Research***, and the funding source for the ***Research.***

PROCEDURES:

Applicability of *HHS Regulations*: The Emory IRB will review the ***Research*** involving human embryonic stem cells, germ cells, stem cell-derived test articles and/or the transplantation of ***Human Fetal Tissue*** for therapeutic purposes (hereinafter collectively referred to as "***Human Fetal Tissue, Embryonic Tissue or Cell Research***") to determine if ***HHS Regulations*** will be applicable to such ***Research***. Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation. Such ***Research*** shall be considered to fall under ***HHS Regulations*** and require Emory IRB review and approval if it meets the following requirements:

> The ***Research*** involves ***Interaction*** or ***Interventions*** with living individuals or obtaining ***Individually Identifiable Private Information***, such as the use of human cell lines in which the donor(s) are identified, including ***Research*** regarding cells that have a link (directly or indirectly) to identifying information.

HHS* and *FDA Regulations:* *HHS Regulations shall not be considered to apply to *in vitro* ***Research*** or ***Research*** in animals that uses already derived and established human cell lines from which the identity of the donor(s) cannot be ascertained by the investigator directly or by links to identifying information. Both ***HHS*** and ***FDA Regulations***, as well as other federal regulations, may apply to the same ***Research*** protocol. Alternatively, either ***HHS*** or ***FDA Regulations*** may apply to a ***Research*** protocol.

Applicability of *FDA Regulations*: The Emory IRB will review the ***Human Fetal Tissue, Embryonic Tissue or Cell Research*** to determine if ***FDA Regulations*** will be applicable to such ***Research***. Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation. Such ***Research*** shall be considered to fall under the ***FDA Regulations*** and require Emory IRB review and approval if it meets the following requirements:

> The ***Research*** includes clinical ***Research*** involving drugs, devices, and/or biological products that are regulated by the FDA, including cells or test articles regulated as drugs, devices and/or biological products. In the case of such ***Research***, ***FDA Regulations*** regarding investigational new drugs shall apply, as well as ***FDA Regulations*** regard informed consent.

Both ***FDA*** and ***HHS Regulations***, as well as other federal regulations may apply to the same **Research** protocol. Alternatively, either ***FDA*** or ***HHS Regulations*** may apply to a ***Research*** protocol.

Applicability of Other Regulatory Requirements to *Research* Involving *Human Fetal Tissue* used in Federally Funded *Research* Involving the Transplantation of Such Tissue for Therapeutic Purposes: The Emory IRB will review the ***Human Fetal Tissue, Embryonic Tissue or Cell Research*** to determine if other federal, state or local regulatory requirements apply in view of the nature and location of the ***Research*** and funding source. Applicable state, federal and local regulations may apply in addition to, or in lieu of, ***FDA*** and ***HHS Regulations***. Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation. The Emory IRB shall consult legal counsel for the University with regard to determining state and local regulatory requirements. The following specific regulatory requirements shall apply to the ***Research*** described below, when that Research is federally funded:

Germ Cell and Stem Cell *Research:*

Research involving the derivation and use of human embryonic germ cell from ***Human Fetal Tissue*** may be conducted with federal funding;

Research on existing human embryonic stem cell lines may be conducted with federal funding if it meets the criteria set forth in the *Notice of Criteria for Federal Funding of Research on Existing Human Embryonic Stem Cells and Establishment of NIH Human Embryonic Stem Cell Registry* (NOT-OD-02-005; November, 2001). Among the requirements in this Notice are the following:

The stem cells must have been derived from an embryo that was created for reproductive purposes;

The embryo was no longer needed for these purposes;

Informed consent must have been obtained for the donation of the embryo; and

No financial inducements were provided for donation of the embryo.

The stem cells that are being used must be listed on the NIH Human Embryonic Stem Cell Registry found at: http://stemcells.nih.gov/research/registry

Research involving the derivation of new stem cells from human embryos or the use of human embryonic stem cells that are not listed on the NIH Registry specified above may not be conducted with federal funding support.

Research* Involving the Transplantation of *Human Fetal Tissue* for Therapeutic Purposes**: If the ***Research involves the transplantation of ***Human Fetal Tissue*** for therapeutic purposes and is funded by a federal agency, then the following requirements also must be met, and the Emory IRB shall document that these requirements are met in the meeting minutes and/or other

appropriate review documentation:

Source of Tissue – The ***Human Fetal Tissue*** may be obtained pursuant to a spontaneous or induced abortion or pursuant to a stillbirth

Informed Consent of Donor – The person providing the ***Human Fetal Tissue*** must sign a written informed consent document that contains the following statements, and the Emory IRB shall review the informed consent documentation to ensure that these requirements are met:

The person is donating the ***Human Fetal Tissue*** for use in ***Research*** on the transplantation of Human Fetal ***Tissue*** for therapeutic purposes;

The donation is made without any restriction regarding the identity of the individuals who may be the recipients of transplantations of the ***Human Fetal Tissue***; and

The person has not been informed of the identity of any such individuals.

Written Statement of Attending Physician: The attending physician who obtains the ***Human Fetal Tissue*** from the donor for use in the ***Research*** must provide a signed, written statement that states as follows, and the Emory IRB shall ensure that a template for this statement is included in the ***Research*** protocol:

The ***Human Fetal Tissue*** has been donated for use in ***Research*** on the transplantation of ***Human Fetal Tissue*** for therapeutic purposes;

Full disclosure has been provided to the donor with regard to the physician's interest, if any, in the ***Research*** to be conducted with the ***Human Fetal Tissue*** and any known medical risks to the donor or risks to their privacy that might be associated with the donation of the tissue and that are in addition to risks of such type that are associated with the donor's medical care; and

In the case of ***Human Fetal Tissue*** obtained pursuant to an induced abortion:

The consent of the individual for the abortion was obtained prior to requesting or obtaining consent for a donation of the ***Human Fetal Tissue*** for use in the ***Research;***

No alteration of the timing, method or procedures used to terminate the ***Pregnancy*** was made solely for the purpose of obtaining the ***Human Fetal Tissue***; and

The abortion was performed in accordance with applicable State laws,

Written Statement of PI: The PI for whose ***Research*** the donated ***Human Fetal Tissue*** is used must sign a written statement stating as follows, and the Emory IRB shall ensure that a template for this statement is included in the ***Research*** protocol:

The PI is aware that the tissue is ***Human Fetal Tissue***; that it may have been obtained pursuant to a spontaneous or induced abortion, or pursuant to a stillbirth; and that it was donated for ***Research*** purposes.

The PI has provided the foregoing information other key personnel who have responsibility regarding the ***Research;***

The PI will provide the foregoing information to the person who is to receive the ***Human Fetal Tissue*** transplantation prior to obtaining this person's consent to participate in the ***Research***.

Written Statement of Transplant Recipient: The recipient of the donation of the ***Human Fetal Tissue*** shall sign a written acknowledgement that the PI provided them with the information set forth in the provision immediately above, and the Emory IRB shall ensure that a template for this statement is included in the ***Research*** protocol.

Recordkeeping Requirements: The PI shall keep copies of all the statements required above as a part of their ***Research*** records and shall make them available for audit by the IRB or by appropriate governmental agencies.

Prohibition Regarding Certain Use of *Human Fetal Tissue*: ***Research*** involving ***Human Fetal Tissue*** is prohibited, no matter what the source of funding for the ***Research***, if the ***Research***:

Involves the unlawful solicitation, knowing acquisition, receipt of, or acceptance of a donation of ***Human Fetal Tissue*** for the purpose of the transplantation of such tissue into another person if the tissue is or will be obtained pursuant to an induced abortion; and

The donation will be or is made pursuant to a promise to the donating individual that the donated ***Human Fetal Tissue*** will be transplanted into a recipient specified by such individual; or

The donated ***Human Fetal Tissue*** will be transplanted into a relative of the donating individual; or

The person who solicits or knowingly acquires, receives, or accepts the donation has provided valuable consideration (not including reasonable payments associated with the transportation, implantation, processing, preservation, quality control or storage of ***Human Fetal Tissue***) for costs associated with the abortion.

Applicable Regulations/Laws/Guidance:

21 CFR Part 50, including 50.20
21 CFR Part 56, including 56.101 through 56.103 and 56.312
45 CFR Part 46, including 46.101 and 46.102
42 U.S.C. 289g-1 and 289g-2
NIH Notice of Criteria for Federal Funding of Research on Existing Human Embryonic Stem Cells and Establishment of NIH Human Embryonic Stem Cell Registry, November 2001, No. NOT-OD-02-005

58 COMPLAINTS

POLICY:

The Emory IRB will inquire into and address, as appropriate, any complaints or concerns reported to the Emory IRB concerning items within the scope of the IRB.

PROCEDURES:

Reporting of Complaints: Complaints or concerns regarding the IRB or ***Research*** that is subject to the oversight of the IRB may be reported directly to the IRB by contacting the IRB ***Chair, Vice-Chair***, ***Director,*** IRB staff or any IRB member. Complaints also may be reported to the IO or to University officials who have administrative responsibility concerning the IRB, such as the IO. Persons who wish to make a complaint anonymously may do so by contacting the Office of Ethics and Compliance or by calling the Emory Trustline at 1-888-550-8850. Complaints that are reported to persons outside of the IRB shall be provided to the IRB ***Chair*** and ***Director*** for inquiry and handling; provided, however, that if the complaints concern the ***Chair*** or ***Director***, they shall be reported to the IO.

Handling of Complaints: Complaints made to the Emory IRB shall be routed to a knowledgeable IRB staff member, preferably the IRB ***Assistant Director, Associate Director,*** or I***RB Director***, immediately. The ***IRB Director*** should be notified of any existing unresolved complaints. The staff member receiving the complaint shall ensure the confidentiality of the exchange and shall respond to the complainant and answer any questions to the best of their ability, in consultation with the ***IRB Director, Chair, Vice Chair, or IO*** if necessary.

The staff member receiving the complaint shall ensure that appropriate follow-up occurs to address the questions. The Emory IRB shall maintain a record of the issues raised and shall observe principles of confidentiality in setting up such records.

The IRB shall promptly inquire into any complaint or concern received to determine the nature and accuracy of the complaint/concern and to determine what, if any, investigative and/or corrective action should be taken to address the complaint/concern. Upon receipt of a complaint/concern, the IRB will evaluate to determine whether it may constitute an ***Unanticipated Problem Involving Risks to Participants or Others*** or other reportable matters and if so, proceed with appropriate reporting procedures. Also, if the IRB determines that the complaint should be appropriately referred to another unit or committee of the University, it shall make such a referral. If the identity of the person who made the complaint or raised the concern is known, the IRB may let them know the findings of any inquiry and or any corrective action implemented, provided that the IRB is not prohibited from sharing any such information based upon legal, privacy, or confidentiality considerations. The IRB may consult with University legal counsel and/or the Office of Ethics and Compliance to seek assistance in the handling of any complaint or concern.

Complaints that the PI receives that need to be reported to the IRB: The PI must report complaints received from participants or others that involve potential risks to these participants or others or that may change the risk/benefit ratio. These reports must be made to the IRB

within 10 business days of the PI receiving the complaint. The IRB may consult with the Office of Ethics and Compliance and the Office of Sponsored Programs if necessary. The PI may also report any complaints about which they believe the IRB should be aware of.

See also, the P&P entitled *Communication Channels for Human Subjects About Research.*

Applicable Regulations, Policies, and Guidance:

59 Communication Channels for Human Subjects About Research

POLICY:

The Emory IRB maintains a safe, confidential, and reliable channel for current, prospective, or past human subjects or their designated representatives that permits them to discuss problems, concerns, and questions, obtain information, or offer input with an informed individual who was unaffiliated with the specific research protocol (except for its IRB review).

PROCEDURES:

Input from Participants

The Emory IRB operates a toll-free telephone line and requests that investigators include the number in the contact information in the informed consent document. The Emory IRB shall make the toll-free number available to the public on its website. For international studies where the phone or internet is not available, the contact information in the informed consent must contain reasonable contact information (such as street address or fax number) to allow subjects to contact a local IRB or the ***Reviewing IRB***.

Complaints made to the Emory IRB shall be handled as described in the P&P chapter titled "Complaints."

Further, the ***IRB Director*** will make reasonable accommodations to requests from participants or members of the public considering participation in research to answer questions via other media besides the telephone (e.g., by written correspondence, email, or meetings).

Community Outreach

The Emory IRB also endeavors to educate the community about human subjects research and to work with other HRPP and area partners in their efforts. Emory IRB maintains a webpage for Participants containing research-related definitions, the Participant Bill of Rights, information about clinical trials, information on how to find opportunities for participating in research, and frequently asked questions. The IRB may also work with the Georgia CTSA Community Engagement Research Program, which supports community-university partnerships, obtains input into university research, and increases health research in community settings that are responsive to the health needs of the community. The ***IRB Director*** periodically assesses the Organization's outreach activities and will work with **IRB Chair(s),** the **IO**, and other Organization and Community stakeholders as needed to make improvements in these efforts.

See also the P&P entitled *Complaints.*

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108
FR Part 46

60 REVIEW OF INSTANCES OF NON-COMPLIANCE FOR DETERMINATION OF SERIOUS OR CONTINUING NON-COMPLIANCE AND REPORTING

POLICY:

All members of the University community involved in ***Human Subjects Research*** are expected to comply with the highest standards of ethical and professional conduct in accordance with federal and state regulations and institutional and IRB policies governing the conduct of ***Human Subjects Research.***

The IRB may receive allegations or reports of ***Non-Compliance*** from a variety of sources such as individual complaints, compliance reviews or audits, investigator self-reports, and reports from ***Sponsors*** or governmental entities.

The Emory IRB will review all instances of non-compliance in ***Research*** for which it is the ***Reviewing IRB***, to determine whether or not they constitute ***Serious*** or ***Continuing Non-Compliance*** as defined in the Glossary. The Emory IRB will report such Serious or Continuing Non-Compliance as set forth elsewhere in these P&Ps**.**

PROCEDURES

Receipt of *Allegations/Reports of Non-Compliance:* The IRB may receive ***Allegations of Non-Compliance*** from a number of sources including complaints or concerns reported directly to the IRB or reported to other University units and/or through the Emory Trustline for anonymous reporting of compliance concerns; findings from audits conducted by or for the IRB or by other University units, governmental entities or sponsors; and items reported by PIs. These allegations/reports shall be handled in accordance with the P&Ps entitled *Protocol Oversight; Procedures for Handling Audits & Violations; and Procedures for Receiving and Conducting Inquiries into Allegations/Reports of Non-Compliance* and reviews/audits, inquiries and other review processes shall be employed as set forth in that section.

See also P&P entitled *Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel*.

Notification to Investigator of IRB Review of Alleged Non-Compliance: The IRB must inform the Investigator that it has received allegations of non-compliance and invite the Investigator to respond. The Investigator may respond to the IRB in writing and/or in person (including via online meeting) or by telephone at a convened meeting.

Referral of Instances of Non-Compliance that May Constitute Serious or Continuing Non-Compliance: A qualified IRB analyst, IRB leadership, or CoRe Team member shall make the initial determination about whether an allegation of non-compliance has a basis in fact. All instances of non-compliance that may potentially constitute Serious or Continuing Non-Compliance shall be referred to the full IRB Committee for review in accordance with the definitions set forth in the Glossary and a vote as to whether the instances constitute Serious and/or Continuing Non-Compliance.

In addition, in accordance with the VHA Research Compliance Reporting Requirements, the IRB must review any report of potential or apparent serious or continuing noncompliance at its next appropriately constituted convened IRB meeting.

The RCO (Research Compliance Officer) needs to be notified in writing if the apparent serious or continuing non-compliance was identified by a RCO audit, regardless of outcome.

An initial report of an IRB determination that serious or continuing noncompliance occurred is required, even where the determination is preliminary, or disposition of the matter has not been resolved at the time of the report.

Further with respect to VA research, the IRB must reach a determination that serious or continuing noncompliance did or did not occur within 30 days after receiving a report of apparent noncompliance. Remedial actions to correct noncompliance must be completed within 180 days after the IRB's determination, unless remediation requires substantial renovation, fiscal expenditure, hiring, legal negotiations, etc. Where remedial actions cannot be completed in 180 calendar days, the VA medical facility Director must provide the appropriate ORO workgroup(s) with written justification and a reasonable timeline for completion.

Reporting: The Emory IRB shall report a determination of Serious or Continuing Non-compliance to any other IRB with jurisdiction over the study, the IO and other appropriate institutional officials, sponsors, and government regulatory and funding agency officials in accordance with the P&P entitled *Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel*.

In addition, for AVAHCS Research or VA-supported Research: Should the IRB determine that the matter constitutes serious or continuing noncompliance, the IRB Chair or designee must report the determination directly (without intermediaries) to the medical center director within five business days of the determination. The IRB Chair or designee's report must be made in writing, with a simultaneous copy to the Associate Chief of Staff for Research. The Emory IRB must also report as follows: (a) to the AVAHCS Institutional Official and Research Office, who in turn will forward this to the VA Office of Research and Development; (b) to the Regional Office of Research Oversight; (c) to the VA Privacy Office if the report involves unauthorized use, loss or disclosure of individually identifiable patient information; and (d) to the VHA Information Security Officer if the report involves violations of VA information security requirements.

Multi-Site Research* for Which Emory is *Reviewing IRB*:** As applicable, Emory IRB will provide to ***Relying Parties any determination letters of serious or continuing noncompliance, suspension, or termination of IRB approval related to the ***Relying Party's*** research activities and will be responsible for the drafting and submission to external or regulatory bodies of any reports required by law or applicable regulations. Prior to submitting any report to external parties, the Emory IRB will provide the final draft of the report to the ***Relying Party's*** IRB.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108 and 56.113
45 CFR Part 46, including 46.113
VHA Directive 1058.01, 2020
VHA Directive Section 1200.05(2), 2021

61 PROTOCOL OVERSIGHT AND PROCEDURES FOR HANDLING AUDITS AND VIOLATIONS

POLICY:

The Emory IRB is responsible for continuing oversight of ***Research*** protocols under its jurisdiction to ensure that they are being carried out in accordance with the requirements of the approved ***Research*** protocol; all determinations of the IRB; all applicable federal and other governmental regulations; and all applicable IRB and University policies.

The Emory IRB may carry out these oversight responsibilities by commissioning or conducting for-cause or not-for-cause compliance reviews or audits of ***Research*** protocols; conducting inquiries into any ***Allegations/Reports of Non-Compliance*** with IRB requirements and/or referring allegations to other appropriate committees or units within the University for inquiry under applicable University policies and procedures.

Depending on the nature of the ***Allegations/Reports of Non-Compliance*** and/or the results of any inquiry, the IRB may take such actions such as requiring additional training for personnel; requiring periodic audit; requiring monitoring; ***Terminating*** or ***Suspending*** IRB ***Approval*** of ***Research*** protocols; and/or instituting sanctions against PIs or other research personnel, up to and including ending their participation on ***Research*** protocols under the Emory IRB's jurisdiction. All allegations or incidences of ***Non-Compliance*** in ***Human Subjects Research***, including protocol violations, failure to comply with applicable federal or other governmental regulations, or failure to comply with the requirements or determination of the IRB will be handled according to the procedures set forth in this P&P.

PROCEDURES:

The Emory IRB may carry out its oversight function using the following methods:

PI Reports:

Requiring PI to provide ***Reports of Non-Compliance*** (e.g. reports of any failure to follow protocol requirements)**;** and/or

Requiring PI to provide a status report on their ***Research*** protocol.

Compliance Reviews/Audits: Conducting, or requesting a third party to conduct, on behalf of the IRB, a compliance review or audit of a ***Research*** protocol.

For research at the AVAHCS:
Audits of research conducted at the AVAHCS may be carried out by the Research Compliance Officer (RCO) in accordance with VA Regulations. If the RCO identifies apparent serious or continuing non-compliance during an audit they must report it directly to the facility director, and copy the ACOS for Research, the R&D Committee, and the IRB no later than 5 business days after the discovery of the potential non-compliance.

The IRB may conduct or may rely on the AVAHCS to carry out audits of research conducted at the AVAHCS. The IRB will work with the AVAHCS to determine if more frequent or focused audits are necessary. The decision to increase the frequency of audits or to audit specific aspects of the study might be based on considerations including, but not limited to:

- Involvement of vulnerable populations.
- Level of risk.
- Phase I or Phase II studies.
- Involvement of FDA approved drugs for which there has been a new safety warning issued or change in the labeling that indicates increased risks.
- Issues of noncompliance.
- Data confidentiality or security concerns.

Inquiries: Conducting an inquiry into ***Allegations of Non-Compliance*** received regarding a ***Research*** protocol under its jurisdiction.

Referrals: Referring allegations of non-compliance received in connection with ***Research*** protocol to an appropriate Emory University unit or committee for inquiry under other applicable Emory policies and procedures and requesting a report on the unit/committee's findings for the Emory IRB's review and use.

PI Reporting Obligations Regarding Protocol Non-Compliance: Each PI shall provide the Emory IRB with a written report of any ***Non-Compliance*** with or failure to follow the requirements of an approved protocol under Emory IRB oversight (e.g., protocol deviations) or to follow applicable laws, regulations or IRB policies or procedures. The report shall be provided to the IRB as soon as possible after the ***Non-Compliance*** occurs, but no later than 10 business days.

Contents of Protocol Non-Compliance Report: The PI's report should specify: (a) protocol requirement, IRB policy or procedure or law or regulatory requirement that was not followed; (b) description of manner in which actions taken deviated from or failed to comply with the requirement including date and time of event; (c) effect of ***Non-Compliance***, including any effect on ***Human Subjects***; (d) reason for deviation/failure; and (e) any action that will be taken in terms of modifying or amending ***Research*** protocol or process/procedure to be put in place to ensure that ***Non-Compliance*** does not occur again.

Status Reports: In addition, the PI shall provide an update on previously unreported instances of ***Non-Compliance*** in any ***Research*** status report that the PI provides to the IRB in connection with ***Continuing Review*** or in response to a request for a status report received from the IRB**.** In cases where Non-Compliance was not reported per policy, the PI will be asked to submit an RNI to capture pertinent details.

Findings: The IRB ***Chair, Director,*** or qualified IRB staff (analyst, Team Lead) shall perform an initial review of all reports received in accordance with the provision entitled ***PI Reporting Obligations Regarding Protocol Non-Compliance*** above. In the fact-finding stage, all reasonably relevant documents shall be reviewed, e.g.,

correspondence, minutes, study records, and site visits and interviews may be conducted, as appropriate. If a determination is made that an inquiry or for-cause audit is necessary, it will be conducted in accordance with the provision below entitled ***Conduct of Review.***

Conduct of Review/Audit: The compliance review/audit may be conducted by IRB personnel (including qualified analysts, Team Leads, IRB Director, CoRe team member, or ad hoc consultant); or personnel from any one or more University administrative personnel with responsibility for ***Research*** compliance (e.g., personnel from Office of Research Compliance and Regulatory Affairs (RCRA), Office of the General Counsel, Office of Sponsored Programs/Grants and Contracts Administration, Office for Clinical Research) acting on behalf of the IRB; or outside consultants with whom the IRB has contracted. A review/audit may be conducted as a for-cause or not-for-cause review/audit. If University legal counsel determines that any review/audit should be conducted under the auspices of attorney-client privilege, the audit will be coordinated or conducted by the University's Office of the General Counsel.

Scope of Review/Audit: ***Research*** protocols shall be reviewed/audited to determine compliance with protocol requirements; applicable federal and state laws and regulations; specific requirements from ***Sponsors***; IRB policies and procedures; and University policies and procedures. The items that may be examined include but are not limited to: informed consent procedures and documentation; adherence to inclusion and exclusion criteria; reporting of ***Unanticipated Problems Involving Risks to Participants or Others and Adverse Events***; adherence to ***HIPAA Regulations***; protocol adherence and fulfillment of documentation and record-keeping requirements. The specific scope of the audit/review shall be determined by the ***IRB Chair, Vice Chair***, or ***IRB Director*** in consultation with review/audit personnel. The scope of the review/audit may be broadened or narrowed as necessary depending on findings made as the review/audit proceeds.

PI Cooperation: The PI and all personnel involved in the study have an obligation to cooperate with any review/audit conducted by or on behalf of the IRB and to provide any testimony, documentation or other materials requested in a timely manner. The PI shall cooperate in making the documents available at the site at which they are kept and shall provide the review/audit personnel with space there to conduct the review/audit.

After a review/audit has been announced or initiated, the PI shall ensure that all records and other materials pertaining to the ***Research*** protocol that is being reviewed/audited are preserved and maintained intact, and without alteration, until the IRB notifies the PI that the materials may once again be subject to their normal record retention schedule. Review/audit personnel shall immediately advise the IRB ***Chair, Vice Chair,*** *or* ***IRB Director*** of any evidence that may indicate that study records have been subject to loss, destruction, or tampering. The Office of Ethics and Compliance at Emory must also be notified.

Not-For-Cause Review/Audit Procedure: Not-for-cause audits may be performed as a part of the IRB's Research oversight measures, including studies reviewed by an external IRB. The IRB shall follow the procedure set forth below for conducting not-for-cause reviews/audits:

The ***IRB Chair***, ***Vice Chair***, ***Director***, or qualified IRB staff shall notify the PI for the ***Research*** protocol to be reviewed/audited and advise them that the protocol has been

selected for a review/audit. The notice shall set forth the protocol(s) to be reviewed/audited; approximate dates of the review/audit; persons who will be performing the review/audit; and records requested.

If the PI requests that a not-for-cause review/audit be re-scheduled due to extenuating circumstances concerning a PI's schedule, the IRB shall make reasonable attempts to do so; provided, however, that any not-for cause review/audit may only be rescheduled by the PI once.

The review/audit shall be on site at the offices at which the PI keeps the protocol records, and the PI shall provide the review/audit personnel with sufficient space within which to examine the study records. Alternatively, the review/audit may be performed remotely if all relevant materials are accessible. The review/audit personnel may examine all relevant documentation and materials including: protocols; all documentation submitted to the IRB; any audit or inspection reports of governmental or ***Sponsor*** auditors or monitors; consent documents; case report forms; and medical records. In addition, review/audit personnel may interview appropriate personnel. Consultants with particular expertise may be retained to assist with the review/audit.

The review/audit personnel shall document the review/audit findings in a report. If the Research is under the review of an external IRB, the review/audit personnel will provide the report to the study's ***Principal Investigator***, along with notifictaion that the report should be sent to the ***Reviewing IRB***. Any corrective and preventive action recommendations shall be included in the report.

For studies under Emory IRB review, the IRB case manager shall present the audit findings, along with any additional suggestions that the case manager may have for corrective action, to the IRB ***CoRe team****, if applicable*.

The CoRe team will identify if a case involves presumptively serious or continuing noncompliance, referring to the IRB guidance document. The CoRe team will assess whether the evidence of error or mitigating and aggravating factors is compelling and may determine that the presumption of serious or continuing noncompliance has been overcome. If such a determination is made by the CoRe team, the case can be closed and does not require further review by Committee Q. If the CoRe team determines that the presumption has not been overcome (yet), it must forward the case to a convened meeting of the Emory IRB. If the analysis by the CoRe team is inconclusive, the CoRe team must forward the case to the convened IRB for review.

The CoRe team may consider relevant criteria, including precedents set by duly constituted subcommittees of the Emory IRB at convened meetings (i.e., precedents of determinations of serious, not serious, continuing, or not continuing noncompliance).

The CoRe team must document its analysis of whether a case is presumptively serious or continuing noncompliance, and whether the presumption has been overcome by the evidence collected to date and mitigating factors, in the case records and report the matter to the Emory IRB.

If a case of non-compliance is referred for Full Committee Review, the IRB Committee will vote on whether to accept the review/audit findings and corrective and preventive actions recommended, or alternatively, on alternative measures that should be taken.

The IRB case manager will write to the PI and inform them of the audit findings and corrective actions/sanctions recommended.

The PI shall agree to a timetable for the completion of any recommended corrective actions and shall provide the IRB with documentation that corrective actions have been completed.

If at any time during a not-for-cause review/audit, it becomes apparent to the review/audit personnel that there is evidence of ***Continuing*** or ***Serious Non-Compliance***, then the review/audit personnel promptly shall report such fact to the ***CoRe team*** and the IRB case manager shall route the case to a convened IRB. The ***Full Committee*** shall review cases of potentially Serious or Continuing Non-Compliance to make the following determinations: (a) necessity of notifying governmental regulatory agencies, institutional officials and/or ***Sponsors;*** (b) adequacy of any corrective and preventive action proposed or taken by PI; (c) necessity of suspending or terminating enrollment or Approval of the ***Research*** protocol; or (d) necessity of conducting for-cause review/audit and/or inquiry; or (e) necessity of referring matter to other university units for consideration and action under other university policies and procedures. In making this determination, the convened IRB may take into consideration, any harm or ill effects to ***Human Subjects*** or others caused by the deficiencies; the seriousness of any review/audit findings; any voluntary reporting by PI; nature of the protocol; and whether the personnel involved have a record of deficiencies on any other ***Research*** protocol. The review/audit shall then follow the procedures set forth for for-cause reviews/audits described in the next section of this P&P.

For-Cause Reviews/Audits Procedure: For-cause reviews/audits may be performed at the request of the IRB ***Chair***, ***Vice Chair,*** or ***Director***, or the **Reviewing *IRB*** (if not Emory IRB), after an initial review of an ***Allegation/Report of Non-Compliance.*** The following procedures shall be used in performing a for-cause review/audit:

A qualified IRB analyst, Team Lead, or ***CoRe Team*** member (senior analyst, Team Lead, Co-Chair, Vice Chair, IRB Director) shall make the initial determination about whether an allegation of non-compliance has a basis in fact. If a decision is made to proceed with the for-cause review/audit, the review/audit may be conducted in consultation with the Office of Research Compliance and Regulatory Affairs (RCRA) (or an outside consultant retained by that office) or through the Office of the General Counsel, if University counsel determine that this is the appropriate route to take. Personnel conducting the review/audit shall contact the PI and promptly secure/sequester all records relating to the protocol. The review/audit may be conducted as a stand-alone review/audit, or it may be conducted in connection with an inquiry being conducted pursuant to the provision below entitled *Conduct of an IRB Inquiry*. If the for-cause review/audit is

conducted as a stand-along review/audit, the results shall be reported to the Core team that will make a recommendation to the full IRB as to whether an inquiry is necessary.

As set forth above, for ***Research*** reviewed by Emory IRB, the ***CoRe team*** shall make a recommendation to the Co-Chairs and/or the convened IRB whether to suspend the ***Research*** protocol or temporarily halt enrollment into the protocol pending the results of the review/audit. This determination will be based on the potential for harm to the ***Research*** subjects, including consideration of the effect of suspension in therapeutic trials, and the nature of the allegations.

The ***CoRe team***, in consultation with applicable compliance offices or individuals to determine whether the matter needs to be referred to any other unit of the University for proceedings under other University policies or procedures.

The review/audit may take place at the ***Research*** site or at such site at which the records have been secured/sequestered. The review/audit personnel may examine all relevant documentation and materials including: protocols; all documentation submitted to the IRB; any audit or inspection reports of governmental or ***Sponsor*** auditors or monitors; consent documents; case report forms; and medical records. In addition, review/audit personnel may interview appropriate personnel. Consultants with particular expertise may be retained to assist with the review/audit.

The review/audit personnel shall document the review/audit findings in a report and provide the report to the inquiry subcommittee (if an inquiry has been initiated); to any subcommittee impaneled to review the audit findings; to the IRB ***CoRe team;*** to applicable compliance offices , in the event of a audit being conducted under the auspices of that office. Any corrective action recommendations shall be included in the report. The report shall also specifically detail any instances of **Serious** or ***Continuing Non-Compliance.***

If the ***CoRe team*** determines the matter(s) to constitute possible Serious or Continuing Non-Compliance, the case will be routed to the IRB Board with any recommended corrective actions, which will include the input of the PI when necessary. The ***IRB Committee*** will vote on whether to accept the review/audit findings and corrective actions recommended, or alternatively, on other actions or measures that should be taken. If an inquiry is recommended and the recommendation is accepted by the IRB, then an inquiry will proceed in accordance with the provision below entitled ***Conduct of IRB Inquiry***. If ***Serious*** or ***Continuing Non-Compliance*** is documented in the findings, then an inquiry shall be required.

If the IRB determines that no inquiry is to be conducted, then the ***CoRe team*** will write to the PI and inform them of the audit findings and corrective actions/sanctions recommended. The IO and other appropriate University officials may also be notified of the findings and recommended actions.

The PI shall provide a corrective action plan detailing how recommended corrective measures will be accomplished and the timetable for their completion. The PI shall

provide the IRB with regular status reports at intervals established by the IRB documenting that corrective actions have been completed.

Conduct of IRB Inquiry: An inquiry may be performed at the request of the IRB ***Chair, Vice Chair, Director, CoRe team*** or ***Full Committee*** after an initial review of an ***Allegation/Report of Non-Compliance*** or at the recommendation of the IRB after review of the results of a standalone for-cause audit. The following procedures shall be used in performing an IRB inquiry:

If a determination has been made that a for-cause review/audit should be conducted in connection with the inquiry, such a review/audit will be conducted in accordance with the procedure set forth in provision above entitled *For-Cause Reviews/Audits Procedure*; provided, however, that the findings of the review/audit shall be provided to the ***CoRe team*** for its review and recommendations prior to going to **Full Committee Review**. .

The ***IRB Staff*** shall formulate a plan for the inquiry including persons to be interviewed and documents to be reviewed. The ***IRB Staff*** may consult with the Office of Ethics and Compliance in formulating the inquiry plan. In addition, upon the ***CoRe team's*** request, personnel from the Office of Ethics and Compliance may provide the ***IRB Staff*** with administrative support for its inquiry by performing tasks including, but not limited to, scheduling interviews; obtaining and copying requested records; and taking notes or minutes at inquiry-related meetings.

The ***IRB Staff*** may consider any testimony or other evidence that comes to its attention from persons inside or outside the university. The ***IRB Staff*** may examine all relevant documentation and materials including: protocols; all documentation submitted to the IRB; any audit or inspection reports of governmental or ***Sponsor*** auditors or monitors; consent documents; case report forms; and medical records. In addition, review/audit personnel may interview appropriate personnel. Consultants with particular expertise may be retained to assist with the inquiry.

During the conduct of the inquiry, the ***IRB Staff*** shall take all reasonable steps to protect the confidentiality of the proceedings and of all persons who brought forward allegations and all persons against whom allegations were made. In this respect, the ***IRB Staff*** shall ask all persons to whom it speaks regarding the matter to refrain from discussing the matter with anyone outside of the committee or appropriate university or governmental compliance or regulatory officials.

After the ***IRB Staff*** has considered all of the evidence (including any evidence produced by any review/audit) it shall draft a report setting forth its findings of fact, conclusions and recommendations. The report shall specifically detail evidence suggesting ***Serious*** or ***Continuing Non-Compliance***. The IRB Staff will send the report for the CoRe team for consideration. If the matter is considered potentially serious or continuing, the report will be sent to an IRB full Committee for further review. A ***CoRe team*** member shall present the report and its recommendations to a full ***IRB Committee,*** if it is a case of ***Serious*** or ***Continuing Non-Compliance***. The full ***IRB Committee*** shall then vote on whether to accept the report and recommendations, or alternative steps that should be taken. These actions may include one or more of the following actions, as well as any other action recommended by the ***IRB Committee***:

Determination of ***Non-Compliance, Serious Non-Compliance, Continuing Non-Compliance***, or not ***Non-Compliance***.

No action.

Modification of the Research protocol.

Modification of the information disclosed during the consent process.

Additional information provided to past participants.

Notification of current participants (required when such information may relate to participants' willingness to continue to take part in the ***Research***).

Requirement that current participants re-consent to participation.

Modification of the ***Continuing Review*** schedule.

Monitoring of the ***Research.***

Monitoring of the informed consent process.

Suspension of accrual to or of ***Approval*** of the ***Research.***

Termination of accrual to or of ***Approval*** of the ***Research.***

Obtaining more information pending a final decision.

Referral to another organization or entity.

Required fulfillment of a CAPA plan.

Other actions as appropriate, including, but not limited to: (a) requiring ***Investigator*** education; (b) requiring additional reviews/audits; (c) imposing compliance monitoring; (d) requiring increased reporting by the ***Investigator***; (e) restricting use of the ***Research*** data for publication; and/or (f) restricting or terminating the ***Investigator's Research*** privileges.

A member of the ***IRB Staff*** will communicate the outcome of the IRB deliberations, as well as the proposed action plan, to the ***Investigator***, the IO and other appropriate University officials. The IRB will notify the relevant governmental and funding agencies as appropriate pursuant to the P&P entitled *Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel.*

Suspension* and *Termination* of IRB *Approval: In accordance with the P&P entitled *Suspension and Terminations of Previously Approved Research,* the Emory IRB may, at any time, ***Suspend*** or ***Terminate*** approval of ***Human Subjects Research*** that is not being conducted in accordance with

the IRB's requirements or that has been associated with harm to ***Human Subjects***. Any ***Suspension*** or ***Termination*** of ***Approval*** shall include a statement of the reasons for the IRB's action and shall be reported promptly to governmental regulatory officials as required; the ***Investigator,*** and their department and division chair; Office of Research Compliance and Regulatory Affairs (RCRA), the Office of Ethics and Compliance; the Office of Grants and Contracts; the Office of Sponsored Programs or Office of Technology Transfer (in the case of sponsored research). ***Research Sponsors*** should be notified according to the applicable contractual provisions***.*** The IRB or the PI shall notify the ***Sponsors***.

Non-Exclusivity of IRB Proceedings and Referrals: At any time before, during or after the conduct of a compliance review/audit or inquiry by or on behalf of the IRB, the ***IRB Chair***, ***Vice Chair, Director,*** or qualified IRB staff may refer some or all allegations or findings to any other unit or committee for which another unit of the University may have responsibility or jurisdiction under other University policies or procedures. Inquiries, investigations, and/or compliance audits/reviews by these other units may occur simultaneously with the IRB's actions, and the various University units involved may share their findings. The IRB shall request a copy of any findings issued by any other committee or unit to whom the IRB has referred a matter for consideration.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108 and 56.113
45 CFR Part 46, including 46.103 and 46.113
VHA Directive 1058.01, 2020

62 SUSPENSIONS AND TERMINATIONS OF PREVIOUSLY APPROVED RESEARCH

POLICY:

The Emory IRB has the authority to either ***Suspend*** or ***Terminate*** its approval of ***Research*** when it determines that the ***Research*** is not being conducted in accordance with the IRB requirements; is in potential serious or continuing noncompliance with federal or other applicable governmental regulations or institutional policies; or when it determines that the **Research** is reasonably likely to cause serious harm to ***Human Subjects*** or others.

Suspensions and terminations do not include interruptions in research resulting solely from the expiration of a protocol approval period. They also do not include administrative closure by the IRB when study teams do not submit their continuing review applications in a timely fashion.

DEFINED TERMS:

Terminate/Termination: An action taken by the IRB for any reason to permanently withdraw approval for all Research activities (except for those follow-up procedures that are necessary to protect the health or welfare of the subjects). Terminated protocols are considered closed and do not require Continuing Review.

Suspend/Suspension: An action taken by the IRB for any reason to temporarily withdraw approval for some or all **Research** activities short of permanently withdrawing approval for all ***Research*** activities. ***Suspended*** protocols are considered open (though not for enrollment or other Research activities), and the IRB will advise on a case-by-case basis if continuing review applications are required during a period of ***Suspension***

PROCEDURES:

Suspension: If there is reason to believe that ***Research*** is not being conducted in accordance with IRB requirements or if the research is associated with unexpected serious harm to ***Human Subjects*** or there are serious safety, rights, and welfare concerns***,*** but there is not yet enough evidence to arrive at a conclusion, the convened IRB may ***Suspend*** approval of any or all ***Research*** activities to protect participants.

Immediate *Suspension:* When circumstances require an immediate ***Suspension*** of ***Research*** when the research is associated with unexpected serious harm to ***Human Subjects*** or to protect the safety, rights or welfare of ***Human Subjects,*** the IRB ***Chair*** (or a designated ***Vice-Chair*** in the IRB Chair's absence) may immediately ***Suspend*** IRB approval of the ***Research*** pending an inquiry. Such ***Suspensions*** of IRB approval will be reported to and evaluated by the convened IRB at the next meeting when the inquiry report is available and at that time the IRB will decide on the next appropriate action (such as ***Suspension, Termination,*** lifting of the ***Suspension, or Renewal of approval*** of the ***Research).***

Termination: The convened IRB may ***Terminate*** its approval of previously approved ***Research*** when the ***Research*** is not being conducted in accordance with IRB requirements; or ***Termination*** of approval is otherwise required to protect the safety, rights, and welfare of ***Human Subjects.*** In general***, Terminations*** of approval should be done by the convened IRB, but in some cases the

IRB Chair may take this action in their discretion, reporting it to the next convened IRB meeting.

IRB Report: Any report of IRB action of ***Suspension*** or ***Termination*** of approval of the ***Research*** shall include a statement of the reasons for the IRB's actions. The report must be sent to the IO, the PI and their department or division chair, the Office of Research Compliance and Regulatory Affairs; and the Office of Grants and Contracts and the Office of Sponsored Programs (in the case of sponsored research). Emory shall report all ***Suspensions*** and ***Terminations*** to the appropriate funding agencies (via Office of Sponsored Programs), regulatory agencies (e.g. OHRP for DHHS funded studies, FDA when research is ***FDA regulated***, AVAHCS when VA research is involved, other federal agencies when the research is overseen by those agencies and they require reporting separate from that to OHRP), any IRBs relying on the Emory IRB for review of the ***Research***, and other ***Sponsors.*** See P&P entitled *Reporting to Governmental Regulatory Authorities, Sponsors, and Institutional Personnel* for further information.

Current *Research* Subjects: If the IRB ***Chair*** (or designated ***Vice-Chair*** in the ***Chair's*** absence) or the convened IRB decides to ***Terminate*** or ***Suspend*** approval of **Research,** the IRB ***Chair*** (or designated ***Vice Chair)*** or convened ***IRB Committee*** will take the following steps:

Ensure that the PI stops all ***Research*** activities except for any follow-up deemed necessary (see below).

Ensure that all ***Human Subjects*** currently participating in the ***Research*** are notified that IRB approval for the study has been ***Suspended*** or ***Terminated.***

In addition, the IRB shall consider taking the following steps to protect the rights and welfare of current participants:

Transfer subjects to another ***Investigator.***

Make arrangements for care or follow-up outside the ***Research.***

Allow continuation of some ***Research*** activities under the supervision of an independent monitor or other designated ***Investigator.***

Require or permit follow-up of subjects for safety reasons; provided, however, that if follow-up for safety reasons is permitted/required by the IRB, then the IRB will require that the subjects be so informed and that any adverse events/outcomes be reported to the IRB and the ***Sponsor.*** The investigator should maintain a record of individual patient ID numbers and provide a statement that it is in the best interests of certain or all subjects to continue to receive study interventions or follow up. This statement may also come from the medical monitor, if applicable.

Notification of former subjects.

Communicate to the PI the actions required to protect the rights and welfare of currently enrolled subjects. (NOTE: This communication may be carried out by the IRB Chair (or a designated ***Vice-Chair,*** in the IRB Chair's absence) or the IRB Director or their Designee .

Further investigation, if indicated, will proceed as described in accordance with these P&Ps or other relevant University policies and procedures.

PI's Responsibilities: The PI shall

- Promptly report to the IRB any failure to follow the approved protocol or IRB requirements.
- Cooperate with any inquiry or investigation by the IRB.
- Cease enrollment and **Research** procedures as required by the IRB **Chair** or convened IRB.
- Notify enrolled subjects of the ***Suspension*** or ***Termination,*** if so required by the IRB **Chair** or convened IRB.
- Ensure that the rights and welfare of subjects withdrawn from ***Suspended*** or ***Terminated Research*** are protected.
- Establish appropriate procedures for follow-up for enrolled subjects as required by the IRB ***Chair*** or convened IRB.
- Report to the IRB and the Sponsor any Adverse Events or **Unanticipated Problems Involving Risks to Participants or Others** encountered during subject withdrawal and follow-up in accordance with the P&P entitled *Investigator Reporting Obligations to the IRB.*

AVAHCS Research:

The terms "suspension" and "termination" apply to interruptions related to concerns regarding the safety, rights, or welfare of human participants, Researchers, Research Staff, or others. Suspensions and terminations do not include interruptions in research resulting solely from the expiration of a protocol approval period, or Administrative Holds or other actions initiated voluntarily by a VA facility official, Researcher, or Sponsor for reasons other than concerns regarding the safety, rights, or welfare of human participants, Researchers, Research Staff, or others.

The notification of suspension or early termination of a non-exempt VA human research study by the IRB or IO must include a statement of the reason for the IRB's or IO's action.

"Administrative Holds:" the VA "administrative hold" is a voluntary interruption of research enrollments and ongoing research activities by an appropriate VA facility official, Researcher, or Sponsor (including the ORD when ORD is the sponsor). This policy must be applied as appropriate. This term does not apply to interruptions of VA research related to concerns regarding the safety, rights, or welfare of human research subjects, research investigators, research staff, or others (i.e., suspensions or terminations). An administrative hold must not be used to avoid reporting deficiencies

or circumstances otherwise covered by the VHA Handbooks or other federal requirements governing research.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46
21 CFR Part 56, including 56.108 and 56.113

63 REPORTING TO GOVERNMENTAL REGULATORY AUTHORITIES, SPONSORS, AND INSTITUTIONAL PERSONNEL

POLICY:

The Emory IRB will fulfill all reporting obligations to governmental regulatory agencies specified in any applicable laws and regulations.

PROCEDURES:

Regulatory Reporting Requirements: The Emory IRB shall report to OHRP and to the FDA any changes in IRB Committee membership in accordance with the P&P set forth above in the P&P entitled *IRB Membership.* In addition, per the requirements of Emory's FWA, for all ***Human Subjects Research*** conducted at Emory and subject to Emory's FWA, the Emory IRB shall report the events set forth below to OHRP and, in the case of FDA-regulated products, to FDA as well. Simultaneously with the reporting of these events to OHRP/FDA, reports also shall be made to appropriate institutional officials and affected ***Research Sponsors*** and other federal or other governmental agencies when the ***Research is*** subject to those agencies and separate reporting is required. When research is not covered by DHHS or FDA regulations, reports of unanticipated problems involving risks to participants or others are not to be reported to OHRP or FDA.

In the case of ***Research*** conducted or supported by the ***DOD***, reporting obligations specific to DOD units are summarized below.

Events to be reported are as follows, with reports to be made as soon as possible after the action is taken by the IRB, and within 30 days:

Determination by the IRB that an event that occurred at an Emory-affiliated site should be considered an ***Unanticipated Problems Involving Risks to Participants*** **or** ***Others*** (also referred to herein as *an* ***Unanticipated Problem);***

Determination by the IRB that there has been ***Serious Non-Compliance*** or ***Continuing Non-Compliance*** with IRB policies, requirements or determinations;

Any IRB ***Suspension*** or ***Termination*** of Emory IRB approval of a ***Research*** protocol.

The Emory IRB need not report to federal agencies already made aware of the event through other mechanisms, such as reporting by the investigator, sponsor, or another organization.

Contact Persons for Reporting and Report Content:

Reports to HHS via OHRP:

Unless otherwise specified by federal regulations, all reports that the Emory IRB is required to make to HHS shall be made to the Office of Human Research Protections (OHRP), Compliance Division. Please see the OHRP website for details on how to report.

Report Content: Reports shall contain the following information:

For *Unanticipated Problems:* (a) Name of the institution conducting the ***Research;*** (b) title of the **Research** project and/or grant proposal in which the problem occurred; (c) name of the PI on the protocol; (d) identification number for the ***Research*** project assigned by the Emory IRB and the identification number of any applicable federal awards (e.g., grant, contract, etc.); (e) detailed description of the problem; (f) the IRB's Findings; (g) corrective and preventive actions the institution is taking or plans to address the problem and the reasons for them (e.g., revise protocol, suspend subject enrollment, revise informed consent, etc.); (h) any further investigation or action recommended to be taken (if applicable); and (i) plans, if any, to send a follow-up or final report by the earlier of a specific date or when the inquiry has been completed or corrective action has been implemented. Consultations between the IRB Director and the IO or ORC Director are encouraged. The IRB **Chair**, or designee (IRB Director, Vice-Chair, or other designated IRB member), shall sign the report and send it out with a copy to the IO and/or ORC Director and to the IRB files.

For *Serious* or *Continuing Non-Compliance:* (a) Name of the institution conducting the ***Research;*** (b) title of the ***Research*** project and/or grant proposal in which the noncompliance occurred; (c) name of the PI on the protocol; (d) identification number for the ***Research*** project assigned by the Emory IRB and the identification number of any applicable federal award (e.g., grant, contract, etc.); (e) detailed description of the noncompliance; and (f) corrective and preventive actions the institution is taking or plans to take to address the noncompliance and the reasons for them (e.g., educate the ***Investigator,*** educate ***Research*** staff, ***Suspend*** the protocol, suspend the ***Investigator,*** conduct random audits, etc.); and (g) plans for continued investigation or action.

For *Suspension* or *Termination:* (a) Name of the institution conducting the ***Research;*** (b) title of the ***Research*** project and/or grant proposal for which Emory IRB approval was ***Suspended*** or ***Terminated;*** (c) name of the PI on the protocol; (d) identification number of the ***Research*** project assigned by the Emory IRB that was ***Suspended*** or ***Terminated*** and the identification number of any applicable federal awards (e.g., grant, contract, etc.); (e) detailed description of the reason for the ***Suspension*** or ***Termination;*** and (f) corrective and preventive actions the institution is taking or plans to take to address the ***Suspension*** or ***Termination*** and the reasons for them (e.g., investigate alleged noncompliance, educate the ***Investigator;*** educate all ***Research*** staff, require monitoring of the ***Investigator,*** etc.); and (g) plans for continued investigation or action.

Report Timing: All reports to OHRP must be made promptly. For a reportable event, reports should be made within 30 calendar days of when the IRB makes a determination that an event is a reportable event. The Emory IRB may determine that it is appropriate to provide an initial report and indicate that a follow-up or final report will follow by the earlier of a specific date or at the completion of an investigation or inquiry or upon implementation of a corrective action plan.

OHRP Response: OHRP guidance states that it will respond in writing to reports received and state whether the report was adequate or request additional information. Questions regarding reporting requirements should be address to the Director of the Division of Compliance Oversight .

Reports to FDA:

For Research protocols involving FDA-regulated products, reports of Unanticipated Problems, Serious or Continuing Non-Compliance and/or Suspension or Termination of a Study shall be made to FDA. Reports to FDA shall contain the information to be included in reports to OHRP plus the following additional facts: (a) name of drug, device or biologic involved; (b) any IND or IDE number; (c) name of drug, device, or biologic ***Sponsor.*** Unless otherwise specified by federal regulations, all reports from the Emory IRB to the FDA shall be made to the following addresses:

Re. General IRB Matters: FDA, Division of Scientific Investigations, Office of Medical Policy, Center for Drug Evaluation and Research (CDER). Please see FDA website for current report details on reporting.

Re. Drug Studies: FDA, Division of Scientific Investigations, Office of Medical Policy, Center for Drug Evaluation and Research (CDER). Please see FDA website for current report details on reporting.

Re. Device Studies: FDA, Division of Bioresearch Monitoring, Office of Ethics and Compliance, Center for Device and Radiological Health (CDRH). Please see FDA website for current report details on reporting.

Re. Biological Studies: FDA, Bioresearch Monitoring Branch, Office of Ethics and Compliance and Biologics Quality, Center for Biologics Evaluation and Research (CBER). Please see FDA website for current report details on reporting.

Report Timing: All reports to FDA must be made promptly. For a reportable event, reports should be made within 30 calendar days of when the IRB makes a determination that an event is a reportable event. The Emory IRB may determine that it is appropriate to provide an initial report and indicate that a follow-up or final report will follow by the earlier of a specific date or at the completion of an investigation or inquiry or upon implementation of a corrective action plan.

Reports to *Sponsors:*

If a study is conducted or funded by a federal agency other than HHS that is subject to the ***Common Rule,*** then a report should be sent to OHRP or to the head of the agency, as required by the agency. Reports to ***Research Sponsors*** shall be made by the ***Principal Investigator*** or the IRB. The report to the Sponsor will become part of the IRB file. If the PI notifies the Sponsor instead of the IRB, the PI should send a copy of the Sponsor notification to the IRB.

Reports of suspensions or terminations of IRB approval shall be forwarded to the Emory Office of Sponsored Programs or Office of Grants and Contracts. The IRB shall consult the Emory Office of Sponsored Programs for any additional contractual reporting obligations. Circulation

of copies of all reports and notices must be completed within 15 business days of the initiating action.

AVAHCS Research:

If the convened IRB or the IRB reviewer determines that a problem or event was serious, unanticipated, and related to the research, OR if an incident constitutes serious or continuing non-compliance, the IRB chair or designee must report in writing the event or incident along with its determination within five business days to:

- Medical center director
- Associate chief of staff for research
- The Research and Development Committee
- Other relevant research review committee(s)

The Emory IRB will then rely on the AVAHCS to make any necessary reports to governmental regulatory authorities. These reports will be made by the AVAHCS Institutional Official (the AVAHCS Director), through the AVAHCS Research Compliance Office. The AVAHCS Institutional Official (the AVAHCS Director), through the AVAHCS Research Compliance Office, must report the problem or event to the appropriate Office of Research Oversight research officer within five business days after receiving such notification. The AVAHCS Research Compliance Office will prepare reports documenting any determinations regarding AVAHCS Resear***c***h to all necessary regulatory authorities, (such as OHRP, FDA, or other governmental agencies) with copies being sent to the AVAHCS Research Office, the Chair of the RDC, the VA Office of Research and Development, and to the Regional VA Office of Research Oversight.

The report of UPs will be sent to (via the AVAHCS) the VA Privacy Office, when the report involves unauthorized use, loss, or disclosure of individually identifiable patient information and the VHA Information Security Officer when the report involves violations of VA information security requirements. IRBs of academic affiliates and the ***Reviewing IRB*** for VA facilities must follow these requirements.

Research Subject to DOD Requirements*:*

For DOD supported research, the following must be promptly reported to the DOD human research protection officer:

- When significant changes to the research protocol are approved by the IRB
- The results of the IRB continuing review.
- Change of ***Reviewing IRB***.
- When the organization is notified by any federal department, agency, or national organization that any part of an HRPP is under investigation for cause involving a DOD-supported research protocol.
- all UPIRTSOs, suspensions, terminations, and findings of serious or continuing noncompliance regarding DOD-supported research involving human subjects.

In addition, findings of serious or continuing non-compliance must be reported to the Director, Defense Research and Engineering. Reporting requirements specific to the DOD

unit providing funding support also must be followed. For example, in the case of studies supported by the Department of the Navy, the following matters must be reported to the Department of the Navy Human Research Protections Program Office: (a) all suspensions or terminations of previously approved DON-supported research protocols; (b) the initiation and results of investigations of alleged non-compliance with human subject protections; (c) unanticipated problems involving risks to subjects or others, or serious adverse events in DON-supported research protocols; (d) all audits, investigations, or inspections of DON-supported research; (e) all audits, investigations, or inspections of the institution's Human Research Protections Program conducted by outside entities; (f) significant communication between institutions conducting research and other federal departments and agencies regarding compliance and oversight; and (g) all restrictions, suspensions or terminations of the institution's assurances.

Notification of Institutional Personnel: Copies of any reports and notices sent to FDA and/or OHRP, any other governmental regulatory agency, and ***Research* Sponsors** shall be sent to the IO and to their designees for oversight of IRB matters. Copies also shall be sent to the Director of the Office of Ethics and Compliance; to the Emory University ***Privacy Officer*** if the event involved unauthorized use, loss, or disclosure of PHI from the ***Covered Entity,*** to the ***Information Security Officer*** if the event involves unauthorized, use, loss or disclosure of electronic PHI from the ***Covered Entity,*** and to any other persons within the University deemed appropriate by the IO. Further, if the Emory IRB determines that the notice pertains to a particular PI or study, as opposed to more general Emory IRB matters, the Emory IRB also shall provide a copy of the notice to the PI in question or PI for the study in question and to the PI's divisional and departmental supervisor(s).

IRB Personnel Tasked with Making Reports: Unless otherwise instructed by the ***Institutional Official,*** the ***IRB* Chair shall sign any letters** of report that are made according to this P&P, or in their absence, the IRB ***Director*** or ***Institutional Official*** shall assume this duty.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108 and 56.113
32 CFR Part 219
38 CFR Part 16, including 16.103 and 16.113
45 CFR Part 46
DOD Directive 3216.02, 20222
OHRP Guidance on Reporting Incidents to OHRP, September 2022
SECNAVINST 3900.39D, 2006
VHA Directive 1058.01, 2016

64 USING FDA-REGULATED PRODUCTS

POLICY:

In reviewing any clinical ***Research,*** including but not limited to ***Research*** involving clinical investigations of drugs, biological products for human use, ***Medical Devices*** for human use, human food additives, color additives, vitamins, dietary supplements, or electronic products, the Emory IRB shall determine the applicability of ***FDA Regulations***. If such ***FDA Regulations*** apply, the Emory IRB shall ensure that the ***Research*** meets all applicable ***human subjects research*** requirements of the ***FDA Regulations***, in addition to any applicable requirements of other ***HHS Regulations*** *(i.e.,* ***the Common Rule****)* and Emory policies. In cases in which both the ***FDA*** and ***the Common Rule*** apply and there are differences between the two sets of regulations differ irreconcilably, the IRB shall follow the stricter rules.

PROCEDURES:

Prior IRB *Approval* Required: With a few limited exceptions (described below), Emory IRB ***Approval*** is required prior to using a non-FDA approved drug or ***Medical Device*** on a ***Human Subject*** in order to generate ***Research*** data that will be used to support an application for the marketing of a non-FDA approved FDA drug or ***Medical Device***; or in order to generate ***Research*** data that will be used to support an application for the marketing of an FDA-approved drug or ***Medical Device*** for a use other than that for which the drug or device was initially approved.

Exemption Categories Under *the Common Rule* do not Apply to *Research* Governed by *FDA Regulations*.

FDA Exemption Categories: The only types of ***Research*** protocols involving FDA-regulated items that do not require prior IRB review are listed below:

> ***Emergency Use*** of a ***Test Article***, as described below, provided that the ***Emergency Use*** is reported to the Emory IRB within five working days of the use and any subsequent use of the item is subject to IRB review.
>
> Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical or environmental contaminant at or below the level found to be safe, by the FDA or approved by the EPA of the Food Safety and inspection Service of the USDA.

FDA Waiver: The FDA, on the application of a ***Sponsor*** (including an investigator who is a ***Sponsor***) can waive the requirement for IRB review for specific ***Research*** activities or classes of ***Research*** activities.

FDA Required Documentation: Investigators and ***Sponsor-Investigators*** are responsible for the accurate and appropriate completion of documentation required to be obtained by/provided to the ***Sponsor*** and/or the ***FDA*** pursuant to ***FDA*** regulations governing the initiation and conduct of clinical investigations of drugs, biological products for human use, ***Medical Devices*** for human

use, human food additives, color additives, vitamins, dietary supplements, or electronic products. Such documentation may include, but is not limited to, FDA Form 1572 – Statement of Investigator, investigator agreement, financial disclosure documentation, safety reports, and annual report. Investigators and Sponsor-Investigators shall consult FDA regulations and appropriate FDA Guidance documents for assistance in the appropriate completion of such documentation.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.103 through 56.105
21 CFR Part 312
21 CFR Part 812

65 INVESTIGATIONAL MEDICAL DEVICES

POLICY:

The Emory IRB shall review and evaluate clinical ***Research*** that involves ***Medical Devices*** in accordance with applicable ***FDA Regulations.*** In reviewing **Research** regarding ***Medical Devices,*** the Emory IRB shall make a determination *as* to whether the ***Medical Device is*** a ***Significant Risk*** or ***Non-Significant Risk Device,*** even if the overall study risk is considered ***Minimal Risk.*** The IRB may not conduct an ***Expedited Review*** (either for an initial review or for the continuing review) of any clinical study that is subject to the ***FDA Regulations*** on IDE exemption (i.e., an SR or an NSR study). The Emory IRB shall have oversight over any ***Emergency Research Use; Treatment Use ("Compassionate Use"); Planned Emergency Research Use;*** or ***Humanitarian Use*** of a ***Medical Device.*** In addition, the Emory IRB shall require PIs to provide a plan for the control and handling of test articles to ensure that test articles are used only in conformance with protocol requirements, as well as proper dispensing and disposition of test articles.

REGULATORY BACKGROUND:

Device Classes: The FDA primarily regulates ***Medical Devices*** based on the level of risk that they pose to users. The FDA divides ***Medical Devices*** into the following classes based on this risk analysis:

Class	Controls	Types of Products
Class I — devices present minimal potential for harm to user and are usually simpler in design.	General Controls – least regulatory control. Include establishment registration, ***Medical Device*** listing, labeling, using GMP in manufacture, and submitting ***Premarket Notification***	Crutches, band aids, examination gloves, hand-held surgical instruments
Class II - devices for which Class I controls are not enough to ensure safety and effectiveness.	Special Controls -- General Controls plus Special Controls; may include special labeling requirements, mandatory performance standards and post-market surveillance.	Wheelchairs, infusion pumps, surgical drapes
Class Ill— usually devices that support or sustain human life, are of substantial importance in preventing impairment of health, or present *a* potential unreasonable risk of illness or injury.	***Premarket Approval-*** Most stringent regulatory category. Requires scientific review to ensure safety and effectiveness. Applies to devices for which insufficient information exists to assure safety and effectiveness solely through General or	Heart valves, implantable pacemaker pulse generators, and other devices known to present hazards requiring clinical demonstration of safety and effectives OR devices for which there is not enough known about safety or effectiveness to assign to

	Special Controls	Class I or II.

IRB review is required for any clinical investigations of such ***Medical Devices*** before their initiation.

Off-Label Use of *Medical Devices: Medical Devices* may be marketed only for the uses approved by the FDA. A physician may use an FDA approved ***Medical Device*** "off-label" – i.e., for a use other than the FDA approved use - in the physician's practice of medicine. The physician may not do ***Research*** regarding the off-label use of the device to develop information regarding the safety or effectiveness or to support marketing of the ***Medical Device*** UNLESS the physician is using the device under an FDA approved ***Investigational Device Exemption*** (see below).

***Investigational Device Exemption* Requirement:**

When submitting to the IRB a protocol involving a ***Medical Device*** that requires an IDE from the ***FDA***, the PI must provide the IRB with documentation of the IDE, e.g., a copy of the industry-sponsored protocol with the IDE number, or a letter from the FDA, or a letter from an industry ***Sponsor*** setting forth the IDE number. If the study involves a ***Medical Device*** and no IDE from the ***FDA*** is in place, the PI should provide an explanation as to why the device is non-significant risk, why IDE considerations do not apply, or how the study qualifies for one of the exempt categories set forth below.

Studies Exempt from IDE Requirement:

Sponsors or PIs are not required to hold an IDE to conduct ***Research*** protocols involving the types of clinical investigations listed below. If a PI believes that a ***Research*** involving a ***Medical Device*** does not require an IDE, they should provide the Emory IRB with documentation establishing that the clinical investigation of the ***Medical Device*** at issue falls within one of the following categories:

A clinical investigation of a FDA-approved, legally marketed device that is being used in accordance with its labeling.

A clinical investigation of 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.

A clinical investigation of a device, other than a transitional device, introduced into commercial distribution on or after May 28, 1976, that the 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 labeling FDA reviewed under Subpart E of 21 CFR Part 807 in determining substantial equivalence.

A clinical investigation involving a ***Diagnostic Medical Device*** if it complies with FDA labeling 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 by another medically established diagnostic product or procedure.

Consumer preference testing, testing of a modification or testing of a combination of devices if the devices(s) are legally marketed devices and *if* the testing is not for the purpose of determining safety or effectiveness and does not put subjects at risk.

Clinical investigation of a device intended solely for veterinary use.

Clinical investigation of a device solely intended for ***Research*** with laboratory animals that contains the labeling *"Caution — Device for investigational use in laboratory animals or other tests that do not involve human subjects."*

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.

Studies Exempt from IDE Require IRB Approval: In all but rare instances, studies involving ***Medical Devices*** that are exempt from requiring an IDE will still require IRB ***Approval*** and informed consent of the subjects who are participating. If the study overall is assessed as ***Minimal Risk***, the study may be reviewed via expedited review. No device risk determination (***Significant Risk*** vs. ***Non-Significant Risk***) is required in these cases.

PROCEDURES:

Control and Inventory of *Investigational Medical Devices* at Sites under Emory IRB Jurisdiction*:* The PI is responsible for controlling the use, dispensing and disposition of ***Investigational Medical Devices*** and ensuring that proper controls and documentation are in place for ***Investigational Medical Device*** inventories.

- For protocols that involve ***Investigational Medical Devices,*** the PI shall include as a part of the application for IRB review a description of the PI's plan for controlling the dispensation, use and disposal of the Investigational Medical Device and maintaining appropriate documentation regarding such dispensation, use and disposal.

Device Risk Determination for non-IDE-exempt Medical Device *Research* Protocols: The FDA employs different criteria for granting an IDE depending on whether the device in question is a ***"Significant Risk Device"*** or a ***"Non-Significant Risk Device."***

Emory IRB Process for Making Device Risk Determination: The Emory IRB will follow the process set forth below in making the determination as to whether a device is a ***Significant Risk or Non-Significant Risk* Device,** when applicable**:**

Initial *Sponsor* Determination: Generally, the ***Sponsor*** of *a* ***Medical Device*** will make an initial determination as to whether the device *is* a ***Significant Risk Device*** (in which case the Sponsor must apply to the FDA for an IDE), or ***a Non-Significant Risk Device.*** This

determination should be provided to the Emory IRB. If a ***Sponsor*** has determined that a device is ***a Significant Risk Device,*** the Emory IRB will not disagree with this determination and will require documentation of an approved IDE application before fully approving the ***Research***.

If the Sponsor or Emory PI asserts that the non-IDE-exempt ***Medical Device*** as used in the proposed Research meets the definition of ***Non-Significant Risk***, and there is no documentation that the FDA has officially made the determination, then the IRB shall determine whether the device should be categorized as a ***Significant Risk*** or ***Non-Significant Risk Device.***

Considerations: The Emory IRB will make its risk determination based on the nature of the harm that may result from the proposed use of the device in the ***Research*** protocol, and not on the device alone. If the subject must undergo a procedure as a part of the study in order to use the ***Medical Device,*** then the Emory IRB will consider the potential harm that could be caused by the procedure in addition to the potential harm caused by the ***Medical Device.***

The Emory IRB will consider the ***Medical Device*** to be a ***Significant Risk Device*** if its use in the study could result in potential harm to subjects that:

Could be life threatening;

Could result in permanent physical impairment of a body function or part; or

Could necessitate medical or surgical intervention to preclude permanent impairment of a body function or part.

Information the IRB Requires for Risk Determination: The PI on a ***Research*** protocol involving a non-IDE-exempt ***Medical Device*** should provide the Emory IRB with the following information:

- Documentation as to whether ***Medical Device*** to be used has a third-party ***Sponsor*** holding an IDE***,*** and if so the ***Sponsor's*** name, or documentation establishing that the Emory faculty member is the ***Sponsor.***
- Documentation of Sponsor's risk assessment of the device.
- Description of the device.
- Proposed investigational plan.
- Description of subject selection criteria.
- Description of monitoring procedures.
- Information on whether any other IRBs have reviewed the study and made a risk determination regarding the device, and if so, the determination that was made.
- Information regarding any assessment of the device's risk made by the FDA.
- Informed consent and HIPAA Authorization forms.

Mode of review and documentation: Studies using a device that requires a ***Significant***

Risk vs a ***Non-Significant Risk*** determination should undergo ***Full Committee Review***, even if the overall risk of the ***Research*** is considered ***Minimal Risk,*** except that ***Expedited Review*** may be used if the ***Medical Device*** and its use fall under FDA's enforcement discretion for Mobile Medical Apps (as documented in FDA guidance). The rationale behind the Emory IRB's determination (if different from the rationale provided by the PI or Sponsor) shall be set forth within the minutes for the meeting at which the decision is made. In addition, any approval notice from the IRB to the PI shall state whether the ***Medical Device*** is classified as a ***Significant Risk*** or ***Non-Significant Risk Device***.

Possible Determinations & Consequences:

Concurrence with *Sponsor* or PI's Assessment that Device is *Non-Significant Risk Device:* If the Emory IRB concurs with the ***Sponsor or PI's*** determination that the ***Medical Device is a* Non-Significant Risk Device,** then, provided the Emory IRB approves the **Research** protocol, the PI may begin the ***Research*** protocol without submitting an IDE application to the FDA. The sponsor and Investigator must comply with the "abbreviated IDE requirements" in 21 CFR 812.2(b).

Disagreement with Sponsor or PI's Assessment that the Device is *Non-Significant Risk Device:* If the Emory IRB disagrees with the with ***Sponsor* or PI's** assessment that a ***Medical Device*** is a ***Non-Significant Risk Device,*** then the Emory IRB will send written notice of its determination to the PI and, if applicable, to the ***Sponsor.*** The PI or ***Sponsor*** must, in turn, notify the FDA and the ***Research*** protocol may not be initiated until the FDA approves the IDE application and assigns a risk determination. The PI must provide the Emory IRB with notice and documentation that the FDA has granted the IDE and the IDE number must appear on the ***Investigator's*** IRB application that is submitted for final ***Full Committee Review***.

FDA Requirements for *Significant Risk Devices:* The FDA and the Emory IRB BOTH must approve a ***Research*** protocol employing *a* ***Significant Risk Device*** BEFORE the study begins.

The following steps must be taken with regard to obtaining and carrying out a ***Significant Risk Device*** study at Emory under an IDE:

Sponsor submits an IDE application to the FDA for review and approval.

Sponsor selects qualified PI(s) at Emory, obtains signed ***Investigator*** agreements, and provides PI(s) with the investigational plan and reports of prior investigations.

PI submits the **Research** protocol and report of prior investigations to the Emory IRB (and to the IRB at **any other site** at which the study is to be conducted) for review and approval. Informed consent materials must also be submitted to the FDA with the IDE application and to the Emory IRB for review and approval.

The FDA will notify the ***Sponsor*** in writing of the date on which the IDE is received. Within 30 days of receipt, the FDA will notify the ***Sponsor*** that the

investigation may not begin or that FDA approves an IDE for the investigation. If the IDE application is not approved by the FDA, the ***PI*** must inform the Emory IRB.

Prior to initiating the study at an Emory site, ***Approval*** from the Emory IRB also must be obtained.

Study participants must sign approved ***Research*** informed consents. The ***Sponsor*** is required to monitor the conduct of the study for safety and compliance. Both the **Sponsor** and ***Investigator*** are required to make certain reports and maintain certain records. (See the FDA's listing of ***Sponsor*** and PI responsibilities at http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/InvestigationalDeviceExemptionIDE/ucm046702.htm for more details.)

FDA Requirements for Non-Significant Risk Devices **with Abbreviated IDEs:**

Clinical investigations at Emory sites involving ***Non-Significant Risk Devices*** that are not banned devices require Emory IRB ***Approval*** but not FDA approval (If the study is conducted at other sites, their IRBs also must approve). Once the IRB approves the study, the FDA considers this type of investigation to have an approved "abbreviated" IDE (that is, approved by the IRB) unless the FDA has otherwise notified the sponsor that an application is necessary.

Once the IRB has concurred with the ***Sponsor or PI's*** determination of non-significant risk and approves the study, the following steps must be taken:

The device should be labeled in accordance with 21 CFR 812.5 as an ***Investigational Medical Device*** and provided only to qualified investigators at the Emory site who are on the study.

Written documentation of informed consent must be obtained from **Research** participants, pursuant to a ***Research*** informed consent form approved by the Emory IRB unless the IRB waives the requirement to obtain written documentation of informed consent in accordance with applicable ***FDA regulations***;

The ***Sponsor and or PI*** must monitor the conduct of the study in accordance with 21 CFR 812.46;

Both the PI and the ***Sponsor*** must submit required reports and keep required records and comply with other IDE responsibilities.

Review of Study with Respect to Risk Determination: ***Research*** protocols involving clinical investigations of non-IDE-exempt ***Medical Devices*** shall be reviewed by ***Full Committee Review*** (with the possible exception of Medical Devices that fall under FDA enforcement discretion as mobile medical apps, which may undergo ***Expedited Review***) after or concurrently with the ***Full***

Committee's determination as to whether the ***Medical Device*** is a ***Significant Risk*** or ***Non-Significant Risk Device***. Generally, these actions take place at the same convened meeting. However, some clinical investigations of non-IDE-exempt ***Medical Devices*** may be eligible for ***Expedited Review***, such as ***Research*** on those "mobile medical applications" (as defined by the FDA) for which the FDA states it will use enforcement discretion. In these cases, both the risk determination of the device as well as the review of the ***Research*** may be done by a ***Designated Reviewer***.

Marketing or Promoting Investigational *Medical Devices* is Prohibited: The FDA prohibits the promotion, commercialization and misrepresentation of an ***Investigational Medical Device***. The Emory IRB shall be aware of this prohibition in reviewing any advertising or recruitment materials for studies involving ***Investigational Medical Devices.***

International Studies: For FDA-regulated Research involving an investigational Device conducted outside of the U.S., an IDE may not be not required provided the study is conducted in accordance with the Good Clinical Practice guidelines and FDA is able to validate the data from the study through an onsite inspection if FDA deems it necessary. However, the IDE equivalent in the country in which the study is being conducted may be required. Emory PIs of investigator-initiated studies involving drugs or devices must provide the IRB with a statement of the applicable in-country regulations governing their study, and in the case of greater than minimal risk studies, they will be required to engage a Contract Research Organization working in the study country, and/or to consult with legal counsel regarding compliance with the country's clinical research regulations.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56
21 CFR Part 812
21 CFR Part 814
21 CFR Part 860
21 CFR Parts 862 through 892
FDA Guidance for Industry and FDA Staff: Humanitarian Device Exemption (HDE) Program, September 2019, No. FDA-2014-D-0223
FDA Draft Guidance: Expanded Access to Investigational Drugs for Treatment Use: Questions and Answers, November 2022, FDA-2013-D-0446

66 EMERGENCY USE OF INVESTIGATIONAL MEDICAL DEVICES

POLICY:

Any ***Emergency Use*** of investigational Medical Devices or ***Humanitarian Use Devices*** by physicians at Emory University shall be carried out per ***FDA Regulations*** and these P&Ps. See further P&Ps about Treatment IDEs, "Compassionate Use," and Humanitarian Use Devices.

Under ***DHHS Regulations,*** patients receiving a test article in an emergency use as defined by FDA regulations may *not* be considered to be research participants. ***DHHS Regulations*** do not permit data obtained from such patients to be classified as human participants' research, nor permit the outcome of such care to be included in any report of a research activity subject to DHHS regulations.

PROCEDURES:

Emergency Use* of an Investigational *Medical Device: The FDA recognizes that there are situations in which a patient may require the use of an ***Investigational Medical Device*** in order to save the patient's life even though there is no current IDE for the device, or the patient does not meet the protocol criteria for the IDE, or the physician or institution is not an approved user/site under the IDE.

In these situations, in order for a physician at Emory to make an ***Emergency Use*** of the ***Investigational Medical Device***, the physician must determine that the following conditions exist:

The patient has a life-threatening or serious disease or condition; and

There is no generally acceptable alternative treatment; and

There is no time to obtain FDA approval for the use because the ***Investigational Medical Device*** needs to be used in the patient immediately.

There is a substantial reason to believe that a potential benefit will occur

Actions Physicians at Emory Must Take: If the foregoing conditions exist, then the physician who wants to make an ***Emergency Use*** of an ***Investigational Medical Device*** must take the following actions:

BEFORE using the ***Investigational Medical Device,*** the physician must take as many of the following patient protection measures as possible:

Obtain a written independent assessment of the use of the device by an uninvolved physician.

Obtain documented informed consent from the patient or their ***Authorized Legal Representative***;

Obtain documented authorization from the holder of the IDE for the ***Investigational Medical Device***, if an IDE exists.

Notify the Emory IRB by contacting the IRB Chair or their designee and provide the Emory IRB with a written description of the circumstances necessitating the use of the device, along with copies of an uninvolved physician's assessment, informed consent and the IDE's holder's authorization. In order to use a medical device in a life-threatening situation without prior IRB review, there must not be sufficient time to obtain IRB approval.

Notify any other institutional officials who require notice under institutional policies.

AFTER using the device, the physician must take the following steps:

Report the use to the Emory IRB in writing within **five business days** and, if not previously provided to the Emory IRB, provide a written description of the circumstances necessitating the use of the device and copies of an uninvolved physician's assessment, informed consent and IDE's holder's authorization, **OR** provide a written explanation as to why any of these items were not obtained, including any required certification from an uninvolved physician as to why informed consent could not be obtained. Any reports provided shall be reviewed by the IRB Chair or their designee for compliance with FDA criteria.

Evaluate the likelihood of a similar use of the device occurring again at Emory, and if such a future use is likely, begin steps to obtain a new IDE or amend an existing IDE to cover the device's future use and to obtain Emory IRB approval. 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. If an IDE application for subsequent use is filed and disapproved by the FDA, then the device may not be used, even if emergency circumstances exist.

The physician must notify the IDE ***Sponsor*** of the ***Emergency Use***, or if there is no IDE, they should notify the FDA of the ***Emergency Use*** by calling the FDA's IDE Staff.

After the use occurs, the physician must provide the FDA with a written summary of the conditions constituting the emergency, patient protection measures taken and patient results.

Inability to Obtain Informed Consent in an *Emergency Use* Situation: The physician must obtain informed consent from the patient or the patient's ***Legally Authorized Representative*** for the use of the ***Investigational Medical Device*** in an emergency situation **UNLESS** the physician meets the conditions set forth in the P&P entitled *Waiver or Alteration of Informed Consent for Research* and the procedure specified therein is followed.

Inability to Obtain Certification from Uninvolved Physician Regarding Inability to Obtain Informed Consent: If a physician determines that all of the conditions set forth in the P&P entitled*: Waiver or Alteration of Informed Consent for Research* for not obtaining informed consent are met, but there is not enough time to get the certification of an uninvolved physician because of the immediate need to use the investigational ***Medical Device*** to save the patient's life, then the physician may use the device. **However, the physician must take the following steps within five business days after the use occurs:**

Have their determination reviewed and evaluated in writing by an uninvolved physician.

Notify the IRB of the use of the device and provide a copy of the review by the uninvolved physician.

Planned Emergency Use* vs. *Planned Emergency Research*: *Emergency Use of a device is the unplanned use of a non-FDA approved ***Medical Device*** due to a patient's severe clinical condition. ***Planned Emergency Research*** is the planned conduct of ***Research*** in life-threatening, emergency situation in which the IRB has approved the waiver of informed consent. Such ***Research*** must be approved by the FDA and must be conducted under a separate IDE. In addition, it must be approved by the IRB and meet the EFIC requirements of 21 CFR 50 Subpart B, including consultation with representatives from the community in which the investigation will be conducted and public disclosure to the community of plans for the investigation and its risks and benefits. See the P&P entitled *Waivers of and Exception from Informed Consent for Planned Emergency Research.*

Responsibility Summary for Emergency Use of an *Investigational Medical Device*

Responsible Person	Action
Physician	Determine that there is life-threatening or serious disease or condition; no acceptable alternative treatment; and no time to get approval from FDA because ***Investigational Medical Device*** must be used immediately.
	Before using device: (a) obtain independent assessment from uninvolved physician; (b) obtain informed consent from patient or ***Legally Authorized Representative***; (c) obtain authorization for use of device from holder of IDE; (d) notify and provide documentation to IRB; and (e) notify any other university officials, as required.
	After using ***Investigational Medical Device***: (a) within 5 business days of use, notify IRB of use and provide any information required to be provided, as described above, or explanation as to why such information could not be provided; (b) evaluate possibility of another emergency use and obtain IDE, as necessary; (c) notify IDE holder of use; and (d) notify FDA of use.
Emory IRB	Receive and review documentation from physician regarding the emergency use of ***Investigational Medical Device*** and the exception to the requirement to obtain consent (if applicable), to determine whether the circumstances met FDA regulations.
	Receive and review follow-up report on use.

Emergency use at a VA facility
Any emergency use of a test article does not require R&D Committee approval but is considered VA research under VHA Directive 1200.05(2), 2022.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50
21 CFR Part 56
21 CFR Part 812
21 CFR Part 814
21 CFR Part 860
21 CFR Parts 862 through 892
FDA Guidance for Industry and FDA Staff: Humanitarian Device Exemption (HDE) Program, September 2019, No. FDA-2014-D-0223
FDA Draft Guidance: Expanded Access to Investigational Drugs for Treatment Use: Questions and Answers, November 2022, FDA-2013-D-0446
FDA Device Approvals, Denials, and Clearances at: https://www.fda.gov/medical-devices/products-and-medical-procedures/device-approvals-denials-and-clearances
VHA Directive 1200.05(2), 2022

67 TREATMENT USE ("COMPASSIONATE USE") OF INVESTIGATIONAL DEVICES

POLICY:

Any ***Treatment Use*** of an Investigational Medical Device by physicians at Emory University shall be carried out per FDA Regulations and these P&Ps.

PROCEDURES:

Compassionate Use* of an Investigational *Medical Device: The FDA permits an ***Investigational Medical Device*** to be used for a single or small group of patients who would benefit from the device but who do not meet the requirements for being included in the IDE clinical investigation under a Treatment Use exemption, which is commonly called a "***Compassionate Use"*** exemption.

Criteria for *Compassionate Use*: In these situations, the physician may make a ***Compassionate Use*** of the ***Investigational Medical Device*** if the following conditions exist **BEFORE** the device is used:

The single patient or small group of patients has a serious disease or condition for which there is no alternative treatment.

There is a current clinical trial being conducted under an IDE for the use at issue.

The FDA approves of the ***Compassionate Use*** as a supplement to the existing IDE.

The IRB ***Chair*** concurs in the use.

An uninvolved physician reviews and provides an independent assessment supporting the use.

Authorization is obtained from the IDE holder.

Information that *Sponsor* Must Provide to the FDA for Approval: The ***Sponsor*** must submit an IDE supplement to the FDA seeking approval for a protocol deviation to treat the patient or small group of patients. The supplement should include the following information:

Description of the number of patients to be treated.

Description of the patient's condition and circumstances requiring treatment.

Description of why alternative treatments are unsatisfactory.

Description of why probable risk from device is no greater than probable risk from disease or condition.

Description of deviations from the protocol that are needed to treat the patient.

Description of all Patient Protection Measures taken, which should include:

Informed consent from patient or patient's legal representative.

Concurrence of IRB ***Chair***.

Assessment of use by uninvolved physician.

Authorization for use from IDE holder.

Full Committee Review: For ***Compassionate Use*** for a small group of patients a complete IRB submission and review by ***Full Committee Review*** is required. For ***Compassionate Use*** of a single individual, IRB approval is not required. Instead, the study team should obtain IRB ***Chair*** concurrence.

Information that Physician Must Provide to the Emory for IRB Concurrence: The following information should be submitted to the Emory IRB **before** the ***Compassionate Use*** occurs:

A description of the circumstances necessitating the use.

IDE protocol with description of device and name of IDE holder.

Copy of uninvolved physician's assessment of use.

Copy of authorization from IDE holder.

Copy of the consent document for expanded access use.

No Use of Device Until FDA and IRB Concurrence/Approval are Obtained: The physician should not use the device unless and until FDA approval of the ***Compassionate Use*** and IRB concurrence (or ***Approval,*** in the case of a ***Compassionate Use*** for a group of patients) have been obtained.

If the FDA approves the ***Compassionate Use*** and the IRB concurs, then the use may occur, after adequate informed consent is secured.

Steps After the *Compassionate Use* Takes Place: After the use takes place, the following steps must be taken:

The physician should develop a monitoring schedule for the patient and follow it in an effort to detect any possible problems arising from the use of the device.

The physician should prepare a follow-up report on the use of the device, including a summary of patient outcome and a description of any problems encountered using the device. This report should be provided to the IRB within 5 business days of the use, as well as to the sponsor.

After the initial report, the physician should report any problems as result of the device use to the IRB and sponsor.

The ***Sponsor*** should provide the FDA with a copy of the follow-up report as an IDE supplement.

Responsibility Summary: *Compassionate Use of an Investigational Device*

Responsible Person	Action
Physician	Establish that criteria for compassionate use of ***Investigational Medical Device*** exist.
	BEFORE USE: Submit IDE supplement to FDA permitting ***Compassionate Use***, along with all supporting documentation.
	BEFORE USE: Submit to Emory IRB all documentation supporting compassionate use and obtain Emory IRB concurrence in ***Compassionate Use***.
	Do not initiate use of device until Emory IRB and FDA approval are obtained.
	AFTER USE: Monitor patient and provide follow-up report to Emory IRB and sponsor.
Emory IRB	Provide ***IRB Chair concurrence*** for a single patient use and provide ***Full Committee Review*** for a small group use.
	Approve any ***Compassionate Use*** before it occurs and obtain documentation of FDA approval as well.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 812
21 CFR Part 814
21 CFR Part 860
21 CFR Parts 862 through 892
FDA Guidance for Industry and FDA Staff: Humanitarian Device Exemption (HDE) Program, September 2019, No. FDA-2014-D-0223
FDA Draft Guidance: Expanded Access to Investigational Drugs for Treatment Use: Questions and Answers, November 2022, FDA-2013-D-0446
FDA Device Approvals, Denials, and Clearances at: https://www.fda.gov/medical-devices/products-and-medical-procedures/device-approvals-denials-and-clearances

68 HUMANITARIAN USE DEVICES – EXEMPTIONS AND USES

POLICY:

Any ***Humanitarian Use Device*** (HUD) used for ***Treatment*** (commonly known as "Compassionate") Use or ***Emergency Use*** by physicians at Emory shall be done in accordance with ***FDA Regulations*** and these P&Ps.

Humanitarian Use Device Exemptions: ***Humanitarian Use Device Exemptions*** (HDEs) are exemptions provided by the Food and Drug Administration (FDA) to allow the use and marketing of an ***Investigational Medical Device*** that is "intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or are manifested in not more than 8,000 individuals per year in the United States."

FDA Criteria for an HDE: The applicant for the HDE must establish to the FDA's satisfaction that (a) the disease or condition that the device is intended to treat affects or is manifested in not more than 8,000 individuals per year in the United States; and (b) no comparable device, other than a ***Humanitarian Use Device*** (HUD) approved under the HDE regulations or a device being studied under an ***Investigational Device Exemption*** (IDE), is available to treat the disease or condition.

The HDE applicant does not need to establish the effectiveness of the HUD but does need to establish that the device does not pose any unreasonable risk of significant illness or injury and the probable benefits to the subject outweigh the risk. It should be noted that if a comparable device is approved under the ***Pre-Market Approval*** or pre-market notification process, then the FDA may rescind the HDE for the HUD. Similarly, the FDA also may rescind an HDE if, after granting it, the FDA determines that the disease or condition that the HDE is designed to treat affects not more than 8,000 people per year in the U.S. Once an HDE is granted, the HUD can be marketed for the FDA approved indication; but, it can only be used at a site after the IRB governing that site has reviewed and approved of the use.

Research HUD: If the health care provider plans to collect data on the safety and effectiveness of the HUD for the FDA-approved indication to support a ***Premarket Approval*** application for the HUD, then the health care provider may do so under the HDE (as opposed to obtaining an ***Investigational Device Exemption***); but**,** such use of the HUD is considered to be ***Research***. In these circumstances the health care provider must have a ***Research*** protocol and ***Research*** informed consent and HIPAA Authorization reviewed and approved by the IRB, and all regular IRB P&Ps should apply.

Listing of Current HDEs: The FDA lists all devices that have been granted an HDE at its Centers for Devices and Radiological Health website at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfHDE/HDEInformation.cfm.

Required IRB Approval of HUD Use: The physician who is using the HUD is responsible for obtaining IRB ***Approval*** **BEFORE** the device is used.

***Non-Research HUDs -- Initial IRB Review*:**

Initial Review of the use of an HUD requires ***Full Committee Review***. The physician who plans to use the HUD should submit to the IRB a basic written plan describing the use of the HUD. Specifically, the physician should submit:

A copy of the HDE approval order;

A description of the device;

The product labeling;

The patient information packet that may accompany the HUD;

A summary of how the physician proposes to use the device, including a description of any screening procedures, the HUD procedure, and any patient follow-up visits, test, or procedures.

The IRB also may request that the physician submit documentation that they are qualified through training and expertise to use the HUD.

The IRB will evaluate requests for approval for use of an HUD in accordance with the review requirements under ***FDA Regulations***, including review of risks to patients set forth in the product labeling; ensuring that those risks are minimized; and evaluating whether risks are reasonable in relation to the proposed use of the HUD.

Informed consent: A ***Research*** informed consent form is not required to use an HUD for an FDA-approved use because the FDA does not consider such use to be ***Research*** and has already approved the HUD for marketing for this use. As no ***Research*** informed consent will be used in this case, the IRB requires that the physician give patients an information sheet describing a general definition of the FDA's HDE program, a brief description of the device and related procedures, risk/benefit ratio, and physician contact information if the patient experiences a device-related adverse event. If the HDE holder has developed a patient information packet, this packet always should be distributed to patients prior to receiving their HUDs. Labeling for the HUD may also be made available to the patient to provide further information regarding the device's HUD status and possible risks/benefits.

Scope of Use: The use of the HUD must be within the indication approved by the FDA. The IRB may, in its discretion, place additional restrictions on the use of the HUD at the Site, e.g., limitations on use of the HUD based on one or more measures of disease progression; prior use and failure of alternative treatments; IRB reporting requirements; or appropriate follow-up precautions and evaluations. The HUD should not be used **unless and until** IRB approval has been obtained, except in the case of an ***Emergency Use*** of a HUD, as described

below. The physician should keep a record of patients who have received the device, their contact information, and any pertinent follow-up.

Non-Research HUDS -- IRB *Continuing Review*:

The IRB also is responsible for ***Continuing Review*** of the HUD protocol. ***Continuing Review*** of the HUD may be by ***Expedited Review***, unless the IRB determines otherwise. As a part of Continuing Review, the IRB may request the HDE holder to provide safety information on the HUD provided to the FDA in periodic reports required under 21 CFR Part 814. When applicable, review of the use of an HUD and reviewing of the investigational use of an HUD in a clinical investigation may be done simultaneously.

Modifications to HDE Protocol: Any changes to the HDE protocol also must be submitted to and approved by the IRB before they are implemented, except for changes necessary to eliminate immediate hazard or risk of harm to the patient.

Required HUD Reports: The HUD user should make the following reports to the IRB and/or other entities, as listed below:

Submit a report of any ***Emergency Use*** of HUD outside of an approved protocol to the IRB by no later than 5 business days after the use occurs.

Submit a report to the FDA, Emory IRB, and manufacturer of the HUD whenever a HUD may have caused or contributed to a death.

Submit a report to the manufacturer (or to the FDA and IRB if the manufacturer is unknown) whenever the HUD may have caused or contributed to a serious injury. "Serious injury" means an injury or illness that (1) is life threatening, (2) results in permanent impairment of a body function or permanent damage to a body structure, or (3) necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

Submit a summary report to the IRB at the time of continuing review that describes each use of the HUD within the previous approval period. Summaries should include a brief description of the patient's condition, how the device was used, and the patient's outcome.

Responsibility Summary: Non-Research Use of *Humanitarian Use Devices*

Responsible Person	Action
Physician	Ensure that HDE exists for use of HUD and that use in question meets HDE requirements.
	Submit a basic written plan for use of HDE and obtain Emory IRB approval for use under HDE before use.
	Submit documentation to IRB for continuing review of HDE.
	Submit all required reports to Emory IRB (and/or FDA or Manufacturer) regarding HUD use.
Emory IRB	Provide initial ***Full Committee Review*** of HDE protocol.
	Provide ***Full Committee*** or ***Expedited Continuing Review*** of HDE protocol.

Emergency Use of an HUD: A physician may make an ***Emergency HUD Use*** for an indication other than that approved by the FDA (i.e., off-label use) in an emergency situation **ONLY IF:** (a) the ***Emergency Use*** of the HUD is necessary to prevent serious harm or death to a patient; (b) there is no generally acceptable alternative device for treating the patient; and (c) because of the immediate need to use the device, there is no time to use existing procedures to get IRB approval of the use.

PROCEDURE TO BE FOLLOWED FOR EMERGENCY USE OF HUD:

BEFORE using the HUD, the physician should take as many of the following Patient Protection Measures as possible:

If possible, contact the IRB ***Chair*** and obtain their concurrence for the use of the HUD.

Obtain treatment informed consent from the patient or their ***Legally Authorized Representative*** and explain to patient that HUD is being used for an indication that is not within its approved labeling.

Provide the patient with any HUD patient information packet before or immediately following the use of the device.

Provide the patient with an information sheet describing a general definition of the FDA's HDE program, a brief description of the device and related procedures, risk/benefit ratio, and physician contact information if the patient experiences a device-related adverse event.

Develop a schedule to monitor the patient, taking into consideration the patient's needs and limited information available about the HUD's risks and benefits. **After** the ***Emergency Use*** of the HUD, the physician should take the following steps:

As soon as possible, and in all events by no later than five business days after the ***Emergency Use***, send a report to the IRB and HDE-holder describing the ***Emergency Use*** and reason for the use, identifying the patient and date of the use, and describing the patient's condition and the Patient Protection measures that were followed.

Send a report to the HDE holder describing the use and the patient's condition.

The physician also should monitor the patient according to the monitoring schedule in order to detect any possible problems arising from the use of the device. Any problems encountered in the ***Emergency Use*** of the device should be reported to the HDE holder and the IRB in accordance with the section above entitled "Required HUD Reports" and/or in accordance with IRB requirements for reporting ***Unanticipated Problems Involving Risk to Participants or Others.***

Responsibility Summary: Emergency Use of HUD

Responsible Person	**Action**
Physician	Ensure that criteria for ***Emergency HUD Use*** are met.
	BEFORE USE, if possible: (a) obtain concurrence of Emory IRB Chair; (b) obtain informed consent from patient; (c) provide patient with HUD information packet and other required information; and (d) develop monitoring schedule.
	AFTER USE: Report to Emory IRB and holder of HDE on use and monitor patient. Provide any information not provided prior to use.

Compassionate Use HUD: A physician may make ***Compassionate Use*** of a HUD for a use other than the FDA-approved indication in a non-emergency situation, if (a) there is no generally acceptable alternative device for treating the patient; and (b) the physician notifies the IRB of the use BEFORE it occurs and obtains IRB approval for the use.

Procedure to be Followed for Compassionate Use of a HUD:

BEFORE using the HUD, the physician using the HUD should:

Provide the IRB with notification of the planned use, identify of patient in whom HUD will be used, reasons necessitating use, and plan for monitoring the patient, and obtain IRB approval.

Obtain treatment informed consent from the patient or their ***Legally Authorized Representative and*** explain to patient that HUD is being used for an indication that is not within its approved labeling.

Provide the patient with any HUD patient information packet before the use of the device.

Provide the patient with an information sheet describing a general definition of the FDA's HDE program, a brief description of the device and related procedures,

risk/benefit ratio, and physician contact information if the patient experiences a device-related adverse event.

Develop a schedule to monitor the patient, taking into consideration the patient's needs and limited information available about the HUD's risks and benefits.

AFTER the ***Compassionate Use*** has occurred, the physician should provide a follow-up report to the IRB within 5 business days of the use. The report should include a description of patient outcome. This report also should be provided to the HDE holder.

The physician also should monitor the patient according to the monitoring schedule in order to detect any possible problems arising from the use of the device. Any problems encountered in the ***Compassionate Use*** of the device should be reported to the HDE holder and the IRB in accordance with the section above entitled "Required HUD Reports" and/or in accordance with IRB requirements for reporting ***Unanticipated Problems Involving Risk to Participants or Others.***

Responsibility Summary: Compassionate Use of HUD

Responsible Person	Action
Physician	Ensure that criteria for ***Compassionate Use*** of HUD are met.
	BEFORE ***Compassionate Use***: (a) obtain IRB approval; (b)obtain informed consent; (c) provide patient with HUD information packet and other required information; and (d) develop monitoring schedule.
	AFTER USE: report to Emory IRB and holder of HDE on use and monitor patient.
Emory IRB	Review and grant approval prior to initiation of ***Compassionate Use.***

Research **Regarding Use of HUD for a Use Other than that Approved by the FDA:** If a PI wants to do clinical ***Research*** on the safety and effectiveness of the HUD for an indication other than the FDA-approved indication and the new indication is not itself eligible for a HDE (e.g., new indication involves a condition that affects more than 8,000 persons per year in the U.S.), then the PI must conduct the clinical ***Research*** under an ***Investigational Device Exemption***. The ***Research*** protocol and ***Research*** informed consent will have to be reviewed and approved by the IRB.

Use of HUD for Another Indication that may Meet HDE Requirements: If a HUD is to be used for another indication that also may meet the requirements of a HDE, then a new HUD designation must be sought for the indication for which the device will be used and a new original HDE for the new indication must be submitted and approved by the FDA. If the HDE is granted, then data regarding the safety and effectiveness of the HUD for the use contemplated by the new HDE may be collected, provided that the IRB reviews and approves the protocol for the HUD's use, including a ***Research*** informed consent.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56
21 CFR Part 812
21 CFR Part 814
21 CFR Part 860
21 CFR Parts 862 through 892
21 U.S.C. 360
FDA Guidance for Industry and FDA Staff: Humanitarian Device Exemption (HDE) Program, September 2019, No. FDA-2014-D-0223
FDA Draft Guidance: Expanded Access to Investigational Drugs for Treatment Use: Questions and Answers, November 2022, FDA-2013-D-0446
FDA Device Approvals, Denials, and Clearances at: https://www.fda.gov/medical-devices/products-and-medical-procedures/device-approvals-denials-and-clearances

69 INVESTIGATIONAL NEW DRUGS (OTHER THAN EXPANDED ACCESS)

POLICY:

The Emory IRB shall review and evaluate clinical Research that involves ***Investigational New Drugs*** in accordance with applicable ***FDA Regulations.*** In reviewing ***Research*** regarding ***Investigational New Drugs,*** the Emory IRB shall make a determination as to whether an ***Investigational New Drug Application*** is required. The Emory IRB also shall have oversight over any Expanded Access- ***Treatment Use, "Compassionate" Use*** or ***Emergency Use*** of an ***Investigational New Drug.***

Any use of ***Investigational New Drugs*** by physicians at Emory shall be done in accordance with ***FDA Regulations*** and these P&Ps.

All ***Investigational Drugs*** used in studies that take place at Emory University shall be kept by and dispensed through the University's ***Investigational Drug*** Service (IDS) according to Emory Policy 7.14. For studies that take place at other sites, the PI shall be responsible for putting in place a plan to ensure the proper storage, handling, dispensing and disposition of ***Investigational Drugs.***

PROCEDURE:

Marketing of Drugs and *Investigational New Drug Applications* (IND): Before a drug can be marketed within the United States or transported or distributed across state lines, it must have ***Pre-marketing Approval*** from the FDA. This approval is granted after the drug's manufacturer (the ***"Sponsor")*** has demonstrated the safety and effectiveness of the drug to the FDA through data gathered in clinical investigations.

In order for a non-FDA approved ***Investigational Drug*** to be distributed for use in such clinical trials, it must be subject to an ***Investigational New Drug Application*** (IND) that has been approved by the FDA. A **Sponsor** cannot begin a clinical investigation of an ***Investigational Drug*** until the ***Sponsor*** has received an approved IND from the FDA, and the IRB at the site at which the study is to be conducted has approved the study. This includes recruiting, obtaining consent, and screening participants for a specific study that is subject to the IND. Accordingly, the Research involving the use of a drug other than the use of a marketed drug in the course of medical practice, must have an IND unless the Research qualifies for an IND exemption as set forth below in the subsection entitled *Studies Exempt from the Requirement for an IND*.

The Emory IRB requires PIs to provide the IRB with an IND number assigned by the FDA for the drug being used in the Research protocol or documentation that establishes that the drug is exempt from IND requirements in accordance with the aforesaid subsection. IRB analysts or Team Leads or Director and/or IRB members shall confirm that the IND number is valid by comparing it to the protocol with pre-printed IND number (i.e., from non-Emory Sponsor), to other correspondence from the Sponsor (if not Emory Sponsor-Investigator), or to correspondence from the FDA (for Emory Sponsor-Investigator).

INDs for Phases of Clinical Investigations: An IND may be submitted to the FDA for one or more

phases of the clinical investigation of an ***Investigational Drug.***

A description of each of the phases is set forth in the chart below:

Description	Phase I	Phase II	Phase Ill	Phase IV
	Initial introduction of an ***Investigational Drug*** into humans	Evaluation of effectiveness of ***Investigational Drug*** for a particular indication	Gathering and evaluation of additional evidence re. effectiveness of ***Investigational Drug***	Study conducted after FDA has approved a drug for marketing
Purpose	Determining metabolism and pharmacological actions of the drug in humans; toxicity/side effects associated with increasing doses; and gain evidence on effectiveness	Determining treatment effectiveness; short-term side effects; and risks	Determining safety and effectiveness of drug to evaluate risk-benefit and to determine how drug should be labeled	Gathering additional data regarding a drug's safety, effectiveness of optimal use
Monitoring	Closely monitored	Well controlled and closely monitored	Expanded controlled and uncontrolled trials	Conducted per agreement between Sponsor and FDA; may be required as a condition of approval
Subjects	May involve patients or normal volunteers, Very small in size - generally 20 to 80 subjects	Patients who have the condition that the drug is being used to treat. Relatively small in size - no more than several hundred subjects	Patients who have the condition that the drug is being used to treat. Relatively large in size - several hundred to several thousand subjects	Persons who have been prescribed the drug as a part of their treatment

Off-Label Use of Drugs: A drug may be marketed only for the uses approved by the FDA. A physician may use an FDA approved drug "off-label" — for a use other than the FDA approved use — in the physician's practice of medicine. The physician may not do ***Research*** regarding the off-label use of the drug to develop information regarding the safety or effectiveness or to support marketing of the drug **unless** the physician is using the drug under an FDA approved

IND.

Control and Inventory of Investigational Drugs: The PI is responsible for controlling the use, dispensing and disposition of ***Investigational Drugs*** and ensuring that proper controls and documentation are in place for ***Investigational Drugs*** inventories. For studies that take place at Emory University sites, all ***Investigational Drugs*** shall be stored at and dispensed through the University's Investigational Drug Service (IDS), and the IDS shall be responsible for all documentation relating to the storage, dispensing and disposition of the ***Investigational Drugs***. If IDS will not be used for these studies, an exception letter from the IDS is required to be submitted to the IRB. For protocols that involve ***Investigational Drugs*** to be used at non-Emory University sites, the PI shall include as a part of the application for IRB review a description of the PI's plan for storage, controlling the dispensation, use and disposal of the ***Investigational Drugs*** and maintaining appropriate documentation regarding such dispensation, use and disposal.

For Research taking place at the AVAHCS, the PI must follow the AVAHCS "Management of Investigational Drugs Procedure," which includes:

- Ensure the local Pharmacy Service or Research Service Investigational Pharmacy receives:
    - Documentation of IRB and any other relevant approvals.
    - A copy of VA Form 10-9012 (if applicable).
    - A copy of the current approval protocol.
    - A copy of the consent document for each participating participant with all appropriate signatures.
    - Documentation of IRB continuing review approval.
    - Copies of sponsor-related correspondence specific to the drugs as appropriate.
    - Copies of all correspondence addressed to the Researcher from the FDA specific to the investigational drugs as appropriate.
- Inform the chief, pharmacy service, the research pharmacy when applicable, and the IRB in writing with a study involving investigational drugs has been suspended, terminated, or closed.
- Comply with all dispensing requirements.
- Comply with all documentation requirements and make relevant records accessible to the investigational drug pharmacist when requested.

Criteria for IND Exemption & Emory IRB Determinations: If the FDA-regulated drug proposed for use in a Research protocol does not already have an IND number for that proposed use, and the PI believes that the use is exempt from an IND, the PI will justify to the IRB in the Protocol Application the request for exemption. The Emory IRB will determine whether an IND is necessary, using the following criteria established by the ***FDA Regulations:***

For an investigation of a drug that is lawfully marketed in the United States:

The results from the study are not intended to be reported to the FDA in support of a new use of the drug or of *a* change in the drug's labeling; and

The drug being used in the study is a prescription drug and the investigation is not intended to support a significant change in advertising for the product; and

The investigation does not involve *a* route of administration or dosage level or use in a patient population or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug; and

The investigation is approved by an IRB and the subjects participating in the investigation provide informed consent in accordance with ***FDA Regulations***.

The ***Research*** is conducted in compliance with the requirements concerning the promotion of and charges for ***Investigational New Drugs*** *set* forth in 21 CFR Section 312.7.

The ***Research*** does not involve an exception from informed consent requirements per 21 CFR Section 50.24 for ***Emergency Research.***

For a ***Clinical Investigation*** involving use of a placebo: if the investigation does not otherwise require submission of an IND.

For a ***Clinical Investigation*** involving an *in vitro* diagnostic blood grouping serum, reagent red blood cells, or anti-human globulin product: if the product is intended to be used in a diagnostic procedure that confirms the diagnosis made by another medically established diagnostic procedure and is shipped in accordance with FDA requirements set forth in 21 CFR Section 312.160.

For a ***Clinical Investigation*** of a drug that is used solely for *in vitro* tests or for tests in laboratory research animals: if the drug is shipped in accordance with the requirements set forth in 21 CFR Section 312.160.

If the Emory IRB determines that an IND is necessary, the PI or industry **Sponsor** must submit an IND application to the FDA for a determination as to whether an IND is required. The PI should provide documentation of the FDA's determination to the Emory IRB, as well as any IND number that is assigned.

IND-Exempt Studies Must Have IRB *Approval:* Even if a study is exempt from having an IND, it must still have IRB ***Approval*** and the subjects generally must provide informed consent.

Studies on Dietary Supplements and Related Items May Require an IND: Clinical investigations of dietary supplements, herbs, botanicals, spices, and/or foods may require an IND, if the investigation is examining whether the item can be used for the prevention, cure, diagnosis, treatment, or mitigation of a condition or disease. In such cases, the item may be considered to be an unapproved drug for purposes of ***FDA*** regulations.

EFIC Studies Must Have IND: Further, if a study seeks an Exception From Informed Consent (EFIC) for planned emergency research under 21 CFR Section 50.24, then a separate IND MUST be sought for that study, even if the product being studied would otherwise qualify for an exemption from IND requirements.

International Studies: For FDA-regulated Research involving an investigational drug conducted

outside of the U.S., an IND may not be not required provided the study is conducted in accordance with the Good Clinical Practice guidelines and FDA is able to validate the data from the study through an onsite inspection if FDA deems it necessary. However, the IND equivalent in the country in which the study is being conducted may be required. Emory PIs of investigator-initiated studies involving drugs or devices must provide the IRB with a statement of the applicable in-country regulations governing their study, and in the case of greater than minimal risk studies, they will be required to engage a Contract Research Organization working in the study country, and/or to consult with legal counsel regarding compliance with the country's clinical research regulations.

IND Applications: The ***Sponsor*** (or the PI, in the case of studies in which the PI is also the ***Sponsor)*** must submit the application for the IND to the FDA for approval and assignment of an IND number. Documentation of the IND number assigned must be provided to the Emory IRB.

The IRB shall verify when study activities (including recruitment, obtaining consent, and screening participants) may commence under a new IND application by requiring that the PI provide, prior to final IRB approval: Documentation of the IND number assigned; the date on which the IND application was submitted; certify that 30 days have passed since the date of the IND submission; and certify that no correspondence was received from the FDA during that period that indicated that the IND may not be granted or that additional information was required regarding the IND application.

IND Modifications and Amendments: Once an IND is in effect, the ***Sponsor*** and PI must conduct the ***Research*** protocol in accordance with the specifications of the IND. If the ***Sponsor*** or PI desire to (a) add a new ***Research*** protocol to the study that is not covered under the IND; or (b) make significant changes to the ***Research*** protocol (including, but not limited to the addition of a new investigator), then the ***Sponsor*** must submit both an IND amendment to the FDA for review and approval and a ***Research*** protocol modification to the Emory IRB for review and approval before the new protocol or change in the protocol can be put in place.

> **EXCEPTION:** The only exception to this requirement of prior FDA and IRB approval is if an immediate modification to the ***Research*** protocol is required to eliminate an apparent immediate hazard to subjects. In such a case, the FDA and IRB must be notified as soon as possible after the change is put in place and the ***PI/Sponsor*** must file appropriate amendments/modifications to the **Research** protocol and the IND.

Responsibility Summary for INDs

Responsible Person	Action
Emory IRB	Determines whether an IND is required for study involving an ***Investigational Drug*** if no IND number is submitted with IRB application. If IRB determines that an IND is required then the IRB will require that the Sponsor and/or PI must submit an IND application and get a determination from the FDA as to whether an IND is required before the protocol is approved. Validates the IND number provided by the investigator.
Principal Investigator	Supplies IND number to IRB or if **PI/Sponsor** does not believe that an IND is necessary supplies supporting information to IRB. Supplies

	documentation of IND number, IND application date to IRB and supplies certification that within 30-day period after submission no information was received from the FDA denying the IND and/or requesting additional information regarding the application. Additional requirements for VA research, above.
	Conducts ***Research*** in compliance with ***Research*** protocol and IND and works with ***Sponsor*** to obtain a modification or amendment to the protocol or an IND before implementing change/amendment or adding a protocol.
	Carries out all duties of ***Sponsor*** if serving in role of ***Sponsor*** and PI.
Sponsor	Submit IND application to the FDA.
	Submit modification or amendment to IND application for change in protocol or new protocol.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.24
21 CFR Part 56
21 CFR Part 312, including 312.7 and 312.160
VHA Handbook 1108.04, 2012
FDA Guidance: Investigational New Drug Applications (INDs) – Determining Whether Human Research Studies Can be Conducted Without an IND, September 2013, No. FDA-2010-D-0503
Emory Policy 07.14, Investigational Drug Management for Clinical Studies, July 2018

70 INVESTIGATIONAL NEW DRUGS – EXPANDED ACCESS

POLICY:

The Emory IRB may review or cede review to another IRBfor any ***Treatment Use, "Compassionate" Use*** of an ***Investigational New Drug*** at an Emory facility, or where an Emory faculty member holds the Expanded Access IND. The Emory IRB shall have oversight of instances of Emergency Use at an Emory facility, or where an Emory faculty member holds the Expanded Access IND.

Any use of ***Investigational New Drugs*** by physicians at Emory shall be in accordance with ***FDA Regulations*** and these P&Ps.

All ***Investigational Drugs*** used in studies that take place at Emory University shall be kept by and dispensed through the University's ***Investigational Drug*** Service (IDS) according to Emory Policy 7.14. For studies that take place at other sites, the PI shall be responsible for putting in place a plan to ensure the proper storage, handling, dispensing and disposition of ***Investigational Drugs.***

Under ***FDA Regulations***, 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.

Under ***DHHS Regulations,*** patients receiving a test article in an emergency use as defined by FDA regulations may *not* be considered to be research participants. ***DHHS Regulations*** do not permit data obtained from such patients to be classified as human participants' research, nor permit the outcome of such care to be included in any report of a research activity subject to DHHS regulations.

REGULATORY BACKGROUND:

Expanded Access to Investigational Drugs for Treatment Use: In certain cases, the FDA Regulations concerning Expanded Access to Investigational Drugs for treatment use permit Investigational Drugs to be used for the treatment of patients who are not enrolled as subjects in studies under the IND that covers the drug being studied. In general, the FDA may permit a licensed physician to have Expanded Access to Investigational Drugs to treat persons with an "immediately life-threatening disease or condition" or a "serious disease or condition" for which there is no comparable or satisfactory alternative therapy for diagnosis, treatment, or monitoring. The FDA also may approve of Expanded Access to approved drugs when supply is limited by an FDA-required risk evaluation and mitigation strategy (REMS).

Types of Expanded Access for Treatment Use:

The FDA recognizes three different types of Expanded Access for treatment use based on the number of people for whom Expanded Access is sought. Each type of Expanded Access is described below:

(1) **Expanded Access for Individual Patients, Including Emergency Use**: Under this type of Expanded Access, the FDA permits the Investigational Drug to be used for the treatment of an individual patient. This type of Expanded Access includes the Emergency Use of an Investigational Drug.

(2) **Expanded Access for Intermediate-size Patient Populations**: Under this type of Expanded Access, the FDA permits the Investigational Drug to be used to treat a patient population that is smaller than the patient population typically treated under a treatment IND or treatment protocol. Situations in which this type of Expanded Access may be required include:

a. The drug is not being developed because the disease or condition it treats is so rare that the sponsor cannot recruit patients for a clinical trial.
b. The drug is being studied in a clinical trial, but the patients for whom Expanded Access is requested cannot participate in the trial because they do not meet enrollment criteria, or the trial site is not geographically accessible.
c. The drug is an approved drug, but it is not being marketed because of safety concerns, failure to meet conditions of the approved application, or a drug shortage.

(3) **Treatment IND or Treatment Protocol:** Under this type of Expanded Access, the FDA permits the widespread use of the Investigational Drug for treatment use under a Treatment IND or Treatment Protocol. Under *a **Treatment Use Protocol,*** the ***Sponsor*** holds the IND for the drug, while under the ***Treatment Use IND,*** the treating physician holds the IND for the drug and serves as both Investigator and Sponsor.

PROCEDURE:

Authorizations Required for Expanded Access Use:

FDA --The FDA must authorize **any type** of Expanded Access use in advance, even Emergency Use for individuals.

IRB -- The reviewing IRB also must approve in advance any Expanded Access use, except for the following two situations: (a) In Emergency Use situations in which prospective IRB approval cannot be obtained, the Investigator must notify the Emory IRB of the Emergency Use within 5 business days of its occurrence and obtain retrospective review; or (b) the FDA approves of a waiver of IRB review and approval in response to a request for individual patient expanded access submitted by an physician on Form FDA 3926 (see below); provided, however, that the physician must obtain concurrence by the IRB chair or another designated IRB member before the treatment use begins.

General Criteria that Must be Met for All Types of Expanded Access for Treatment Use:

In order to permit ***any type*** of Expanded Access to Investigational New Drugs for treatment, the FDA must determine that the following criteria are met:

The patient(s) to be treated has (have) a serious or immediately life-threatening disease or condition;

There is no comparable or satisfactory alternative therapy to diagnose, monitor or treat the disease or condition;

The potential patient benefit justifies the potential risks of the treatment use;

The potential risks of the treatment use are not unreasonable in the context of the disease or condition to be treated; and

Providing the Investigational New Drug for the treatment use will not interfere with the initiation, conduct or completion of clinical investigations that could support marketing approval of the Expanded Access use, or otherwise compromise the development of the Expanded Access use.

Requirements for All Expanded Access Request Submissions to FDA (other than Emergency Use):

Format for Submission to FDA: The physician who wants to make use of the Investigational Drug or the sponsor who holds the IND for the Investigational Drug may make the Expanded Access request to the FDA. The request may be submitted as a new IND or as a protocol amendment to existing IND. For protocol amendments to existing INDs, the amendment may reference information contained in the existing IND if the sponsor of that IND provides a letter granting a right of reference.

Components of FDA Submission:

Physician Request for Individual Patient Use: The FDA has made available Form FDA 3926 for physicians requesting expanded access to an investigational drug outside of a clinical investigation, or to an approved drug where availability is limited by a REMS, for an individual patient who has a serious or immediately life-threatening disease or condition and there is no comparable or satisfactory alternative therapy to diagnose, monitor, or treat the disease or condition. This form will comply with the IND submission requirements in 21 CFR 312. FDA intends to consider a completed Form FDA 3926 with the box in Field 10 checked and the form signed by the physician to be a request in accordance with 21 CFR Section 312.10 for a waiver of any additional requirements in 21 CFR Part 312 for an IND submission, including additional information ordinarily provided in Form FDA 1571 and Form FDA 1572 (Statement of Investigator, which provides the identity and qualifications of the investigator conducting the clinical investigation).

Sponsor Submissions: For sponsors submitting a proposed Expanded Access request to the FDA under their current IND or as an individual submission, must include the following materials/information in their request. All materials submitted must be plainly marked: "EXPANDED ACCESS SUBMISSION."

A completed FDA Form 1571 and all applicable attachments, including a treatment protocol that describes how drug will be used for treatment, monitoring and treatment

data collected.

Reason for intended treatment use of the Investigational New Drug

List of available therapeutic options that would usually be tried before using the Investigational New Drug OR an explanation of why the Investigational New Drug is preferable to available therapies.

Criteria for patient selection for Expanded Access if the use is for more than one individual OR a description of patient's disease/condition, medical history and previous treatment for Expanded Access for an individual patient.

Dose and method of administration for the Investigational New Drug and duration of therapy.

Description of facility where Investigational New Drug is manufactured.

Chemistry, manufacturing, and controls information about the Investigational New Drug that ensure proper identification, quality, purity and strength.

Pharmacology and toxicology information that adequately establishes that the Investigational New Drug is reasonably safe at the dose and duration proposed for the Expanded Access Use.

Description of the clinical procedures, laboratory test or other monitoring necessary to evaluate the effects for the drug and minimize its risks.

Components of IRB Submission:

The reviewing IRB will review by ***Full Board Review*** all materials submitted in support of an Expanded Access request and determine if the submission satisfies the requirements for the type of Expanded Access requested, as well as any other pertinent provisions of ***FDA Regulations***. A physician submitting an individual patient expanded access IND using Form FDA 3926 may select the appropriate box on that form to request authorization to obtain concurrence by the IRB chairperson or by a designated IRB member before the treatment use begins, in lieu of obtaining IRB review and approval at a convened IRB meeting at which a majority of the members are present.

The physician planning to undertake the Expanded Access use should submit the following documents to the Emory IRB for review:

A copy of all information submitted to the FDA in connection with the Expanded Access use request.

Informed consent form to be used or information demonstrating qualification for ***Emergency Use*** exception from informed consent. See the P&P entitled: *Waiver or Alteration of Informed consent for Research*, subsection entitled *Emergency Medical Care Exception – Exception to the Requirement to Obtain Informed Consent for the Use*

of a FDA-Regulated Item in Emergency Medical Care Situations.

Documentation of FDA approval for the Expanded Access Use request.

Once the Expanded Access use takes place, then Adverse ***Event*** reports must be submitted to the ***Sponsor*** as usual, as well as to the Emory IRB, in accordance with standard Investigator reporting obligations. In addition, a report on the outcome of each patient's treatment should be provided to the Emory IRB, FDA and drug ***Sponsor.***

Sponsor, Investigator and IRB General Responsibilities Pertaining to All Types of Expanded Access for Treatment Use:

Sponsor Responsibilities:

Who is the Sponsor? The licensed physician or entity that submits the Expanded Access Use IND or the Expanded Access protocol amendment to an existing IND is considered the "Sponsor."

Sponsor Responsibilities: The Sponsor must perform all FDA Sponsor responsibilities listed under 21 CFR Part 312, Subpart D that apply to Expanded Access Use.
These responsibilities include:

Ensuring that licensed physicians who administer the Investigational New Drug are qualified to do so.

Providing the physicians administering the Investigational New Drug with the information that they need to minimize the risk and maximize the potential benefits of the Investigational New Drug.

Providing the Investigator with the Investigator's Brochure for the Investigational New Drug, if a brochure exists.

Maintaining an effective IND for the Expanded Access use.

Submitting IND safety reports and annual reports to the FDA.

Maintaining adequate records regarding the disposition of the Investigational New Drug.

Retaining records in accordance with 21 CFR Section 312.57.

Investigator Responsibilities:

Who is the Investigator? The licensed physician under whose immediate direction an Investigational New Drug is administered or dispensed for Expanded Access use is considered the "Investigator."

Investigator Responsibilities: The Investigator must perform all FDA Investigator responsibilities under 21 CFR Part 312, Subpart D that are applicable to Expanded Access use. These responsibilities include:

Obtaining IRB review and approval of informed consent documents and processes to be used in conjunction with the Expanded Access use in accordance with 21CFR Part 50.

Obtaining IRB review and approval of the Expanded Access request in accordance with the requirements of the type of Expanded Access use requested and 21 CFR Part 56.

Seeking informed consent from each prospective participant or the participant's legally authorized representative, in accordance with and to the extent required by 21 CFR 50, and appropriately documenting informed consent, in accordance with and to the extent required by 21 CFR 50.27.

Maintaining accurate case histories and drug disposition records.

Retaining records as required under 21 CFR Section 312.62.

IRB Responsibilities: For each type of Expanded Access Use, Emory IRB as the reviewing IRB must perform the following responsibilities:

Provide ***Full Board Review*** to determine if the use meets the criteria for approval under 21 CFR Part 56 and satisfies the criteria for the type of Expanded Access use requested. Generally, this review will be provided before the Expanded Access use; provided, however, that in the case of Emergency Use of a test article, this review can take place retroactively if patient care considerations make it impossible for the IRB to review the Emergency Use before it takes place.

Review the informed consent process to determine if it meets the requirements of 21 CFR Part 50, subject to the exception from general requirements for informed consent for the Emergency Use of a test article under 21 CFR Section 50.23.

A physician submitting an individual patient expanded access IND using Form FDA 3926 may select the appropriate box on that form to request authorization to obtain concurrence by the IRB chairperson or by a designated IRB member before the treatment use begins, in lieu of obtaining IRB review and approval at a convened IRB meeting at which a majority of the members are present.

Specific Criteria, Submission Requirements and Responsibilities that Must be Met for Each Particular Type of Expanded Access for Treatment Use:

In addition to meeting the above-specified general criteria, submission requirements and responsibilities for all types of Expanded Access, each type of Expanded Access has specific criteria that must be met. The specific criteria, submission requirements and responsibilities particular to each type of Expanded Access are described below.

INDIVIDUAL PATIENTS -- **Specific Criteria and Submission Requirements for Expanded Access for Treatment Use for Individual Patients:**

Specific Criteria for Individual Use:
The licensed physician who will make the use must provide the FDA with their determination that probable risk to the patient from the Investigational New Drug is not greater than the probable risk from the disease or condition.

The FDA must determine that the patient cannot obtain the drug under another IND or protocol.

Specific FDA Submission Requirements for Individual Use:

Apply for expanded access to an investigational drug under a single patient IND. Form FDA 3926 can be used by physicians when submitting requests for individual patient expanded access to investigational drugs, including in emergencies. This form is designed specifically for single patient IND requests. It can also be used for certain submissions to FDA after the initial application is filed. For more information, including instructions, see FDA Guidance Document: Individual Patient Expanded Access Applications: Form FDA 3926

Ask the medical product company for a Letter of Authorization (LOA), if applicable. A LOA from a company allows the physician submitting the single patient IND to satisfy some of the submission requirements by relying on information in the company's existing IND. It also authorizes FDA to refer to the company's IND when reviewing the single patient IND.

Complete the necessary paperwork and submit the request to FDA.

Obtain IRB review and approval, consistent with 21 CFR part 56. A physician submitting an individual patient expanded access IND using Form FDA 3926 may select the appropriate box on that form to request authorization to obtain concurrence by the IRB chairperson or by a designated IRB member before the treatment use begins, in lieu of obtaining IRB review and approval at a convened IRB meeting at which a majority of the members are present. Although Form FDA 1571 does not include a specific field for making such a request, a physician submitting an individual patient expanded access IND using Form FDA 1571 may include a separate request with the application.

Review the requirements for expanded access with the patient and obtain informed consent. Contact information for review divisions may be found on FDA's Web site.

Specific Investigator and Sponsor Responsibilities for Individual Use:

Investigator:
The Investigator must limit treatment to a single course of therapy for a specified duration unless the FDA expressly permits multiple courses of therapy or chronic therapy.

The licensed physician must provide the Sponsor with a written summary of the results of the Expanded Access use, including any adverse effects. Either the licensed physician or the Sponsor must provide a copy of this summary to the FDA.

Sponsor:
Upon FDA request, the Sponsor may be required to monitor a patient's Expanded Access Use.

Upon FDA request, the Sponsor may be required to submit an Expanded Access request for an intermediate-size patient population in cases in which a significant number of individual requests have been received.

Time When Treatment Can Begin Under a Request for Expanded Access for Individual Treatment:

For non-emergency situations, and after receiving Form FDA 3926 (i.e., the IND), the FDA will assign an individual IND number to the IND application and will either allow the treatment use to proceed or put the application on clinical hold. The IND will go into effect (i.e., treatment with the investigational drug may proceed) after FDA notifies the physician or, if no notification occurs, 30 days after FDA receives the completed Form FDA 3926. Generally, the FDA provides the sponsor with notification acknowledging the complete submission. If the treatment use is not allowed to proceed, FDA usually will notify the physician of this decision initially by telephone (or other rapid means of communication) and will follow up with a written letter that details the reasons for FDA's decision to place the IND on clinical hold.

EMERGENCY USE -- Specific Criteria and Submission Requirements for Expanded Access for Emergency Use for Individual Patients:

Specific Criteria for Emergency Use:

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

- The participant is in a life-threatening or severely debilitating situation.
- No standard acceptable treatment is available.
- There is not sufficient time to obtain IRB approval.
- The use is reported to the IRB within five working days.
- Any subsequent use of the test article is subject to IRB review.

There must be an emergency situation in which the patient requires treatment before a complete written submission for Expanded Access can be made to the FDA. In such cases, the FDA may immediately authorize the Emergency Use by telephone or email.

FDA authorization must occur before the Emergency Use can take place. To achieve this, the licensed physician requesting Emergency Use must request such use by telephone, facsimile, or email. The physician may choose to use Form FDA 3926 for the expanded access application. FDA contact information is as follows:

Biological Drug Products -- For investigational biological drug products evaluated by the Center for Biologics Evaluation and Research, during normal business hours, the request

should be made to the Office of Communication, Outreach and Development, Center for Biologics Evaluation and Research. Contact information can be found here.

Other Investigational Drugs -- For all other investigational drugs during normal business hours, the request should be directed to the Division of Drug Information, Center for Drug Evaluation and Research. Contact information can be found here. a. Please also refer to FDA guidance for more specific information.

All Drugs After Normal Business Hours -- After normal business hours, any request should be directed to the FDA Office of Crisis Management & Emergency Operations Center – After-Hours at phone number 301-796-8240, 866-300-4374, or email address emergency.operations@fda.hhs.gov.

Specific FDA Submission Requirements for Emergency Use:
The licensed physician who will perform the use or the sponsor requesting the Emergency Use must explain how the Emergency Use will meet the criteria specified above for individual treatment use and why there is insufficient time to provide the FDA with a written request for Expanded Access.

If the FDA grants its immediate authorization to proceed with the Expanded Access Emergency Use, then the physician performing the use must provide the FDA with a written Expanded Access submission (including the LOA if applies) within **15 working days** of the date on which the FDA gave its' authorization for the use. This written Expanded Access submission must meet all of the requirements for Expanded Access for treatment use for an individual patient, as described above.

Encrypted email must be used to send any communications with confidential patient information to the FDA. Emory encryption can be used by typing "(encrypt)" in the subject line of the email. Additionally, secure email between FDA and sponsors can be established for informal communications when confidential information may be included in the message (e.g., confidential patient information). Emory OIT has established an encrypted, secured email connection with the FDA to send emails containing PHI for the purposes of an expanded access request or IND/IDE communication. This only applies when sending emails from an email address with these domains: @emory.edu or @emoryhealthcare.org.

Specific IRB Submission Requirements for Emergency Use:
If possible, the physician who will be making the use at an Emory site should notify the Emory IRB that the Emergency Use will be made and obtain IRB approval in advance of the use. The PI should provide the Emory IRB with any information that the PI has provided to the FDA. In addition, the PI should advise the Emory IRB when FDA authorization is obtained.

The information provided by the physician shall be evaluated by IRB Full Board Review prospectively if possible, or retrospectively, if time does not permit evaluation before the Emergency Use must be made. A physician submitting an individual patient expanded access IND using Form FDA 3926 may select the appropriate box on that form to request authorization to obtain concurrence by the IRB chairperson or by a designated IRB

member before the treatment use begins, in lieu of obtaining IRB review and approval at a convened IRB meeting at which a majority of the members are present.

The IRB shall determine whether applicable Emergency Use requirements were met and, if necessary, whether the requirements for the Exception to Requirement to Obtain Informed Consent for the Use of an FDA-Regulated Item in Emergency Medical Care Situations have been met. This informed consent exception is described below and in the P&P chapter, *Informed Consent*.

Situations in Which There is no Time to Obtain IRB Prospective Review of an Emergency Use: If there is no time to obtain IRB prospective review of an Emergency Use and the physician undertakes the use after receiving immediate authorization from the FDA, then within **five working days** of the use, the physician must provide the IRB with notice of the use including:

Any information provided to the FDA to obtain verbal authorization.

Protocol that describes how drug was administered; dosage; frequency; mode of administration; monitoring measures; and data collected on response to be treatment.

Informed consent form used or information establishing that situation qualified for ***Emergency Use*** exception from informed consent. See section below entitled "Emergency Medical Care Exception – Exception to Requirement to Obtain Informed Consent for the Use of an FDA-Regulated Item in Emergency Medical Care Situations"

A copy of the written Form FDA 3926 that the physician provides to the FDA within 15 working days after the FDA's immediate authorization of the Emergency Use.

Specific Investigator and Sponsor Responsibilities for Emergency Use:

Sponsor Responsibilities:
Within 15 business days of the FDA's authorization of the Emergency Use, the licensed physician or sponsor making the Emergency Use request must submit a written Expanded Access submission that meets the criteria for Individual Treatment Use.

The licensed physician or sponsor making the request must fulfill any other responsibilities specified for an Individual Treatment Use.

Investigator Responsibilities:
The Investigator should evaluate the likelihood of a similar use of the drug occurring again at Emory, and if such a future use is likely, the Investigator should begin steps to obtain a new IND or amend an existing IND to cover use of the drug in the future. 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.

Time When Treatment Can Begin Under a Request for Expanded Access for Emergency Use: Treatment can begin for an Emergency Use at the time that the FDA reviewing official grants authorization to proceed.

Emergency Medical Care Exception – Exception to Requirement to Obtain Informed Consent for the Use of an FDA-Regulated Item in Emergency Medical Care Situations (See also the P&P chapter, *Informed Consent*, from which this Subsection is taken.): In certain emergency medical care situations, informed consent for the use of an item regulated by the FDA in a ***Human Subject*** does not need to be obtained by the ***Investigator*** who needs to use the FDA-regulated item, nor must the exception from the general requirement for informed consent be approved in advance by the Emory IRB, if the following criteria are met:

Certification: The ***Investigator*** and a licensed physician who is not participating in the medical care protocol must certify in writing that:

The ***Human Subject*** in which the FDA-regulated item is to be used is confronted by a life-threatening situation that necessitates the use of the item.

Informed consent cannot be obtained from the ***Human Subject*** because of an inability to communicate with or obtain legally effective informed consent from the ***Human Subject.***

There is not sufficient time to obtain informed consent from the ***Human Subject's Legally Authorized Representative.***

There is no available alternative method of FDA-approved or generally recognized therapy that provides an equal or greater likelihood of saving the ***Human Subject's*** life.

If the ***Investigator*** determines that the immediate use of the FDA-regulated item is necessary to preserve the ***Human Subject's*** life, and there *is* not enough time to obtain the written certification of the non-participating physician before the item must be used, then the ***Investigator*** may make their written certification and provide it to *a* non-participating physician for the completion of that physician's written review and evaluation within five (5) working days after the item is used.

Documentation Provided to Emory IRB: The written certification and/or review/evaluation by the ***Investigator*** and the non-participating physician must be provided to the Emory IRB before the use, if possible, and if not possible, then within five (5) working days after the use of the item/process. The Emory IRB shall review the documentation provided for compliance with applicable regulatory requirements at the same time that it reviews the Emergency Use. If the Emory IRB determines that the criteria for the exception are/were not met, then the Emory IRB shall notify the Investigator that the exception may not be used, or if use has already occurred, that the

use of the exception constitutes non-compliance with regulatory requirements, and the normal procedures for non-compliance shall be followed.

NOTE: ***HHS Regulations*** do not permit the initiation of ***Research*** activities involving ***Human Subjects*** without prior IRB review and approval, even in emergency situations. The IRB shall review all instances in which an Emergency Use occurs, to determine if the contemplated activity would fall within the definition of Human Subjects Research. The Emory IRB will not permit an Emergency Use that is initiated without prior IRB review and approval, to be considered to be Research; will prohibit the patient from being considered to be a ***Human Subject;*** and will prohibit data regarding the care from being included in any report of a prospective **Research** study.

Specific Criteria and Submission Requirements for Expanded Access for Treatment Use for Intermediate-size Patient Populations:

Specific Criteria for Expanded Access Use in Intermediate-Size Patient Populations:
The FDA must determine that:

The drug is being investigated in a controlled clinical trial under an IND designed to support a marketing application for the Expanded Access use OR all clinical trials of the drug have been completed; and

The sponsor is actively pursuing marketing approval of the drug for the Expanded Access use with due diligence; and

When the Expanded Access use is for a serious disease or condition, there is sufficient clinical evidence of safety and effectiveness to support the expanded access use. (This evidence will usually consist of data from Phase 3 trials, but could consist of compelling data from completed phase 2 trials.); or

When the Expanded Access use is for an immediately life-threatening disease or condition, the available scientific evidence, taken as a whole provides a reasonable basis to conclude that the Investigational New Drug may be effective for the Expanded Access use and would not expose patients to an unreasonable and significant risk of illness or injury. (This evidence would usually consist of data from Phase 3 or Phase 2 trials, but could be based on more preliminary clinical evidence).

Specific FDA Submission Requirements for Expanded Access Use in Intermediate-Size Patient Populations: The sponsor or the investigator making the Expanded Access request submission to the FDA, should provide the FDA with information and documentation to establish that both the General Criteria for all Expanded Access submissions and the Specific Criteria for use in Intermediate-Size Populations have been met.

Specific IRB Submission Requirements for Expanded Access Use in Intermediate-Size Patient Populations: The investigator who will be performing the use should provide the IRB with:

Copies of all information and materials submitted to the FDA.

The informed consent form and HIPAA Authorization to be used.

Documentation of FDA approval.

Specific Sponsor and Investigator Responsibilities for Intermediate-Size Patient Populations:

Sponsor Responsibilities*:*
Submit IND Safety Reports and an Annual IND report to the FDA. The FDA will review each Annual Report and determine whether it is appropriate to permit the Expanded Access Use to continue taking into consideration whether or not the drug is being actively developed and if so, whether the Expanded Access is interfering with that development, or if not, whether a clinical study of the Expanded Access use should be developed.

Monitoring the Expanded Access protocol to ensure that licensed physicians performing the use comply with the protocol and the applicable FDA regulations.

Investigator Responsibilities:
Adverse Event reports must be submitted to Sponsor and to the Emory IRB as usual.

Time When Treatment Can Begin Under a Request for Expanded Access for an Intermediate-Size Patient Population: Unless the FDA provides earlier notice of acceptance, an Expanded Access IND goes into effect 30 days after the FDA receives the IND. Treatment can begin after FDA acceptance and IRB approval. An Expanded Access protocol under an existing IND becomes effective at the time that it is submitted to the FDA for review and approved by the IRB

WIDESPREAD TREATMENT USE -- Specific Criteria and Submission Requirements for Expanded Access under a Treatment IND or Treatment Protocol:

Specific Criteria for Widespread Treatment Use Under a Treatment IND or Treatment Protocol:
The FDA may permit an Investigational Drug to be used for widespread treatment use if it determines that:

The drug is being investigated in a controlled clinical trial under an IND designed to support a marketing application for the Expanded Access use; OR

All clinical trials of the drug have been completed; AND

The sponsor is activity pursuing marketing approval of the drug for the Expanded Access Use with due diligence; AND

When the Expanded Access use is for a serious disease or condition, there is sufficient clinical evidence of safety and effectiveness to support the Expanded Access use (i.e., clinical data from phase 3 trials or compelling data from completed phase 2 trials); OR

When the Expanded Access use is for an immediately life-threatening disease or condition, the available scientific evidence, taken as a whole provides a reasonable basis to conclude that the Investigational Drug may be effective for the Expanded Access use and would not expose patient to unreasonable and significant risk of illness or injury (i.e.,

clinical data from phase 3 or phase 2 trials, or in some cases, more preliminary clinical evidence).

Specific FDA Submission Requirements for Widespread Treatment Use under a Treatment IND or Treatment Protocol:

The sponsor or the investigator making the Expanded Access request submission to the FDA, should provide the FDA with information and documentation to establish that both the General Criteria for all Expanded Access submissions and the Specific Criteria for widespread treatment use under a Treatment IND or Treatment Protocol have been met.

Specific IRB Submission Requirements for Widespread Treatment Use Under a Treatment IND or Treatment Protocol:

The investigator who will be performing the use should provide the IRB with:

Copies of all information and materials submitted to the FDA.

The informed consent form and HIPAA Authorization to be used.

Documentation of FDA approval.

Specific Sponsor and Investigator Responsibilities for Widespread Treatment Use Under a Treatment IND or Treatment Protocol:

Sponsor:
Submit IND Safety Reports and an Annual IND report to the FDA.

The sponsor must monitor the implement of the treatment protocol to ensure that the physicians implementing the use comply with the protocol and the applicable FDA regulations.

Investigator:

Adverse Event reports must be submitted to Sponsor and to the Emory IRB as usual.

Time When Treatment Can Begin Under a Request for Expanded Access for Widespread Treatment Use Under a Treatment IND or Treatment Protocol:

Treatment can begin 30 days after FDA receipt of the Treatment IND or Treatment Protocol or upon earlier notice from the FDA and receipt of IRB approval.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.24
21 CFR Part 56
21 CFR Part 312
FDA Guidance: Individual Patient Expanded Access Applications: Form FDA 3926, October 2017, No. FDA-2015-D-0268

FDA Guidance: Investigational New Drug Applications (INDs) – Determining Whether Human Research Studies Can be Conducted Without an IND, September 2013, No. FDA-2010-D-0503
FDA Guidance for Industry and FDA Staff: Humanitarian Device Exemption (HDE) Program, September 2019, No. FDA-2014-D-0223
FDA Draft Guidance: Expanded Access to Investigational Drugs for Treatment Use: Questions and Answers, November 2022, FDA-2013-D-0446

71 SPONSOR-INVESTIGATOR DRUG SAFETY REPORTING OBLIGATIONS

POLICY:

A PI who is serving as a ***Sponsor-Investigator*** for a ***Clinical Investigation*** being conducted under an FDA Investigational New Drug Application (IND), or for a bioavailability or bioequivalence study ("BA/BE Study") that is IND-exempt, must develop and implement appropriate processes for collecting, reviewing, analyzing and reporting to the FDA and other investigators any potential serious risks that qualify for reporting under the FDA's IND Safety Reporting regulations at 21 CFR Part 312 and 21 CFR Part 320. In addition, the ***Sponsor-Investigator*** must copy the Emory IRB on any such reports and include an analysis of whether the ***Sponsor-Investigator*** believes the event constitutes an ***Unanticipated Problem Involving Risks to Subjects or Others.***

DEFINITIONS APPLICABLE TO CLINICAL INVESTIGATIONS CONDUCTED BY A SPONSOR-INVESTIGATOR OR AN INVESTIGATOR UNDER A FDA IND, OR AN IND-EXEMPT BIOAVAILABILITY OR BIOEQUIVALENCE STUDY:

Adverse Event: any untoward medical occurrence associated with the use of a drug in humans, whether or not considered drug related.

Life-threatening Adverse Event or Life-threatening Suspected Adverse Reaction: an **Adverse Event** or **Suspected Adverse Reaction** is **Life-threatening** if in the view of the **Sponsor, Investigator** or **Sponsor-Investigator**, its occurrence places the subject at immediate risk of death. It does not include an **Adverse Event** or **Suspected Adverse Reaction** that had it occurred in a more severe form, might have caused death.

Reasonable Possibility: existence of evidence to suggest a causal relationship between the drug being investigated and the **Adverse Event** or **Adverse Reaction**. In the case of a **Suspected Adverse Reaction**, there is a lesser degree of certainty about causality.

Serious Adverse Event or Serious Suspected Adverse Reaction: An **Adverse Event** or **Suspected Adverse Reaction** is **Serious** if it results in death, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions, or a congenital anomaly/birth defect. Important medical events that may not result in death, be life-threatening or require hospitalization may be considered **Serious** when, based upon appropriate medical judgment, they may jeopardize the patient or subject and may require medical or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in inpatient hospitalization or the development of drug dependency or drug abuse.

Suspected Adverse Reaction: any **Adverse Event** for which there is a **Reasonable Possibility** that the drug caused the **Adverse Event**.

Unexpected Adverse Event or Unexpected Suspected Adverse Reaction: An **Adverse Event** or **Suspected Adverse Reaction** is **Unexpected** if it is not listed in the investigator brochure or is not listed at the specificity or severity that has been observed; or if an investigator brochure is not required or available, is not consistent with the risk information described in the general investigational plan or elsewhere in the current FDA application (including any amendments). **Unexpected** also refers to **Adverse Events** or **Suspected Adverse Reactions** that are mentioned in the investigator brochure as occurring with a class of drugs or as anticipated from the pharmacological properties of the drug but are not specifically mentioned as occurring with the particular drug under investigation.

PROCEDURES:

Information that a Sponsor-Investigator Must Regularly Collect and Promptly Review. The Sponsor-Investigator must develop and implement procedures to regularly collect and promptly review the following information about the drug being investigated:

- All reports of **Serious Adverse Events** that the Sponsor-Investigator generates or receives from other Investigators on the Clinical Investigation or BA/BE Study.

- All reports of non-**Serious Adverse Events** that the Sponsor-Investigator generates or receives from other Investigators on the Clinical Investigation or BA/BE Study.

- Information relative to the safety of the drug being investigated that is obtained or received from sources located both inside and outside of the United States, including, information from clinical or epidemiological investigations; animal studies; *in vitro* studies; published scientific literature; unpublished scientific papers; reports from non-United States regulatory authorities; and reports of non-United States foreign commercial marketing experience for drugs not marketed in the United States.

Sponsor-Investigator's Recording of Safety Information and Receipt of Safety Reports from Other Investigators on the Clinical Investigation:

- **Serious Adverse Events:** The Sponsor-Investigator must have a method and appropriate forms for the immediate recording of any **Serious Adverse Event**, whether or not considered drug related, including those listed in the protocol or investigator brochure. This report must include an assessment of whether there is a reasonable possibility that the drug caused the event. If there are other Investigators besides the Sponsor-Investigator, the Sponsor-Investigator must provide the Investigators with the appropriate reporting forms and train them on a process for immediately reporting any **Serious Adverse Event** to the Sponsor-Investigator.

    - **Study Endpoints that are Serious Adverse Events**: In the case of a study endpoint that also meets the definition of a **Serious Adverse Event**, the endpoint should be reported in accordance with protocol's endpoint reporting guidance UNLESS there is evidence suggesting a causal relationship between the drug and the endpoint, in which case, the event should be recorded by the Sponsor-Investigator or reported to the Sponsor-Investigator as a **Serious Adverse Event**.

•**Non-Serious Adverse Events**: The Sponsor-Investigator must have a method and appropriate forms for recording non-**Serious Adverse Events**. If there are other Investigators besides the Sponsor-Investigator, the Sponsor-Investigator must provide the Investigators with appropriate reporting forms, include in the protocol a timetable for reporting non-**Serious Adverse Events**, and train the Investigators on appropriate reporting.

Sponsor-Investigator Required Safety Reports to the FDA and to Other Investigators: The Sponsor-Investigator must report potential serious risks of the drug being investigated that are identified in clinical trials, *or in any other source*, to the FDA and to **all** Investigators who are receiving the drug being studied under the Sponsor-Investigator's IND *or under any other IND,* **within 15 calendar** days after the Sponsor-Investigator determines that the potential serious risk qualifies for reporting as one of the following events or findings:

•**Serious and Unexpected Adverse Reaction** for which there is evidence to suggest a causal relationship between the drug and **Adverse Event**. Reporting may include the following:

- A single occurrence of an event that is uncommon and known to be strongly associated with drug exposure.
- One or more occurrences of an event that is uncommon and is known to be strongly associated with exposure to the drug and is uncommon in the population being exposed to the drug.
- An aggregate analysis of specific events seen in clinical trials that indicates the events are occurring more frequently in the drug treated group than in a control group.

•Findings from other epidemiological studies, pooled analysis of multiple studies or clinical studies that suggest a significant risk in humans exposed to the drug. Studies may or may not be conducted under an IND, and they may be conducted by the Sponsor-Investigator or by another person or entity

•Findings form animal or in vitro testing that suggest a significant risk in humans exposed to the drug (e.g., mutagenicity, teratogenicity, carcinogenicity, significant organ toxicity at or near expected human exposure. Studies may be conducted by Sponsor-Investigator or by another person or entity.

•Increased rate of occurrence of **Serious Suspected Adverse** reactions that show a clinically important increase in the rate of a **Serious Suspected Adverse Reaction** over that listed in the protocol or investigator brochure.

•Study endpoints that constitute a **Serious and Unexpected Adverse Event** for which there is evidence suggesting a causal relationship between the drug being investigated. Study endpoints that fall within this category should be reported as a **Serious and Unexpected Suspected Adverse Reaction**. Study endpoints not falling into this category should be reported as required in the protocol.

In reviewing of the abovementioned events or findings, the Sponsor-Investigator should determine whether safety related changes are required in the protocol, informed consent, investigator brochure or other aspects of the clinical investigation's or BA/BE Study's conduct. Any necessary modifications should promptly be submitted to the IRB for review.

Special FDA Reporting Rule for Unexpected Fatal or Life-Threatening Suspected Adverse Reaction Reports: The Sponsor-Investigator must notify the FDA of any **Unexpected Fatal or Life-threatening Suspected Adverse Reaction** as soon as possible, but in no event later than 7 calendar days after the Sponsor initially receives information on the event.

Reporting Format: The Sponsor-Investigator should use FDA Form 3500A or a narrative format that contains the information set forth in that form for all aforementioned **Sponsor-Investigator Required Safety Reports to the FDA and to Other Investigators**; provided, however, that reports of overall findings or pooled analyses from other studies must be in a narrative format. If approved by FDA in advance, the Sponsor-Investigator may use an electronic reporting format. All reports must be labeled as "IND Safety Report" and must be sent to the review division in the Center for Drug Evaluation and Research (CDER) or the Center for Biologics Evaluation and Research (CBER) that has responsibility for the IND or study. If the FDA requests additional information after receiving a report, then the Sponsor-Investigator must provide that additional information within 15 calendar days after receiving the request. Form 3500A can be found on the FDA Website:
http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm

Reporting to Emory IRB: The ***Sponsor-Investigator*** should concurrently provide a copy of any **Sponsor-Investigator Required Safety Report sent to the FDA and to Other Investigators** to the Emory IRB and also provide the Emory IRB with a written analysis of whether ***Sponsor-Investigator*** believes the reported event constitutes an ***Unanticipated Problem Involving Risks to Subjects or Others***. For FDA-regulated trials, the ***Sponsor-Investigator*** should only classify events that meet the following criteria as constituting ***Unanticipated Problems Involving Risks to Subjects or Others***:

- A single occurrence of a ***Serious, Unexpected Adverse Event*** that is uncommon and strongly associated with drug exposure.

- A single occurrence, or a small number of occurrences, of a ***Serious, Unexpected Adverse Event*** that is not commonly associated with drug exposure, but is otherwise uncommon in the study population.

- Multiple occurrences of an ***Adverse Event*** that, based on aggregate analysis, is determined to be an unanticipated problem. Analysis should include a determination that the series of ***Adverse Events*** represents a signal that the ***Adverse Events*** were not just isolated occurrences and involve risk to human subjects.

- An ***Adverse Event*** 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.

- A ***Serious Adverse Event*** 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.

- Any other ***Adverse Event*** or safety finding (e.g., based on animal or epidemiologic data) that 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.

The Emory IRB will review all reports received from ***Sponsor-Investigators*** and make the final decision as to whether an event constitutes an ***Unanticipated Problem Involving Risks to Subjects or Others (UP)***. The Emory IRB will report those events if classified as ***UPs*** to appropriate government agencies and institutional officials in accordance with the process set forth in Emory IRB Policy and Procedure: Investigator Safety Information Reporting Obligations to IRB.

Follow-Up to Safety Reports and Other Safety Information Received by Sponsor-Investigator: The Sponsor-Investigator must promptly follow up and investigate all safety reports and other safety information that the Sponsor-Investigator receives. If a Sponsor-Investigator initially determined that that an Adverse Event was not reportable to the FDA and other investigators, but later investigation reveals that the Adverse Event should have been reported, then the Sponsor Investigator must make the report as soon as possible, but in no event later than 15 calendar days after determining the report should be made. In addition, the Sponsor-Investigator should provide the FDA and other investigators with a report labeled "Follow-up IND Safety Report" that sets forth any other relevant information received via investigation and follow-up. This Follow-up IND Safety Report should be provided as soon as the additional information is available.

Record-Keeping: The Sponsor-Investigator is responsible for keeping copies of all records and reports required under this Policy and Procedure as a part of study records.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 312, including 312.32
21 CFR Part 320, including 320.31
FDA Guidance for Industry and Investigators: Safety Reporting Requirements for INDs (Investigational New Drug Applications) and BA/BE (Bioavailability/Bioequivalence) Studies, December 2012, No. FDA-2010-D-0482
FDA Guidance for Clinical Investigators, Sponsors, and IRBs: Adverse Event Reporting to IRBs – Improving Human Subject Protection, January 2009, No. FDA-2007-D-0202

72 INVESTIGATOR SAFETY INFORMATION REPORTING OBLIGATIONS TO IRB

POLICY:

In order to appropriately evaluate on-going Research, the Emory IRB must receive from PIs and/or Sponsors information that may impact the risk/benefit analysis of ***Research***. Such information may include ***Unanticipated Problems Involving Risks to Subjects or Others***, ***Serious Adverse Events***, ***Serious Suspected Adverse Reactions*** and ***Unanticipated Adverse Device Effects*** and is collectively referred to in this Policy and Procedure as "Safety Information." The PI is responsible for making any Safety Information reports to the Emory IRB and/or forwarding to the Emory IRB any Safety Information reports received from a study ***Sponsor*** as required by the ***HHS, FDA*** and ***VA Regulations*** and Emory IRB Policies and Procedures. The Emory IRB will report ***Unanticipated Problems Involving Risks to Subjects or Others*** and to the FDA, OHRP and/or other regulatory agencies as required by applicable regulations and in accordance with the procedures and timetable set forth below. In addition, the Emory IRB will report ***Unanticipated Problems Involving Risks to Subjects or Others*** to appropriate institutional officials as described below.

DEFINITIONS: The following definitions apply to all subsections of this Policy and Procedure:

Adverse Event*:** Any untoward medical occurrence associated with the use of a test article in humans, including any abnormal sign, symptom or disease that is temporally associated with the subject's participation in the ***Research, whether or not considered related to the drug or device being studied in the ***Research*** (the "Test Article") or the subject's participation in the ***Research.*** For purposes of ***Research*** regulated by the FDA, this term encompasses the term "***Adverse Reaction"*** as used in 21 CFR Section 312.32 and the term "***Unanticipated Adverse Device Effect***" as defined in 21 CFR Section 812.3(s).

External Adverse Event or ***Unanticipated Problem Involving Risks to Subjects or Others***– An ***Adverse Event*** or an ***Unanticipated Problem Involving Risks to Subjects or Others*** experienced by subjects enrolled by investigators at sites other than Emory University sites.

Internal Adverse Event *or* ***Unanticipated Problem Involving Risks to Subjects or Others*** – An ***Adverse Event*** or an ***Unanticipated Problem Involving Risks to Subjects or Others*** experienced by subjects enrolled by investigators at Emory University sites or at site(s) for which the Emory IRB is the ***Reviewing IRB***, or at external site(s) under the oversight of an Emory Sponsor-Investigator.

Possibly Related*:** There is a ***Reasonable Possibility that an incident, experience or outcome may have been caused by the Test Article or a procedure involved in the ***Research***. ***Adverse Events*** that are determined to be at least partially caused by the Test Article or a procedure involved in the ***Research*** are considered to be related, or at least ***Possibly Related***, to the Test Article or participation in the ***Research***. ***Adverse Events*** are considered unrelated to the Test Article or participation in the ***Research*** if they are solely caused by the underlying disease, disorder, or condition of the subject,

or by other circumstances unrelated to the Test Article, ***Research,*** or the underlying disease, disorder, or condition.

Reasonable Possibility**:** Evidence exists to suggest a causal relationship between the Test Article being investigated and/or the ***Research*** procedures and an ***Adverse Event*** or ***Unanticipated Problem Involving Risks to Subjects or Others.***

Serious: An event that is life-threatening (i.e., places the participant at immediate risk of death from the event as it occurred) or results in death, inpatient hospitalization, prolongation of inpatient hospitalization, persistent or significant disability/incapacity or substantial disruption of the ability to conduct normal life functions, congenital anomaly/birth defect, or if based on appropriate medical judgment, the event may jeopardize the subject's health and may require medical or surgical intervention to prevent one of the foregoing outcomes.

Suspected Adverse Reaction: For FDA-regulated clinical investigations involving drugs or biologics, any ***Adverse Event*** for which there is a ***Reasonable Possibility*** that the drug caused the ***Adverse Event***.

***Unanticipated Problem Involving Risks to Subjects or Others* (*UPs*)**: Any incident, experience or outcome that meets all of the following criteria:

(a) It is ***Unexpected*** (in terms of nature, severity or frequency) given (i) the Test Article or ***Research*** procedures that are described in the protocol related documents, such as the IRB approved research protocol, informed consent documents and/or investigator's brochure; and (ii) the characteristics of the subject population being studied; and
(b) It is related or ***Possibly Related*** to participating in the ***Research***; and
(c) It places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

Unanticipated Adverse Device Effect**:** Any serious adverse effect on health or safety, or any life-threatening problem, or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or FDA application (including a supplementary plan or application), or any other ***Unexpected Serious*** problem associated with a device that relates to the rights, safety, or welfare of subjects.

Unexpected:

For Research Exclusively Regulated by the FDA: An event or reaction that is not listed in the investigator brochure or not listed at the specificity or severity that has been observed; or if an investigator brochure is not required or available, is not consistent with the risk information described in the general investigational plan or elsewhere in the current FDA application (including any amendments). ***Unexpected*** also refers to ***Adverse Events*** or ***Suspected Adverse Reactions*** that are mentioned in the investigator brochure as occurring with a class of drugs or as anticipated from the pharmacological properties of the drug, but are not specifically mentioned as occurring with the particular drug under investigation.

For Research Not Exclusively Regulated by the FDA: An event for which the nature, severity or frequency of the event is not consistent with either (a) the known or foreseeable risks associated with the Test Article or procedures involved in the ***Research*** that are described in the protocol-related documents; or (b) other relevant sources of information (e.g., product labeling); or (c) the expected natural progression of any underlying disease, disorder, or condition of the subject suffering the event and the subject's predisposing risk factor profile for the event.

For VA Research: The terms "unanticipated" and "unexpected" refer to an event or problem in VA research that is new or greater than previously known in terms of nature, severity, or frequency, given the procedures described in protocol-related documents and the characteristics of the study population

PROCEDURES

WHAT SAFETY INFORMATION NEEDS TO BE REPORTED?

The following types of Safety Information need to be reported to the Emory IRB, either promptly or at continuing review (see later in this section for guidance):

- ***Unanticipated Problems Involving Risks to Subjects or Others (UPs)***
- Some ***Serious Adverse Events*** or ***Serious Suspected Adverse Reactions*** that are not ***UPs***
- Some ***Unanticipated Adverse Device Effects***

Each category of Safety information and related reporting requirements, including time for reporting is described below. The requirements apply regardless of whether the events occur during the study, after study completion, or after participant withdrawal or completion.

Unanticipated Problems Involving Risks to Participants or Others (***UPs***)

PIs must promptly report to the IRB, through direct reporting or forwarding of a Sponsor's report, all potential ***UPs*** including ***Adverse Events*** that constitute ***UPs***. [Note: Not all ***Adverse Events*** constitute ***UPs,*** and there are ***UPs*** that may not be ***Adverse Events***.] Reports must be made using the forms and in accordance with the timetable set forth at the end of this subsection. The Emory IRB, in turn, shall review the submission and promptly report ***UPs*** to Emory and other entities per the P&P entitled *Reporting To Governmental Regulatory Authorities, Sponsors, And Institutional Personnel*

Types of *UPs*:

Adverse Events* that Constitute *UPs: ***Adverse Events*** that are considered to be ***UPs*** must be reported to the Emory IRB. In general, an ***Adverse Event*** observed during the conduct of a ***Research*** protocol should be considered to be a ***UP*** only if it meets all of the following criteria:(i) the ***Adverse Event*** is ***Unexpected***; (ii) the ***Adverse Event*** is ***Serious***; and (iii) the ***Adverse Event*** is related or possibly related to participating in the

Research. ***Serious*** and ***Unexpected Adverse Events*** have implications for the conduct of the study such as requiring modifications to the protocol or protocol-related documents and/or they place subjects at greater risk of harm than previously known, thus requiring re-evaluation of the risk/benefit ratio should always be considered to be related or possibly related to participating in the ***Research***. Other ***Adverse Events*** that are ***Unexpected*** and related or possibly related to participation in the research, but *not* serious, would also ***UPs*** if they suggest that the research places subjects or others at a greater risk of physical or psychological harm than was previously known or recognized. Again, such events routinely warrant consideration of substantive changes in the research protocol or informed consent process/document or other corrective actions in order to protect the safety, welfare, or rights of subjects or others.

Special Requirement for *Research* Regulated Exclusively by the FDA: In the case of ***Research*** regulated exclusively by the FDA, per FDA guidance, only the following ***Adverse Events*** should be considered to be ***UPs*** that should be reported to the Emory IRB:

- A single occurrence of a ***Serious, Unexpected Adverse Event*** that is uncommon and strongly associated with an exposure to the Test Article (such as angioedema, agranulocytosis, hepatic injury, or Stevens-Johnson Syndrome)
- A single or small number of occurrences, of a ***Serious***, ***Unexpected Adverse Event*** that is not commonly associated with Test Article exposure but is uncommon in the study population (e.g. tendon rupture, progressive multifocal leukoencephalopathy).
- Multiple occurrences of an ***Adverse Event*** that based on aggregate analysis is determined to be a ***UP*** based on determination that the series of ***Adverse Events*** were not just isolated occurrences, and they involve risk to participants (e.g. comparison of rates across treatment groups reveals higher rate in the drug treatment arm versus a control). Analysis supporting the determination should accompany the report.
- An ***Adverse Event*** that is described or addressed in the investigator's brochure, protocol or informed consent, but for which the rate of occurrence, specificity, or severity represents a clinically significant difference (e.g. investigator's brochure and consent list transaminase elevation, but hepatic necrosis is observed in study subjects). A discussion of the divergence from expected frequency or severity should accompany the report.
- Any other ***Adverse Event*** or safety finding, including a finding based on animal or epidemiologic data that 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 participants.

UPs* that are Not *Adverse Events*:** Some ***UPs may not constitute ***Adverse Events***. A ***UP*** that is not an ***Adverse Event*** should be reported to the Emory IRB if it is (a) ***Unexpected***; (b) ***Related*** or ***Possibly Related*** to the ***Research***; and (b) exposes ***Research*** participants, or individuals other than the ***Research*** participants (e.g., ***Investigators, Research***

assistants, students, the public, etc.), to potential risk of harm (including physical, psychological, economic or social harm) greater than previously known or recognized. For example:

- Information that indicates a change to the risks or potential benefits of the ***Research*** such as an interim analysis or safety monitoring report, or publication in the literature that indicates that frequency or magnitude of harms or benefits may be different than initially presented to the IRB.
- A publication from another study that shows that the risks or potential benefits of ***Research*** at issue may be different than initially presented to the Emory IRB.
- A breach of confidentiality.
- Complaint of a participant when the complaint indicates unexpected risks or cannot be resolved by the ***Research*** team.
- ***Sponsor-***imposed ***Suspension.***

WHO HAS THE RESPONSIBILITY FOR ANALYZING POTENTIAL UPS AND REPORTING TO THE EMORY IRB?

UPs* Occurring at Emory Sites and Emory Affiliated Sites:** PIs and ***Sponsor-Investigators at Emory should promptly report to the Emory IRB all ***Internal Adverse Events*** that constitute ***UPs*** **(**within 10 business days of the PI becoming aware of the event/report, unless the event was life-threatening or fatal, in which case reporting must be immediate). The report should include the ***PI's/Sponsor-Investigator's*** analysis as to why they believe that the event being reported constitutes a ***UP***. The Emory IRB will make the final determination as to whether a reported event constitutes a ***UP***, and if so, the Emory IRB will report the ***UP*** to the Institutional Official and Director of the Office of Ethics and Compliance, as well as to the FDA, OHRP and/or other regulatory authorities, as appropriate. In addition, the Emory IRB will review any proposed protocol modifications and/or make any determinations as to changes required to the ***Research.***

UPs* Occurring at Sites External to Emory in multisite *Research* for which an Emory PI Serves as *Sponsor-Investigator : The Emory ***Sponsor-Investigator*** is responsible for collecting and analyzing ***External Adverse Event*** reports and reports of other potential ***UPs*** from all study sites and promptly reporting any ***UPs*** to the Emory IRB (within 10 business days of the PI becoming aware of the event/report, unless the event was life-threatening or fatal, in which case reporting must be immediate). The Emory ***Sponsor-Investigator*** shall provide a report to the Emory IRB that designates any ***External Adverse Events*** that that the ***Sponsor-Investigator*** believes constitute ***UPs,*** as well as any other potential ***UPs*** that are not ***Adverse Events***. The Emory IRB will review the report and make a final determination as to whether a reported event constitutes a ***UP***, and if so, the Emory IRB will report the ***UP*** to the Institutional Official and the Director of the Office of Ethics and Compliance, as well as to the FDA, OHRP and/or other regulatory authorities, as appropriate. The Emory ***Sponsor-Investigator*** will include in the report a description of any suggested changes to the protocol and submit any necessary modifications for the Emory IRB's review. In addition to reporting to the IRB, the Emory ***Sponsor-Investigator*** also

shall be responsible for providing its report to all sites and investigators participating in the ***Research***.

UPs* Occurring at Sites External to Emory in *Research* for which a Non-Emory Affiliated Person/Entity is Serving as *Sponsor: The Emory IRB will rely on the ***Sponsor*** to process and analyze information regarding ***External Adverse Events*** and other potential ***UPs*** that occur at non-Emory sites at which the ***Research*** is being conducted. The ***Sponsor*** is expected to promptly provide to the PI a report analyzing ***External Adverse Events*** and other potential ***UPs*** from non-Emory sites. The report should designate ***UPs***, explain why an event constitutes a ***UP,*** and set forth any protocol changes or other action to be taken in response to the ***UP***. ***Sponsor*** IND and IDE-related safety reports should include such a ***UP*** analysis. On receipt, the PI will promptly submit any UP reports to the Emory IRB with a copy of any Safety Information report from the ***Sponsor*** (within 10 business days of the PI becoming aware of the event/report, unless the event was life-threatening or fatal, in which case reporting must be immediate). The Emory IRB will rely on the ***Sponsor's*** report and determinations as to whether particular events do/do not constitute ***UPs*** without the need for further analysis.

If the ***Sponsor***'s report does not contain an explicit ***UP*** determination, the PI will review the Sponsor's report on the external events and provide the Emory IRB with a report designating which, if any, reported external events constitute a ***UP***, explaining the designation, and setting forth any protocol changes or other action to be taken in response to the ***UP***. The Emory IRB will consider the analysis provided by the PI and either request a ***UP*** determination from the ***Sponsor*** as to a particular event or make its own determination.

If the ***Sponsor's*** report includes recommendations as to changes in the ***Research*** protocol, then, at a minimum, the Emory IRB shall ensure that such recommendations are implemented through appropriate processes; provided, however, that the IRB also may require changes to the ***Research*** protocol in addition to those recommended by the ***Sponsor***.

The Emory IRB shall rely upon the ***Sponsor*** and/or the IRB at the non-Emory site at which the ***UP*** occurred to carry out reporting of the ***UP*** to the FDA, OHRP and other appropriate regulatory agencies, as well as to investigators at non-Emory sites. The Emory IRB notifies the Director of the Office of Ethics and Compliance of UP determinations.

Data Safety Monitoring Board* (DSMB) Reports**: DSMB reports are often used as the primary means of collecting and tracking information on ***UPs obtained from other sites participating in multi-site studies, particularly as they relate to changes in risks that may require changes to the protocol or informed consent form. If UPs are reported in a DSMB report, the PI should provide the report promptly to the Emory IRB, along with a cover memo. This cover memo should indicate that the PI has reviewed the DSMB report and further state whether the information set forth in the DSMB report requires revision to the protocol or

to the informed consent form. If revision is suggested, then the appropriate protocol modification also should be submitted.

In addition to reporting individual ***UPs*** at the time of their occurrence, the total number of ***UPs,*** along with the types of events that occurred and their relationship to the study shall be provided to the Emory IRB in a summary report at the time of continuing renewal. See P&P entitled *Continuing Review*.

Special UP Reporting Requirements for AVAHCS Research: For VA studies, prompt reporting of ***UPs*** is defined as reporting within 5 business days of becoming aware of the event.

If a DSMB or committee is being used for the ***Research***, then all ***Serious Adverse Events*** and ***Unexpected Adverse Events*** must be reported to the DSMB or committee, which, in turn, must report a summary of its findings to the IRB. In addition, any other ***Adverse Events*** as defined by any safety monitoring plan for the protocol must be reported to the IRB as required per the plan.

Serious Adverse Events or Serious Suspected Adverse Reactions That Are Not UPs

At the time of renewal for the study, the PI should report to the Emory IRB a summary of any ***Serious Adverse Events*** or ***Serious Suspected Adverse Reactions*** (for studies involving drugs or biologics) occurring in the previous approval period at Emory or external sites for Emory Sponsor-Investigator studies that do not constitute ***UPs*** and for which there is a ***Reasonable Possibility*** that the Test Article or ***Research*** procedures caused the event or reaction; provided, however, that any life-threatening or fatal ***Serious Adverse Event*** or ***Serious Suspected Adverse Reaction*** should be reported to the IRB immediately. For minimal risk studies that do not require Continuing Review, no periodic reporting is required.

Unanticipated Adverse Device Effects

For FDA-regulated clinical investigations of devices, the Emory PI shall provide the Emory IRB and ***Sponsor*** with a report of an ***Unanticipated Adverse Device Effect*** occurring at an Emory site. An Emory ***Sponsor-Investigator*** shall provide the Emory IRB with a report of any ***Unanticipated Adverse Device Effect*** occurring at an Emory site or at an external site for which the Emory ***Sponsor-Investigator*** is serving as ***Sponsor***. Reports to the Emory IRB shall be made within 10 business days of the PI becoming aware of the event/report, unless the event was life-threatening or fatal, in which case reporting must be immediate. Using the process described above for determining whether an ***Adverse Event*** constitutes a ***UP***, the Emory PI/Emory ***Sponsor-Investigator*** shall analyze the ***Unanticipated Adverse Device Effect*** to determine if it constitutes a potential ***UP*** and include such analysis in their report, along with any recommended changes to the protocol. The Emory IRB shall perform a ***UP*** analysis and make any required reports as described above in the subsections entitled ***UPs* Occurring at Emory Sites** and ***UPs* Occurring at Sites External to Emory in *Research* for which a Non-Emory Affiliated Third Party is Serving as *Sponsor.*** The Emory IRB shall handle reports of ***Unanticipated Adverse Device Effects*** at non-Emory sites that are received from non-

Emory affiliated ***Sponsors*** in accordance with the process set forth above in ***UPs*** **Occurring at Sites External to Emory in *Research* for which a Non-Emory Affiliated Third Party is Serving as *Sponsor.***

Timetable for Safety Information Reporting to IRB: The PI should consult the table below to determine when particular types of Safety Information should be reported and the type of form that should be used for reporting. In the event that a contract or protocol specifies reporting criteria or timetables, the most stringent criteria/timetables should be followed.

EVENT	REPORTER	TIME FOR REPORT	FORM
UPs of All Types	PI (including PI's transmittal to Emory IRB of report received from Sponsor)	Within 10 business days after occurrence or receipt of report from Sponsor, unless life-threatening or fatal, in which case immediate reporting is required.	RNI form
Serious Adverse Events or ***Serious Suspected Adverse Reactions*** that are not ***UPs*** and for which there is a ***Reasonable Possibility**** that the Test Article and/or ***Research*** procedures caused the event or reaction. Applies to events that occurred at Emory and/or external site(s) of an Emory S-I study.	PI (including PI's transmittal to Emory IRB of report received from Sponsor)	At study renewal, unless life-threatening or fatal, in which case immediate reporting required.	Continuing Review Form for reports at study renewal. RNI for life-threatening or fatal events.
Unanticipated Adverse Device Effects	PI (including PI's transmittal to Emory IRB of report received from ***Sponsor***)	Report to Emory IRB within 10 business days after becoming aware of the event, unless life-threatening or fatal, in which case immediate reporting required.	RNI

Any events that were initially determined not to be associated with the Test Article or **Research procedures for which a **Reasonable Possibility** of association is subsequently determined, must be reported according to the criteria listed above. If the relationship of the event to the Test Article or **Research** procedure is unknown, the PI should report the event.*

Reporting Forms: PIs should use the forms specified in the table above for reporting events in accordance with this P&P. All events that should be reported at the renewal of the study should be included in a summary attached to the application that is filed with the Emory IRB for

continuing review/renewal of a ***Research*** protocol. Failure to include this information in the application may result in the protocol being ***Deferred.***

Reporting to *Sponsors*: PIs are responsible for reporting to ***Research Sponsors*** all events reported to the Emory IRB, as well as any other reports required per contractual agreement with the ***Sponsor*** or per FDA or ***HHS Regulations.*** The PI should follow the ***Sponsor's*** reporting procedures for making such reports. In the case of ***Sponsor-Investigators***, the PI assumes the responsibilities of both ***Sponsor*** and ***Investigator***.

Emory IRB Review of Reported Events

Appropriately trained IRB staff will initially assess each reported event, including any information and assessment provided by the sponsor. As appropriate, the information will be forwarded to the ***CoRe Team*** for further review and handling in accordance with the ***CoRe Team's*** standard operating procedures.

If the initial staff reviewer is unable to appropriately categorize the event, they will consult with the IRB Director, ***IRB Chair* or *Vice-Chair.***

The ***CoRe Team*** shall review all reports of ***Internal UPs*** and all potential ***External UPs*** for which the ***Sponsor*** has not made an explicit ***UP*** determination and make recommendations/determinations as to any ***IRB Committee*** review/actions that should take place in light of such reports in adherence with ***CoRe Team*** SOPs.

Special Requirement for IRB Review of Reported Events on AVAHCS Research: Within five business days after a report of a serious unanticipated problem involving risks to participants or others, or of a local unanticipated serious adverse event, the convened IRB or a qualified IRB member-reviewer must determine and document whether the reported incident was serious and unanticipated and related to the research.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108
21 CFR Part 312, including 312.32 and 312.64
21 CFR Part 812, including 812.150
45 CFR Part 46, including 46.103
FDA Guidance for Clinical Investigators, Sponsors, and IRBs: Adverse Event Reporting to IRBs – Improving Human Subject Protection, January 2009, No. FDA-2007-D-0202
FDA Guidance for Industry and Investigators: Safety Reporting Requirements for INDs (Investigational New Drug Applications) and BA/BE (Bioavailability/Bioequivalence) Studies, December 2012, No. FDA-2010-D-0482
OHRP Guidance: Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events, January 2007
VHA Directive 1058.01, 2020
VHA Directive Section 1200.05(2), 2021

73 REPORTING TO EMORY IRB OF PROTOCOL DEVIATIONS/PROTOCOL NON-COMPLIANCE; NON-COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, OR IRB POLICIES AND PROCEDURES; AND REPORTS REQUIRED BY PROTOCOL OR CONTRACT

POLICY

PIs should report to the Emory IRB protocol deviations and/or protocol non-compliance, except for ***Minor Protocol Deviations/Protocol Non-Compliance***.

A ***Minor Protocol Deviation/Protocol Non-Compliance*** does not require reporting to the Emory IRB for review unless:

Reporting is required by the ***Research*** protocol
Reporting is required by the ***Research Sponsor*** or by the protocol or agreement governing the conduct of the ***Research***

PIs also should report to the Emory IRB any failure to follow applicable laws, regulations, or Emory IRB Policies and Procedures, as well as making any reports to the Emory IRB required by applicable protocols or contracts.

Report timeline and reporting forms are described in the table at the end of this Policy and Procedure.

Investigators from institutions relying on Emory IRB for a particular protocol must also follow this policy.

PROCEDURES

Protocol Deviations/Protocol Non-Compliance -- The PI shall review any instance of a deviation from a ***Research*** protocol that has not been approved in advance by the Emory IRB or non-compliance with a ***Research*** protocol to determine if the protocol deviation/protocol non-compliance meets any of the following criteria:

(a) Adversely affects the rights, welfare, or safety of subjects.
(b) Adversely affects the integrity of the ***Research*** data.
(c) Adversely affects the subject's willingness to continue participation in the ***Research***.
(d) Concerns study documentation associated with an FDA-regulated study.
(e) Was a protocol deviation undertaken to prevent an immediate hazard to a ***Human Subject***.

If the PI determines that any of the aforementioned criteria listed under (a) through (e) are met, then the PI shall report the protocol deviation/protocol non-compliance to the Emory IRB.

If the PI determines that none of the aforementioned criteria listed under (a) through (e) are met, then the PI may consider the protocol deviation/protocol non-compliance to be a ***Minor Protocol Deviation/Protocol Non-Compliance*** and reporting of the matter to the Emory IRB is not required, unless mandated by ***Research Sponsor***, protocol or contract. The PI should

document in the ***Research*** record their review of the protocol deviation/protocol non-compliance and reasons for determining that it constitutes a ***Minor Protocol Deviation/Protocol Non-Compliance.***

Minor Protocol Deviations/Protocol Non-Compliance noted during a ***Human Research Protections Program*** (***HRPP***) record review or audit will be recorded in an appropriate review/audit database, and this information may be accessed by units responsible for oversight of the ***HRPP*** for appropriate tracking/trending and referral to the Emory IRB or other HRPP oversight unit for any appropriate action. Several instances of ***Minor Protocol Deviations/Protocol Non-Compliance*** may constitute a reportable event.

Non-Compliance with Applicable Laws, Regulations, and/or Emory IRB Policies and Procedures: The PI shall notify the Emory IRB of any instance of failure to follow applicable laws, regulations, or Emory IRB Policies and Procedures of which the PI becomes aware. The Emory IRB will work with the PI to develop a reasonable corrective and preventative action plan to address the non-compliance.

Reports Required by Protocol or Contract: The PI should carefully review the terms of the ***Research*** protocol and any contract governing the ***Research*** (e.g., contract with ***Sponsor*** for the conduct of a clinical trial) to determine what matters those documents require to be reported to the IRB and/or to the ***Sponsor***. The PI should adhere to these reporting requirements, including any specified reporting timelines or forms.

Timetable for Reporting and Applicable Reporting Forms

EVENT	REPORTABLE TO EMORY IRB	TIME TO REPORT TO EMORY IRB	REPORTING TO SPONSOR	EMORY IRB REPORTING FORM
Protocol Deviation/ Protocol Non-Compliance	Yes	Within 10 business days of the date of occurrence	Follow protocol, contract, or sponsor directions	Protocol Deviation Form
Minor Protocol Deviation/Protocol Non-Compliance	No, unless required by Sponsor, protocol, or contract	Follow timeline prescribed by Sponsor, protocol, or contract	Follow protocol, contract, or sponsor directions	Protocol Deviation Form
Non-Compliance with Applicable Laws, Regulations and/or Emory IRB Policies and Procedures	Yes	Within 10 business days after becoming aware of noncompliance	Follow protocol, contract, or sponsor directions	Protocol Deviation Form
Reports Required by Protocol or Contract	Yes, as required by protocol/contract	Follow timetable in protocol/contract	Follow protocol, contract, or sponsor directions	Protocol Deviation Form

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.108
45 CFR Part 46, including 46.103

74 HIPAA AND OTHER APPLICABLE PRIVACY LAWS AND POLICIES

POLICY:

The Emory IRB shall serve as the Emory University's ***Institutional Privacy Board*** for purposes of compliance with all applicable requirements of the ***Health Insurance Portability and Accountability Act*** (HIPAA), and for other institutions upon mutual agreement. The Emory IRB is established in accordance with, and meets the membership and other requirements of, ***HHS and FDA Regulations***, and any other applicable federal regulations. The Emory IRB performs the functions of a privacy board pursuant to 45 CFR Section 164.512.

The Emory IRB has the authority to determine whether a ***HIPAA Authorization*** is required; to determine to what extent the ***Researcher*** may have access to, use or disclose health information regarding subjects; and/or to determine whether to grant a ***Waiver of HIPAA Authorization***. The IRB will not grant a ***Waiver of HIPAA Authorization*** or permit access to PHI for review until adequate information to assess whether the access and/or use meets the criteria for waiver is obtained.

In general, HIPAA requirements will apply to ***Research*** conducted by a ***Workforce*** member of a ***Covered Component*** of Emory University's ***Hybrid Covered Entity*** when that ***Research*** involves treatment for which ***Payment*** is collected by or on behalf of the ***Covered Component*** or ***Hybrid Covered Entity*** using ***HIPAA-Covered Billing***.

A Researcher who has a ***Research*** protocol that falls under the jurisdiction of the Emory IRB and that seeks to use PHI of living individuals that belongs to:

- a Covered Component of the Emory University Hybrid Covered Entity,
- the Emory Healthcare Affiliated Covered Entity, or
- another Covered Entity/Component

must have an Authorization, or a Waiver of Authorization approved by the Emory IRB (or other IRB or privacy board designated by Emory) before accessing such PHI, unless the access to such PHI is granted as being preparatory to Research pursuant to Emory University HIPAA Privacy Rule Policy D.16, *HIPAA Policy Regarding Preparatory to Research Pathway for Accessing PHI*.

Where Emory is serving as the ***Reviewing IRB*** for a ***Multi-Site Research***, Emory may serve as the Privacy Board for ***Relying Parties*** depending upon the language of the ***Reliance Agreement*** negotiated. Even when Emory is not serving as the Privacy Board, Emory IRB may agree that the ***Relying Party's*** requested HIPAA authorization language be included in the ***Relying Party's*** HIPAA authorization document (whether stand-alone or incorporated into the informed consent document) as part of its review. However, the ***Relying Party*** will be responsible for its performance of all other applicable HIPAA obligations.

Under HIPAA, PHI has one or more of the following identifiers associated with it:

1. Names;
2. All geographical subdivisions smaller than a State, including street address, city,

county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census:

(1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/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 (note this does not mean the unique code assigned by the investigator to code the data)

Other Applicable Privacy Laws: In some cases, privacy laws other than HIPAA may apply to data used for Human Subjects Research (e.g., the Family Educational Rights and Privacy Act may apply to research using educational records; or Georgia state law's concept of "privilege" regarding genetic information). Emory or other institutional policies (e.g., the policy on Sensitive Information) as well as policies of funding agencies (e.g., NIH policies concerning Certificates of Confidentiality) may apply. In such cases, the IRB shall follow the requirements of applicable laws and policies regarding acquisition, use, and disclosure of data covered by those laws and policies.

PROCEDURES:

Determinations:

For each Research protocol that it considers, the Emory IRB will make the following determinations:

a. whether the protocol includes as Research personnel researchers who are Workforce members of one of the Emory University Hybrid Covered Entity's Covered Components as listed in Emory University HIPAA Privacy Rule Policy D.14; and, if so,

b. whether the Research includes Treatment for which a Covered Component is collecting Payment using HIPAA-Covered Billing, in which case the Research will be considered to take place within the Covered Component and be subject to HIPAA;

OR, alternatively,

c. whether the protocol is being conducted in a non-Emory Covered Entity for which the Emory IRB is performing the role of a privacy board.

AND, in all of the foregoing cases

d. Whether an Authorization is required, or whether the Research meets the standards for the grant of a Waiver of Authorization

If the IRB determines that the Research does not include Treatment for which Payment is collected using HIPAA-Covered Billing, then the Research shall be considered as taking place outside of the Covered Component. Thus, any Identifiable Health Information (IHI) collected as a part of the Research shall not be considered to be PHI or be subject to HIPAA requirements when held by the Researcher in a separate Research record. However, if IHI is placed by the Researcher in a medical record or other Designated Record Set maintained by a Covered Entity/Component, then that information shall be considered to belong to the Covered Entity/Component and shall be subject to HIPAA Requirements when held by the Covered Entity/Component.

Research* to be Reviewed for Compliance with *HIPAA Regulations: Any ***Research*** that is subject to the jurisdiction of the Emory IRB shall be reviewed to determine if the ***HIPAA Regulations*** apply, and, if applicable, to ensure compliance with the ***HIPAA Regulations***. In addition, the Emory IRB shall review any request for the use or disclosure of PHI for ***Research*** purposes, and any and all requests involving the use of Emory University's non-public information to identify or contact ***Human Subjects*** or prospective ***Human Subjects.***

Standard of Review: In reviewing any ***Research*** matters involving the use or disclosure PHI, the IRB will make a determination as to whether the use or disclosure requires (a) ***Authorization*** by the ***Research*** participant or their ***Legally Authorized Representative***; or (b) the grant of a partial or complete alteration or ***Waiver of HIPAA Authorization*** requirement.

Review Process:

In reviewing a request for the Use or Disclosure of PHI for Research, the Emory IRB will follow its policies and applicable law in applying appropriate review procedures (e.g., full board or expedited review). An expedited review procedure may be used only if the Research involves no more than minimal risk to the privacy of the Individuals who are the subject of the PHI for which Use or Disclosure is sought. Any expedited review must be carried out by the Chair of the IRB, or one or more members of the IRB designated by the Chair. If a full board review process is used the review will take place at a convened meeting of the IRB that meets the requirements of ***HHS and FDA Regulations***.

***Determination of Whether the Protocol is Being Conducted in a Non-Emory Covered Entity*:** When performing the role of a privacy board for a non-Emory entity, the Emory IRB will review the list of research sites along with any reliance arrangements in place for the study to

determine if the protocol is being conducted in a non-Emory Covered Entity. If the IRB determines that the Research is being conducted in a Covered Entity (or Covered Component of a Hybrid Covered Entity) then, any Identifiable Health Information collected as a part of the Research shall be considered to be PHI and shall be subject to all HIPAA requirements when held by the Covered Component.

Determination of Whether an Authorization or Waiver of Authorization is Required:
If a Researcher wants to obtain PHI maintained within a Covered Entity or Covered Component (e.g., collect data from medical records for a retrospective study), then the IRB will require the Researcher to have an Authorization from the study participant, or a Waiver of Authorization.

Documentation to be Submitted to IRB for HIPAA Review: In general, if a ***Researcher*** who works for a unit that is a part of an ***Emory University Covered Component***, or who wants to receive PHI from a unit that is an ***Emory University Covered Component***, they must either submit a ***HIPAA Authorization*** form to the IRB for review, or submit an application for a ***Waiver of HIPAA Authorization*** for IRB consideration, or provide information that substantiates why another provision of the HIPAA regulations will permit use or disclosure of the PHI (e.g. subjects are decedents, or the data is a Limited Data Set with Data Use Agreement).

HIPAA Authorizations for Research: The Emory IRB will post on its website for use by ***Researchers*** template language to be used for ***HIPAA Authorization***. ***Researchers*** are advised to use this template language. In evaluating any ***HIPAA Authorization*** language that is submitted for review, the IRB will review the ***HIPAA Authorization*** to make sure that it meets each of the following criteria, unless a waiver or alteration of some or all of the requirements of the Authorization is granted by the IRB:

> The form is written in plain language and states that the person who signs the form will be provided with a copy of the signed document and that the ***Researcher*** and the ***Emory University Covered Component*** that provides any PHI to the ***Researcher*** also will retain a copy of the document as required by HIPAA.
>
> A description of the PHI to be used or disclosed that identifies the information in a specific and meaningful fashion.
>
> The name or other specific identification of the person(s) or class of persons, authorized to make the requested use or disclosure.
>
> The name or other specific identification of the person(s), or class of persons, to whom the PHI will be disclosed or by whom it will be used.
>
> A description of each purpose of the requested use or disclosure; provided, however, that as of January 25, 2013, the description of purpose no longer needs to be study specific. The ***Authorization*** must include a description of each purpose of the requested use or disclosure of PHI, including a description of any use or disclosure for future ***Research*** purposes. The description of the future ***Research*** purposes must provide reasonable notice to the individual that would cause them to expect that their PHI will be used or disclosed for the described future ***Research*** purposes.

An expiration date or expiration event that relates to the person whose PHI is requested, or the purpose of the use or disclosure of the PHI. Note: The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of PHI for ***Research***, including for the creation and maintenance of a ***Research*** database or ***Research*** repository.

The signature of the individual study subject and date, or if the ***HIPAA Authorization*** is to be signed by a legally authorized representative of the individual, the representative's signature along with a statement of the representative's authority to act for such individual (e.g., parent, legal guardian, etc.).

A statement of the individual study subject's right to revoke the ***HIPAA Authorization*** *in writing* along with a description of how the study subject may revoke the ***Authorization*** and the IRB-approved and/or HIPAA permitted exceptions to the right to revoke.

A statement that the Covered Component/Covered Entity Health Care Provider may condition the provision of Research-related Treatment on provision of an Authorization for the Use or Disclosure of PHI for such Research, along with a statement of the consequences to an Individual for refusing to sign an Authorization in such circumstances.

A statement of the potential for information disclosed pursuant to the ***HIPAA Authorization*** to be re-disclosed by the person(s) who receive the information and who are not covered by HIPAA, thus rendering the information unprotected by HIPAA requirements.

Criteria for *Waiver of HIPAA Authorization*: In certain circumstances, the Emory IRB may grant a complete or partial ***Waiver of HIPAA Authorization*** requirement and permit a ***Researcher*** working in or receiving information from a unit that is a part of an ***Emory University Covered Component*** to access PHI without a subject's written ***HIPAA Authorization***. The IRB will not grant an alteration or ***Waiver of HIPAA Authorization***, in whole or in part, unless the ***Researcher*** has submitted, as part of the IRB application, information that establishes that the following waiver/alteration criteria are met. Explanations as to how each of these elements is met MUST be included in the application:

The use or disclosure of PHI involves no more than minimal risk to the subject based on the presence of at least the following elements:

An adequate plan to protect the identifiers from improper use and disclosure;

An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the ***Research***, unless there is a health or ***Research*** justification for retaining the identifiers, or such retention is otherwise required by law;

Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity, except as required by law for

authorized oversight of the ***Research***, or for other ***Research*** for which the use or disclosure of PHI is permitted under the ***HIPAA Regulations*** (e.g., certain ***Research*** conducted by governmental public health agencies).

The alteration or waiver will not adversely affect the privacy rights and the welfare of the individuals;

The ***Research*** could not practicably be conducted without the alteration or waiver;

The ***Research*** could not practicably be conducted without access to and use of the PHI; and

The privacy risks to persons whose PHI is to be used or disclosed are reasonable in relation to the anticipated benefits if any to these persons, and the importance of the knowledge that may reasonably be expected to result from the ***Research***.

Documentation of the Grant of an Alteration or Waiver of the HIPAA Authorization Requirement: If the IRB determines that a request for an alteration or waiver, in whole or in part, of the ***HIPAA Authorization*** requirement meets the foregoing waiver/alteration criteria then it may grant the alteration or waiver and provide the **Researcher** with documentation of the approval. The primary Researcher is responsible for providing a copy of this documentation to the appropriate unit or person within that unit that is a part of an ***Emory University Covered Component*** that will be providing any PHI for the ***Research***, and a copy of the documentation also will be placed in the protocol file. The documentation provided by the IRB must include the following elements:

A statement identifying the IRB and the date on which the grant of the alteration or waiver of the ***HIPAA Authorization*** requirement occurred;

A statement that the foregoing waiver criteria have been satisfied;

A brief statement identifying whether the request for alteration or waiver was reviewed under convened IRB review procedures or expedited review procedures;

A brief description of the PHI for which use or access has been determined to be necessary by the IRB, subject to the Minimum Necessary Rule (see below); and

The signature of the ***IRB Chair***, or another member of the IRB as designated by the ***Chair***.

Partial HIPAA Authorization Waivers: The IRB may grant a partial ***Waiver of HIPAA Authorization*** to allow access to PHI for the purpose of identifying potential subjects prior to subject enrollment. Once a potential subject has been identified, no further PHI may be

reviewed or collected until the subject gives ***HIPAA Authorization*** at the time they decides to participate in the study.

Compound Authorizations: As of January 25, 2013, some compound ***Authorizations*** that combine certain conditioned and unconditioned ***Authorizations*** for ***Research*** are permitted.

> A "conditioned ***Authorization***" is an ***Authorization*** that conditions the provision of treatment, payment, enrollment in a health plan or eligibility for benefits (e.g., obtaining a ***Research***-only treatment in the context of a clinical trial) upon signing the ***Authorization*** to permit certain uses and disclosures of PHI (e.g., disclosure of the PHI to the ***Sponsor*** of the clinical trial).
>
> A "compound ***Authorization***" is one that combines ***Authorization*** of the use or disclosure of PHI for the conditioned purpose (e.g., receiving ***Research*** only treatment in the context of a clinical trial) with use or disclosure of PHI for a separate purpose (e.g., optional biospecimen banking) that is not required to obtain the conditioned treatment, payment, enrollment or eligibility.
>
> The ***Authorization*** for the use or disclosure of PHI for a ***Research*** study may be combined with any other type of written permission for the same or another ***Research*** study provided that the following requirements are met:
>
> (a) the ***Authorization*** must clearly differentiate between the conditioned and unconditioned components;
> (b) the ***Authorization*** must provide the individual with an opportunity to affirmatively opt-in to the ***Research*** activities that are described in the unconditioned component; and
> (c) an ***Authorization*** for the use or disclosure of Psychotherapy Notes can only be combined with another ***Authorization*** for the use and disclosure of ***Psychotherapy Notes***.

Prohibition on Sale of PHI: As of January 25, 2013, the sale of PHI (including PHI contained in a Limited Data Set) by a Covered Entity of a Covered Component for research or public health purposes is prohibited; provided, however, that a Covered Entity or Covered Component may receive a reasonable cost-based fee that covers that cost of preparing and transmitting PHI for research or public health purposes. Limited Data Set and Data Use Agreements entered into prior to January 24, 2013 that provided for disclosure of a Limited Data Set in exchange for remuneration in excess of a fee that covers the cost of preparing and transmitting the PHI may remain in effect until the earlier of the date of renewal, modification or September 22, 2014.

Researchers who are granted a ***Waiver of HIPAA Authorization*** requirement should sign, and have all ***Research*** staff members who will have access to PHI sign, confidentiality agreements.

Minimum Necessary Rule: In determining the type and scope of the PHI for which the IRB determines use or access under a waiver or alteration of the HIPAA Authorization requirement is necessary, the IRB must limit access to only that PHI which is reasonably necessary to accomplish the purpose for which the request is made. For example, if the ***Research*** requires access only to certain test results in order to accomplish the purpose of the ***Research***, the IRB

should deny a request by the researcher for access to the entire medical record. If an ***Emory Covered Component*** is disclosing the PHI, it may rely on a researcher's documentation or representations that the information being requested is the minimum necessary PHI if the documentation/representations have been reviewed by the IRB and reliance is reasonable under the circumstances.

Accounting Rule: If a researcher who is a part of the ***Emory Covered Component*** obtains PHI for ***Research*** purposes pursuant to a waiver of the HIPAA authorization requirement, then the researcher must account for any subsequent disclosure that is made of the PHI. Records of disclosure should be maintained for six years after the disclosure occurs. A ***Human Subject*** may request the ***Researcher*** to provide them with an accounting of the persons to whom and purposes for which their PHI was disclosed.

Acceptable Method of Accounting for Disclosure of PHI for Particular Research Purposes: If an ***Emory University Covered Component***, or employee thereof, makes a disclosure of PHI to a ***Researcher*** for a particular ***Research*** purpose and the disclosure involves the PHI of 50 or more people (e.g., a disclosure of certain medical information from the records of 50 or more people to a ***Researcher*** for screening for subjects for a specific ***Research*** protocol), then the ***Emory University Covered Component***/employee must keep an individual record showing the specific ***Research*** protocol or activity to which an Individual's PHI was disclosed **OR** it may use the following more general method of accounting for such disclosures:

> **List of Elements in Disclosure:** For each of disclosure within this category, keep a record of: (1) the name of the ***Research*** protocol or other ***Research*** activity for which the disclosure was made; (2) a description, in plain language, of the ***Research*** protocol or activity, including the purpose of the protocol and the criteria for selecting certain records; (3) a description of the PHI that was disclosed; (4) the period when the disclosures were made, including the date of the last disclosure made within this period; (5) the name, address and telephone number of the entity that sponsored the ***Research*** and or the *Researcher* to whom the information was disclosed; and (6) a statement that the PHI of the Individual who is requesting the accounting may or may not have been disclosed for a particular protocol or ***Research*** activity.
>
> **Provision of List of Protocols Upon Request:** If the general method of accounting is employed, then each individual who requests an accounting of the disclosure of their PHI in accordance with applicable ***HIPAA Regulations*** and Emory University HIPAA policies shall be provided with a list of all ***Research*** protocols at Emory for which the PHI of 50 or more people was disclosed. This list shall contain all of the elements set forth above in the subsection entitled *List of Elements in Disclosure*. In addition to providing this list of protocols (if any), the ***Emory University Covered Component***/employee also shall provide the individual making the request with an accounting of any other non-***Research*** related disclosures of that individual's PHI or ***Research*** disclosures for fewer than 50 people, as required by applicable ***HIPAA Regulations***.
>
> **Additional Assistance:** If the ***Emory University Covered Component***/employee provides its accounting of disclosures for ***Research*** protocols in the format described

above (i.e., providing a list of ***Research*** protocols to which an individual's PHI *might have been disclosed*, instead of providing a list of those protocols to which it *actually was disclosed*), then if it is reasonably likely that the individual's PHI was disclosed to a particular protocol or activity, the ***Emory University Covered Component***/employee must, upon the individual's request, assist the individual in contacting the ***Research Sponsor*** and ***Researcher*** involved in the protocol.

Right to Revoke HIPAA Authorization: Under HIPAA, unless the Authorization states otherwise, HIPAA requires a subject to revoke their Authorization in writing in order to revoke the subsequent use or disclosure of their PHI. The Authorization is required to state that Research subject has the right to make a revocation of the Authorization in writing.

NOTE: Even though an Authorization form may specify that the revocation of Authorization is to be in writing, if a verbal revocation is received, or if the participant verbally withdraws from the study, then the best practice is that the Researcher should not access any further PHI of the participant from that point on.

For studies conducted at the **AVAHCS**, the revocation must be in writing. An oral discussion between the subject and member of the research team does not revoke a HIPAA authorization. If the intent of the subject is to revoke, the ***Principal Investigator*** must provide a revocation form to the subject or request the subject's revocation in writing. A revocation can be on any document.

Revocation of a Compound *Authorization*: Where it is clear from the ***Research*** subject's written revocation that only one part of a compound ***Authorization*** is being revoked, then the remainder of the ***Authorization*** may remain in effect. If the written revocation is not clear, however, then written clarification must be obtained from the ***Research*** subject as to which ***Research*** activities are in included in the revocation. If clarification is not forthcoming, then the revocation shall apply to all ***Research*** activities set forth in the compound ***Authorization***.

Use of PHI After Withdrawal from Participation in a Study.

Withdrawal by Means Other than Writing. If the ***Authorization*** specified that revocation of ***Authorization*** was to be in writing, and a subject withdraws from participation in a ***Research*** study by any means other than in writing, then, when ***Authorized*** by the IRB, PHI that has been collected for approved ***Research*** purposes *may be* included in data analysis and study results, unless otherwise stated in the informed consent form/***Authorization.***

NOTE: The most cautious approach with regard to such data, however, is to refrain from any further use or disclosure of the PHI except as is permitted in the sub-section immediately below.

Withdrawal In Writing. Once a subject withdraws their ***Authorization*** in writing then no further use or disclosure of the subject's PHI is permitted except to the extent that the ***Emory University Covered Component*** has taken action in reliance on the original ***Authorization*** or as is otherwise permitted as an exception to revocation under HIPAA that was set forth in the ***Authorization.*** For example, if data was already collected in

reliance on the ***Authorization***, enough of the data can be disclosed to a study ***Sponsor*** to advise the ***Sponsor*** of the subject's revocation/withdrawal, and any data that was submitted to the ***Sponsor*** prior to the revocation does not have to be retrieved. In addition, data that was collected prior to the revocation may be submitted to a study ***Sponsor*** if the submittal is necessary to preserve the integrity of the study.

Transition Period Provisions. PHI that was created or received before or after HIPAA's compliance effective date of April 14, 2003 may be used for the ***Research*** purposes for which it was obtained, if the PHI was obtained pursuant to one of the following means, and then, only to the extent allowed by the means by which it was obtained:

An ***Authorization*** or other express legal permission from an Individual to use or disclose PHI for the ***Research***.

The informed consent of the Individual to participate in the ***Research.***

A waiver by the IRB of informed consent for the ***Research***; provided, however, that if informed consent is sought from an Individual after the HIPAA effective compliance date, then an ***Authorization*** must be sought and obtained as well.

Additionally, HIPAA authorizations and waivers of informed consent and authorization obtained prior to January 25, 2013, shall remain effective.

De-Identified Data, Limited Data Sets and Research Using Decedent's Information: Emory University's requirements for the ***Research*** use of use of De-Identified Data, Limited Data Sets and Decedent's Information are described in Emory University's HIPAA policies, Sections C.4. and C.5 at http://compliance.emory.edu/hipaa/HIPAA-policies.html.

Other Applicable Privacy Laws: In the event that the research data used is governed by laws other than HIPAA, the IRB shall seek the advice of the Office of General Counsel with regard to legal requirements regarding the acquisition, disclosure and use of the data.

Applicable Regulations, Policies, and Guidance:

34 CFR Part 164, including 164.508 and 164.512
45 CFR Part 164, including 164.512, 164.514, 164.532
78 FR 5565, 2013
VHA FAQ Topic: Revocation of HIPAA Authorization for Research, February 2017
Emory University HIPAA Privacy Rule Policies, September 2013, including C.4, C.5, D.14 D.16

75 MANDATORY REPORTING TO LAW ENFORCEMENT AGENCIES

POLICY:

State law may require Researchers who are members of certain professions or employees of certain types of organizations to report to Enforcement Agencies certain information gained during Research the gives the Researcher reasonable cause to believe that a Child is a victim of Child Abuse or that a Disabled Adult or Elder Person has suffered Adult Abuse. The Emory IRB requires Researchers to inform participants of any such reporting requirements in any informed consent and HIPAA Authorization forms.

NOTE: Virtually all Researchers employed by or volunteering at Emory University are encompassed within the legal definitions of the below-listed terms, and therefore, have mandatory reporting obligations regarding suspected Child Abuse and Adult Abuse. Specifically, all Emory employees and volunteers are included within either the definitions of the various categories of "SCHOOL" personnel or "CHILD SERVICE ORGANIZATION PERSONNEL." The legal definition of the term "SCHOOL" includes any college, university or institution of post-secondary education, and the legal definition of "CHILD SERVICE ORGANIZATION PERSONNEL" includes "persons employed by or volunteering at a business or an organization, whether public, private, for profit, not for profit, or voluntary, that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs or shelter to children.

NOTE: For ***Multi-Site Research*** for which Emory is serving as a ***Reviewing IRB***, all study teams should follow their state and local law on mandatory reporting.

PROCEDURES:

CHILD ABUSE

Applicability: The following reporting requirements apply with regard to persons under 18 years of age who are suspected to have suffered Child Abuse.

Persons Required to Report: Under Georgia law, if any of the following persons has reasonable cause to believe that a Child has been the victim of Child Abuse, then they must make the reports to the individual or agency as described below. Note that the terms in ALL CAPS that appear below are defined in O.C.G.A. Section 19-7-5.

(a) Physicians licensed to practice medicine, physician's assistants, interns, or residents; hospital or medical personnel;
(b) Dentists;
(c) Licensed psychologists and persons participating in internships to obtain licensing pursuant to O.C.G.A. Chapter 39 of Title 43;
(d) Podiatrists;
(e) Registered professional nurses or licensed practical nurses licensed pursuant to O.C.G.A. Title 43, Chapter 24;
(f) Professional counselors, social workers, or marriage and family therapists licensed pursuant to O.C.G.A. Title 43, Chapter 10A;

(g) SCHOOL teachers;
(h) SCHOOL administrators;
(i) SCHOOL guidance counselors, visiting teachers, school social workers, or school psychologists certified pursuant to O.C.G.A. Title 20, Chapter 2;
(j) CHILD welfare agency personnel, as defined pursuant to O.C.G.A. Section 49-5-12;
(k) CHILD-counseling personnel;
(l) CHILD SERVICE ORGANIZATION personnel;
(m) CLERGY members who receive information about child abuse outside of the context of confession or other similar communication;
(n) Law enforcement personnel; or
(m) REPRODUCTIVE HEALTH CARE FACILITY or PREGNANCY RESOURCE CENTER personnel and volunteers.

Privileged Communications and Reporting by Clergy Members: Suspected Child Abuse which is required to be reported by any of the persons listed above shall be reported notwithstanding that the reasonable cause to believe Child Abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law; provided, however, that a CLERGY member is not be required to report Child Abuse that is reported to them solely within the context of confession or other similar communication required to be kept confidential under church doctrine or practice. CLERGY members who receive information about Child Abuse in the context of confession, or similar communication, and from any other source apart from such confession, must comply with the Child Abuse reporting requirements outlined in this P&P.

Reporting Process: If a Researcher who falls under one of the above-referenced categories of persons gain knowledge from the Research and/or interactions occurring during the Research that gives them reasonable cause to believe that Child Abuse has occurred, then the Researcher must adhere to the following reporting requirements:

If a person is required to report Child Abuse because that person has contact with a Child as a part of the person's duties as a member of the staff of a hospital, school, social agency, or similar facility (a "Staff Member Reporter"), that Staff Member Reporter shall notify the person in charge of the facility, or their designee. The person in charge (or their designee) shall report to law enforcement authorities, as set forth below. The person in charge (or their designee) may not control or make any modification or change to the information provided by the Staff Member Reporter, although the Staff Member Reporter may be consulted prior to the making of a report and may provide any additional, relevant, and necessary information for the report.

Any required reporter, other than a Staff Member Reporter, who has reasonable cause to believe that a Child has been the victim of Child Abuse shall report directly to Child Law Enforcement Agencies.

An oral report shall be made immediately, but in no case later than 24 hours from the time the reporter determines there is reasonable cause to believe a Child has suffered Child Abuse. The oral report shall be followed by a report in writing, if requested, to Child Law Enforcement Agencies.

Reports shall contain the names and addresses of the Child and the Child's Parents or caretakers, if known, the Child's age, the nature and extent of the Child's injuries, including any evidence of previous injuries, and any other information that the reporter believes might help establish the cause of the injuries and the identity of the perpetrator. Photographs of the Child's injuries to be used as documentation in support of allegations by hospital employees or volunteers, physicians, law enforcement personnel, school officials, or staff of legally mandated public or private child protective agencies may be taken without the permission of the Child's Parent or Legal Guardian. Such photographs shall be made available as soon as possible to the chief welfare agency providing protective services and to the appropriate police authority.

Informed Consent and HIPAA Authorization Forms: For Research that involves (a) Children or other situations in which information regarding Children may come to light; and (b) Researchers who fall into the categories of persons listed above, the informed consent forms and HIPAA Authorization forms should clearly state that the Researcher may be required by law to report to Child Law Enforcement Authorities if they have reasonable cause to believe that a Child has suffered Child Abuse. All informed consent and HIPAA Authorization forms should state that information gained during the Research will be disclosed or reported as may be required by law. If a Certificate of Confidentiality is obtained for a study that involves Children or participants' interactions with Children, mandatory reporting of suspected Child Abuse must be included as a voluntary disclosure that may be made, and that will not be subject to the Certificate of Confidentiality.

Reporting Requirements Outside the State of Georgia: The Child Abuse reporting requirements set forth herein apply to Research activities that take place within the State of Georgia. If the Research activities take place in a jurisdiction other than Georgia and/or if the Child and/or their Parents/Legal Guardian live in a jurisdiction other than Georgia, the Researcher should consult the University's Office of the General Counsel for guidance regarding applicable law and reporting requirements.

ADULT ABUSE

Reporting Adult Abuse of Disabled Adults or Elder Persons Not Residing in Long-Term Care Facilities:

Applicability: The following reporting requirements apply to Disabled Adults or Elder Persons who are not residing in Long-Term Care Facilities and who did not suffer the Adult Abuse that is being reported while they were a resident in a Long-Term Care Facility.

Persons Required to Report: Under Georgia law, if any of the following persons has reasonable cause to believe that a Disabled Adult or Elder Person has been the victim of Adult Abuse, other than by accidental means, then they must make the reports to the individual or agency as described below:

(a) Any person who is listed above in categories (a) to (n) under the section entitled "CHILD ABUSE." [NOTE: All definitional information set forth in the CHILD ABUSE section also applies to this section.]
(b) Physical Therapists
(c) Occupational therapists
(d) Day-care personnel

(e) Coroners
(f) Medical Examiners
(g) Emergency medical services personnel who are licensed by the Georgia Department of Public Health.
(h) Emergency medical technicians, cardiac technicians, paramedics or first responders certified by the Georgia Composite Medical Board.
(i) Employees of a public or private agency engaged in professional health-related services to Elder Persons or Disabled Adults.
(j) Clergy Members.
(k) Employees of financial institutions

[NOTE: Refer to *Privileged Communications and Reporting by Clergy Members* under the Child Abuse section above for specific reporting requirements when information regarding Child Abuse is obtained via privileged communications.]

Reporting Process: If a Researcher who comes under one or more of the above-referenced categories of persons gains knowledge from the Research that gives them reasonable cause to believe that a Disabled Adult or Elder Person has been the victim of Adult Abuse, other than by accidental means, then the Researcher must adhere to the following reporting requirements:

a) When the person having a reasonable cause to believe that a Disabled Adult or Elder Person has been the victim of Adult Abuse, other than by accidental means, performs services as a member of the staff of a hospital, social agency, financial institution, or similar facility, such person shall notify the person in charge of the facility. The person in charge or their designee shall report or cause reports to be made as set forth below under subsection (b).

b) A report that a Disabled Adult or Elder Person has been the victim of Adult Abuse shall be made to a Georgia Department of Human Resources designated adult protection agency that provides protective services and to an appropriate law enforcement agency or prosecuting attorney.

c) The report may be made by oral or written communication. The report shall include the name and address of the Disabled Adult or Elder Person and should include the name and address of the Disabled Adult´s or Elder Person´s caretaker; the age of the Disabled Adult or Elder Person; the nature and extent of the Disabled Adult´s or Elder Person´s injury or condition resulting from Adult Abuse; and other pertinent information.

Informed Consent and HIPAA Authorization Forms: For Research that involves (a) Disabled Adults or Elder Persons or other situations in which information regarding such persons may come to light; and (b) Researchers who fall into the categories of persons listed above, the informed consent forms and HIPAA Authorization forms should clearly state that the Researcher may be required by law to report to Georgia adult protection agencies and to law enforcement authorities if they reasonable cause to believe that a Disabled Adult or Elder Person has suffered Adult Abuse.

All informed consent and HIPAA Authorization forms should state that Research information will be disclosed or reported as may be required by law. If a Certificate of Confidentiality is obtained

for a study that involves Disabled Adults or Elder Persons or participants' interactions with such persons, then mandatory reporting of suspected Adult Abuse must be included as a voluntary disclosure that may be made and that will not be subject to the Certificate of Confidentiality.

Reporting Requirements Outside the State of Georgia: The Adult Abuse reporting requirements set forth herein apply to Research activities that take place within the State of Georgia. If the Research activities take place in a jurisdiction other than Georgia and/or if the Disabled Adult/Elder Person lives in a jurisdiction other than Georgia, the Researcher should consult the University's Office of the General Counsel for guidance regarding applicable law and reporting requirements.

Reporting Adult Abuse of Disabled Adults or Elder Persons Residing in Long-Term Care Facilities:

Applicability: The following reporting requirements apply to Disabled Adults or Elder Persons who are residing in Long-Term Care Facilities and/or who suffered the Adult Abuse that is being reported while they were a resident in a Long-Term Care Facility.

Persons Required to Report:

(a) Any person who is listed above in categories (a) to (n) under the section entitled "CHILD ABUSE." [NOTE: All definitional information set forth in the CHILD ABUSE section also applies to this section.]
(b) Administrators, managers or other employees of hospitals or Long-Term Care Facilities
(c) Physical Therapists
(d) Occupational therapists
(e) Day-care personnel
(f) Coroners
(g) Medical Examiners
(h) Emergency medical services personnel who are licensed by the Georgia Department of Public Health.
(i) Emergency medical technicians, cardiac technicians, paramedics or first responders certified by the Georgia Composite Medical Board.
(j) Employees of a public or private agency engaged in professional health-related services to residents of Long-Term Care Facilities
(k) Clergy Members.

[NOTE: Refer to *Privileged Communications and Reporting by Clergy Members* under the Child Abuse section above for specific reporting requirements when information regarding Child Abuse is obtained via privileged communications.]

Reporting Process:

If a Researcher who comes under one or more of the above-referenced categories of persons gains knowledge from the Research that gives them reasonable cause to believe that a Disabled Adult or Elder Person has been the victim of Adult Abuse at a Long-Term Care Facility, then the Researcher must adhere to the following reporting requirements:

- Immediately report in-person or by phone to the Georgia Department of Human Services and an appropriate law enforcement agency or prosecuting attorney, as well as send a follow-up written report to the Georgia Department of Human Services within 24 hours after making the initial report.

- The report shall include the name and address of the person making the report; the name and address of Disabled Adult or Elder Person; the name and address of the Long-Term Care Facility in which the reported event took place; the nature and extent of the Disabled Adult´s or Elder Person´s injury or condition resulting from the reported event; the suspected cause of the reported event; and other pertinent information useful in determining the cause of the Disabled Adult's or Elder Person's injuries/condition and in determining the identity of the responsible individual(s).

Informed Consent and HIPAA Authorization Forms: For Research that involves a) Disabled Adults or Elder Persons who are or were residing in Long-Term Care Facilities or other situations in which information regarding such persons may come to light; and b) Researchers who fall into the categories of persons listed above, the informed consent forms and HIPAA Authorization forms should clearly state that the Researcher may be required by law to report to Georgia adult protection agency and to law enforcement authorities if they has reasonable cause to believe that a Disabled Adult or Elder Person has suffered Adult Abuse while residing in a Long-Term Care Facility.

All informed consent and HIPAA Authorization forms should state that Research information will be disclosed or reported as may be required by law. If a Certificate of Confidentiality is obtained for a study that involves Disabled Adults or Elder Persons who are or were residing in a Long-Term Care Facility or interactions with such persons, then mandatory reporting of suspected Adult Abuse must be included as a voluntary disclosure that may be made and that will not be subject to the Certificate of Confidentiality.

Reporting Requirements Outside the State of Georgia: The Adult Abuse reporting requirements set forth herein apply to Research activities that take place within the State of Georgia. If the Research activities take place in a jurisdiction other than Georgia and/or if the Disabled Adult/Elder Person lives in a jurisdiction other than Georgia, the Researcher should consult the University's Office of the General Counsel for guidance regarding applicable law and reporting requirements.

SPOUSAL ABUSE:

State of Georgia: There are no mandatory reporting requirements concerning spousal abuse in Georgia unless the spouse falls within the category of Disabled Adult or Elder Person. Note, however, that any physician, nurse, security person, or another person with patient care related duties who is employed by a medical facility must report to the person in charge of the facility if they believe that a patient has had physical injuries inflicted other than by accidental means. The person in charge of the facility must, in turn, report the injury to local law enforcement agencies. The report must contain the following information: patient's name and address; nature and extent of injuries; and any other information the reporter believes will help establish the cause of the injuries and the identity of the perpetrator.

Informed Consent and HIPAA Authorization Forms: For Research conducted by Researchers who fall into the categories of required reporters and that involves activities that include the collection of Research information concerning participants' physical injuries, the informed consent forms and HIPAA Authorization forms should clearly state that the Researcher may be required by law to report to medical center administration, and in turn to law enforcement authorities if they have reasonable cause to believe that an adult has suffered physical injuries caused by other than accidental means. All informed consent and HIPAA Authorization forms should state that Research information will be disclosed or reported as may be required by law. If a Certificate of Confidentiality is obtained, then mandatory reporting of physical injury caused by other than accidental means should be included as a voluntary disclosure that may be made, and that will not be subject to the Certificate of Confidentiality.

States Other than Georgia: Researchers should check with the Office of General Counsel regarding spousal abuse mandatory reporting requirements in other jurisdictions.

Applicable Regulations, Policies, and Guidance:

OCGA 16 Chapter 6, including 16-6-9
OCGA 16 Chapter 12, including 16-12-100
OCGA 19 Chapter 7, including 19-7-5
OCGA 20 Chapter 2
OCGA 30 Chapter 5, including 30-5-3 through 30-5-10
OCGA 31 Chapter 7, including 31-7-9
OCGA 31 Chapter 8, including 31-8-8
OCGA 43 Chapter 10A
OCGA 43 Chapter 24
OCGA 43 Chapter 39
OCGA 49 Chapter 5, including 49-5-12

76 RECRUITMENT OF SUBJECTS

POLICY:

The Emory IRB must approve all recruitment methods and materials, as well as any study sponsor plans for encouraging recruitment of subjects, in order to ensure that they are accurate and non-coercive and do not unfairly bias subjects to participate or induce researchers to recruit subjects who do not meet enrollment criteria.

Special requirements apply to ***more than minimal risk Research*** conducted or supported by the ***DOD*** in which DOD or U.S. military personnel are enrolled as Human Subjects; as well as to FDA-regulated studies and to VA Research.

PROCEDURES:

Recruitment of Subjects: Per the ***HHS*** and ***FDA Regulations***, the Emory IRB is charged with ensuring that the recruitment of subjects for ***Research*** studies at Emory is equitable and that all participation of subjects is strictly voluntary.

In order to ensure that these goals are accomplished, the Emory IRB requires researchers to submit to the IRB for review the following materials/information regarding a study under consideration by the IRB:

The purpose of the research, the setting in which the research is conducted, the selection (inclusion/exclusion) criteria, and the amount and timing of payments to participants for equitable selection.

Actual copies of all advertisement materials used to recruit subjects, including but not limited to, flyers, print ads, videos, or audio presentations regarding the study, etc., and the final copy of printed advertisements to evaluate the relative size of type used and other visual effects. When advertisements are to be taped for broadcast, the final audio/video tape must be submitted.

The IRB may review and approve the wording of the advertisement prior to taping to preclude re-taping because of inappropriate wording.

The review of the final taped message prepared from IRB-approved text may be accomplished through expedited procedures.

The IRB cautions investigators to obtain IRB approval of message text prior to taping, in order to avoid re-taping because of inappropriate wording.

A description of any incentives and compensation that are to be provided to subjects for participation in the study, and the method and timing of the compensation. Incentives and compensation include, but are not limited to, gifts; gift cards or certificates; chances to win prizes; or monetary compensation to subjects.

A description of any incentive or compensation provided by the study sponsor to researchers or Research staff for conducting studies or recruiting subjects into studies, including, but not limited to, monetary compensation, travel vouchers, gifts, etc.

Review Standards: The Emory IRB shall follow the standards below in reviewing recruitment materials and incentives in order to determine if they are permissible:

Advertisement materials must be truthful and accurate. Advertisement materials must not: (a) state or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and protocol; (b) include exculpatory language; (c) emphasize the payment or the amount to be paid, by such means as larger or bold type; and (d) promise "free treatment" when the intent was only to say participants would not be charged for taking part in the investigation.

Advertisements must be limited to the information prospective participants need to determine their eligibility and interest, such as: (a) the name and address of the investigator and research facility; (b) the purpose of the research; (c) the criteria that would be used to determine eligibility for the study; (d) a brief list of participation benefits, if any; (e) the time or other commitment required of the participants; and (f) the location of the study and the person or office to contact for further information.

Compensation or incentives given or paid to subjects may compensate participants for their time, discomfort, risk, travel, effort, and inconvenience in participating in the study, but should not constitute payment for deciding to participate in the research.

The timing of a study participant's receipt of the incentive should not compromise or unduly influence the participant's ability to withdraw from the study at any time, e.g. by requiring completion of all study procedures before accruing compensation.

Any incentives for study subjects that involve giveaways, chances to win prizes, lotteries, etc. must conform to all state laws regarding games of chance and gambling. In general, under Georgia law, lotteries and games of chance are prohibited.

Compensation for conduct of a study should not exceed the fair market value of the services provided.

Researchers may not accept any incentives from study sponsors that are in any way linked to or based on the number of enrollees in the study, (e.g., payment of monetary incentive for enrolling a certain number of study subjects). In addition, researchers must ensure that any incentives received from study sponsors conform to: (a) Emory conflict of interest policies; and (b) Emory Human Resources and any other applicable policies regarding gifts or incentives from persons with whom the University does business. As necessary, the Emory IRB may refer matters regarding incentives to the appropriate individual committees or units in charge of reviewing matters of conflict of interest.

FDA-Regulated Research and Advertisements: For research that is ***FDA regulated***, advertisements must not: (a) make claims about the drug, biologic, or device under investigation

that are inconsistent with FDA labeling or; (2) use terms such as “new treatment,” “new medication,” or “new drug” without explaining that the test article is investigational.

FDA-Regulated Research Compensation: The IRB must not allow compensation for participation in an FDA-regulated trial to include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

Clinical Trial Websites: The Emory IRB recognizes that clinical trial postings on the web are an effective way to notify the public of important research for which they may want to participate. Basic descriptive information may be posted to the web without IRB review and approval. Basic information includes:

- study title
- purpose of the study
- protocol summary
- basic eligibility criteria
- study site location(s), and
- how to contact the study site for further information.

Information exceeding such basic listing information includes descriptions of clinical trial risks and potential benefits, or solicitation of identifiable information. When information posted on a clinical trial website goes beyond directory listings with basic descriptive information, such information is considered part of the informed consent process and therefore requires IRB review and approval.

Special Requirement for VA Research:
During the recruitment process, members of the research team must make initial contact with potential subjects in person or by letter prior to initiating any telephone contact, unless there is written documentation that the subject is willing to be contacted by telephone about the study in question or a specific kind of research as outlined in the study.

> NOTE: If existing information from sources such as a medical record or database (research or non-research) are used to identify human subjects, there must be an IRB-approved waiver of HIPAA authorization for this activity in the new protocol.

Any initial contact by letter or telephone must provide a telephone number or other means that the potential subject can use to verify that the study constitutes VA research. If a contractor makes the initial contact by letter, the VA investigator must sign the letter.

> NOTE: This paragraph does not apply to situations where a Veteran calls in response to an advertisement.

Research conducted or supported by the ***DOD***: Civilian researchers attempting to access military volunteers should seek collaboration with a military researcher familiar with service-specific requirements.
When more than minimal risk Research enrolls Department of Defense or U.S. military personnel as human subjects then the following additional requirements must be included in the IRB application and followed:

(a) Non-commissioned officers shall not be permitted to influence the decisions of their subordinates as to whether or not to participate in the Research.
(b) Unit officers and senior non-commissioned officers in the chain of command shall not be permitted to be present at the time of research subject solicitation and consent during any research recruitment sessions in which members of units under their command are offered the opportunity to participate in the Research. However, these officers and non-commissioned officers who are excluded shall separately be offered the opportunity to participate as research subjects, if applicable.
(c) For research involving recruitment of D)D-affiliated personnel in ***Human Subject Research*** determined greater than minimal risk, as defined by ***DOD Regulations***, and when HSR recruitment occurs in a group setting, the IRB must appoint an ombudsperson. The ombudsperson:
    a. Must not have a conflict of interest with the research or be a part of the research team.
    b. Must be present during the HSR recruitment, monitoring that the recruitment and informed consent explain that participation is voluntary and that the information provided about the research is consistent with the IRB-approved script and materials, including digitally provided materials.
    c. Should be available to address DOD-affiliated personnel's concerns about participation.
(d) Service members and all Reserve Component and National Guard members in a federal duty status are considered for purposes of this issuance to be adults. If a Service member, Reserve Component or National Guard member in federal duty status, student at a Service Academy, or trainee is under 18 years of age, the IRB must carefully consider the HSR recruitment process and the necessity of including such member as a human subject.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.111
32 CFR Part 219
38 CFR Part 16, including 16.111
45 CFR Part 46, including 46.111
OCGA 16 Chapter 12, including 16-12-20 through 16-12-38
DOD Instruction 3216.02, 2022
FDA Guidance for Institutional Review Boards and Clinical Investigators: Recruiting Study Subjects, January 1998
OHRP Guidance: IRB Review of Clinical Trial Websites, September 2005
VHA Directive Section 1200.05(2), 2021

77 PAYMENT OF SUBJECTS

POLICY:

Payment in the form of money is sometimes an appropriate form of compensation for the time, effort, discomfort, and other contributions of human subjects to research. The Emory IRB must approve all payments to subjects, including the amount of payment and the proposed method and timing of disbursement, in order to ensure that such payments are not coercive and do not present undue influence.

PROCEDURES:

Payment to Subjects: Per the ***HHS*** and ***FDA Regulations***, the Emory IRB is charged with ensuring that payments to subjects in ***Research*** studies are not likely to unduly influence (sometimes also expressed as coercing) the prospective subject to decide to participate. The subjects should not be put into a situation where the positive appeal of a payment is likely to prevent them from thinking clearly about the risks and benefits of participation. In order to ensure that these goals are accomplished, the PI of a ***Research*** study must submit the following materials and information for consideration by the Emory IRB:

A detailed description of proposed payments to research subjects. This description should include timing of payment, pro-rating schedule, payment for participants who withdraw before completion, and completion bonus plans, if applicable;

A description of any alteration in payments to research participants. This information should be submitted prior to implementation; and

An informed consent document that includes all information concerning payment. This information should not be included in the benefits section as payments are considered to be compensation, not a benefit. The informed consent document should state that the Researchers may have to collect the names and social security numbers of research subjects for accounting purposes.

Emory policy will set a threshold for tax reporting requirements. The informed consent should reflect the requirements of the Emory policy.

Review Standards: The Emory IRB will include the following issues in its review of the proposed payments to research subjects:

The payment arrangements among sponsors, organizations, investigators and those referring research subjects to determine whether those arrangements are permissible;

The amount of payment and the proposed method and timing of disbursement to ensure that they are neither coercive nor unduly influential;

Any credit for payment should accrue as the study progresses and not be offered contingent upon the subject completing the entire study. Unless it creates undue

inconvenience or a coercive practice, payment to subjects who withdraw from the study should be paid when they would have completed the study (or completed a phase of the study) had they not withdrawn. For example, in a study lasting only a few days, an IRB may find it permissible to allow a single payment date at the end of the study, even to subjects who had withdrawn before that date.

The amount paid as a bonus for completion must be reasonable and not so large as to unduly influence subjects who might otherwise withdraw to stay in the study;

Advertisements must not be coercive or present undue influence, and they must not emphasize the payment aspects of the ***Research*** or the amount to be paid by such means as large or bolded type;

Payment made to a minor must be appropriate in that it does not present the risk of undue influence; and

Payments to professionals in exchange for referrals of potential participants ("finder's fees") are prohibited.

Payments designed to accelerate recruitment that were tied to the rate or timing of enrollment ("bonus payments") are permitted only if paid to compensate for additional recruitment costs (e.g., paid staff effort, advertising).

In reviewing a proposal to give human subjects payment or incentives to recruit other subjects (e.g., family member, friend), the IRB must consider the principle of fairness/justice, the principle of beneficence (minimizing risk and maximizing benefit), and respect for persons (informed consent). The IRB should consider whether the proposed arrangement would intervene negatively in the subject's relationship with the other individuals, and whether the proposal introduces a new risk or higher level of risk to the study.

The Emory IRB (and the ***VA RDC***, if VA research) will require that the PI of a ***Research*** study provide the following information for review if payment is to be made to a research subject:

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

Include the terms of the research subject's participation and the amount of payment in the informed consent; and

Substantiate that the payments are fair and appropriate, and that they do not constitute (or appear to) undue influence on the prospective research subject to volunteer for or continue to participate in the research study, or do not constitute (or appear to) coercion to participate or continue to participate in the research study.

Research conducted or supported by the ***DOD*****:** If Research conducted or supported by the ***DOD*** involves DOD personnel, including U.S. military personnel, then the following limitations regarding participant compensation apply:

(a) Compensation to DOD-affiliated personnel for participation in research while on duty is prohibited in accordance with Title 5, U.S.C., with particular reference to Subparts G and H, with some exceptions for purposes consistent with Section 30 of Title 24, U.S.C.
(b) An individual cannot receive pay from more than one position for more than 40 hours of work in a calendar week. This limit on dual-compensation includes temporary, part-time and intermittent positions.
(c) Individuals may receive compensation for research activities if they do not take place during scheduled work hours.
(d) Federal employees while on duty and non-federal persons may be compensated for blood draws for research up to $50 for each blood draw.
(e) Non-federal persons may be compensated for research participating other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46
21 CFR Part 50, including 50.20
DOD Instruction 3216.02, 2022
VHA Directive Section 1200.05(2), 2021
24 U.S.C. 30
FDA Guidance for Institutional Review Boards and Clinical Investigators: Recruiting Study Subjects, January 1998

78 EMORY UNIVERSITY AND OTHER STUDENTS AS SUBJECTS – INCLUDING DEPARTMENT OF EDUCATION REQUIREMENTS

POLICY:

The Emory IRB is charged with ensuring that recruitment of subjects for ***Research*** studies is equitable and strictly voluntary. When the subjects to be recruited are students of Emory, additional consideration must be given to ensure that recruitment methods and materials are non-coercive and that confidentiality is strictly maintained. When subjects to be recruited are students of any institution, including Emory, the **Family Educational Rights and Privacy Act** (**FERPA**) applies.

Some ***Research*** involving students as subjects is funded by the Department of Education (ED). In addition, some schools where ***Research*** is conducted receive funding from the ED. This chapter also describes the additional rules and regulations that apply to such ***Research***, including the Protection of Pupil Rights Amendment.

PROCEDURES:

Recruitment of Subjects: The Emory IRB must approve all recruitment methods and materials, in accordance with **Policy & Procedure***: Recruitment of Subjects*, when students are to be specifically targeted and recruited as ***Research*** subjects

Recruitment of Students: In addition to following the procedures established in the P&P entitled: *Recruitment of Subjects*, the PI must also take the following issues into consideration when recruiting students for ***Research*** studies:

A PI who is a faculty member or instructor and is recruiting students for a ***Research*** study must advertise and recruit to students generally, rather than recruiting individual students. NOTE: An exception to this rule may be made when the use of the PI's own students is integral to the ***Research*** study;

Where student participation is a class component:

The IRB may approve the giving of course credit or extra credit to students who are expected to participate in ***Research*** activities as part of a class curriculum only when alternative means of obtaining course credit or extra credit is available to students who do not wish to volunteer as ***Research*** subjects;

Research studies involving Emory students as participants should not include recruiting plans that unfairly or unduly pressure or coerce them to consent to participate based on the threat of withholding academic credit or favor, or by setting up an exclusive alternative that is proportionately more burdensome than participating;

The ***Research*** studies may not involve more than ***Minimal Risk.***

The use of extra credit points for participation in ***Research*** studies should be limited as a reward, used only when the ***Research*** is closely tied to the course subject matter, and should not raise the student's grade more than one-half of a letter grade;

Students should be recruited through general announcements, bulletin board postings, or advertisements, rather than individual solicitations. Students must be told that they can withdraw from the ***Research*** study at any time without losing the extra credit;

and

Research interventions should not be conducted during class time;
Students should not be recruited into ***Research*** of a sensitive nature (e.g., drug use, alcoholism, sexual preferences).

Recruiting Emory School of Medicine students:

Emory medical students may only participate in ***Research*** involving ***Minimal Risk*** and minimal interruption of time;

The Emory IRB has the authority to review and approve ***Research*** involving Emory medical students. Any Emory IRB concerns regarding the use of medical students should be promptly forwarded to the Office of the Dean of the School of Medicine for review; and

Emory medical students generally should not be recruited into ***Research*** of a sensitive nature (e.g., drug use, alcoholism, sexual preferences).

Recruiting students from a particular Emory department or school:

After the Emory IRB approval has been granted, ***Research*** studies targeted for or designed specifically for students from a particular Emory department or school may require the approval of the appropriate Dean before the study may begin.

Departmental Subject Pool: The Department of Psychology subject pool consists of all students enrolled in Psychology 110 and 111. Each student in Psychology 110 and 111 must complete 6 credits of research (1 credit for 45 minutes, or portion thereof, of participation in an approved study) for course credit in each of these classes. Students who do not wish to participate in research studies will be provided with an alternative equivalent task (i.e., summary reports of journal articles) in order to earn the required credits. The Department of Psychology conducts all ***Research*** and training in accordance with the ethical guidelines set forth by the American Psychological Association, and as appropriate, with the approval of the Emory IRB.

Applicability of Family Educational Rights and Privacy Act (FERPA or the Buckley Amendment):

Emory University, as well as many other educational institutions, are subject to the provisions of this Federal law, which affords matriculated students certain rights with respect to their educational records. FERPA applies when researchers obtain student records or personal education information from an education program as defined as any program principally engaged in the provision of education, including, but not limited to, early childhood education, elementary and secondary education, postsecondary education, special education, job training, career and technical education, and adult education. These records or information can only be obtained under the following conditions:

1. Consent -- Student consent is obtained; or

2. FERPA Research Exception – The FERPA Research Exception is utilized. Although student consent generally is required in order to release student education records containing personally identifiable information, requests for access to student educational records from researchers or research organizations acting on behalf of educational institutions may be permitted without prior approval from the student based upon the FERPA "research exception" provision. This exception permits the release of personally identifiable student records for research purposes, but only if all of the following apply:

   a. The disclosure of student records is to be made to a research or research organization conducting studies, for or on behalf of, educational agencies or institutions, in order to:

      - Develop, validate, or administer predictive tests, or
      - Administer student aid programs, or
      - Improve instruction.

   b. Researchers or Research Organizations desiring to obtain personally identifiable student records under this exception must first receive a determination from the Emory IRB that the exception applies to the intended research.

   c. After receiving a determination from the Emory IRB that the exception applies, the Researcher or Research Organization must sign a written agreement with the institution that specifies the following:

      - The information to be disclosed
      - The purpose, scope, and duration of the study.
      - That information from education records may be used only to meet the purposes of the study as stated in the written agreement and which contains the current requirement in 34 CFR Section 99.31, regarding disclosure and destruction of the information.
      - That the study will be conducted in a manner that does not permit personal identification of parents and students by anyone other than the Researcher or Research Organization or representatives of the Researcher or Research Organization with legitimate interests.

- That the Researcher or Research Organization is required to destroy or return all personally identifiable information when no longer needed for the purposes of the study.
- The time period after which the Researcher or Research Organization must either destroy or return the information.

Requests for access to student educational records based upon the above records must be submitted in writing to the IRB at the time of submission of the proposed research.

Per Emory Policy 8.3 on *Confidentiality and Release of Information About Students*, the following Emory student records containing personally identifiable information will not be approved for release by the IRB:

a. Counseling and Testing records
b. Disciplinary Records
c. Medical Records

3. Education records also may be released without informed consent under FERPA if all personally identifiable information has been removed, including:

a. Student's name and other direct personal identifiers, such as the student's social security number or student number.
b. Indirect identifiers, such as the name of the student's parent or other family member; the student's or family's address, and personal characteristics or other information that would make the student's identity easily traceable; date and place of birth and mother's maiden name.
c. Biometric records, including one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting.
d. Other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.

Protection of Pupil Rights Amendment and Research Funded by the Department of Education (ED)

For Research projects conducted in a school that receives funding from the Department of Education, regardless of the source of funding for the Research, the ***PI*** must provide documentation to the IRB confirming that the school(s) are compliant with the Protection of Pupil Rights Amendment, by having policies and procedures regarding the following:

1. The right of a parent of a student to inspect, upon the request, any of the following, along with procedures for granting such requests:

(a) surveys created by a third party before the survey is administered or distributed by a school to a student.
(b) any instructional material used as part of the educational curriculum for the student
(c) any instructional material used in a research or experimentation program, as described in 34 CFR 98.3:
    (i) All instructional material—including teachers' manuals, films, tapes, or other supplementary instructional material—which will be used in connection with any research or experimentation program or project shall be available for inspection by the parents or guardians of the children engaged in such program or project.
    (ii) "Research or experimentation program or project" means any program or project in any program under 34 CFR Section 98.1 that is designed to explore or develop new or unproven teaching methods or techniques.
    (iii) For the purpose of the section children means persons not above age 21 who are enrolled in a program under 34 CFR Section 98.1 not above the elementary or secondary education level, as determined under State law.

2. Arrangements to protect student privacy if a survey is administered to a student containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):
    - Political affiliations or beliefs of the student or the student's parent.
    - Mental or psychological problems of the student or the student's family.
    - Sex behavior or attitudes.
    - Illegal, anti-social, self-incriminating, or demeaning behavior.
    - Critical appraisals of other individuals with whom respondents have close family relationships.
    - Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
    - Religious practices, affiliations, or beliefs of the student or the student's parent.
    - Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

    If the Research is funded by the ED, then no student consent will be required, as part of any research project, to submit without prior consent to surveys, psychiatric examination, testing, or treatment, or psychological examination,

testing, or treatment, in which the primary purpose is to reveal information concerning any of the above items. Prior consent means:

Prior consent of the student, if the student is an adult or emancipated minor, or

Prior written consent of the parent or guardian, if the student is not an emancipated minor

3. Policies and procedures on the administration of physical examinations or screenings that the school or agency may administer to a student.

4. Policies and procedures governing the collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use. These should include the right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information before the instrument is administered or distributed to a student.

Applicable Regulations, Policies, and Guidance:

21 CFR Part 56, including 56.111
34 CFR Part 97
34 CFR Part 98, including 98.3
34 CFR Part 99, including 99.31
45 CFR Part 46, including 46.111
20 U.S.C. 1232g

79 EMORY EMPLOYEES AS SUBJECTS

POLICY:

The Emory IRB is charged with ensuring that recruitment of subjects for ***Research*** studies is equitable and strictly voluntary. When the subjects to be recruited are employees of Emory and/or Emory Healthcare, additional consideration must be given to ensure that recruitment methods and materials are non-coercive and that confidentiality is strictly maintained.

If the proposed Research involving employees would take place elsewhere than Emory, the same principles of safeguarding against coercion and undue influence shall be applied.

PROCEDURES:

Employee Recruitment: In addition to following the procedures established in the P&P entitled: *Recruitment of Subjects*, the PI must also take the following issues into consideration when recruiting Emory employees for ***Research*** studies:

The PI should minimize the likelihood that employees who participate in ***Research*** programs perceive that the decision will affect performance evaluations or job advancement;

Employees should be recruited through general announcements, listservs, or advertisements, rather than individual solicitations;

Employees of a particular PI or laboratory should not be directly recruited for participation in any study conducted by that PI or laboratory, although they may volunteer to participate;

PIs who include colleagues or subordinates as ***Research*** subjects should be able to provide a rationale other than convenience for selecting those individuals and should show that recruitment methods do not lead colleagues to think that they will be compromised by not participating.

Review Standards: In addition to the standards established in the P&P entitled: *Recruitment of Subjects*, the Emory IRB will follow the standards below in reviewing the recruitment of Emory and/or Emory Healthcare employees for ***Research*** studies:

The Emory IRB will exercise oversight of the use of faculty, instructors, students, medical students, and Emory employees as the targeted population in ***Research*** studies;

The Emory IRB will review the proposed involvement of faculty, instructors, students, medical students, and Emory employees as the targeted population in ***Research*** studies, and when making its final determination will assure that:

- Consent for participation is sought only under circumstances which minimize the possibility of coercion or undue influence, and which clearly identify methods used to maintain confidentiality;
- There are genuinely equivalent alternatives to participation available;
- The selection of ***Research*** subjects is equitable;
- The risk of coercion is minimized; and
- Added protections for ***Vulnerable Populations*** have been assured, if required.

The Emory IRB will promptly forward any concerns regarding the use of employees to the Dean of the appropriate school or department.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.111
21 CFR Part 46, including 56.111

80 INVESTIGATOR QUALIFICATIONS

POLICY:

It is the policy of the Emory University IRB that all Investigators involved in human subjects research be appropriately trained and qualified to engage in such research. All investigators, including students, must comply with all requirements outlined below in order to be eligible to conduct ***Human Subjects Research*** at Emory University and its affiliates. It is further the policy of the Emory University IRB that all protocols submitted to the IRB from academic departments or units, including student submissions, shall include at least one investigator with faculty rank. Investigators from non-academic departments or units within Emory (e.g., administrative offices and clinical nursing quality-of-care review units staffed by non-faculty) do not need to have an investigator of faculty rank on the study. The study must still include appropriate collaborative care.

Note: Investigators should consult their schools' policies about who can serve as ***Principal Investigator***.
The determination of who may serve as ***Principal Investigator*** on an IRB submission is separate from the determination of who is allowed to submit research proposals to external research sponsors as ***Principal Investigator***

Please see the P&P "*Research Conducted by Students and Trainees*" for more information regarding investigator eligibility.

DEFINED TERMS:

Study Personnel: Includes ***Principal Investigator***, co-investigators, research coordinators, and any other research team members, including students, who have contact with research participants and/or their research data and identifiers for the conduct of the study. In general, individuals participating in the informed consent process are considered to be ***Study personnel.*** In general, individuals whose primary contact with the subject is in the context of clinical care, or who function solely as interpreters, are not considered ***Study personnel*** if they play no further role in the research.

PROCEDURES:

All faculty, staff, students and/or ***Employees or Agents*** of Emory University engaged in the conduct of human subject research must have reviewed and be familiar with the principles of "*The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research"*, along with applicable Federal and State laws and institutional policies regarding ***Human Subjects Research***.

Training Requirement:

Prior to submitting research protocols for review and approval by the EU IRB, all Emory ***Study personnel*** listed on an Emory IRB submission, regardless of their position, must be currently certified in the Emory or equivalent version of the web-based Collaborative IRB Training

Initiative (CITI) Program in the Protection of Human Subjects in Research, which can be accessed through the Emory IRB Website. The specific CITI training requirements, including which courses are required and the certification period are posted on the Emory IRB website under the "Education" area, and at the Emory CITI website. The EU IRB may accept other human research training certifications at their discretion.

In ***Collaborative Research*** where the non-Emory collaborators are overseen by another institution's IRB, the agents of the other institution shall comply their own institution's training requirements. When non-Emory collaborators rely on Emory IRB for review, their institutional training requirements shall apply, if such requirements exist. The Emory IRB may request attestation from the collaborating institution or collaborating PI that their study personnel are in compliance or may state in the ***Reliance Agreement*** that the ***Relying Party*** is responsible for verifying their investigators' training completion. For collaborators who are independent of any institution or whose institutions do not require human subjects research training, Emory shall require and verify completion of Emory's CITI training or equivalent.

Researchers who are subject to VA regulations are required to: complete training in good clinical practice and the ethical principles on which human research is to be conducted before they may participate in human participants' research. They must update such training every three years thereafter. VA shall ensure that all VA investigators and VA staff participating in human subject research complete all VA and Emory training requirements (per ***AVAHCS Memorandum of Understanding***).

Other training requirements may apply based on funding agency, research location, or other research context.

Investigator Responsibilities:

Prior to submitting research applications for the review and approval of the EU IRB the Investigator will:

Complete and maintain currency for the required CITI training on human research protections (initial and continuing review);

For clinical research staff on FDA-regulated clinical trials, complete the applicable clinical research training for their role, as described in the policy put forth by the Associate Dean of Clinical Research, and on the website of the Office for Clinical Research;

Complete any additional human research ethics or other training required by applicable funding agencies or other entities that oversee the research (e.g., AVAHCS, NIH, DOD).

Disclose any conflicts of interest of the Investigator or key study personnel;

Assure that other Investigators and key study personnel have completed the required human subjects research training (initial and continuing) and other applicable required training certifications; and are familiar with the proposed research;

Assure other Investigators and key study personnel are competent and licensed, if applicable, relevant to the scope and complexity of the research conducted.

Conduct research in accordance with the ethical principles of *The Belmont Report*, Federal and State regulations, Institutional policies and procedures, EU IRB policies and procedures, and if applicable, Good Clinical Practice standards.

Read, understand and agree to abide by all terms of the Statement of Investigator Responsibilities in conducting Human Subjects Research.

For ***VA Research***:

- The VA Researcher must uphold professional and ethical standards and practices and adhere to all applicable VA and other federal requirements, including the local VA facility's standard operating procedures, regarding the conduct of research and the protection of human participants. The responsibilities of the Researcher may be defined in the protocol or IRB application
- Researchers are required to ensure appropriate telephone contact with participants. This pertains to contacting the participant by telephone. Research team members are prohibited from requesting social security numbers by telephone

Students (Including Post-Doctoral) Research Projects:

All student investigators must satisfy all applicable Investigator Responsibilities outlined above.

Additionally, all student submissions must, at a minimum, include a co-investigator with faculty rank who also shall be responsible for oversight of the research and compliance with ***HHS Regulations*** regarding ***Human Subjects Research***.

Student activities that must be reviewed by the Emory IRB (or by another IRB under a ***Reliance Agreement***) include, but are not necessarily limited to:

All undergraduate honors theses, master's theses and doctoral dissertations that involve ***Human Subjects Research***; and

Class projects that involve human subjects if they are intended to contribute to generalizable knowledge beyond the classroom or Emory-specific setting, or whose findings may inform future research studies.

Students and their faculty advisors are encouraged to consult with the IRB staff to determine if an IRB submission is required.

Students (including Post-Doctoral researchers) may not hold an IND or IDE; if one is a requirement of a grant, a faculty member must make this commitment.

Listing of *Study Personnel* on Documentation Required for *FDA*-Regulated Clinical Investigations: The fact that a person meets the definition of ***Study personnel*** does not necessarily mean that that person should be listed on documentation required by Sponsors, ***Sponsor-Investigators*** or the ***FDA*** for clinical investigations subject to ***FDA*** regulations. Investigators should follow ***FDA*** regulations and guidance in determining the persons that should be listed on documentation associated with the conduct of ***FDA***-regulated clinical investigations (e.g., Form 1572 – Statement of Investigator). Similarly, the fact that a person is listed on documentation associated with the conduct of ***FDA***-regulated clinical investigations does not mean that such person automatically meets the definition of ***Study personnel***. Rather, an independent assessment should be performed to determine if the person is ***Study personnel***, according to the definition of that term listed above.

Training Requirements for External Investigators When Emory IRB is Serving as the *Reviewing IRB*: Individuals not affiliated with any institution or affiliated with a non-FWA-holding institution whose research activities are being reviewed by Emory IRB pursuant to an IIA are required to complete the same training as Emory personnel for the given protocol. For personnel at other FWA-holding institutions collaborating with Emory researchers, Emory IRB may accept certification of the completion of a comparable human research training program as a substitute for completion of Emory's required training. Emory IRB accepts alternative training certifications as described in the Emory IRB website.

Applicable Regulations, Policies, and Guidance:

FDA Guidance for Sponsors, Clinical Investigators, and IRBs: Frequently Asked Questions – Statement of Investigator (Form 1572), June 2020, No. FDA-2008-D-0406

81 RESEARCH CONDUCTED BY STUDENTS AND TRAINEES

POLICY:

Emory students and trainees who conduct ***Human Subjects Research*** are required to familiarize themselves with and adhere to all applicable regulations and policies. The requirements stated in these procedures constitute the minimum requirements for student protocols involving ***Human Subjects Research*** at Emory University. Emory College and/or the individual schools and departments may have separate, additional requirements for student ***Research*** protocols.

Student researchers are responsible for consulting with their faculty sponsors and/or schools and departments regarding any such additional requirements.

Note: Investigators should consult their schools' policies about who can serve as ***Principal Investigator***.
The determination of who may serve as ***Principal Investigator*** on an IRB submission is separate from the determination of who is allowed to submit research proposals to external research sponsors as ***Principal Investigator***

PROCEDURES:

Student Responsibilities: Emory students involved in the conduct of ***Human Subjects Research*** should become familiar with and develop a comprehensive understanding of its ethical and regulatory requirements as a part of their educational experience.

Students are encouraged to interact with both their faculty sponsors and the Emory IRB staff regarding questions about compliance with these requirements.

Emory Students - Status as Investigators: Each school at Emory University has its own policy about whether students may or may not be listed as ***Principal Investigator*** on ***Research*** studies submitted to the Emory IRB.

For studies where the faculty advisor serves as ***Principal Investigator,*** departmental –not faculty—review is required and the study application does not need to indicate that it is "student research." The research protocol should, however, indicate that it is student research. The faculty advisor is responsible for communicating to the students the ethical and regulatory requirements of ***Human Subjects Research***, for ensuring the protection of ***Human Subjects*** and that a process is in place for obtaining voluntary informed consent from subjects whenever applicable; and for monitoring the students' progress. Any questions should be directed to the ***IRB Office***.

Classroom and Training activities: Faculty are responsible for determining whether any classroom or training activities (including dissertations, theses, special study projects, et cetera) constitute ***Human Subjects Research*** and are encouraged to contact the IRB Office for guidance.

In making a determination of whether or not a classroom or training activity constitutes ***Human Subjects Research*** and requires IRB review, the faculty is encouraged to err on the side of caution. Such approval may NOT be awarded retroactively. See the P&P entitled *Human Subjects Research Determination* and *Exempt Research* for more information.

When designing a classroom or training activity that may involve ***Human Subjects***, students should be instructed on the ethical conduct of ***Research*** and on the preparation of the IRB application when such is required. In particular, instructors should ensure that students:

- understand the elements of informed consent;
- develop appropriate consent documents;
- plan appropriate recruitment strategies for identifying subjects;
- identify and minimize potential risks to subjects;
- assess the risk-benefit ratio for the project;
- establish and maintain strict guidelines for protecting confidentiality

VA Research

A Researcher sufficiently experienced in the area of the trainee's research interest must serve as ***Principal Investigator (Researcher)*** or co-principal Researcher and is responsible for oversight of the research and the trainee

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.101 and 46.102
VHA Directive Section 1200.05(2), 2021

82 IRB REVIEW OF ORAL HISTORY PROJECTS

POLICY

The decision as to whether oral history projects are subject to the policies and regulations outlined in the Emory FWA and ***HHS regulations*** for the protection of human research subjects is based on the prospective intent of the Investigator and the regulatory definition of ***Research***. Oral history projects and activities that fall within the standards set forth in Section A below must be submitted to the Emory IRB for review and approval.

PROCEDURES

A. Standards for determining whether Oral History Projects and Activities require IRB review

Whether a specific oral history project or activity is subject to ***HHS Regulations*** on human subjects research and is therefore subject to IRB review requires evaluation of the investigator's prospective intent and the application of the regulatory definition of ***Research.***[1] The regulations define ***Research*** as:

> **"**a systematic investigation, including research development, testing and evaluation designed to develop or contribute to generalizable knowledge**."**

Accordingly, the determination of whether IRB review is required for oral history projects and activities hinges upon:

1. Whether the activity involves a prospective research plan that incorporates data collection, including qualitative data, and data analysis to answer a research question; AND
2. Whether the activity is designed to draw general conclusions, inform policy, or generalize findings.

Activities that meet <u>both</u> of the above standards are subject to the University's human research protections policies and must be submitted for IRB review.

For purposes of this part, the following activities are deemed not to be research:

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.

---

[1] An institution should perform an initial two-step evaluation prior to deciding whether an activity constitutes human subject research:

a. determine whether the activity constitutes "research" as defined by 45 CFR §46.102(d), AND
b. determine whether the "research" includes human subjects as defined by 45 CFR §46.102(f).

Oral history activities, by their very nature, meet the second prong of this test (i.e., research includes human subjects because they involve the collection of data "through intervention or interaction with the individual." See 45 CFR §46.102(f)).

The principles and examples listed in Section B of this procedure should be helpful in making this determination.

B. General Principles for Evaluation of Oral History Projects and Activities:

The following principles and examples illustrate application of the standards set forth in Section A of this procedure.

Oral history activities, such as open-ended interviews, that ONLY document a specific historical event or the experiences of individuals without an intent to draw conclusions or generalize findings would NOT constitute "research" as defined by ***HHS Regulations***.

> **Example:** An oral history video recording of interviews with holocaust survivors is created for viewing in the Holocaust Museum. The creation of the videotape 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.

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" as defined by ***HHS Regulations***.

> **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.

Oral historians and qualitative investigators may want to create archives for the purpose 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 as defined by ***HHS Regulations***, the creation of such an archive WOULD constitute 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 as research, since the intent is to collect data for future research.

Investigators are advised to consult with the IRB Office regarding the determination about whether their oral history project or activity requires IRB review.

IMPORTANT NOTE REGARDING PUBLICATION OF RESULTS: IRB review of the research protocol is often a required condition for publication of research results by many scholarly journals. Accordingly, many publishers require that a determination that the protocol is NOT subject to IRB review be made by the IRB itself, and not by the ***Principal Investigator***. If the ***Principal Investigator*** is contemplating publication of results from oral history activities, they should submit the protocol to the IRB for determination of the need for IRB review.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.102
38 CFR Part 16, including 16.102

83 GENETIC STUDIES

POLICY:

Genetic studies may involve various kinds of risks for ***Human Subjects*** and their relatives, including potential medical, psychological, and economic consequences. Privacy interests of subjects also must be carefully considered in the review of genetic studies. Genetic materials collected and stored by ***Researchers*** working under the Emory FWA should be ***Anonymized*** whenever feasible under the protocol.

PROCEDURES:

Preference for Anonymized Information:

Genetic ***Research*** studies may create special risks to ***Human Subjects*** and their relatives. These involve medical, psychosocial, and economic risks, such as the possible loss of privacy, insurability, and employability, change in immigration status, limits on educational options, and creation of social stigma. Knowledge of one's genetic make-up may also affect one's knowledge of the disease risk status of family members.

The ability to identify subjects whose data is included in a genetic study is an issue of particular concern for the Emory IRB. Consequently, whenever feasible under the protocol, genetic materials collected and/or stored for research purposes should be ***Anonymized*** such that the identity of the individual who provided the specimen may not be ascertained in the future.

Items to be Addressed in All Protocols for Genetic Studies:

Protocols for genetic studies should provide the following information:

Specific purpose of the genetic analysis;

Particular genetic information that will be acquired;

Kinds of biological specimens on which the genetic analysis will be performed;

Whether specimens be stored, and if so where; for how long; for what purposes; with what associated information; and by whom and how will access and disposition be controlled.

Whether the genetic information will be linkable in any way to the subject, and if so, where the master list linking code to subject will be stored and how will it be safeguarded; and what identifiers will be kept.

Any potential consequences of the genetic information to insurability, employability or social esteem of the subject;

How, if at all, the genetic information will be transmitted to the subject and whether the subject will be given the options to know, or not to know, the results of the genetic analysis, and how that decision will be recorded. Specifically:

Whether subjects or family members will be given the choice as to whether or not to receive study information, and/or will research findings be provided to the subject's healthcare provider for clinical use.

Whether family members will receive information regarding the research; at what point in the research such information will be received; the meaning and implications of the information (e.g., diagnostic, predictive, etc.); and how interim or inconclusive results will be handled.

Any practical limitations on the subject's right to withdraw from the ***Research***, withdraw data, and/or withdraw DNA. Specifically:

How will data and samples be handled if: (a) a subject wishes to withdraw from a genetic study after it has begun; (b) if a subject wishes to withdraw after the study has been completed; or (c) if the researchers wishes to use the data/samples for different research purposes or transfer them to other researchers.

Whether the subject may participate in the treatment portion of a study while refusing to undergo genetic testing otherwise required by the protocol;

If Children are involved in the Research, whether they will benefit directly from participating in the project;

If extended family members are involved in the Research: (a) how they will be contacted and recruited in a way that does not unduly influence or coerce them to participate; (b) whether there are confidentiality issues involved (e.g., extended family members may not know an individual has a certain condition) and, if so, how they will be handled; and (c) what measures will be taken to minimize family pressure on children in the extended family to participate.

Provisions, if any, for genetic counseling.

Human Subjects Research **Determination:** Upon review of the protocol, the IRB will determine whether or not the genetic material/information can be identified with the individuals providing the specimens and whether the specimens were collected ***retrospectively*** or will be collected ***prospectively***. See the P&Ps entitled *Research Involving Coded Private Information or Biological Specimens* and *Human Subjects Research Determination.*

Risk Level: Although genetic studies may be limited to a collection of family histories or blood draws, the IRB will not necessarily consider them to be ***Minimal Risk***. The degree to which the information collected can be linked back to the individual providing the specimen will be a significant factor in the determination of risk.

Genetic Material to be Transferred to Research Subjects: For those protocols that involve the transfer of recombinant DNA to subjects, review by the University's Institutional Health and Biosafety Committee and, in some cases, the NIH Recombinant DNA Advisory Committee (RAC) may be required. See the P&P entitled *Emory IRB Coordination with Other University Compliance Entities.*

See also the P&P entitled: *Research Involving Coded Private Information or Biological Specimens* (Coded and Private Information) and *Collection Processing and/or Banking of Human Research Subjects Specimens*.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.102

84 COLLECTION, PROCESSING, AND/OR BANKING OF HUMAN RESEARCH SUBJECT SPECIMENS

POLICY:

Any proposed ***Research*** that involves human tissue, blood, genetic material and data shall be reviewed by the Emory IRB to ensure that the ***Research*** and repository of these materials will operate in accordance with applicable ***HHS Regulations*** and ***HIPAA*** privacy and security regulations. The Emory IRB is not responsible for the oversight of specimens and/or data collected and stored as part of routine clinical care or hospital procedures.

PROCEDURES:

Applicability of *HHS Regulations*: The Emory IRB will review ***Research*** involving human tissue, blood, genetic material and data to determine if it constitutes ***Human Subjects Research*** and is therefore subject to ***HHS Regulations***. Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation. See also the P&Ps entitled *Human Subjects Research Determination, Genetic Studies,* and *Coded and Private Information.*

Applicability of Other Regulatory Requirements: The Emory IRB also will review ***Research*** involving human tissue, blood, genetic material, and data to determine if other Federal, state or local regulatory requirements apply in view of the nature of the ***Research*** and the source of the funding. Applicable state, local and Federal regulations may apply in addition to, or in lieu of, ***HHS*** **Regulations**. Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation. The Emory IRB shall consult the Office of General Counsel with regard to determining state and local regulatory requirements.

Review of Consent Documents:

The consent/authorization document for the donation of samples for possible future ***Research*** use should contain the following information:

Separate HIPAA authorization language within the main informed consent/authorization document for the banking and future research, if optional and if HIPAA applies; alternatively, a separate informed consent/HIPAA authorization document may be used. The description of the future ***Research*** purposes must provide reasonable notice to the individual that would cause them to expect that their PHI will be used or disclosed for the described future ***Research*** purposes. (See the P&P entitled *HIPAA* for more information on Compound Authorizations.)

If the banking is optional and described within the main consent/authorization form: A separate place for the subject to indicate that s/he has provided their consent and HIPAA authorization to the storage and genetic testing (if applicable) of the samples;

A statement as to whether or not there will be identifying information on the stored samples

A statement that the samples may be used for possible future ***Research***, including the area(s) of ***Research*** for which they will be used, if known;

If applicable: A statement that the ***Research*** subject does not have to agree to the donation of the samples in order to participate in any specific, current known ***Research*** project in which the subject has been asked to participate and for which the sample will be used;

If the samples are being donated, then the consent document should contain a statement to the effect that the subject has voluntarily donated the samples to Emory University; that Emory University will have full control over any further use and disposal of the samples; and that the subject will not have any rights in the samples or any profits or products derived from the samples. If the samples are not donated, then a statement should be included that describes the rights, if any, the subject has with regard to the samples and/or to profits made from products derived from their samples.

A statement regarding who other than the ***PI*** will have access to the samples, and with what identifiers, and whether the PI may transfer or dispose of the samples;

A separate sign-off requesting permission to re-contact the ***Research*** subject if the ***PI*** anticipates a need to verify information;

If samples will retain any codes linkable to the donor: An individual name and number to contact should a ***Research*** subject wish to have their samples destroyed and withdrawn from the future study, along with an explanation that out of respect for the subject, the University will honor such a request to the extent possible even in cases in which the samples are donated and the subject has no further rights in the samples.

The informed consent document for any primary, known ***Research*** project to be conducted using the sample at the time that the sample is received should contain any required elements of informed consent and appropriate additional elements of informed consent (see the P&P entitled *Informed Consent Policy*), as well as the following information:

If applicable: A statement that the subject may participate in the ***Research*** without the necessity for donating a sample for possible future ***Research*** use;

If applicable (verify plans in protocol for Sponsored multicenter studies): A statement that if the subject has not signed a separate consent donating any sample for possible future ***Research*** use, then the sample will be destroyed at the end of the ***Research*** project in which the subject is participating;

If a ***Certificate of Confidentiality*** is appropriate, the Emory IRB will recommend that the PI obtain a ***Certificate of Confidentiality***, and will verify receipt of that ***Certificate of Confidentiality***, and that the protections afforded by this ***Certificate*** are described in the informed consent documents.

Specimens/Data Sent to Outside Repository: If a PI plans to send any specimens/data to an outside repository for storage, AND the specimens/data can be linked back to a ***Research*** subject, the Emory IRB may request one or more of the following:

The identification of the outside repository and a copy of its IRB approval;

An external "Data Use Agreement" between the outside repository and the PI; and

That a ***Certificate of Confidentiality*** be obtained by the PI to assure ***Research*** subject confidentiality if there is not an IRB overseeing the outside repository or when genetic information or tissue samples are involved.

The following defined terms will be used for the purposes of this portion of this policy:

Human Biological Specimens: Any materials derived from ***Human Subjects***, such as blood, urine, tissues, organs, hair, nail clippings, or any other cells or fluids, whether collected for research purposes or as residual specimens from diagnostic, therapeutic or surgical procedures.

Banked Specimens: Those specimens collected and stored for future research programs.

Non-Banked Specimens: Specimens that are used only for the specific purposes described in a protocol and destroyed either when the specific use is complete or at the end of the protocol.

Research protocols requiring RDC review and approval and Emory IRB approval shall be reviewed in accordance with the P&P entitled *Human Subjects Research at the Atlanta Veterans Affairs Health Care System* (*AVAHCS)/Foundation for Atlanta Veterans Education and Research (FAVER).* In general, approval should first be obtained from the Emory IRB before being submitted for review/approval by the RDC.

New ***Research*** protocols submitted to the RDC should include a plan for the collection, processing, disposition and/or banking of ***Human Biological Specimens***. Established ***Research*** protocols must provide such a plan at the time of continuing review.

The RDC will review the informed consent documents to verify that the requirements detailed in VHA Directive 1200.05 (2021) are met, and that the informed consent documents clearly state:

Whether the specimen will be used for future ***Research;***

That the subject will be allowed to choose how the specimen will be used;

Whether ***Research*** results of re-use of the specimen will be conveyed to the subject;

Whether the subject will be re-contacted after the original study is completed; and

That the specimen and all links to the clinical data will be destroyed at the subject's request.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 46, including 46.101, 46.104, 46.110, and 46.116
45 CFR Part 164
42 U.S.C. 241
VHA Directive Section 1200.05(2), 2021
NIH Notice: Notice of Changes to NIH Policy for Issuing Certificates of Confidentiality, September 2017, No. NOT-OD-17-109
NIH Grants Policy 4.1.4 Confidentiality, 2022
OHRP Guidance: Certificates of Confidentiality – Privacy Protection for Research Subjects, February 2003

85 RESEARCH INVOLVING CODED PRIVATE INFORMATION OR BIOLOGICAL SPECIMENS

POLICY:

Any proposed ***Research*** that involves ***Coded Private Information*** or biological specimens shall be reviewed by the Emory IRB to determine whether the ***Research*** is or is not ***Research*** involving ***Human Subjects*** as defined under ***HHS Regulations*** for the protection of ***Human Subjects***.

Under certain conditions, research involving only ***Coded Private Information*** or biological specimens is not ***Human Subjects Research***. Such a determination shall be made based on the OHRP guidance on Coded Private Information or Specimens Use in Research (2008), (hereinafter "OHRP Guidance Document").

PROCEDURES:

The Emory IRB will review the research involving ***Coded Private Information*** or biological specimens to determine whether or not the research is ***Human Subjects Research*** as defined under ***HHS Regulations.***

Use of Private Information **Constituting** ***Human Subjects Research*****:** ***Obtaining Private information*** that is individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) constitutes research involving ***Human Subjects***.

Use of Private Information **that MAY NOT Constitute** ***Human Subjects Research:***

In accordance with the OHRP Guidance Document, research **will not be** considered to be ***Human Subjects Research*** if the following conditions are met:

The private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals; and

The investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:

The key to decipher the code is destroyed before the research begins;

The investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the ***HHS Regulations*** do not require the IRB to review and approve this agreement);

There are IRB-approved written policies and operating procedures for a repository or data management center that prohibit the release of the key to the investigators under any circumstances, until the individuals are deceased; or

There are other legal requirements prohibiting the release of the key to the investigators, until the individuals are deceased.

Results of the review shall be documented in the IRB meeting minutes or in appropriate review documentation.

Research Not Involving *Human Subjects* versus *Exempt Human Subjects Research*:

Research involving ***Private Information or*** *biological specimens* is distinct from ***Human Subjects Research*** that is ***Exempt*** from the requirements of ***HHS Regulations***. ***Exempt Research*** involves ***Human Subjects Research*** as defined in ***HHS Regulations*** but falls under one or more of the exemptions provided under the same regulatory authority (see the P&P entitled *Exempt Research*).

Research Involving Coded Private Information or Biological Specimens subject to FDA Regulations:

In some cases, ***HHS*** conducted or supported research involving ***Private Information*** or biological specimens may be subject to ***FDA Regulations***. The ***FDA*** regulatory definitions of ***Human Subject*** and ***Subject*** differ from the definition of ***Human Subject*** under ***HHS Regulations.***

The OHRP Guidance Document does not apply to research regulated by the ***FDA*** involving coded private information or specimens, and guidance on that research should be obtained directly from the **FDA**.

Comparison with the *HIPAA Privacy Rule*:

The ***HIPAA Privacy Rule*** permits the ***Covered Entity*** to determine that ***Health Information*** is ***De-identified*** even if the ***Health Information*** has been assigned, and retains, a code or other means of record identification, **provided that**:

The code **is not** derived from or related to the information about the individual (see **Note**, below);

The code could not be translated to identify the individual; and

The ***Covered Entity*** under the ***HIPAA Regulations*** does not use or disclose the code for other purposes or disclose the mechanism for re-identification.

Note – Differences between *HIPAA Privacy Rule* and *HHS Regulations*:
There are important differences between the ***HIPAA Privacy Rule*** and ***HHS Regulations*** regarding research involving ***Coded Information*** and Biological Specimens.

In contrast with the ***HHS Regulations*** for the protection of ***Human Subjects***, a key to the coded information may be retained without violating the ***HIPAA Privacy Rule***; however***,*** possession of the key by the investigator(s) will cause research involving ***Coded Information*** to constitute ***Human Subjects Research*** under ***HHS Regulations*** and will therefore be subject to all applicable ***Human Subjects*** protections.

Also, under ***HHS Regulations*** for the protection of ***Human Subjects***, information that is linked with a code derived from identifying information or related to information about the individual **is not** considered to be individually identifiable if the investigators cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimen pertains.
For purposes of ***HIPAA Privacy Rule*** compliance, however, a ***HIPAA Waiver of Authorization*** is still required for research involving ***coded information*** even if the research does **not** constitute ***Human Subjects Research*** under ***HHS Regulations IF*** the code is "derived from or related to the information about the individual."

Applicable Regulations, Policies, and Guidance:

21 CFR Part 50, including 50.3
21 CFR Part 56, including 56.102
21 CFR Part 312, including 312.3
21 CFR Part 812, including 812.3
45 CFR Part 46, including 46.101 46.102, and 46.104
45 CFR Part 160
45 CFR Part 164
HHS Guidance: Institutional Review Boards and the HIPAA Privacy Rule, August 2003, No. 03-5428

86 DEPARTMENT OF ENERGY (DOE)

POLICY:

The Department of Energy (DOE) has adopted the Common Rule at 10 CFR Part 745. Research conducted by or at Emory University that is conducted or supported by the DOE requires compliance with additional regulations. All research conducted at DOE institutions, supported with DOE funds, or performed by DOE employees, including research that is classified and proprietary, whether done domestically or in an international environment, must comply with all federal regulations and DOE requirements that address the protection of human subjects, and must be done under an FWA. These regulations may apply even when a project does not meet the definition of ***human subjects research*** as defined by ***HHS Regulations***.

Requirements for human participant protections for classified research apply to all research conducted or supported by the DOE, including contracts, and including Human Terrain Mapping research.

Requirements for human participant protections and their accompanying Contractor Requirements Documents (CRDs) apply to all research conducted at DOE institutions regardless of funding source, or by DOE employees/contractor personnel regardless of funding source or location conducted, and whether done domestically or in an international environment, and including Human Terrain Mapping research. DOE workers are considered vulnerable subjects and shall be afforded additional protections as determined by the IRB.

PROCEDURES:

Even if the IRB does not view a project as meeting the literal definition of ***human subjects research*** as defined in ***HHS Regulations***, the DOE requires initial review by the IRB of the application and supporting materials to determine whether the individuals included in the research will be properly informed and protected. Adherence to the specific requirements of ***HHS Regulations*** is not required in such a case, but DOE does require that:

- An application and supporting materials be submitted to the IRB;
- The Chair decide the level of review;
- When conducting classified research, the use of exemptions is prohibited. The fact that research meets a particular exemption category may be noted, but review by a convened IRB is required.
- The IRB must have a voting quorum of at least five members, which must include both a non-scientist and a non-affiliated member. This can be the same person.
- The non-affiliated member must be a non-governmental member with the appropriate security clearances. This individual cannot be a current federal employee or contractor.
- Any IRB member can appeal a vote to approve research to the Institutional Official, Secretary of Energy, and Director of the Office of Science and Technology, in that order.
- During the review, the IRB assess risks associated with the research and whether the individuals to be included in such research will be properly informed and protected.

Subject Matter Experts should be used, as needed, in assessing risks and in determining whether risks have been mitigated to the extent practicable (to minimal risk).

- After the review, the IRB sends a letter to the PI indicating that the project has been reviewed in accordance with DOE expectations and will be monitored and tracked by the IRB, which means that the PI will:
    - Implement any IRB recommendations before the project begins;
    - Notify the IRB of any proposed changes to the protocol in the future and ensure IRB review and authorization to proceed before implementing these changes;
    - Provide an annual update to the IRB; and
    - Follow the notification and reporting requirements in DOE Order 443.1C for reporting adverse events, annual update of the DOE HSRD, etc.

Research studies supported by the DOE include both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Generalizable studies in human environments (e.g., occupied homes and offices, classrooms, and transit centers like subway systems and airports) include studies that use tracer chemicals, particles, and/or other materials, such as perfluorocarbons, to characterize airflow.

Generalizable should be viewed in terms of contribution to knowledge within the specific field of study. Generalizable studies also include studies in occupied homes and/or offices that:

- Manipulate the environment to achieve research aims, e.g., increasing humidity and/or reducing influx of outside air through new energy-saving ventilation systems.
- Test new materials (e.g., sequentially changing the filter materials in the HVAC system while monitoring the effects on air quality and energy use).
- Involve collecting information on occupants' views of appliances, materials, or devices installed in their homes or their energy saving behaviors through surveys and focus groups. Some surveys may be online surveys administered through providers such as Amazon Mechanical Turk and Survey Monkey.

For classified human subjects research (in whole or in part):

- Exemptions and expedited review cannot be used. If the research meets a particular exemption or expedited category it may be noted, but full IRB review is required.
- A waiver of informed consent may only be granted by the convened IRB for minimal risk research that qualifies for exemption under 10 CFR Part 745.
- The identity of the sponsoring Federal agency will be disclosed to subjects, unless the sponsor requests that it not be done, because doing so could compromise intelligence sources or methods; the research involves no more than Minimal Risk to subjects; and the IRB determines that by not disclosing the identity, the investigators will not adversely affect the subjects.
- The informed consent document will state that the project is classified, what that means for the purposes of that project, and to which part of the research it applies.
- The IRB must determine whether the potential human subjects need access to classified information to make a valid informed consent decision.
- Any IRB member can appeal an approval decision to the DOE IO, Secretary of Energy, Director of the Office of Science and Technology Policy (OSTP) or designee, and then the

Director of National Intelligence (ODNI) or designee, in that order. The Director of OSTP (or designee), or the Director of National Intelligence (or designee) will review and approve or disapprove the research, or will convene or designate an IRB that is, to the extent possible, made up of unaffiliated members with the appropriate qualifications and clearance to approve or disapprove the research.

- Information on each project that is classified must be submitted annually (or in accordance with the directions and schedules provided by the appropriate HSP program manager) by the responsible HSP program managers.
- If the IRB believes that the project, in whole or in part, can be thoroughly reviewed in an unclassified manner, a request for a waiver from some or all of the requirements of classified HSR can be submitted. The study-specific waiver request must be signed by the IRB Chair and reviewed and approved by the appropriate HSP Program Manager (and if the waiver request relates to an intelligence-related project, also the DOE Office of Intelligence and Counterintelligence). A list of waiver requests and the actions taken will be provided.
- HSR that is classified, in whole or in part, must not be initiated without IRB approval. After IRB approval, the DOE IO reviews and determines whether they will approve/disapprove the project or brief the Secretary about the project prior to their approval/disapproval.

For research involving protected classes:

- Research involving prisoners, children, and individuals with impaired decision making must be conducted in accordance with the appropriate Subpart(s) of ***HHS Regulations***.
- Proper protections must be in place for DOE/NNSA federal and/or contractor employees who may be subject to coercion or undue influence. DOE and DOE site employees are considered vulnerable subjects when participating in research and additional care must be taken to ensure their participation is truly voluntary (e.g., by ensuring they do not report to members of the research team) and that data collected about them is kept confidential.

Protection of Personally Identifiable Information (PII): Researchers are required to follow DOE requirements for the protection of PII by completing and complying with the requirements of the IRB Investigator Checklist for Verification of Compliance with the DOE requirements for the Protection of Personally Identifiable Information (PII) or Protected Health Information (PHI), which can be found on the Emory IRB Website. In order to comply with this checklist, studies under the DOE regulations should provide the following information in the study protocol:

- Process to ensure the confidentiality of PII;
- Releasing PII only under a procedure approved by the responsible IRB(s) and DOE, where required;
- Using PII only for purposes of the IRB, DOE-approved research and/or EEOICPA;
- Handling and marking documents containing PII as “containing PII” or “containing PHI”;
- Establishing reasonable administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of PII;
- Making no further use or disclosure of the PII except when approved by the responsible IRB(s) and DOE, where applicable, and then only under the following circumstances:

- In an emergency affecting the health or safety of any individual;
- For use in another research project under these same conditions and with DOE written authorization;
- For disclosure to a person authorized by the DOE program office for the purpose of an audit related to the project;
- When required by law; or
- With the consent of the participant/guardian

- Protecting PII data stored on removable media (CD, DVD, USB Flash Drives, etc.) using encryption products that are Federal Information Processing Standards (FIPS) 140-2 certified;
- Using passwords to protect PII used in conjunction with FIPS 140-2 certified encryption that meet the current DOE password requirements cited in DOE Guide 205.3-1;
- Sending removable media containing PII, as required, by express overnight service with signature and tracking capability, and shipping hard copy documents double wrapped;
- Encrypting data files containing PII that are being sent by e-mail with FIPS 140-2 certified encryption products;
- Sending passwords that are used to encrypt data files containing PII separately from the encrypted data file (i.e., separate e-mail, telephone call, separate letter);
- Using FIPS 140-2 certified encryption methods for websites established for the submission of information that includes PII;
- Using two-factor authentication for logon access control for remote access to systems and databases that contain PII. (Two-factor authentication is contained in the National Institute of Standards and Technology (NIST) Special Publication 800-63 found at: http://csrc.nist.gov/publications/nistpubs/800-63-1/SP-800-63-1.pdf;
- Reporting the loss or suspected loss of PII immediately upon discovery to (1) the DOE funding office program manager, and (2) the applicable IRBs (as designated by the DOE program manager); if the DOE program manager is unreachable, immediately notify the DOE Joint Cybersecurity Coordination Center.

Research that is conducted by multiple DOE sites is reviewed by one of the two Central DOE IRBs.

Requirement for Reportable Events
Immediately upon learning of an event, researchers must report the following to the HSP Program Manager and the IRB. Immediately is defined as within 48 hours:

- Any significant adverse events, unanticipated risks; and complaints about the research, with a description of any corrective actions taken or to be taken.
- Any suspension or termination of IRB approval of research.
- Any significant non-compliance with HRPP procedures or other requirements.
- Any compromise of personally identifiable information must be reported immediately.

Applicable Regulations, Policies, and Guidance:

10 CFR Part 745
DOE Order 443.1C, 2019

DOE Guidance: Frequently Asked Questions for IRB Manager and Administrators, accessed April 2022

87 DEPARTMENT OF JUSTICE (DOJ)

POLICY:

Research conducted by or at Emory University that is conducted or supported by the Department of Justice (DOJ) requires compliance with additional regulations. The National Institute of Justice (NIJ) and recipients of its funds are required to comply with DOJ regulations at 28 CFR Part 46 (henceforth referred to as ***DOJ Regulations***). If IRB approval is required for a project, applicants must submit a copy of the IRB's approval as well as supporting documentation concerning the IRB's institutional affiliation, necessary assurances, etc., to NIJ prior to the initiation of any research activities that are not exempt from the requirements of ***DOJ Regulations***. The DOJ is not a signatory of the Revised Common rule, the ***DOJ regulations*** regarding human subjects protections remain in effect for DOJ's research awards; the provisions of the Revised Common Rule do not apply. IRB documentation from NIJ/OJP awardees must reflect ***DOJ Regulation*** citations and can no longer be accepted using ***HHS Regulation*** references after January 21, 2019. Exemption categories listed in ***HHS Regulations***' Revised Common Rule cannot be accepted until such time the DOJ has signed on to the Revised Common Rule. However, certain research studies sponsored by NIJ may fall within the scope of Exemptions under 28 CFR section 46.101.

PROCEDURES:

Research conducted within the Bureau of Prisons must have an adequate research design and contribute to the advancement of knowledge about corrections. The Researcher must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the Researcher, as required in 28 CFR 512.

Research requirements: The Organization, IRB and Researchers and Research Staff must follow the requirements of 28 CFR Part 512, including:

- The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing;
- The research design must be compatible with both the operation of prison facilities and protection of human participants. The Researcher must observe the rules of the institution or office in which the research is conducted;
- Any Researcher who is a non-employee of the Bureau must sign a statement in which the Researcher agrees to adhere to the requirements of 28 CFR 512;

All research proposals will be reviewed by the Bureau Research Review Board. The Researcher must have academic preparation or experience in the area of study of the proposed research. When submitting a research protocol, the applicant must provide the following information:

A summary statement, which includes:

- Names and current affiliations of the Researchers;
- Title of the study;
- Purpose of the study;
- Location of the study;

- Methods to be employed;
- Anticipated results;
- Duration of the study;
- Number of participants (staff or inmates) required and amount of time required from each;
- Indication of risk or discomfort involved as a result of participation.

A comprehensive statement, which includes:

- Review of related literature;
- Detailed description of the research method;
- Significance of anticipated results and their contribution to the advancement of knowledge;
- Specific resources required from the Bureau of Prisons;
- Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur, and description of steps taken to minimize any risks;
- Description of physical or administrative procedures to be followed ensure the security of any individually identifiable data that are being collected for the study and to destroy research records or remove individual identifiers from those records when the research has been completed;
- Description of any anticipated effects of the research study on organizational programs and operations;
- Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.

A statement regarding assurances and certification required by federal regulations, if applicable.

NOTE: For research conducted within the Bureau of Prisons, the implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be ***research***.

IRB Responsibilities: The IRB should ensure that studies funded or conducted by the Department of Justice fulfill additional requirements. These requirements include:

- That the selection of participants must be equitable;
- That incentives may not be offered to help persuade inmate participants to participate. However, soft drinks and snacks to be consumed at the test setting may be offered
- That reasonable accommodations such as nominal monetary recompense for time and effort may be offered to non-confined research participants who are both:
    - No longer in Bureau of Prisons custody;
    - Participating in authorized research being conducted by Bureau employees or contractors.

Informed consent requirements: For research studies funded by the National Institute of Justice, the informed consent form should include following elements. Those elements include:

- A statement that the study involves research.
- The name(s) of the funding agency(ies);
- An explanation of the purposes of the research.
- The expected duration of the subjects participation.
- A description of the procedures to be followed and what the subjects will be required to do in the study.
- Identification of any procedures which are experimental.
- A description of any reasonably foreseeable risks or discomforts to the subject. Risks are not limited to physical injury, but also include psychological, social, financial, legal, and others.
- A description of any benefits to the subject or to others that may reasonably be expected from the research; there may be none other than a sense of helping the public at large when balanced by the appropriate level of risk.
- A disclosure of appropriate alternative procedures or course of treatment, if any, that might be advantageous to the subject. In most NIJ studies the alternative will be to not participate in the study.
- A statement describing the extent to which confidentiality of records identifying the subject will be maintained.
    - For studies sponsored by NIJ the subject should be informed that private, identifiable information will be kept confidential and will only be used for research and statistical purposes. If, due to sample size or some unique feature, the identity of the individual cannot be maintained, the participants need to be explicitly notified. If the Researcher intends to disclose any information, the participant needs to be explicitly informed what information would be disclosed, under what circumstances, and to whom. The participant must be informed of any risks that might result from this disclosure and must explicitly provide written consent prior to participating in the research;
    - For research involving more than minimal risk, and explanation as to whether any compensation, and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained.
    - An explanation of whom to contact for answers to questions about the research and research subject's rights, and whom to contact in the event of a research-related injury to the subject. This should include name and telephone number or other appropriate methods.
    - A statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled, and that the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
- A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility.
- Additional elements of informed consent. When appropriate, one or more of the following elements of information shall also be provided to each participant:
    - A statement that the particular treatment or procedure may involve risk to the participant (or to the embryo or fetus, if the participant is or may become pregnant) which are currently unforeseeable;

- Anticipated circumstances under which the participant's participation may be terminated by the researcher without regard to the subject's consent;
- Any additional costs to the participant that may result from participation in the research;
- The consequences of a participant's decision to withdraw from the research and procedures for orderly termination of participation by the participant;
- A statement that significant new findings developed during the course of the research which may relate to the participant's willingness to continue participation will be provided to the participant; and
- The approximate number of participants involved in the study.
- A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, a researcher may not guarantee confidentiality when the participant indicates intent to commit future criminal conduct or harm themself or someone else, or, if the participant is an inmate, indicates intent to leave the facility without authorization.

Additional requirements:

- For National Institute of Justice-funded research: A copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.
- All projects are required to have a privacy certificate approved by the NIJ human subjects protection officer.
- All Researchers and Research Staff are required to sign employee confidentiality statements, which are maintained by the responsible Researcher.

For research conducted with the Bureau of Prisons, the study team should ensure the fulfillment of the following items:

- At least once a year, the Researcher must provide the Chief, Office of Research and Evaluation, with a report on the progress of the research;
  - At least 12 working days before any report of findings is to be released, the Researcher must distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The Researcher must include an abstract in the report of findings;
  - In any publication of results, the Researcher must acknowledge the Bureau's participation in the research project;
  - The Researcher must expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau;
  - Prior to submitting for publication, the results of a research project conducted under this subpart, the Researcher must provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.

- Except for computerized data records maintained at an official DOJ site, records that contain non-disclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system.
- If the Researcher is conducting a study of special interest to the Office of Research and Evaluation (ORE) but the study is not a joint project involving ORE, the Researcher may be asked to provide ORE with the computerized research data, not identifiable to individual participants, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.

Applicable Regulations, Policies, and Guidance:

28 CFR Part 22
28 CFR Part 46
28 CFR Part 512
NIJ Form: Protection of Human Subjects Assurance Identification/IRB Certification/Declaration of Exemption (Common Rule), No. 0990-0263

88 ENVIROMENTAL PROTECTION AGENCY (EPA)

POLICY:

Research conducted or supported by the Environmental Protection Agency (EPA) must be compliant with 40 CFR 26 (henceforth referred to as ***EPA Regulations***), and it sets forth procedures designed to help assure such compliance.

PROCEDURES:

Research studies conducted or supported by the EPA require the submission of IRB determinations and approval to the EPA human subjects research review official for final review and approval before the research can begin.

Specific requirements for vulnerable populations: the IRB will not approve research conducted or supported by the EPA, or intended for submission to the EPA, that intends to intentionally expose human subjects who are pregnant (and therefore their fetuses), nursing, or children to any substance.

Research studies conducted or supported by the EPA requires application of ***EPA Regulations*** Subparts C and D to provide additional protections to pregnant persons and children as participants in observational research (i.e., research that does not involve intentional exposure to any substance).

Research not conducted or supported by any federal agency that has regulations for protecting human research participants and for which the intention of the research is submission to the EPA, the EPA regulations protecting human research participants apply, including:

> EPA extends the provisions of the ***EPA Regulations*** to human research involving the intentional exposure of non-pregnant, non-nursing adults to substances;
>
> EPA prohibits the intentional exposure of pregnant persons, nursing individual, or children to any substance.

EPA-funded studies will adapt regulations of the Department of Health and Human Services providing additional protections beyond those of the Common Rule to pregnant persons, fetuses, and children as subjects in EPA observational research (i.e., research that does not involve intentional exposure to any substance).

The IRB may review and approve observational research involving children that does not involve greater than minimal risk only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in 40 CFR Section 26.406. Research involving greater than minimal risk to the subjects can be approved by IRBs only when justified by direct benefits to the subjects.

The IRB may review and approve observational research involving children that involves greater than minimal risk but presenting the prospect of direct benefit to the individual participants if the IRB finds and documents that:

The intervention or procedure holds out the prospect of direct benefit to the individual participant or is likely to contribute to the participant's well-being;

The risk is justified by the anticipated benefit to the participants;

The relation of the anticipated benefit to the risk is at least as favorable to the participants as that presented by available alternative approaches;

Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in 40 CFR Section 26.406.

Applicable Regulations, Policies, and Guidance:

45 CFR Part 26, including 26.406
EPA Order 1000.17A, 2023

89 GLOSSARY

Abstain: Decline to vote either for or against a proposal or motion.

Abused: See **Adult Abuse** and/or **Child Abuse**.

Adult Abuse: The exploitation, neglect and/or, willful infliction of physical pain, physical injury, Adult Sexual Abuse, mental anguish, unreasonable confinement, or the willful deprivation of essential services, to a Disabled Adult or Elder Person.

"Disabled Adult" means a person 18 years of age or older who not a resident of a Long-Term Care Facility, as defined in OCGA 31-8-4, but who is mentally or physically incapacitated or has Alzheimer's Disease or Dementia.

"Elder Person" means a person 65 years of age or older.

"Exploitation" means the illegal or improper use of a Disabled Adult or Elder Person or that person's resources through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own or another's profit or advantage.

"Long-term Care Facility" means any skilled nursing home, intermediate care home, assisted living community, personal care home, or community living arrangement now or hereafter subject to regulation and licensure by the State of Georgia.

"Long-Term Care Facility Resident or Former Resident" means any person receiving treatment or care, or who previously received treatment or care, in a Long-Term Care Facility

"Neglect" means the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a Disabled Adult or Elder Person.

"Adult Sexual Abuse" means the coercion for the purpose of self-gratification by a guardian or other person supervising the welfare or having immediate charge, control, or custody of a Disabled Adult or Elder Person to engage in any of the following conduct: (a) Lewd exhibition of the genitals or pubic area of any person; (b) Flagellation or torture by or upon a person who is unclothed or partially unclothed; (c) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is unclothed or partially clothed unless physical restraint is medically indicated; (d) Physical contact in an act of sexual stimulation or gratification with any person's unclothed genitals, pubic area, or buttocks or with a female's nude breasts; (e) Defecation or urination for the purpose of sexual stimulation of the viewer; or (f) Penetration of the vagina or rectum by any object except when done as part of a recognized medical or nursing procedure.

Adult: A person, or persons, who has/have attained the legal age of majority under the applicable law of the jurisdiction in which the Research will be conducted.

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

Adverse Experience: An experience or event that has a negative impact or outcome. The experience is undesirable and unintended but not necessarily unexpected and does not necessarily have a causal relationship with the treatment.

Allegation of Non-Compliance: An unproved assertion of Non-Compliance.

Anonymized Information: Information for which all potential identifiers have been removed and no key exists by which the information could be linked back to the individual who provided the specimens.

Anticipated Event: An event (including an experience or event associated with *a* drug or device) that negatively affects the rights, safety or welfare of subjects **and** that *is* described as such in the materials describing risks associated with the study.

Anticipated Problem: An Adverse Experience or event (including an experience or event associated with a drug or device) that negatively affects the rights, safety or welfare of subjects and that is described as such in the materials describing risks associated with the study.

Approval in Principle: 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. One is if the study procedures are to be developed during the course of the Research, but Human Subjects 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 in Principle without having reviewed the as yet 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 Pending: The status of a research protocol that has been submitted and reviewed by the IRB and is missing minor supporting documentation or simple changes to informed consent documents are necessary for approval. The PI may not begin any activities under the Research protocol until the IRB Chair, Vice Chair or a designated reviewer accepts the information/changes on behalf of the Emory IRB.

Approval: The determination by the IRB that the research protocol has been reviewed and may be conducted within the constraints set forth by the IRB and by other institutional and Federal requirements. [21 CFR § 56.102(m), 45 CFR § 46.102(h)]

Approved Research/Approved: Research protocols that have been reviewed by the IRB and that may be conducted as clinical investigations within the constraints set forth by the IRB and by other institutional and Federal requirements [21 CFR § 56.102(m), 45 CFR § 46.102(h)]

Assent: A Child's affirmative agreement to participate in Research. Failure to object, absent affirmative agreement, shall not be construed as Assent. [45 CFR § 46.402(b)].

Assistant Director: The Assistant Director oversees the review process or research protocols and assists the Director in developing, implementing, evaluating and improving operational policies and procedures related research protocols. The Assistant Director's is also responsible for: updating Emory FWA, Emory IRB registration and IRB Committee membership rosters; providing updates to OHRP; maintaining updated P&Ps; and ensuring agreements are in place for review of Human Subjects Research from other entities and/or deferral to other IRBs for review of Emory-related Research involving Human Subjects.

Associated: One of the following types of connectivity between an event or experience and interventions associated with a study**:**

Definitely Associated: Any event that meets all four of the following conditions: (a) has a reasonable temporal relationship to the intervention; (b) could not readily have been produced by the research participant's clinical state; (c) could not readily have been due to environmental or other interventions; or (d) follows a known pattern of response to the intervention.

Possibly Associated: Any event that: (a) has a reasonable temporal relationship to the intervention; (b) could not readily have been produced by the research participant's clinical state; (c) could not readily have been due to environmental or other interventions; or (d) follows a known pattern of response to the intervention.

Probably Associated: Any event that meets three of the following conditions: (a) has a reasonable temporal relationship to the intervention; (b) could not readily have been produced by the research participant's clinical state; (c) could not readily have been due to environmental or other interventions; or (d) follows a known pattern of response to the intervention.

Foundation for Atlanta Veterans Education and Research (FAVER): Non-profit foundation associated with the AVAHCS to support research done at AVAHCS.

Atlanta Veterans Affairs Health Care System (AVAHCS): The Veterans Affairs Administration Medical Center that is located in Atlanta with which Emory University has a Memorandum of Understanding regarding certain matters concerning medical services and Research.

AVAHCS Memorandum of Understanding The document that outlines the responsibilities of the AVAHCS/FAVER and Emory University through its Emory IRB. Emory University, AVAHCS, and the FAVER have documented their relationship through the AVAHCS Memorandum of Understanding. The Emory IRB is subject to and agrees to abide by the terms of its FWA: Number FWA00005792 (the Emory FWA). The Emory IRB agrees to provide initial review of and oversight to AVAHCS Research in accordance with the

terms and conditions of the Emory FWA and per the requirements set forth in these P&Ps.

AVAHCS Research and Development Committee (RDC): Committee operated by AVAHCS that is responsible for reviewing and approving all Human Subjects Research projects that take place at the AVAHCS.

AVAHCS Research Office: AVAHCS office that provides administrative support AVAHCS Research and the RDC.

AVAHCS Research Compliance Office: AVAHCS office that provides compliance oversight for AVAHCS Research.

AVAHCS Research: All Human Subjects Research that is to be undertaken by or under the direction of the AVAHCS or FAVER, involving AVAHCS patients, conducted at the AVAHCS and/or carried out by AVAHCS-paid PIs. All AVAHCS Research must be reviewed and approved by both the Emory IRB and the RDC.

Belmont Report: The Belmont Report attempts to summarize the basic ethical principles identified by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research during the course of the Commission's deliberations in February, 1976. It is a statement of basic ethical principles and guidelines that should assist in resolving the ethical problems that surround the conduct of research with human subjects.

Broad Consent: Consent for an unspecified range of future research subject to a few content and/or process restrictions.

Captured or Detained Personnel: For purposes of ***Research*** conducted or supported by the ***DOD*** that incorporates requirements specific to the Department of the Navy, ***Captured or Detained Personnel*** are defined as "any person captured, detained, held or otherwise under the control of DOD personnel, including Enemy Prisoners of War, Civilian Internees, Retained Persons, Lawful and Unlawful Enemy Combatants. This term does not include DOD personnel held for law enforcement purposes.

Certificate of Confidentiality*:* A certificate of confidentiality is granted by NIH to protect identifiable study data from discovery pursuant to legal process. Regardless of funding source, NIH may grant a Certificate of Confidentiality to protect information that: (a) is identifiable; (b) is for research approved by the IRB; and (c) constitutes Sensitive Information.

Chair: The Emory IRB Committee member whose duty it is to convene and chair IRB Committee meetings. The Chair provides day-to-day oversight and leadership for the IRB Committee. The Chair's duties include making the ultimate decision with regard to which research protocols require IRB review and the type of review required. The Chair will also perform Expedited Reviews or delegate such reviews to Vice Chairs or other designated reviewers who are members of the Emory IRB.

Child abuse: Includes Child Abuse, Child Sexual Abuse, and Child Sexual Exploitation where "Child Abuse" means: (A) Physical injury or death inflicted upon a child by a parent or

caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child; (B) Neglect or exploitation of a child by a parent or caretaker thereof; (C) Child Sexual Abuse; or (D) Child Sexual Exploitation.

"Child Sexual Abuse" means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves: (A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex; (B) Bestiality; (C) Masturbation; (D) Lewd exhibition of the genitals or pubic area of any person; (E) Flagellation or torture by or upon a person who is nude; (F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude; (G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts; (H) Defecation or urination for the purpose of sexual stimulation; or (I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

Child Sexual Abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than five years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

"Child Sexual Exploitation" means conduct by any person who allows, permits, encourages, or requires that child to engage in: (A) Prostitution, as defined in O.C.G.A. Section 16-6-9; or (B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in O.C.G.A. Section 16-12-100

Child Law Enforcement Agencies: Any Child welfare agency providing protective services, as designated by the Georgia Department of Human Resources; or, in the absence of such agency, to an appropriate police authority or district attorney.

Child/Children: Person(s) under the legal age for consent to treatments or procedures involved in the Research under the law of the jurisdiction in which the Research is to be conducted. [45 CFR § 46.402(a)]. [NOTE: In Georgia, generally a person who has not attained 18 years of age is considered a Child, but there are certain procedures to which a person younger than 18 years of age can consent, as discussed in **Section 42** (entitled: Legally Authorized Representatives & Surrogate Consent). Researchers should consult legal counsel for the University with regard to determining the legal age of consent in jurisdictions other than Georgia.]

CITI Training Course: The **"**Collaborative IRB Training Initiative ("CITI") Human Subjects Research Education Program" a web-based program of courses for Biomedical Researchers and courses for Social Behavioral Researchers, each focused on a different aspect of bio-ethics and human subjects research.

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(i) or 520(g) of the FDA Act, or is not subject to requirements for prior submission to the FDA under these sections of the FDA Act, but the results of which are

intended to be submitted later to, or held for inspection by, the FDA as part of an application for a research or marketing permit. The term does not include Experiments that are subject to the provisions of Part 58 [of Title 21 of the CFR], regarding non-clinical laboratory studies. The terms research, clinical research, clinical study, study, and clinical investigation are synonymous for the purposes of FDA regulations. [21 CFR Section 50.3(c), 21 CFR 56.102(c)].

Clinical Trial (HHS Definition): 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 (§ 46.102).

Coded: (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 (i.e., the code); and (2) a key to decipher the code exists, enabling the linkage of the identifying information to the private information or specimens. Guidance on Research Involving Coded Private Information or Biological Specimens (October 16,, 2008) at www.hhs.gov/ohrp/humansubjects/guidance/cdebiol.htm

Coded Information: Information that would enable the Investigator to readily ascertain the identity of an individual or individual's specimen that has been replaced with a number, letter, symbol, or combination thereof. Coded information also includes a key to decipher the code, enabling linkage of the identifying information to the private information or specimens.

Collaborative Research: a study where parts of the protocol are conducted at different sites outside of Emory University or Emory Healthcare.

Common Rule, The: Refers to the codification of federal policy for the protection of human subjects. DHHS regulations incorporate the Common Rule as Subpart A of 45 CFR 46. The common rule is incorporated in various other parts of the Code of Federal Regulations for other federal agencies which may be involved in human subjects research.

Compassionate Use: The FDA's Compassionate Use provisions allow access to Investigational Medical Devices for patients who do not meet the requirements for inclusion in the clinical investigation but for whom the treating physician believes the device may provide a benefit in treating and/or diagnosing their disease or condition. The provision is typically approved for individual patients but may be approved to treat a small group.

Conflict of Interest (COI): means any ***Significant Financial Interest*** Requiring Disclosure that is determined by Emory University to significantly and directly affect the design, conduct or reporting of research. *See also:* **Financial Conflict of Interest**

Continuing Non-Compliance: A pattern of non-compliance that indicates a lack of understanding or disregard for the regulations or institutional requirements that protect the rights and welfare of participants and others, compromises the scientific integrity of a study such that important conclusions can no longer be reached, suggests a likelihood that non-compliance will continue without intervention, or involves frequent instances of minor non-compliance. Continuing non-compliance may also include failure to

respond to a request from the IRB to resolve an episode of non-compliance or a pattern of minor non-compliance.

Continuing Review: Except for human research studies that have been granted Exempt registration, DHHS and FDA regulations require the Emory IRB to conduct substantive and meaningful review of ongoing research at intervals appropriate to the potential risk to participants, but at least annually [45 CFR § 46.109(e) and 21 CFR § 56.109(f)]. Continuing Review is the process through which the Emory IRB meets this statutory requirement.

CoRe (Compliance Review) team: A designated group of the IRB Chair, Director, and qualified IRB staff and/or qualified compliance staff from the AVAHCS (for VA cases only) to investigate cases of reported events (including alleged non-compliance, potential UPs, potentially serious or continuing non-compliance), suspensions, and determinations. The CoRe team triages cases to determine whether they need review at a convened meeting of the Emory IRB. The CoRe may engage the assistance of ad hoc consultants. The CoRe team also reviews Conflict of Interest management plans, which they may also refer for further review at a convened IRB meeting.

Corrective and Preventive Action (CAPA) Plan: a plan developed by an investigator, with or without the assistance and guidance of the IRB, following a root cause analysis into an instance of noncompliance or other problems in the conduct of human subjects research. The CAPA must include measures designed to correct the immediate problem and prevent its recurrence or the recurrence of a similar type of problem. CAPA plans are reviewed and may be modified by the IRB before being approved. Investigators are responsible for implementing CAPAs in a timely manner.

Covered Component: a component of a Hybrid Covered Entity that functions as a Health Plan, Health Care Clearinghouse; or Health Care Provider that transmits any Health Information in electronic form in connection with a transaction covered under HIPAA regulations, as defined at 45 CFR §160.103. [45 CFR §160.103].

Covered Entity: A health plan, a health care clearinghouse or a health care provider that transmits any health information in electronic form in connection with a transaction covered by HIPAA regulations. The Emory Units that are a part of an Emory University Covered Component are considered to be Covered Entities.

Covered Function: Those functions of a Covered Entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

Data and Safety Monitor (DSM): An individual assigned to conduct interim monitoring of accumulating data from Research activities to assure the continuing safety of Human Subjects, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. The individual should have expertise in the relevant medical, ethical, safety and scientific issues.

Data and Safety Monitoring Board (DSMB): A formally appointed independent group consisting of at least three (3) members assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of Human Subjects,

relevance of the study question, appropriateness of the study, and integrity of the accumulating data. Membership should include expertise in the relevant field of study, statistics, and Research study design.

Data and Safety Monitoring Committee (DSMC): Another term for DSMB.

Data and Safety Monitoring Plan (DSMP): A DSMP describes how the Principle Investigator plans to oversee the Human Subject's safety and welfare and how adverse events will be characterized and reported. The intensity and frequency of monitoring should be tailored to fit the expected risk level, complexity, and size of the particular study.

Dead Fetus: A Fetus that does not exhibit heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles nor pulsation of the umbilical cord.

Deferral: The action taken by the Emory IRB to postpone approval if substantive and complex additional information is needed to assess that required criteria for approval are met per 45 CFR 46.111/21 CFR 56.111. Upon revision of the application and resubmission to the IRB, the study must be reviewed by Convened IRB.

Delivery: Complete separation of the Fetus from the pregnant person by expulsion or extraction or any other means.

Department of Defense (DOD) Regulations: The rules set forth by the Office of the Secretary of Defense through Title 32 of the Code of Federal Regulations, Part 219.

Department of Defense (DOD) Requirements: All mandates set forth in the regulations set forth at 32 CFR Part 219; and any DOD unit specific mandates, i.e., mandates specific to the DOD unit (Navy, Marine Corps, etc.) that is conducting or supporting the research.

Designated Reviewer: A member who has been designated by the Chair or designee to perform expedited reviews on a term basis, indefinitely, preferably in writing. To be eligible for consideration as a Designated Reviewer, the person must be a member of the Emory IRB and meet current training requirements.

Department of Health and Human Services (HHS): The United States government's principal agency for protecting the health of all Americans and providing essential human services. The department includes more than 300 programs, covering a wide spectrum of activities.

Diagnostic Medical Device: An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve 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 its primary intended purposes. [21 U.S.C. § 321(h)].

Director: The member of the Emory IRB who directs, manages, implements and administers policies and procedures related to research involving human subjects. The Director provides for all compliance and regulatory functions of the IRB ensuring adherence to all federal, state, and local regulations and policies governing research involving human

subjects including the Belmont Report and the requirements set forth in Title 45, Part 46 of the Code of Federal Regulations

Disability: A substantial disruption of a person's ability to conduct routine life activities in comparison to level of function prior to the event. [21 CFR § 312.32(a)]

Disabled Adult: An Adult who is subject to Adult Abuse as a result of that Adult's mental or physical incapacity and who is in need of Protective Services.

Disapproval/Disapprove: Research protocols that have been reviewed by the IRB and the IRB determines that the information is so lacking or the science is inappropriate for the study to occur.

DSM: see *Data and Safety Monitor*

DSMB: see *Data and Safety Monitoring Board*

DSMC: see *Data and Safety Monitoring Committee*

DSMP: see *Data and Safety Monitoring Plan*

Egregious Event: an event of the highest seriousness, that will require a report to other offices within our HRPP or the Emory University at large. Examples of egregious events are surgery occurring on the wrong side of the body, dispensation of an incorrect drug, and fabrication or falsification of data.

Elder Person: A person 65 years of age or older who is not a resident of a long-term care facility as defined in O.C.G.A. Title 31, Chapter 8, Article 4.

Electronic Protected Health Information or ePHI: individually identifiable health information that is transmitted by electronic media or maintained in electronic media. [45 CFR §160.103].

Emancipated Minor: A person who has not attained the legal age of majority under the applicable law of the jurisdiction in which the Research will be conducted, but who is otherwise considered to have the legal capacity of an Adult due to the person's specific circumstances or status. For example, in Georgia a person under 18 who is married is considered to be an Emancipated Minor.

Emergency Research: A limited class of research activities involving human subjects who are in need of emergency medical intervention but cannot provide legally effective informed consent. [21 CFR § 50.24(a)]

Emory-affiliated Site: Any site owned or operated by Emory University or Emory Healthcare, as well as the AVAHCS, CHOA, Grady Healthcare, and any other entity subject to Emory IRB oversight by written agreement.

Emory IRB: Emory University's Institutional Review Board. The Emory IRB has been formally designated by the University to review research involving humans as subjects, to approve the initiation of and conduct periodic review of such research. [21 C.F.R. § 50.3(i)]

Emory University Covered Component: Any of the units that make up the Emory University Robert Woodruff Health Sciences Center including the School of Medicine, School of Nursing, School of Public Health, and Yerkes National Primate Research Center; Emory Healthcare; Emory Hospitals; Emory Student Health Services; Emory Psychological

Center; University Counseling Center and Oxford College Student Health Service and Counseling Center.

Emory University HIPAA: Emory University's policies and procedures that ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) for all Emory University biomedical research involving humans as subjects.

Employees or Agents: Per the OHRP formal guidance on engagement, an institution's *employees or agents* refers to individuals who: (1) act on behalf of the institution; (2) exercise institutional authority or responsibility; or (3) perform institutionally designated activities. "Employees and agents" can include staff, students receiving credit toward their university degree, contractors, and volunteers, among others, regardless of whether the individual is receiving compensation.

Engaged in Human Subjects Research: An institution is considered to be engaged in ***Human Subjects Research*** whenever 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; or (2) Identifiable Private Information about the subjects of the Research, unless the activity falls into one or more of the exceptions listed in OHRP's formal guidance on engagement of institutions in human subjects research (http://www.hhs.gov/ohrp/policy/engage08.html and http://www.hhs.gov/ohrp/policy/institutions/ohrp20090113.html). This definition and the OHRP guidance are also used by the Emory IRB to determine when *individuals* are considered "engaged" in human subjects research activity.

Enrollment: A subject is considered to be enrolled in a study when they gives informed consent to participate. Accessing the identifiable information of an individual similarly counts as enrolling a subject.

Essential Services: Social, medical, psychiatric, or legal services necessary to safeguard the Disabled Adult's or Elder Person's rights and resources and to maintain the physical and mental well-being of such person. These services shall include, but not be limited to, the provision of medical care for physical and mental health needs, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, and protection from health and safety hazards but shall not include the taking into physical custody of a Disabled Adult or Elder Person without that person's consent.

Ex Officio: A non-voting consultant of the IRB whose involvement is dependent upon the office from which they represent.

Exempt Research: Research that is not subject to regulation under 45 CFR § 46 because it falls under the narrow exceptions set forth under 45 CFR 46.101(b).

Expedited/Expedited Review: A procedure through which certain kinds of research may be reviewed and approved without convening a meeting of the IRB. The FDA and OHRP regulations (21 CFR § 56.110 and 45 CFR § 46.110 respectively) permit, but do not require, an IRB to review certain categories of research through an expedited procedure if the research involves no more than minimal risk. The IRB may also use the expedited review procedure to review minor changes in previously approved research during the period covered by the original approval.

Experiment: Any use of a drug other than the use of a marketed (FDA approved) drug in the course of medical practice. [21 CFR 312.3(b)].

Expiration Date: The date on which a protocol expires. Failure on the part of the PI to submit a protocol for continuing review prior to the protocol's expiration date shall result in expiration of the protocol and immediate termination of all research-related activities, except for limited subject safety measures, as delineated by federal regulations.

Exploitation: The illegal or improper use of a Disabled Adult or Elder Person or that person's resources for another's profit or advantage.

External events: Events that involve study participants who are not enrolled at a study site approved by the Emory IRB, or where the PI is not under the oversight of the Emory IRB. The PI typically receives notification of these Experiences from the Sponsor (e.g., Investigator Alert, Med Watch Reports).

External Serious Adverse Experiences: Adverse Experiences that involve study participants who are not enrolled at a study site approved by the Emory IRB, or where the PI is not under the oversight of the Emory IRB. The PI typically receives notification of these Experiences from the Sponsor (e.g., Investigator Alert, MedWatch Reports).

Family Member: Any 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 a Human Subject is the equivalent of a family relationship. [21 CFR 50.3 (m)].

FDA Regulations: The rules set forth by the U.S. Department of Health and Human Services, Food and Drug Administration through Title 21 of the Code of Federal Regulations.

FDA Regulations' Definition of Human Subject: An individual who is or becomes a participant in Research, either as a recipient of the Test Article or as a control. A subject may be either a healthy human or a patient. [21 CFR Section 50.3(g)]. In the case of an investigational medical device, a human subject/participant also means a human on whose specimen an investigational medical device is used.

FDA Regulations' Definition of Institutional Review Board: Any board, committee or other group formally designated by an institution to review, to approve the initiation of, and to conduct periodic review of, biomedical Research involving Human Subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the Human Subjects. This term has the meaning as the phrase "institutional review committee as used in Section 520(g) of the FDA Act. [21 CFR Section 56.102(g)].

FDA-regulated research: research using a drug, device or biologic, approved for marketing or not, outlined under 21 CFR 312 (drugs), 21 CFR 812 (devices), and 21 CFR 600 (biologics). FDA regulations for informed consent (21 CFR 50) and Institutional Review Boards (21 CFR 56) also apply

Federalwide Assurance (FWA): A FWA is an assurance of compliance with applicable federal regulations for the protection of Human Subjects in all Research conducted under the auspices of the institution holding the assurance and that is conducted or supported by any U.S. department or agency that has adopted the Common Rule (see above). An FWA is approved by OHRP, as an agency of DHHS, for federal-wide use, and therefore,

other federal departments and agencies that have adopted the Common Rule may rely upon the FWA for the Human Subjects Research that they conduct or support.

Emory FWA: FWA 5792, held by Emory University. The Institutional Official (IO) who has signed the Emory FWA is the Vice President for Research Administration, Emory University. The Human Protections Administrator named on the Emory FWA is the Emory IRB Director.

Fetal Material: Material obtained from a dead Fetus after Delivery, including, but not limited to, macerated fetal material and/or cells, tissue or organs excised from a dead Fetus. [45 CFR § 46.206(a)]

Fetus: The product of conception from implantation until Delivery. [45 CFR § 46.202(c)].

Final Approval Date: When a Research protocol is granted Approval Pending, the PI must provide the IRB Committee with documentation that they have provided any additional information or made any changes requested by the IRB Committee. The PI may not begin any activities under the Research protocol until the IRB Chair, Vice Chair or a designated reviewer accepts the information/changes on behalf of the Emory IRB. The date on which the information/changes are accepted is the Final Approval Date, and the Emory IRB shall send a written notice that sets forth the Final Approval Date and notifies the PI that the Research protocol is now approved.

Financial Conflict of Interest: A conflict of interest that exists when a designated reviewer(s) of the University reasonably determines that a ***Significant Financial Interest*** of an Investigator will directly and significantly affect the design, conduct, or reporting of research.

Full Committee Review: Review of proposed research at a convened meeting of the IRB, at which a majority of the membership of the IRB are present, including at least one member whose primary concerns are in a nonscientific area [45 CFR § 46.109; 21 CFR § 56.108].

Full Committee: A majority of the membership of the IRB, including at least one member whose primary concerns are in a nonscientific area.

Full Review: see *Full Committee review*.

FWA: see *Federalwide Assurance*.

Generalizable Knowledge: knowledge from which conclusions will be drawn that can be applied to populations outside of the specific study population. This usually includes one or more of the following concepts: Knowledge that contributes to a theoretical framework of an established body of knowledge; the primary beneficiaries of the research are other researchers, scholars, and practitioners in the field of study; dissemination of the results is intended to inform the field of study (though this alone does not make an activity constitute research "designed to contribute to generalizable knowledge"); the results are expected to be generalized to a larger population beyond the site of data collection; the results are intended to be replicated in other settings.

Genetic Information: With respect to an individual, information about (i) the individual's Genetic Tests; (ii) the Genetic Tests of family members of the individual; (iii) the

manifestation of a disease or disorder in family members of such individual; or (iv) any request for, or receipt of Genetic Services, or participation in clinical research which includes Genetic Services, by the individual or any family member of the individual. This definition includes the genetic information of a fetus carried by the individual or a family member who is a pregnant person; and an embryo legally held by an individual or family member utilizing assisted reproductive technology. This definition excludes information about the age or sex of an individual.

Genetic Services: (1) a Genetic Test; (2) genetic counseling (including obtaining, interpreting, or assessing genetic information); or (3) genetic education.

Genetic Test: An analysis of human DNA, RNA, chromosomes, proteins, or metabolites, of the analysis detects genotypes mutations, or chromosomal changes. Genetic test does not include an analysis of proteins of metabolites that is directly related to a manifested disease, disorder or pathological condition.

Guardian: An individual who is authorized under applicable State or local law to consent on behalf of a Child to general medical care, [45 CFR § 46.402(e)] or when an FDA-regulated item is involved, to consent on behalf of a Child to general medical care when general medical care includes participation in Research, or who is authorized to consent on behalf of a Child to participate in Research. [21 CFR § 50.3(g)].

Health Information: any information, including Genetic 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.

Health Insurance Portability and Accountability Act (HIPAA): HIPAA is the Health Insurance Portability and Accountability Act, the federal law passed in 1996 that provides national standards and privacy protections for health information. It allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. HIPAA establishes standards for privacy and security, unique health identifiers, as well as standards for Electronic Data Interchange (EDI). The two main goals of HIPAA are: making health insurance more portable when persons change employers, and making the health care system more accountable for costs, trying especially to reduce waste and fraud. [45 CFR §§ 160, 164].

HHS Regulations: The HHS Regulations set forth the Federal Policy for the Protection of Human Subjects.

HHS Regulations' Definition of Human Subject: A living individual about whom an investigator (whether professional or student) conducting Research obtains: (a) data through Intervention or Interaction with the individual; or (b) Identifiable Private Information. [45 CFR Section 46.102(f).]

HHS Regulations' Definition of Institutional Review Board: An Institutional Review Board established in accord with and for the purposes expressed in the HHS Regulations. [45 CFR Section 46.102(g)].

HHS Secretary: The head of the United States Department of Health and Human Services.

HHS: see *Department of Health and Human Services.*

HIPAA Authorization: The signed authorization which must be provided by an individual before a covered entity can use their PHI for research purposes. There are several areas where authorizations are likely to come into use. These areas include psychotherapy notes, research (except where waived by an IRB or privacy board determination) marketing, fundraising, and general requests for the release of protected health information (such as information required as part of an insurance coverage application). [45 CFR § 164.508].

HIPAA Privacy Officer: The individual responsible for developing, implementing, and maintaining the Privacy Policies and Procedures regarding the privacy of Protected Health Information (PHI). The Privacy Officer is responsible for compliance with the HIPAA Privacy Rule for Emory. [45 CFR. § 164.530(a)].

HIPAA Privacy Policies: Emory's policies and procedures that are developed to make Emory compliant with the HIPAA standards, implementation specifications, and other requirements of the HIPAA Privacy Regulations.

HIPAA Privacy Regulations: 45 CFR §§ 160 and 164, Subsections A and E. These Sections of The Code of Federal Regulations set forth what PHI must be protected under the HIPAA Privacy Rule.

HIPAA Privacy Rule: The Privacy Rule, at 45 CFR §§ 160 and 164, establishes a category of health information, defined as protected health information (PHI), that a covered entity may only use or disclose to others in certain circumstances and under certain conditions. In general, the Privacy Rule requires an individual to provide signed permission, known as an Authorization under section 164.508 of the Privacy Rule, before a covered entity can use or disclose the individual's PHI for research purposes.

HIPAA Regulations: The federal regulations found at 45 CFR Parts 160 and 164.

HIPAA Security Officer: The individual responsible for development, implementation, and oversight of the organization's security policies and procedures as they relate to patient health information.

HIPAA Security Policies: Policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information.

HIPAA Security Regulations: 45 CFR §§ 160 and 164, Subsections A and E. These provisions of the Code of Federal Regulations set forth what electronic PHI ("ePHI") must be protected under the HIPAA Security Rule.

HIPAA Security Rule Policies: The Security Rule is intended to ensure the confidentiality, integrity, and availability of all ePHI an organization creates, receives, maintains, or transmits; protect against threats or hazards to the security or integrity of such information; protect against uses or disclosure of such information that are not permitted or required by the Privacy Rule; and ensure compliance by a covered entity's workforce**.** Unlike the HIPAA Privacy Rule, which applies to protected health information (PHI) in "any form or medium," the Security Rule covers only PHI that is electronically stored or transmitted by covered entities. (Hence the abbreviation ePHI).

Although protection against unauthorized use or disclosure is also a core goal here, this standard aims at assuring the integrity and availability of electronic PHI too. As such, the Security Rule addresses issues such as data backup, disaster recovery and emergency operations. The three key areas to satisfying HIPAA security are administrative safeguards (process and documentation), technical safeguards (methods for securing systems containing ePHI), and physical safeguards (ensuring that facility and environmental factors do not impact systems contaminant ePHI).

HIPAA Waiver/Waivers of HIPAA Authorization: In certain circumstances, the Emory IRB may grant a complete or partial waiver of the HIPAA Authorization requirement and permit a researcher working in or receiving information from an Emory Covered Component to access identifiable health information without a subject's written HIPAA Authorization. The IRB will not grant an alteration or waiver of the HIPAA Authorization requirement, in whole or in part, unless the researcher has submitted a HIPAA Waiver Application that establishes that specific "Waiver Criteria" are met.

HIPAA: see *Health Insurance Portability and Accountability Act.*

HIPAA-Covered Billing: means transmitting Health Information in electronic form in connection with a transaction covered under HIPAA (i.e., submitting a claim to a health plan electronically).

Human Fetal Material: Material obtained from a dead Fetus after Delivery, including, but no limited to, macerated fetal material and/or cells, tissue or organs excised from a Dead Fetus. [45 CFR § 46.206(a)]

Human Fetal Tissue, Embryonic Tissue or Cell Research: Research that involves human embryonic stem cells, germ cells, stem cell-derived test articles and/or the transplantation of Human Fetal Tissue for therapeutic purposes.

Human Fetal Tissue: Tissue or cells obtained from a dead human embryo or ***Fetus*** after a spontaneous or induced abortion, or after a stillbirth. [42 USC § 498A(g)].

Human Fetal/Embryonic Tissue or Cell Research: Research that involves human embryonic stem cells, germ cells, stem cell-derived test articles and/or the transplantation of Human Fetal Tissue for therapeutic purposes.

Human Research Protection Program (HRPP): The Emory HRPP is a multi-tiered program involving the administration of the University, the ***Institutional Official,*** the ***Institutional Review Board***, other research administrative and compliance offices, investigators and research support staff. The HRPP includes mechanisms to:

- Establish a formal process to monitor, evaluate and continually improve the protection of human research participants.
- Dedicate resources sufficient to do so.
- Educate investigators and research staff about their ethical responsibility to protect research participants.
- When appropriate, intervene in research and/or respond directly to concerns of research participants.

Emory University fosters a ***Research*** environment that promotes the respect for the rights and welfare of individuals recruited for, or participating in, ***Research*** conducted

by or under the auspices of Emory University. Emory University is guided by applicable laws, regulations and principles in its review and conduct of ***Human Subjects Research.*** To fulfill this mission, Emory University has established a Human Research Protection Program. The mission of the Emory HRPP is:

- To safeguard and promote the dignity and well-being of participants in research conducted at or by Emory by assuring their rights, safety and welfare are protected;
- To provide timely and high quality review and monitoring of human subjects research; and
- To facilitate excellence in human subjects research by providing accurate guidance and education to Emory investigators, IRB members, and research officials.
- To ensure compliance with all regulatory and ethical obligations involved in Human Subjects Research conducted at or by Emory.

Human Subject(s): An individual who meets the definition of this term: (a) as set forth in the ***HHS Regulations*** (specified below); (b) and, for projects subject to ***FDA Regulations,*** the definition of this term as set forth in the ***FDA Regulations*** (specified below); and (c) for projects conducted or supported by the ***DOD*** the definition of ***Research Involving a Human as an Experimental Subject*** (specified below).

Human Subjects Research: Research that involves Human Subjects, including, for protocols subject to a DOD Addendum, Research Involving a Human Being as an Experimental Subjects.

Human Subjects Research (DOD Definition*):* Research that involves Human Subjects and/or for research projects conducted by or at Emory University that are conducted or supported by the ***DOD***, ***Research Involving a Human Being as an Experimental Subject*** (defined below).

Human Subject (FDA Definition): An individual who is or becomes a participant in ***Research***, either as a recipient of the ***Test Article*** or as a control. A subject may be either a healthy human or a patient. [21 CFR Section 50.3(g)]. When medical device research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as human subjects

Human Subject (HHS Definition) pre Revised Common Rule: A living individual about whom an investigator (whether professional or student) conducting Research obtains: (a) data through ***Intervention*** or Interaction with the individual; or (b) Identifiable Private Information. [45 CFR Section 46.102(f).]

Human Subject (post *Revised Common Rule*): A living individual about whom an investigator (whether professional or student) conducting Research obtains: (a) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (b) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens. [45 CFR Section 46.102(e).]

Human Subjects' Legally Authorized Representatives: see *Legally Authorized Representative.*

Humanitarian Use Device (HUD) means a medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in not more than 8,000 individuals in the United States per year. [21 CFR 814.3(n)].

Humanitarian Use Device Exemptions (HDEs) are exemptions provided by the Food and Drug Administration (FDA) to allow the use and marketing of an investigational device that is "intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or are manifested in not more than 8,000 individuals per year in the United States." [21 CFR 814.3(n)].

Hybrid Covered Entity: single legal entity (a) that is a Covered Entity; (b) that conducts business activities that include both Covered and Non-Covered Functions; and (c) that designates Health Care Covered Components in accordance with 45 CFR 164.105(a)(2)(iii)(C). [45 CFR § 164.103].

Immediately Life-Threatening Disease or Condition: A stage of disease in which there is reasonably likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

Individual Investigator Agreement (IIA): A mechanism wherein an institution holding a FWA may extend the applicability of its FWA to cover two types of collaborating individual investigators: independent or institutional. Investigators covered by an IIA may not be an employee or agent of the assured institution and must be conducting the ***Collaborative research*** activities outside the facilities of the assured institution. Independent investigators must furthermore not be an employee or agent of any institution with respect to their involvement in the research being conducted by the assured institution. Institutional investigators must furthermore be acting an employee or agent of a non-assured institution which does not routinely conduct human subject's research.

Individually Identifiable Health Information or Individually Identifiable Private Information: Health Information, including demographic information collected from an Individual that is: (a) created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse; and (b) 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 (i) that identifies the Individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. [45 CFR §160.103].

Individually Identifiable: Information in a form such that the identity of the Human Subject is or may readily be ascertained by the Investigator or associated with the information. [45 CFR Section 46.102(f)].

Informed Consent: A person's voluntary agreement, based upon adequate knowledge and understanding of relevant information, to participate in research or to undergo a diagnostic, therapeutic, or preventive procedure. In giving informed consent, participants may not waive or appear to waive any of their legal rights, or release or appear to release the investigator, the sponsor, the institution or ***Agents*** thereof from liability for negligence. [21 CFR 50.20 and 50.25, 45 CFR § 46.116]

Institutional Authorization Agreement (IAA): An agreement that permits one or more institutions to cede review of human subjects research to another institution's IRB or to an independent IRB. The agreement sets forth the authorities, roles, and responsibilities of each institution and their IRBs when ceding or providing IRB review.

Institutional Official (IO). The IO is the university official responsible for ensuring that the Emory HRPP has the resources and support necessary to comply with all federal regulations and guidelines that govern human subjects 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. The IO is the point of contact for correspondence addressing human subjects research with OHRP and FDA. For AVAHCS Research, the IO is the Medical Center Director of the AVAHCS.

Institutional Privacy Board: Any board, committee or other group formally designated by an institution to determine whether an activity in question requires compliance with HIPAA Privacy Policies, and if so the processes and procedures that must be followed.

Institutional Review Board (IRB): A convened group that meets the definition of this term as set forth in the HHS Regulations (specified below) and, for projects subject to FDA Regulations, the definition of the term as set forth in the FDA Regulations (specified below): HHS Regulations' Definition of Institutional Review Board: An Institutional Review Board established in accord with and for the purposes expressed in the HHS Regulations. [45 CFR Section 46.102(g)]. FDA Regulations' Definition of Institutional Review Board: Any board, committee or other group formally designated by an institution to review, to approve the initiation of, and to conduct periodic review of, biomedical Research involving Human Subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the Human Subjects. This term has the meaning as the phrase "institutional review committee as used in Section 520(g) of the FDA Act. [21 CFR Section 56.102(g)].

Interaction: Interaction includes communication or interpersonal contact between investigator and ***Human Subject***. [45 CFR Section 46.102(f)].

Intervention (pre *Revised Common Rule*): Both physical procedures, by which data are gathered (e.g., venipuncture), and manipulations of the Human Subject's or the Human Subject's environment that are performed for Human Subjects Research purposes. Intervention includes communication or interpersonal contact between Investigator and Human Subject. [45 CFR Section 46.102(f)].

Intervention (after *Revised Common Rule*): Both physical procedures, by which information or biospecimens are gathered (e.g.,

Investigational Device Exemption (IDE) An IDE allows an Investigational Device to be used in a clinical study in order to collect the safety and effectiveness data required to support a Premarket Approval (PMA) application or a Premarket Notification submission to the Food and Drug Administration (FDA). [21 CFR § 812(c)].

Investigational Device: means a device, including a transitional device that is the object of an investigation. [21 CFR § 812.3(g)] An investigational device is permitted by the FDA to be tested in humans but not yet determined to be safe and effective for a particular use in the general population and not yet licensed for marketing.

Investigational Drug or Investigational New Drug: An Investigational Drug or Investigational New Drug means a new drug or biological drug that is used in a clinical investigation or a biological product that is used in vitro for diagnostic purposes. [21 CFR § 312.3(b)]

Investigational New Drug Application: An application that must be submitted to the FDA before a drug can be studied in humans. This application includes results of previous experiments; how, where, and by whom the new studies will be conducted; the chemical structure of the compound; how it is thought to work in the body; any toxic effects found in animal studies; and how the compound is manufactured. [21 CFR § 312]

Investigator (or **Researcher**): A person (whether professional or student) who conducts Research. Any person (including but not limited to the Primary Investigator, any collaborator, co-investigator, staff member, student or visiting professor) who is responsible for the design, conduct or reporting of the Research project or proposed Research project. When an FDA-regulated item is involved, it means an individual who actually conducts a clinical investigation (i.e., under whose immediate direction the test article is administered or dispensed to, or used involving, a subject) or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team [21 CFR § 56.102(h)]. For purposes of the Conflict of Interest Policy, Investigator shall include the Investigator's spouse or domestic partner and dependent children. [See 42 CFR Section 50.603 & 45 CFR Section 94.3].

IO: see *Institutional Official*

IRB Committees: The committees who hold regularly scheduled meetings for the purpose of providing initial and continuing review for Research protocols that come before the Emory IRB and for conducting IRB business.

Legal Guardian: An individual who is authorized under applicable State or local law to consent on behalf of a Child to general medical care, [45 CFR 46.402(e)] or when an FDA-regulated item is involved, to consent on behalf of a Child to general medical care when general medical care includes participation in Research, or who is authorized to consent on behalf of a Child to participate in Research [21 CFR 50.3(q)]. [NOTE: In Georgia, the Guardian of a Minor is a person who has a legal relationship with a Minor in which the person is given responsibility for the care of the Minor. For Research conducted in jurisdictions other than Georgia, the Research must comply with the laws of the jurisdiction in which the Research is conducted. Legal counsel for the University will provide assistance with regard to making determinations as to applicable law.]

Legally Authorized Representative: An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research. If there is no applicable law addressing this issue, legally authorized representative means an individual recognized by institutional policy as acceptable for providing consent in the non-research context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research. [45 CFR Section 46.102(i), 21 CFR § 50.3(l)]

Life-Threatening Adverse Experience: Any Adverse Experience that places the patient or subject, in the view of the Investigator, at immediate risk or death from the reaction as it occurred.

Limited IRB Review: review that allows certain research to be categorized as exempt, even when the identifiable information might be sensitive or potentially harmful if disclosed. To qualify for exemption, the study must meet the standards of the limited IRB review, as specified under § __.104 (Exempt Research)

Medical Device: Any health care product that does not achieve its primary intended purpose by chemical action or by being metabolized. [21 U.S.C. § 321(h)].

Minimal Risk: The probability and magnitude of harm or discomfort anticipated in the Research are not greater than and of themselves than those ordinarily encountered in daily life or during the performance or routine physical or psychological examination or tests. [45 CFR Section 46.102(i); 21 CFR Sections 50.3(k) & 56.102(i)]. For ***Research*** involving ***Prisoners***, ***Minimal Risk*** is defined as 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. For ***Research*** funded or conducted by the ***Department of Defense***, the phrase "ordinarily encountered in daily life or during the performance of routine physical or physiological examinations or tests" is not interpreted to include the inherent risks certain categories of human subjects face in their everyday life (for example, in their work environment or through having a medical condition).

Minimum Necessary Rule: In determining the type and scope of the PHI for which the IRB determines use or access under a Waiver of HIPAA Authorization is necessary, the IRB must limit access to only that PHI which is reasonably necessary to accomplish the purpose for which the request is made. For example, if the research requires access only to certain test results in order to accomplish the purpose of the research, the IRB should deny a request by the researcher for access to the entire medical record. If an Emory Covered Component is disclosing the PHI, it may rely on a researcher's documentation or representations that the information being requested is the minimum necessary if the documentation/representations have been reviewed by the IRB and reliance is reasonable under the circumstances.

Minor: A person who has not attained the legal age of majority under the applicable law of the jurisdiction in which the Research will be conducted. In the State of Georgia the legal age of majority is 18 years of age.

Multi-site Research (Study): Study with more than one site, affiliated or not with Emory University or Emory Healthcare, where the same protocol is conducted at each site.

Neglect: The absence or omission of Essential Services to the degree that it harms or threatens with harm the physical or emotional health of a Disabled Adult or Elder Person.

Neonate: A newborn. [21 CFR § 46.202(d)].

Non-Compliance: Failure to comply with any of the regulations and policies in these P&Ps and failure to follow the determinations of the IRB. Non-compliance may be minor or sporadic or it may be serious and/or continuing. Non-Compliance can be on the part of Researchers, staff, other employees, and of the IRB.

Non-Scientist Member: Member of an IRB who does not have a scientific background, but may be affiliated with the institution [45 CFR § 46.107(c); and, 21 CFR § 56.107(c)]. At least one nonscientist member must be present at convened meetings to approve research [45 CFR § 46.108(b); and, 21 CFR § 56.108(c)].

Non-Significant Risk Device: A device that does not pose a significant risk to human subjects. Examples of Non-Significant Risk Devices include most daily wear contact lenses and Foley catheters. [21 CFR § 812.3]

Nonviable Neonate: A Neonate after Delivery that, although living, is not Viable. [45 CFR § 46.202(e)].

Not Associated: Any experience or event for which there is evidence that it was Definitely Associated with a cause other than the investigational drug/agent/therapy.

Not Within the Definition of Research: Activities that do not meet the statutory definition of research as set forth in [45 CFR § 46.102.]

Obtaining: Means receiving or accessing identifiable private information or identifiable specimens for **Research** purposes.

Office of Human Research Protections (OHRP): The administrative agency that oversees the United States' system for protecting volunteers in research conducted or supported by the U.S. Department of Health and Human Services (HHS).

Other Research Review Committees: Separate Emory University and non-Emory University Committees (collectively referred to in this section as the "Other Research Review Committees") that have responsibilities with regard to the review of Research, including Human Subjects Research, conducted at Emory University, by Emory University faculty, staff or students, or using Emory University resources. These include (a) Emory University Radiation Safety Committee (RSC); (b) Emory University Institutional Health & Biosafety Committee (IHBC); (c) Emory University Conflict of Commitment and Conflict of Interest Committee(s); and (d) National Institutes of Health (NIH) Recombinant DNA Advisory Committee (RAC).

Parent: A Child's biological or adoptive mother or father. [45 CFR § 46.402(d)].

Payment: activities (a) undertaken by a Health Plan to obtain premiums or determine coverage and provision of benefits; or (b) undertaken by a Health Care Provider or Health Plan to obtain or provide reimbursement for providing Health Care. [45 CFR § 164.501].

Pediatrics Designation: A classification assigned to research protocols involving children as Human Subjects.

Periodically Reportable: Events that the PI is required to report to the IRB within a certain time frame, which is most commonly at the time of renewal.

Permission: Agreement of the Parent(s) or Guardian(s) to participation of their Child or ward in Research. [45 CFR § 46.402 (c)].

PHI: see *Protected Health Information.*

PI: see ***Principal Investigator***.

PI's Research: The ***Principal Investigators*** Research based on the design set forth in the Research Protocol and approved by the Emory IRB.

Planned Emergency Research is the planned conduct of Research in life-threatening, emergency situation in which the IRB has approved the waiver of informed consent

Policy & Procedures (P&P) Subcommittee: A committee made up of at least three members of the IRB whose duty it will be, at least yearly, to participate in the review and revision of the IRB's Policies and Procedures.

Pregnancy: The period of time from implantation until delivery. A person assigned female at birth shall be assumed to be pregnant if they exhibit any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

Pregnant Person: A person who is experiencing Pregnancy.

Premarket Notification: An application submitted to the FDA to demonstrate that the medical device to be marketed is substantially equivalent to a legally marketed device that was or is currently on the U.S. market. [21 CFR § 807]

Pre-marketing Approval: (PMA) FDA approval granted after a drug's manufacturer (the "Sponsor") has demonstrated the safety and effectiveness of the drug to the FDA through data gathered in clinical investigations [21 CFR § 814]

Promptly Reportable: Events that the PI is required to report to the IRB within 10 business days if serious and 30 calendar days if not serious.

Protocol Deviations: A deviation is a departure from the IRB-approved protocol. Deviations may represent minor departures and/or non-compliance.

Principal Investigator (PI): The scientist or scholar with ultimate responsibility for the design and conduct of a research project.

Prisoner Representative: A member of the IRB who is knowledgeable about and experienced in working with Prisoners. [45 CFR § 46.107(a)]

Prisoner: Any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial or sentencing. [45 CFR § 46.303(c)].

Prisoner of War: For purposes of ***Research*** conducted or supported by the ***DOD*** that incorporates
requirements specific to the Department of the Navy, a ***Prisoner of War*** is a detained person as defined in Articles 4 and 5 of the *Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949*. In particular, one who, while engaged in combat under orders of their government, is captured by the armed forces of the enemy. For purposes of ***Research*** conducted or supported by the ***DOD*** from a DOD unit other than the Department of the Navy, that unit's definition of the term ***Prisoner of War*** shall apply.

Privacy Officer: The individual who oversees all ongoing activities related to the development, implementation, maintenance of, and adherence to the organization's policies and procedures covering the privacy of, and access to, patient health information in

compliance with federal and state laws and the healthcare organization's information privacy practices.

Private Information (before *Revised Common Rule*): Information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private Information must be Individually Identifiable in order for the obtaining the information to constitute Human Subjects Research. [45 CFR Section 46.102(f)].

Private Information (after *Revised Common Rule*): Information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Identifiable private information is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information. An identifiable biospecimen is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen [45 CFR Section 46.102(e)].

Prospective: Research utilizing human participants' specimens/data that will be collected after the Research protocol is approved by the IRB.

Protected Health Information (PHI): Individually Identifiable Health Information that a Covered Entity transmits or maintains in electronic media, or in any other form or medium, excluding Individually Identifiable Health Information in records covered by the Family Educational Rights and Privacy Act (FERPA); certain student health records as defined in FERPA at 20 U.S.C. 1232g(a)(4)(B)(iv); employment records held by a Covered Entity in its role as employer; and records regarding a person who has been deceased for more than 50 years.

Protective Services: Services necessary to protect a Disabled Adult or Elder Person from Adult Abuse. Such services shall include, but not be limited to, evaluation of the need for services and mobilization of essential services on behalf of a Disabled Adult or Elder Person.

Protocol Analyst: The individual who**,** in consultation with the IRB Director or Assistant Director, shall make a preliminary review of Research protocols and other submissions to determine applicability of HIPAA Privacy Policies and forward recommendations in this regard to IRB Chair or Vice Chair. Protocol Analysts shall consult with the Emory University Privacy Officer as necessary with regard to matters concerning compliance with HIPAA regulations.

Protocol Application: The initial submission of a human subjects research plan by an investigator. All new protocol applications to the Emory IRB are currently filed through the eIRB online system found at: https://eresearch.emory.edu/Emory. Materials must include, but are not limited to, the scientific plan, informed consent and HIPAA materials, recruiting plan and materials, data and safety monitoring plan, site approval letters, and data collection instruments such as questionnaires.

Protocol Deviation/Protocol Non-Compliance, Minor: A deviation from a Research protocol that was approved by the Emory IRB or non-compliance with a ***Research*** protocol that does not (a) adversely affect the rights, welfare or safety of subjects; (b) adversely affect the integrity of ***Research*** data; (c) adversely affect the subjects willingness to continue participation in the ***Research;*** or (d) was not undertaken to prevent an immediate hazard to a human subject.

Psychotherapy Notes: 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.

Qualified Interpreter: an individual who has the characteristics and skills necessary to interpret for an individual with a disability, for an individual with limited English proficiency, or for both. The fact that an individual has above average familiarity with speaking or understanding a language other than English does not suffice to make that individual a qualified interpreter for an individual with limited English proficiency.

Qualified Translator: an individual who has the characteristics and skills necessary to translate a document in a foreign language to English or vice versa. A translator must have adequate training or a certification in order to perform these duties, and provide a translation certificate documenting the validity of the translation.

Quorum: A quorum is the minimum number of members that must be present to conduct official Emory IRB business. A ***Quorum*** shall be established when the following criteria are met: (a) a majority of the primary IRB members (or their designated alternates) are present (e.g., ***Quorum*** for an ***IRB Committee*** of sixteen (16) primary members would be nine (9)); (b) one of the voting members present is a non-Emory non-scientist (see **Section 21,** *IRB Membership*); (c) if a protocol involving an FDA-regulated article is being reviewed, then a licensed physician must be present.

RDC: see *Research and Development Committee.*

Reliance Agreement: A blanket term which encompasses institutional authorization agreements, individual investigator agreements, umbrella authorization agreements, memorandums of understanding relating to reliance, and any other version of an agreement through which Emory provides IRB review for outside institution or investigator or cedes IRB review to an outside entity.

Relying Party: The relying party is the individual, site, institution, or entity that has ceded IRB review to an external IRB for a ***Multi-site or Collaborative*** human subjects ***Research*** study pursuant to a reliance agreement.

Report of Non-Compliance: An allegation of Non-Compliance that is can reasonably be taken as true without the need for further investigation (e.g., self-report of Non-Compliance received from PI).

Research and Development Committee (RDC): A Committee operated by VAMC that is responsible for reviewing and approving all human subjects research projects that take place at the VAMC.

Research Protocol Analysts: see *Protocol Analyst.*

Research protocols: The formal design or plan of an experiment or research activity. The protocol includes a description of the research design or methodology to be employed, the eligibility requirements for prospective subjects and controls, the treatment regimen(s), and the proposed methods of analysis that will be performed on the collected data.

Research: A Clinical Investigation (as defined above) or a Systematic Investigation, including research development, testing and evaluation, designed to develop or contribute to Generalizable Knowledge. [45 CFR § 46.102(d); 45 CFR § 164.501]. Activities that meet this definition constitute Research for purposes of the HHS Regulations whether or not they are conducted or supported under a program that is considered Research for other purposes. For example, some demonstration and service programs may include Research activities. [45 CFR § 102(d)].

For the purposes of the COI Policy, this term encompasses basic and applied Research as well as product testing and development. The term includes, but is not limited to, any activity for which Research funding is available from a Public Health Service component that awards funds under grants, cooperative agreements or otherwise. For the purposes of FDA regulations, the terms research, clinical research, clinical study, study, and clinical investigation are synonymous [21 CFR 50.3 (c), 21 CFR 56.102(c)].

Research Involving a Human Being as an Experimental Subject: For conducted or supported by the ***DOD***, this term means an activity, for research purposes, where there is an intervention or interaction with a human being for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Examples of interventions or interactions include, but are not limited to, a physical procedure, a drug, a manipulation of the subject or subject's environment, the withholding of an intervention that would have been undertaken if not for the research purpose. This term does not include:

Activities carried out for the purposes of diagnosis, treatment or prevention of injury and disease in members of the Armed Forces and other mission essential personnel under Force Health Protection programs of the DOD.

Authorized health and medical activities as part of the reasonable practice of medicine or other health professions.

Monitoring for compliance of individuals and organizations with requirements applicable to military, civilian or contractor personnel or to organizational units. This includes activities such as drug testing, occupational health and safety monitoring and security clearance reviews.

Research Senior Leadership Compliance Team ReSeLeCT) The **ReSeLeCT** is composed of representatives from all University units that have day-to-day operational responsibility

for University Research compliance activities. The **ReSeLeCT** meets on a monthly basis to ensure that dialog and coordination is maintained among the various units at the University that have compliance responsibilities.

Researcher: see *investigator*.

Retrospective: Research utilizing human participants' specimens/data that were previously collected (i.e., on the shelf) before the Research was approved by the IRB.

Revised Common Rule, the: rule at https://www.govinfo.gov/content/pkg/FR-2017-01-19/pdf/2017-01058.pdf

Reviewing IRB: Also called IRB of record, single IRB (usually in the context of NIH-funded research), or central IRB/independent IRB (usually in the context of a commercial IRB service); the Reviewing IRB is the IRB that conducts IRB review on behalf of another institution or entity pursuant to a reliance agreement when Emory is involved in ***Multi-Site or Collaborative*** human subjects ***Research***.

SAE: see *serious adverse event.*

Secondary research: Research use of information or biospecimens originally collected for non-research purposes (e.g., leftover blood from routine clinical tests, general information collected for the census) or research studies other than the proposed one (e.g., use of blood samples left over from a study evaluating a new diabetes drug for a new study on genetic predisposition of diabetic patients to Alzheimer's disease)

Select Agents: Those biological agents listed in 7 CFR § 331, 9 CFR § 121, and 42 CFR § 73. The agents and toxins subject to requirements under these Sections are those that have the potential to pose a severe threat to public health and safety.

Senior Research Protocol Analysts: The member of the Emory IRB whose duty it is to provide guidance to PIs regarding consent forms and process; HIPAA forms; and changes to protocols recommended by the IRB Chair, Vice Chair, or IRB Committee members.

Senior Reviewer: a senior IRB staff member, qualified IRB member, or the Chair or a Vice-Chair of the Emory IRB.

Sensitive Information: Sensitive Information is information regarding sexual attitudes, preferences or practices; information relating to the use of alcohol, drugs or other addictive products; information regarding an individual's psychological well-being or mental health; genetic information or tissue samples; or information that if released might be damaging to an individuals' financial standing, employability or reputation within the community or might lead to social stigmatization or discrimination.

Serious Adverse Event (SAE): Any adverse experiences occurring that result in any of the following outcomes: death, a life-threatening adverse experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect. For the purposes of this policy, death is never expected.

Serious Disease or Condition: A disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will

usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

Serious Non-Compliance: Failure to follow any of the regulations and policies described in these P&Ps of failure to follow the determination of the IRB and which, in the judgment of either the IRB Chair or the convened IRB, increases risks to participants, decreases potential benefits, or compromises the integrity of the Human Research Protections Program. Research being conducted without prior IRB approval is considered Serious Non-Compliance.

Serious: Significant harm or increased risk for human subjects or others, including the following circumstances: findings from tests in laboratory animals that suggest a significant risk for humans (including reports of mutagenicity, teratogenicity or carcinogenicity); placing the subject at immediate risk of death; in-patient hospitalization or prolongation of existing hospitalization; persistent or significant disability or incapacity; congenital anomaly/birth defect; or any important medical event, when based upon appropriate medical judgment, the event may jeopardize the subject's health or welfare and may require medical or surgical intervention to prevent death, life-threatening adverse experience, in-patient hospitalization, prolongation of existing hospitalization, persistent or significant disability or incapacity, or congenital anomaly or birth defect

Sexual Abuse: A person's employing, using, persuading, inducing, enticing, or coercing any Minor who is not that person's spouse to engage in any act which involves: Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex; Bestiality; Masturbation; Lewd exhibition of the genitals or pubic area of any person; Flagellation or torture by or upon a person who is nude; Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude; Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts; Defecation or urination for the purpose of sexual stimulation; or Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure. Sexual Abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an Adult who is not more than five years older than the Minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

Sexual Exploitation: Conduct by a Child's Parent or caretaker who allows, permits, encourages, or requires that Child to engage in: Prostitution, as defined in Official Code of Georgia Annotated (O.C.G.A.) Section 16-6-9; or Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in O.C.G.A. Section 16-12-100

Short Form: A written consent document stating that the elements of informed consent required by 45 CFR § 46.116 have been presented orally to the subject or the subject's legally authorized representative. [45 CFR § 46.117(b)(2)].

Significant Financial Interest: means holding any management position (e.g., director, officer,

trustee, management employee) in a for-profit entity, or anything of monetary value, including but not limited to, gifts to the Investigator, salary or other payments for services (e.g., consulting fees or honoraria); equity interests (e.g., stocks, stock options or other ownership interests); receipt of patent/copyright licensing fees or royalties; and technology related to an Investigator's teaching, research, administrative, or clinical duties at Emory.

*The following items are **NOT** considered to be a **Significant Financial Interest**:*

(a) Salary or other payments for services from Emory University.
(b) Gifts to Emory University provided the Investigator does not have signing authority for the Emory account.
(c) Income from non-promotional educational seminars, lectures, or teaching engagements sponsored and paid for by governmental entities.
(d) Income from service on advisory committees or review panels established by and paid for by governmental entities.
(e) Salary or other Compensation that when aggregated for the Investigator and the Investigator's spouse or domestic partner and dependent children currently and over the next 12 months are less than $5,000 UNLESS the value of the Compensation can be affected by the Investigator's Research, in which case ANY amount of Compensation shall be considered to be a ***Significant Financial Interest***.
(f) Equity interests in publicly traded companies [1] , excluding mutual funds, that are less than $5,000 in value as determined through reference to public prices or other reasonable measures of fair market value.

[1] A publicly traded company is one whose stock is traded on a stock exchange such as NYSE, NASDAQ, etc. All equity holdings in privately held companies related to Research must be reported.

Significant Financial Interest* Requiring Disclosure** means, for non-PHS projects, an Investigator's ***Significant Financial Interest (a) that would reasonably appear to be affected by the Research on which the Investigator is working; or (b) that is held in an entity whose financial interests would reasonably appear to be affected by the Investigator's Research.

PHS Investigators must disclose all ***Significant Financial Interests*** related to their Institutional Responsibilities – teaching, research, clinical or administrative duties. Additionally, they must disclose any reimbursed or sponsored travel (i.e., the travel was paid for on their behalf, but not reimbursed to them by Emory), related to their administrative, clinical, or teaching duties at Emory. It does not include travel that is reimbursed or sponsored by the following:

- Federal, state, or local government agency,
- an Institution of higher education,
- academic teaching hospital,
- medical center, or

- research institute that is affiliated with an Institution of a higher education.

Significant Risk Device: A Investigational Medical Device that (i) is intended as an implant and presents a potential for serious risk to the health, safety or welfare of a subject; (ii) is for use in supporting or sustaining human life and represents a potential for serious risk to the health, safety or welfare of a subject; (iii) 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 (iv) otherwise presents a potential for serious risk to a subject. Examples of Significant Risk Devices include orthopedic implants, and cardiac pacemakers. [21 CFR § 812.3(m)].

Sponsor: A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator. [21 CFR § 312.3].

Study Personnel: Includes ***Principal Investigators***, co-investigators, research coordinators, and any other research team members, including students, who have contact with research participants and/or their research data and identifiers for the conduct of the study. In general, individuals participating in the informed consent process are considered to be Study personnel. In general, individuals whose primary contact with the subject is in the context of clinical care, or who function solely as ***Qualified Interpreters***, are not considered Study personnel if they play no further role in the research.

Suspend/Suspension: An action taken by the IRB for any reason to temporarily withdraw approval for some or all **Research** activities short of permanently withdrawing approval for all ***Research*** activities. ***Suspended*** protocols are considered open (though not for enrollment or other Research activities), and the IRB will advise on a case-by-case basis if continuing review applications are required during a period of ***Suspension***.

Systematic Investigation: An activity that involves a prospective Research plan which incorporates data collection, either quantitative or qualitative, and data analysis to answer a Research question.

Tabled: The IRB removes the item from a Convened IRB agenda prior to discussion or vote, due to loss of quorum or a determination that the submission is not ready for review.

Terminate/Termination: An action taken by the IRB for any reason to permanently withdraw approval for all Research activities (except for those follow up procedures which are necessary to protect the health or welfare of the subjects). Terminated protocols are considered closed and do not require Continuing Review.

Test Article. A test article is a drug, device, or other article including a biological product used in clinical investigations involving human subjects or their specimens.

Treatment: the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party; consultation between Health Care Providers relating to a patient; or referral of a patient from one Health Care Provider to

another. Additionally, and solely for purposes of determining whether Research includes Treatment, the definition of Treatment shall also include the administration of a drug, device or procedure to normal, healthy volunteers in the context of a clinical investigation. [45 CFR §164.501].

Treatment Use of an Investigational New Drug: The Treatment Use provisions of the FDA Regulations permit certain Investigational New Drugs to be used for the treatment of patients who are not enrolled as subject under the IND under which the drug is being studied. In general, in the case of a serious disease, the FDA may permit drugs to be made available for Treatment Use during Phase 3 clinical investigations or after all clinical trials have been completed, but before approval is granted. In the case of life-threatening illnesses, a drug may be made available for Treatment Use earlier than Phase 3 clinical investigations, but not ordinarily earlier than Phase 2 trials. [21 CFR § 312.34.]

Treatment Use Protocol: Treatment Use of a drug may be made under a Treatment Use Protocol obtained by the Sponsor. The Sponsor who holds the IND under which the Investigational Drug is being studied may serve as a Sponsor for the Treatment Use of the drug by submitting a Treatment Use Protocol to the FDA for approval. Licensed physicians who receive the Investigational Drug for use under a Treatment Use Protocol are considered to be PIs, and must meet all PI obligations. This mechanism allows promising investigational drugs to be used in "expanded access" protocols--relatively unrestricted studies in which the intent is both to learn more about the drugs, especially their safety, and to provide treatment for people with immediately life-threatening or otherwise serious diseases for which there is no real alternative. These expanded access protocols also require researchers to formally investigate the drugs in well-controlled studies and to supply some evidence that the drugs are likely to be helpful. The drugs cannot expose patients to unreasonable risk. [21 CFR § 312.34.]

Unanticipated Adverse Drug Experience: An Unexpected Adverse Experience that is associated with the use of a drug, such that there is a reasonable possibility that the experience may have been caused by the drug.

Unanticipated Event: An event or experience that has not been previously observed and/or described in the documents describing risks associated with the study or in the investigator brochure (rather than from the perspective of such experience not being anticipated from the properties of the investigational item).

Unanticipated and Unexpected, as applied to VA Research: The terms “unanticipated” and “unexpected” refer to an event or problem in VA research that is new or greater than previously known in terms of nature, severity, or frequency, given the procedures described in protocol-related documents and the characteristics of the study population (VHA HANDBOOK 1058.01, under DEFINITIONS §4 BB.P6).

Unanticipated Problem Involving Risks to Participants or Others (referred to herein as **UP**): Any unexpected problem related to the Research, including any Unexpected Adverse Experience, whether Serious or not, that affects the rights, safety or welfare of subject or others or that significantly impacts the integrity of the Research data. The problem may be physical, or it could involve social harm or risk (i.e., breach of confidentiality or

harm to a subject's reputation) or psychological or legal harm or risk thereof in the future. The problem may or may not involve drugs or devices. Examples: (a) breach of confidentiality stemming from theft of lap top computer containing identifiable data; (b) protocol violations; (c) complaints about research procedures or treatment by research study personnel.

(**Please note**: it is important to bear in mind that a UP as defined here is not the opposite of an Anticipated Problem (defined above). The key distinction lies in the qualifying phrase "involving risk to participants or others." By contrast, the true opposite of an Anticipated Problem would be an Adverse Experience or event (including an experience or event associated with a drug or device) that negatively affects the rights, safety or welfare of subjects and that is **not** described as such in the materials describing risks associated with the study.)

Unexpected Adverse Device Effect: Any Unexpected Adverse Experience that impacts a research subject's health or safety, or poses 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 any supplement); OR any other serious Unanticipated Problem associated with a device that relates to a subject's rights, safety, or welfare.

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

Unexpected Adverse Experience: Any ***Adverse Experience***, the specificity or severity of which is not consistent with the risk information described in the general investigational plan; the current IRB application for the research protocol; or the current investigator's brochure. Examples: (a) hepatic necrosis would be unexpected (by virtue of greater severity) if the investigator brochure (or other generally accepted medical literature) only referred to elevated hepatic enzymes or hepatitis; and (b) cerebral thromboembolism and cerebral vasculitis would be unexpected (by virtue of greater specificity) if the investigator brochure only listed cerebral vascular accidents. An ***Unexpected Adverse Experience*** (including those that involve drugs or devices) may constitute an ***Unanticipated Problem***.

Unexpected Experience: An event or experience that has not been previously observed and/or described in the documents describing risks associated with the study or in the investigator brochure.

VA Regulations: The Federal Policy for the Protection of Human Subjects (the ***Common Rule***) as adopted by the Department of Veterans Affairs and set forth in 38 CFR Part 16 and Veterans Health Administration Handbook 1200.05, which sets forth the procedures implementing the ***Common Rule***, are collectively referred to herein as the ***VA Regulations***. **VA Research:** see *AVAHCS Research.*

VA: see *Atlanta Veterans Affairs Health Care System.*

Viable: A neonate who, after Delivery, is able to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration. [45 CFR § 46.202(h)].

Vice-Chair: The Emory IRB Committee member whose duty it is to assume and perform the responsibilities of the IRB Chair in the Chair's absence. The Vice Chair will perform other duties as delegated by the IRB Chair and as set forth elsewhere in these P&Ps. On OHRP roster, listed as Alternate Chair.

Voting Member: An IRB member whose presence during review of an item at a convened meeting is counted toward satisfaction of the compositional requirements for that review, and is therefore eligible to vote on that item.

Vulnerable Populations: This is a regulatory phrase which refers to a group of people who have some condition or situation that makes them more susceptible to coercion or undue influence [45 CFR § 46.107(a)].

Wards of the State: Children who are under the care of a governmental agency either directly or through placement in an individual or institutional foster care setting.

Workforce: employees, volunteers, trainees and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate is under the direct control of the Covered Entity or Business Associate, whether or not they are paid. [45 CFR §160.103].