UNIVERSITY OF ILLINOIS, COLLEGE OF MEDICINE PEORIA INSTITUTIONAL REVIEW BOARD

POLICY & PROCEDURE MANUAL

Version 3.4

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<td>Approved By: Sara L. Rusch, M.D., MACP Regional Dean University of Illinois College of Medicine Peoria</td>
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UNIVERSITY OF ILLINOIS

COLLEGE OF MEDICINE PEORIA
INSTITUTIONAL REVIEW BOARD
ONE ILLINI DRIVE
PEORIA, IL 61605

University of Illinois, College of Medicine Peoria (UICOMP)
for Faculty, Staff, and Student Researchers

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08/29/18
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Section 1: Introduction

1.1 Purpose and Scope of the Policy and Procedure Manual

This policy and procedure manual, and any additional relevant standard operating procedures, describes the Human Subject Protections Program (HSPP) at the University of Illinois, College of Medicine Peoria (UICOMP). The UICOMP HSPP encompasses the Peoria Institutional Review Board (PEORIA IRB), the Human Subjects Education Program, the Continuous Quality Improvement & Monitoring Initiative, the Institutional Official (IO), and the Human Protections Administrator (HPA).

UICOMP’s Office of Human Research Oversight (OHRO) is responsible for the administration and operations of the UICOMP HSPP to serve UICOMP’s students, residents, and employed faculty and is responsible for the operations of the PEORIA IRB for its Affiliated Community Institutions as illustrated below:
The PEORIA IRB is a community IRB that serves as the IRB of record for UICOMP student, resident and employed faculty research and also as an IRB for its Affiliated Community Institutions.

This manual also describes the policies and procedures followed by the PEORIA IRB that are integral to the UICOMP HSPP and to the Affiliated Community Institutions served by the PEORIA IRB.

The goal of the UICOMP HSPP is to provide IRB review and education to researchers regarding the ethical and responsible conduct of human subjects research and to protect the rights and welfare of individuals who participate in research.

The PEORIA IRB is engaged:

- Before research is initiated
- During research if the protocol requires continuing review
- During research if the research protocol needs to change
- During research if an unanticipated problem occurs
- After research ends in order to close the file

The UICOMP HSPP is charged with additional responsibilities for research conducted at or under the auspices of the University and to ensure UICOMP's compliance with federal regulations regarding the protection of human subjects.

To uphold this charge, UICOMP policy requires all UICOMP employed faculty, students, or staff engaged in human subjects research to work directly and conscientiously with the PEORIA IRB and the Office of Human Research Oversight at the following times:

- Before research is initiated
- During research if the protocol requires continuing review
- During research if the research protocol needs to change
- During research if an unanticipated problem occurs
- During compliance review auditing
- After research ends in order to close the file

The HSPP works with UICOMP faculty, students, or staff engaged in human subjects research as primary research stakeholders. The OHRO, through its IRB services, works with the affiliated community institutions (i.e., those institutions holding an FWA, and a PEORIA IRB Authorization Agreement or Memorandum of Understanding), as secondary research stakeholders.

This manual includes the policies and procedures required under the terms of UICOMP Federalwide Assurance FWA00005172. In addition, the manual includes the Institutional
Review Board (IRB) policies and procedures governing the University of Illinois, College of Medicine Peoria IRBs that are registered with the Office of Human Research Protections (OHRP) as IRB00000688 and IRB00000689. These IRBs are registered as the University of Illinois, College of Medicine Peoria IRB #I, and IRB #II. IRB I meets once a month and reviews all protocols. IRB II meets immediately after IRB I and was established for those studies that include mandatory contraception. Consent forms reviewed in IRB II do not contain the PEORIA IRB approved language for women of child-bearing potential.

Peoria IRBs #I and #II are registered with the Office of Human Research Protections (OHRP) (45CFR46.501) and the Food and Drug Administration (FDA) (21CFR56.106), which require registration of institutional review boards (IRBs) conducting reviews of human research studies conducted or supported by HHS or involving the use of FDA regulated products.

Subsequent use of the term PEORIA IRB will refer to both PEORIA IRBs as a unit.

1.2 Mission Statement of the UICOMP HSPP

The mission of the UICOMP HSPP is to ensure that there are adequate mechanisms developed and maintained to maximize the protection of the rights and welfare of all human subjects involved in research. (Refer to UICOMP HSPP Policy and Procedures Manual Section 3.3 “Required Training in Human Subject Protections”). It is also the mission of the UICOMP HSPP to be an exemplary and innovative HSPP fulfilling the mandate to uphold the public's trust to respect and protect people who participate as subjects of human research in the Central Illinois region.

Section 2: Human Subjects Protection Program Components and Roles

2.1 Introduction to the UICOMP HSPP

The UICOMP HSPP has several components that work together to protect the rights, welfare and safety of human subjects involved in research (Refer to UICOMP policy entitled Institutional Oversight and Assurance). These components include the PEORIA IRB, the Human Subjects Education Program, the Continuous Quality Improvement & Monitoring Initiative, the IO, and the HPA.

The principal means by which the human subject protection program at UICOMP ensures that the rights and welfare of research subjects are adequately safeguarded is through its PEORIA IRB review and oversight. In addition to this primary mechanism, the UICOMP HSPP employs other elements. One responsibility includes developing educational programs and monitoring education compliance to ensure that educational requirements regarding the protection of research subjects are met and maintained by
UICOMP faculty, staff, students, and PEORIA IRB board members. This includes completing initial training in human subject protections, research privacy protections, good clinical practice and responsible conduct of research before investigators are allowed to participate in the conduct of research, and then completing continuing education as required by this policy. The human subject protection program also includes means to ensure that financial conflicts of interest are reviewed and managed, and that appropriate information is provided to the PEORIA IRB for its review so it may include elements of disclosure in the informed consent process or might consider other mechanisms that may be appropriate to ensure that the conflicts are adequately managed.

Based upon the organizational structure of the UICOMP HSPP and the PEORIA IRB, the UICOMP HSPP policies and procedures, and any modifications to those policies, will be approved by the Regional Dean of the University of Illinois, College of Medicine Peoria. The Regional Dean will involve the members of the Liaison Committee, PEORIA IRB Chairs, and other OHRO staff members for advice and guidance before approving these policies, or any modifications thereto. **The Affiliated Community Institutions are expected to incorporate the PEORIA IRB policies and procedures in this manual in order to fulfill the terms of their own Assurances.**

### 2.2 HSPP: Role of the Institutional Official

The Institutional Official (IO) at UICOMP, the Regional Dean of the University of Illinois, College of Medicine Peoria, is ultimately responsible for the conduct of research when UICOMP is engaged in the research. The IO must understand the responsibilities of this role as specified by the terms of the Assurance and by educational materials available on the website of the Office for Human Research Protections (OHRP).

The IO also holds ultimate responsibility for:

- Oversight of the UICOMP Institutional Review Board (IRB);
- Oversight over the conduct of research conducted by all UICOMP investigators;
- Assuring the PEORIA IRB members are appropriately knowledgeable to review research in accordance with ethical standards and applicable regulations;
- Assuring that all investigators are appropriately knowledgeable to conduct research in accordance with ethical standards and applicable regulations;
- Oversight of the development and implementation of an educational plan for PEORIA IRB members, staff and investigators.

In the performance of these duties the IO has delegated responsibility to the HPA in order to effectively administer the program. However, the IO is ultimately responsible and is expected to be knowledgeable of all UICOMP HSPP responsibilities.
2.3  HSPP: Role of the Human Protections Administrator

As required under the terms of its Assurance, the UIComp will have a designated Human Protections Administrator (HPA), who is the second institutional official on the UIComp FWA. The HPA is the primary contact person for human subject protections issues for the UIComp. The HPA will exercise operational responsibility for the OHRO and UIComp’s HSPP. The HPA must have comprehensive knowledge of all aspects of the UIComp’s system of protections for human subjects, as well as be familiar with the institution’s commitments and responsibilities under its FWA. The HPA must be prepared to fulfill these responsibilities for all research covered under the FWA00005172. The HPA is also responsible for fulfilling the following:

1. Developing, managing and evaluating policies and procedures that ensure compliance with all state, and federal regulations governing research. This includes monitoring changes in regulations and policies that relate to human research protection and overseeing all aspects of the UIComp HSPP program.

2. Advising the IO on key matters regarding research at UIComp.

3. Implementing the institution’s approved HSPP policy.


5. Managing the finances of UIComp HSPP.

6. Assisting investigators in their efforts to carry out Organization’s research mission.

7. Developing and implementing needed improvements and ensuring follow-up of actions, as appropriate, for the purpose of managing risk in the research program.

8. Developing training requirements as required and as appropriate for investigators, subcommittee members and research staff, and ensuring that training is completed on a timely basis.

9. Serving as the primary contact at UIComp for OHRP of DHHS and other federal regulatory agencies.

10. Day-to-day responsibility for the operation of the OHRO office, including supervision of OHRO staff.

11. Responding to questions regarding the UIComp’s HSPP.

12. Reviewing complaints and/or concerns of investigators, research staff, or other institutional employees or agents communicated through the PEORIA IRB Complaint Form.

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

The HPA is responsible for maintaining and updating this manual.

The current approved version of this document is maintained in the IRBNet Forms Library for availability to IRBNet registered researchers, research staff, and IRB members. Communication of new policies occur through articles in the quarterly HSPP Newsletter, emails to users of IRBNet and presentations at seminars, departmental meetings and courses where students will be engaging in research.

2.4 Role of the PEORIA IRB Liaison Committee

In the fulfillment of its role as a resource for the Peoria research community, the UICOMP Institutional Official and Human Protections Administrator participate in a larger community advisory Committee that assists in the oversight and direction of the PEORIA IRBs. The Liaison Committee consists of one research leader selected by each Affiliated Community Institution, the Chair(s) of the IRB, and the Regional Dean at UICOMP. The IRB Director chairs this committee. The Committee is consulted regarding appointments of PEORIA IRB board members and Chairs.

In addition, the Liaison Committee may be approached by an investigator if he/she wishes to appeal a determination by the PEORIA IRB or the operation of the OHRO (please refer to Section 2.10 “HSPP: Complaints, Concerns, and IRB Appeals” for a description of the IRB appeals process). The Liaison Committee may choose to appoint a subcommittee of the PEORIA IRB to review the appeal and provide a written report of its findings and recommendations to the PEORIA IRB.

The IRB functions independently of, but in coordination with the affiliated community institutions. The IRB, however, makes its independent determination whether to approve or disapprove a protocol based upon whether or not human subjects are adequately protected. The IRB has review jurisdiction over all research involving human subjects conducted, supported, or otherwise subject to regulation by any federal department or agency that has adopted the human subjects regulations.

Research that has been reviewed and approved by the PEORIA IRB may be subject to review and disapproval by officials of the affiliated community institution. However, those officials may not approve human research that has not been approved by the IRB.

2.5 HSPP: Role of the PEORIA IRB

The role of PEORIA IRB is to ensure the adequacy of proposed research plans are consistent with the Institutional Oversight and Assurance and to minimize risks and
maximize the potential for benefit from human subjects’ participation in research. It is also the PEORIA IRB’s role to oversee the ongoing conduct of the research through continuing reviews, changes in research, submission of UPIRSOs and evaluation of any concerns. The PEORIA IRB also oversees that the protections approved by the PEORIA IRB are implemented, and that human subjects are only allowed to participate in research after providing legally effective, fully informed consent (except when it is ethically appropriate to approve a waiver of this requirement).

When the PEORIA IRB serves as the IRB of record for a UICOMP or an affiliate-initiated research study, the PEORIA IRB’s duties include: monitoring of the research to ensure prompt reporting of changes and that no material changes have been made to the research without prior PEORIA IRB approval, except to eliminate an apparent immediate hazard to a subject; creation of a management plan by the UIC COI Office, as to potential conflicts of interest that may affect human subject studies; and offering legal guidance and interpretation of local, state and federal laws and regulations as they relate to research.

For UICOMP initiated studies, compliance will be assessed primarily through active monitoring activities. All UICOMP employed investigators with open studies will be subject to periodic monitoring of their study post approval.

The compliance of affiliate-initiated studies will only be assessed outside of the continuing review process by the OHRO as a directive of the convened IRB.

The PEORIA IRB’s decisions are based on the ethical principles in the Belmont Report. The rules of conduct under which the PEORIA IRB functions are established from the Code of Federal Regulations, most frequently 45 CFR 46, 45 CFR 160, 45 CFR 164, 21 CFR 50, and 21 CFR 56 and from this policy.

The PEORIA IRB exercises autonomy in its decision-making. The UICOMP, the OHRO and the HSPP support their independence from external influences. Additionally, the PEORIA IRB Chairs foster an environment that encourages the free and full participation of all members in the deliberations of the committee. As an integral component of the UICOMP HSPP, PEORIA IRB maintains an open line of communication with the HPA, who is the primary contact person between the PEORIA IRB and the federal oversight agencies that have jurisdiction over the PEORIA IRB (including OHRP for DHHS funded research and FDA for research involving drugs, biologics, and medical devices). The PEORIA IRB also has a direct relationship with the Regional Dean, who is the institutional official with final responsibility over the PEORIA IRB and the HSPP.

Additionally, the PEORIA IRB is responsible for research involving the use of protected health information (PHI) at UICOMP. The PEORIA IRB is charged with responsibility for ensuring that the standards of the Privacy Rule (45 CFR 160, 45 CFR 164, 21 CFR 50, and 21 CFR 56 and from this policy).
164) are met when PHI is used or disclosed for research purposes. The PEORIA IRB reviews and approves authorization agreements, applications for the use or disclosure of limited or de-identified data sets, and applications for waiver of the authorization requirements.

### 2.5.1 Descriptions of the Institutional Review Boards and the Office of Human Research Oversight (OHRO)

The University of Illinois, College of Medicine Peoria IRBs are created and maintained by the University of Illinois, College of Medicine Peoria. In order to ensure high quality review, the Regional Dean may choose to add additional panels, or to remove one or more of the IRBs based on the level of work and the need for fewer or more panels. These decisions will be made only after consultation with the Liaison Committee.

### 2.5.2 Description of the Purpose for the Two PEORIA IRB Panels

UICOMP has established and maintains two IRB panels to review research projects for different purposes. PIRB #1 oversees research that may engage any one or more of the following institutions: University of Illinois, College of Medicine Peoria (UICOMP), UnityPoint Methodist and Proctor, OSF Saint Francis Medical Center in Peoria, OSF St. Mary in Galesburg, OSF St. Joseph in Bloomington, OSF St. Anthony in Rockford, OSF Heart of Mary in Urbana, OSF Sacred Heart in Danville, Illinois CancerCare, St. Jude Midwest Affiliate, and Galesburg Cottage Hospital. PIRB #2 is established to review research that might engage UnityPoint Methodist or Proctor; Illinois CancerCare, Galesburg Cottage Hospitals and UICOMP, but would not be acceptable for approval at the OSF sites or the St. Jude Midwest Affiliate.

### 2.5.3 Extension of PEORIA IRB Oversight Outside of an Affiliated Institution

PEORIA IRB may extend its oversight to other institutions or organizations on a fee-for-service basis. When this occurs, those institutions will be required to have and maintain their own OHRP-approved FWA. The institution may rely upon the PEORIA IRB on a project-by-project basis through separately executed IRB Authorization Agreements with UICOMP that will be in effect before any research is initiated. Institutions or investigators entering into an agreement to rely on PEORIA IRB beyond an individual project must enter into a Memorandum of Understanding that is negotiated with the assistance of University Counsel. Affiliated institutions are likewise able to extend Individual Investigator Agreements based on their own FWAs, but by doing so are not authorized to extend the oversight of PEORIA IRB.
Additionally, outside investigators may utilize PEORIA IRB through an Individual Investigator Agreement with UICOMP. Individual Investigator Agreements will only be attached to the UICOMP FWA when UICOMP is the recipient of a direct award, or when a UICOMP faculty member is the Principal Investigator (PI) of the project and is directly responsible for the oversight of any research activities outside of the UICOMP.

PEORIA IRB may only be designated as the institutional review board of record for clinical research conducted at non-affiliated institutions when an IRB Authorization Agreement has been executed. As outlined in the Agreement, each institution assumes responsibility for the oversight of research conducted under the auspices of its own FWA.

2.6 HSPP: Role of the Office for Human Research Oversight (OHRO)

The PEORIA IRB is administratively supported through the Office of Human Research Oversight (OHRO). OHRO staff members include an IRB Director and IRB Specialists. The IRB Director, with the HPA, is responsible for ensuring OHRO’s overall compliance within the HSPP. The OHRO staff supports the PEORIA IRB, develops and sponsors continuing education programs in research ethics, and performs post-approval monitoring of UICOMP researchers and IRB-directed monitoring of affiliated community researchers. The OHRO maintains the UICOMP FWA, and is responsible for updating the IRB Member rosters, which are shared upon request for those affiliated institutions that rely upon PEORIA IRB review and approval.

The OHRO will be responsible for the hiring and dismissal of staff and the administrative duties related to IRB membership appointments under UICOMP policy. In addition, the office will monitor education and continuing education of PEORIA IRB members and staff, as well as investigators and authorized study personnel from UICOMP.

2.6.1 IRB Director

The IRB Director is responsible for all aspects of the IRB throughout the review process of a research proposal involving human subjects. This responsibility includes the initial review of documents and screening of research proposals prior to its review by the IRB, as well as serving as the liaison between the investigators and the IRB. The IRB Director reviews the IRB minutes for accuracy and ensures proper documentation of discussions, including controverted issues and actions taken by the IRB during its convened meetings.

The Chairs of PEORIA IRB and the IRB Director will provide educational materials and continuing education on research ethics and other current research issues to investigators, coordinators, committee members and board members.
Financial Affairs personnel at UICOMP will receive billing requests from the IRB Director on behalf of the PEORIA IRB and will provide research invoices.

Financial Affairs personnel will collect and retain all financial records for the PEORIA IRB office. The IRB Director is responsible for the distribution of any Past Due Notices to the research sites.

2.6.2 IRB Specialists

The IRB Specialist is responsible for providing administrative and clerical support to the IRB Chair(s), the IRB Director, and the research community as well as scheduling and coordinating all IRB functions. The IRB Specialist is also responsible for IRB record retention and the initial review of documents received in IRBNet. The IRB Specialist is responsible for maintaining complete IRB files, records of all research protocols, IRB correspondence, as well as Research Credentialing records of investigators and research staff.

The OHRO IRB Specialists, are responsible for:

- Informing and providing investigators/study coordinators with the policies and procedures of PEORIA IRB, the Investigator’s Guidebook, and reference material for continuing education programs,
- Orientation for newly appointed PEORIA IRB members,
- Providing a copy of the Federal Regulations, as well as a summary of the Role and Responsibilities of PEORIA IRB Member prior to their first meeting of PEORIA IRB,
- Maintaining PEORIA IRB filing and record keeping systems as required by the federal regulations (including computer database(s), meeting minutes, correspondence, project files, etc.)
- Reviewing investigator and Authorized Study Personnel human subject education completions for compliance with UICOMP education requirements;
- Reviewing all PEORIA IRB protocol submissions for completeness,
- Serving as a resource for other institutions for which PEORIA IRB reviews protocols, and for investigators and study coordinators/staff,
- Communicating with the research community electronically about any updates to the policy and procedures manual,
- Posting the quarterly HSPP Newsletter and any new or past presentations to the PEORIA IRB LibGuide at https://researchguides.uic.edu/UICOMP-IRB
- Distributing sponsored research invoices to the research sites,
- Preparing and distributing material to PEORIA IRB Members for use in their meeting including:
  - Agenda for the current meeting,  
  - Minutes of the previous meeting,
o Access to Study Histories, consisting of summary information on those initial and continuing reviews as required by PEORIA IRB,

o Expedited Review Minutes, consisting of protocols, amendments and other actions approved and/or acknowledged through the expedited review process and any report of approval of a drug or device on an emergency use basis,

o Application forms and consent forms for each presented project,

o Conflict of Interest Disclosures and Responsibilities of Investigator Form, and

o Other information and educational materials relevant to the agenda items.

2.7 HSPP Resources

The OHRO is located in offices at the University of Illinois College of Medicine Peoria campus and is equipped with all the necessary office, meeting, storage space and equipment to perform the functions required by the HSPP. The adequacy of personnel and non-personnel resources of the HSPP is assessed on an annual basis by the Director with the OHRO staff and are reviewed and approved by the IO. These resources include but are not limited to; space, personnel, the HSPP education program, legal counsel, conflict of interest, the quality improvement plan, community outreach, and the IRB.

The evaluation conducted annually consists of the following:

(1) Review of IRB physical location for space assessment and staffing;
(2) Review of HSPP training records and methods for tracking training;
(3) Engagement of Legal Counsel as appropriate;
(4) Review of conflict of interest and proposed management plans via review of minutes; and
(5) Review of the HSPP QA/QI program via PI feedback.

The UICOMP Institutional Official provides resources to the IRB and OHRO, including adequate meeting and office space, and staff for conducting HSPP business. Office equipment and supplies, including technical support, file cabinets, computers, internet access, and copy machines, will be made available to the IRB and staff. The resources provided for the IRB and OHRO will be reviewed during the annual budget review process.

2.8 HSPP: Reporting Lines

The Regional Dean of the UICOMP functions as the IO with ultimate local authority over University’s human subject protection program at the UICOMP. With regards to all matters pertaining to research and regulatory compliance for University employees,
the Regional Dean will report directly to the Vice Chancellor for Research at the University of Illinois at Chicago. UICOMP maintains the OHRO. The Director of the OHRO serves as the Human Protections Administrator and will report directly to the Regional Dean for all matters relating to his or her work as the HPA for this institution.

The OHRO IRB Specialists at the UICOMP who support the work of the PEORIA IRB will report directly to the Director of the OHRO.

2.8.1 Clinical and/or Research Supervisor

The individual who is responsible for the clinical and/or the research supervision of a PI must ensure that the Principal Investigator (PI) is qualified by training and experience to conduct the proposed research. In addition, this individual is responsible for ensuring that the PI has sufficient resources and access to the environment required for satisfactory completion of this project. For each protocol submitted to PIRB for approval, the individual responsible for the clinical and/or the research supervision of a PI must certify that he/she will hold the PI accountable for compliance with human subjects protection policy and procedures.

This individual is required to review all proposals before they are submitted to the IRB for review. The signature of the individual responsible for the clinical and/or the research supervision of a PI indicates that the study has been reviewed for scientific merit rigor and meets the expectations of our discipline.

2.8.2 The Investigator

The investigator is the ultimate protector of the human subjects who participate in research. The investigator is expected to abide by the highest ethical standards and for developing a protocol that incorporates the principles of the Belmont Report. He/she is expected to conduct research in accordance with the approved research protocol and to oversee all aspects of the research by providing supervision of support staff. All subjects must give informed consent (unless waived by the IRB) and the investigator must establish and maintain an open line of communication with all research subjects within his/her responsibility. In addition to complying with all the policies and standards of the governing regulatory bodies, the investigator must comply with institutional and administrative requirements for conducting research. The investigator is responsible for ensuring that all research staff completes appropriate training and must obtain all required approvals prior to initiating research. When investigational drugs or devices are used, the investigator is responsible for providing written procedures for their storage, security, dispensing and disposal.
2.8.3 Affiliated Community Institutions’ Pharmacies

Affiliated Community Institutions’ Pharmacies will follow their internal policies regarding the general dispensing of investigational drugs. Upon receipt of a prescription or copy of the physician’s original order signed by one of the authorized investigators, the required quantity of the investigational drug shall be prepared and dispensed by the Pharmacy. A copy of the Protocol or Investigator’s Brochure will be required from the Investigator by the Pharmacy, for proper preparation and dispensing. A copy of a signed patient informed consent will be required from the Investigator to be available in the patient’s medical record. This will be made accessible to providers and caregivers of the patient.

Each pharmacy is responsible for the maintenance of records, storage of the drugs according the manufacturer’s / protocol specifications, and disposal of unused materials in accordance with instructions from the PI, sponsor, or Drug Enforcement Administration.

2.8.4 UIC’s Counsel’s Office

PEORIA IRB relies on the Office of University Counsel at the UIC for the interpretations and applications of Illinois law and the laws of any other jurisdiction where UICOMP employed faculty research is conducted as they apply to human subjects research.

2.8.5 UIC’s Office of Research Services

UIC’s Office of Research Services (ORS) handles all of UICOMP’s pre-award and non-financial post-award activities. Pre-award activities include activities from the pre-proposal stage to the receipt and processing of the award, up to the point of account set up. ORS assists UICOMP faculty and staff in proposal development, review and endorsement of proposals, submission of electronic proposals, negotiation and execution of contracts, reporting, receipt and processing of the Notice of Awards (NOA), interpretation of sponsor guidelines, and ensuring compliance with both agency and University policies.

UIC’s Office of Business and Financial Services (OBFS) and ORS will not release funding until the applicable IRB has approved the human subjects research or an exemption determination has been issued by OPRS.
2.9 Protocol-Specific Coordination and Interaction with Affiliated Community Institutions

The successful fulfillment of the PEORIA IRB’s intent to protect human research subjects is dependent upon open communication among the affiliated community institutions. These institutions and their various research departments exchange information, when necessary, to assure that, in addition to IRB review, human subjects research receives all appropriate review prior to implementation of the research activities. Human subjects research is not allowed to commence until all applicable reviews are complete and notification of approval is published in IRBNet.

The Initial Protocol Application to the IRB should consider the submission of documentation of approvals from other ancillary committees, institutions or departments to ensure support of research, for example:

- Permission from hospitals/clinics
- Permission to enter classrooms
- Permission from external research location(s) (sites)
- Departmental approvals
- Nursing Research Committee approvals
- Research Advisor/Mentor approvals

For permissions to enter classrooms or permission from external research locations, a letter of support or collaboration must be included and the appropriate designated individual must sign the form that is uploaded into IRBNet. All other permissions/approvals may be evidenced by a signature in IRBNet. The protocol will be reviewed in the HSPP Office to ensure that all necessary letters and signatures are included.

2.10 HSPP: Complaints, Concerns, and IRB Appeals

Complaints and Concerns

Complaints or concerns from the investigators, research staff, other institutional employees or agents should be directed to the UICOMP HPA. Complaints or concerns should be reported via the UICOMP Complaint Form. The complainant may complete the PEORIA IRB Complaint Form to communicate concerns regarding a research protocol (including the investigator or the conduct of the research), a particular PEORIA IRB or a research site. The form may be completed with complainant details or anonymously.

The HPA may direct the IRB to review the complaint or meet with the involved parties and OHRO staff in order to reach a recommended resolution. When related to a specific protocol, complaints will be formally documented with resolutions noted as formal
actions in the protocol files. In contrast, when the complaint is not related to a specific protocol, the complaint along with resolution will be retained in the investigator file. In both cases, the matter will be reported to the investigator and reported to the IO.

**IRB Appeals**

If an investigator feels that their research proposal was denied or restricted unnecessarily, they may initiate the following appeals procedure:

- Request of the Chairperson of PEORIA IRB, in writing, within ten days, that an evaluation be completed.
- The Chairperson requests the Liaison Committee to appoint a subcommittee of PEORIA IRB to review the complaint or determination in question.
- The subcommittee reviews the project and sends a written report of its findings to PEORIA IRB with their recommendations.
- PEORIA IRB will again review the project and deliver their decision, considering the report of the subcommittee, while not bound by its recommendation. The investigator will be notified of the decision. The decision of PEORIA IRB on a reconsidered protocol will be final.

While the research institution may disapprove the conduct of a research study that has been approved by PEORIA IRB, the decision of PEORIA IRB to disapprove the conduct of a research study will be final. The institutions that rely upon one of the IRBs may not allow an investigator whose research has been disapproved by the PEORIA IRB to then apply for approval by another IRB.

### 2.11 HSPP: Reporting Policy for Unanticipated Problems Involving Risks to Subjects or Others (UPIRSO)

(In addition, please refer to UICOMP HSPP Policy and Procedures Manual Section 9 “When Problems Occur”).

The UICOMP HPA will work openly and collaboratively with the HPAs and/or Research Compliance Officers (RCO) of any other affiliated community institutions or organizations engaged in research that hold an Assurance when there are reports of Unanticipated Problems Involving Risks to Subjects or Others (UPIRSO). An UPIRSO, in general, includes any incident, experience, or outcome that meets all of the following criteria:

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

An incident, experience, or outcome that meets the three criteria above generally will 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.

For local events, the PI will report such incidences, experiences, or outcomes that meet the three criteria above on the Unanticipated Problems Form as described in Section 9.12. In the written approval letter, the PEORIA IRB ensures that the investigator is aware of their responsibility to promptly report UPIRSOs to the IRB.

Adverse events occurring in a multicenter study (NON-LOCAL EVENTS) should be reviewed and analyzed by a monitoring entity (e.g., the research sponsor, a coordinating or statistical center, or a DSMB/DMC) in accordance with a monitoring plan described in the IRB-approved protocol. The PEORIA IRB will not accept NON-LOCAL events that have not been determined to meet the definition of an UPIRSO by the monitoring entity (e.g., the research sponsor, a coordinating or statistical center, or a DSMB/DMC).

All UPIRSO Reports are initially assessed by OHRO staff in a timely manner, and may be referred by a designated member of the PEORIA IRB to be reviewed by the PEORIA IRB at a convened meeting.

The UICOMP HPA and OHRO staff will ensure that the relevant PEORIA IRB that is responsible for review of the study is promptly notified, in accordance with its policies. When more than one Institution is engaged in the research, the UICOMP HPA will establish a hierarchy with the HPAs of the other engaged sites in order to designate which is the “lead” site, and will allow the lead site HPA to take the initiative in any investigation into allegations or reports of non-compliance, if any, resulting from a UPIRSO. While the HPA of the designated “lead” institution will assume responsibility for the reporting of UPIRSOs to federal department heads or agencies as appropriate (including OHRP, FDA, and any funding agency), the UICOMP HPA will be responsible for ensuring that these reports are promptly made whenever UICOMP is engaged in the research and will maintain files of this correspondence within the UICOMP offices.

2.12 HSPP: Reporting Policy for Protocol Violations/Frequent Deviations of the Same Nature

Federal regulations require that the IRB reviews proposed changes in the research protocol and ensures that the investigator does not initiate the change prior to obtaining
IRB approval. The only exception to this requirement is when it is necessary to make a change to eliminate apparent immediate harm to the subject [45 CFR 46.103 (b) (4) (iii), 21 CFR 56.108 (a) (4)]. Any changes to the research must be either prospectively approved or promptly reported to the IRB according to the federal regulations and UICOMP policy and procedures.

Protocol Deviations

The term “protocol deviation” is not defined by either DHHS human subjects regulations (45 CFR 46) or FDA human subjects regulations (21 CFR 50).

For UICOMP purposes, a protocol deviation is defined as any change, divergence, or departure from the approved study design or procedures of a research protocol that is under the investigator’s control and that has not been approved by the IRB, and does not affect the participant’s safety, rights, or welfare and/or the completeness, accuracy and integrity of the study data. This term is (i) most often used when the variance is an unintended change that is not considered as serious as a violation, (ii) is considered minor or administrative, and (iii) may involve no more than minimal risk to participants or others.

A deviation becomes reportable to the IRB as a protocol violation when the event occurs frequently enough to suggest a pattern or a process problem. Deviations do not typically negatively affect the participant’s safety, rights, or welfare and/or the completeness, accuracy and integrity of the study data, however, frequent deviations of the same nature may be indicative of a pattern or a process problem. Frequent deviations of the same nature are unanticipated problems that must be reported to the IRB on the Unanticipated Problem Form.

Frequent deviations of the same nature may include but are not limited to:

1. More than 3 subjects signing an outdated or unstamped version of the consent form;
2. More than 3 subjects with missing protocol-required lab tests;
3. More than 3 subjects having “out-of-window” visits; and
4. More than 3 subjects deviating from specific protocol eligibility requirements (i.e. enrolling subjects with a blood pressure or a laboratory value slightly higher or lower than dictated by the protocol when all other criteria are met.)

“Frequent” is defined as occurring in more than 3 subjects in a single research study. Frequent deviations of the same nature are reportable to the IRB when the PI or a member of the research team becomes aware of the occurrences.
Protocol Violations

Protocol Violation: Any deviation that may adversely affect the subject’s rights, safety, or welfare, and/or the completeness, accuracy and integrity of the study data. A protocol violation is often considered a major, more serious, variance from an approved protocol than a deviation.

Protocol violations may be considered as noncompliance and are to be reported to the IRB. Per the UICOMP Unanticipated Problems Form, the PI must develop a corrective action plan for review and approval. This corrective action plan will outline what steps the investigator has taken or will take to resolve the event and to prevent such events from occurring in the future.

2.13 HSPP: Reporting Policy for Serious or Continuing Noncompliance (In addition, please refer to UICOMP HSPP Policy and Procedures Manual Section 9 “When Problems Occur”).

When an allegation of serious or continuing noncompliance with the federal regulations or UICOMP policy is received by the OHRO, the UICOMP HPA will be immediately notified. The HPA will assess the report and refer it to an IRB Chairman for review.

Non-compliance. Failure to comply with applicable Federal Regulations, PEORIA IRB policies and procedures, or the requirements or determinations of the PEORIA IRBs.

Noncompliance can occur by:
- The Principal Investigator
- The Research Staff (members of the research team including the co-investigators, study coordinators or others)
- Any member of the HSPP, including the IRB staff

Determinations of the IRB Relative to Noncompliance

When reviewing allegations of serious or continuing noncompliance, the IRB will determine if the noncompliance is serious versus non-serious and if it is continuing versus non-continuing.

Serious noncompliance. An action or omission taken by an investigator or study personnel that any other reasonable investigator would have foreseen as compromising the rights or welfare of the participant.

Continuing noncompliance. A pattern of repeated actions or omissions taken by an Investigator or study personnel that indicates a lack of ability or willingness to comply.
with federal regulations, UICOMP IRB policies and procedures, or the determinations of the PEORIA IRBs.

If the IRB determines that the noncompliance is serious or continuing, the UICOMP HPA will be immediately notified if notification has not already occurred.

Allegations and/or reports of noncompliance can be received in a number of ways:

The most common ways are:
1. Via reporting on the UICOMP Unanticipated Problems Form as a Protocol Violation and/or Frequent Deviations of the Same Nature
2. Via Affiliate audit finding
3. Via IRB audit finding

When an allegation of serious or continuing noncompliance with the federal regulations or UICOMP policies are received by the OHRO the UICOMP HPA will be notified. The HPA will share the report with the IRB Chair who will review the report and determine if prompt action is required to eliminate apparent immediate hazards to the subject or the integrity of the study.

Regardless of the necessity of prompt action, the report or alert will be referred to the convened IRB for a formal determination of serious or continuing noncompliance.

The convened IRB may consider whether to implement one or more of the following actions:

1. IRB-directed corrective action plan;
2. PI-initiated corrective action plan; and/or
3. IRB Directed Monitoring Visit for further investigation

An IRB-directed corrective action plan could involve one or more of the following:

1. Imposition of ethics and/or human subjects research education for the investigator and/or research staff;
2. Modification of the protocol;
3. Modification of the consent process;
4. Providing information to past participants;
5. Requiring notification to and re-consent of current participants;
6. Modification of the continuing review schedule; and/or
7. Monitoring of the consent process
If a finding requires a PI-initiated corrective action plan, the plan will be shared with the convened IRB and the IRB. The PEORIA IRB retains final authority in determining whether the corrective action plan is adequate.

If an IRB Directed Monitoring Visit is required by the convened IRB and more than one Institution is engaged in the research, the UICOMP HPA will work with the Affiliates’ RCOs/HPAs to establish a hierarchy to designate the “lead” site. If UICOMP is the “lead” site, the HPA will work with the Affiliate’s RCO/HPA to request PIRB access to the necessary study documents for review. PIRB will take the initiative in any investigation into allegations or reports of noncompliance and will assume responsibility for sharing updates.

If UICOMP is not the “lead” site, the “lead” site’s RCO/HPA will take the initiative in any investigation into allegations or reports of noncompliance and will assume responsibility for sharing updates.

2.14 HSPF: Administrative Closure, Suspension, Termination Policy and Investigator Hold

An IRB shall have authority to administratively close, suspend or terminate approval of research that is not being conducted in accordance with the IRB’s requirements or that has been associated with unexpected serious harm to subjects or others. In addition to the PEORIA IRB, the UICOMP Institutional Officials (Regional Dean/IO, Human Protections Administrator) or IRB Chairs may act to suspend or terminate research. Any suspension or termination of approval shall include a statement of the reasons for the IRB’s action and shall be reported promptly to the investigator, appropriate institutional officials, and the Department or Agency head [45 CFR 46.113, 38 CFR 16.113] or Food and Drug Administration [21 CFR 56.113] within 30 days. (University Department Heads may be included in reporting, as applicable).

2.14.1 Administrative Closure by the IRB

Sixty days prior to the expiration of the current project approval, the investigator is notified by OHRO staff that they are required to complete the Continuing Review Form and return it to PEORIA IRB prior to the expiration date. If the investigator does not respond, 45 days prior a follow-up letter will be sent and a phone call will be placed. OHRO will request a continuing review form twice from the investigator by letter, and once by phone. If the investigator does not provide or submit the appropriate documentation in time for Continuing Review by the PEORIA IRB by the end of the one-year approval period, the protocol will be administratively closed by the IRB. OHRO staff will inform the PI of the administrative closure by letter, posted in the IRBNet system.
Once a study has lapsed, it is administratively closed by the IRB and no additional patients may be entered into this research and research activities must cease.

The PEORIA IRB will consult with the PI and ask him/her to notify any subjects currently participating that the study has been administratively closed by the IRB. The IRB, in consultation with the PI, will consider whether procedures for withdrawal of enrolled subjects are necessary to protect their rights and welfare of subjects, such as: transferring participants to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of participants for safety reasons. Enrollment of any subjects past the posting of an administrative closure letter will be an act of noncompliance. The PEORIA IRB retains final authority in determining whether the lapse in IRB approval represents serious or continuing noncompliance.

2.14.2 Suspension of IRB Approval

Suspension of IRB approval is a directive of the convened IRB, IRB Chair, Regional Dean/IO or HPA to temporarily stop some or all previously approved research activities short of permanently stopping all previously approved research activities. Suspension directives made by the IRB Chair must be reported to a meeting of the convened IRB. Suspended protocols remain open and require continuing review.

IRB approval may be suspended or terminated if research is not being conducted in accordance with IRB or regulatory requirements or has been associated with unexpected problems or serious harm to subjects.

The IRB notifies the PI in writing of the suspension. The communication contains:

1. Reason for the suspension;
2. Corrective actions mandated by the IRB;
3. A request for the number of currently active subjects and any measures needed to protect their rights and welfare if some or all research activities are stopped;
4. Timelines for implementing the proposed actions and follow-up reporting to the IRB;
5. Notification that any request by the investigator for the IRB to reconsider the suspension should be submitted within 30 days.
6. If the investigator wishes to pursue re-starting the research, he/she must address all concerns noted by the IRB.
The investigator shall be provided with an opportunity to respond in person or in writing.

When study approval is suspended by the IRB, in addition to stopping all research activities, they will ask the PI to notify any subjects currently participating that the study has been suspended. The IRB, in consultation with the PI, will consider whether procedures for withdrawal of enrolled subjects are necessary to protect their rights and welfare of subjects, such as: transferring participants to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of participants for safety reasons.

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

The investigator MUST continue to provide reports of UPIRSOs to both the IRB and sponsor just as if there had never been a suspension (i.e., all events that need to be reported during a study need to continue to be reported during the suspension period.)

When the PI has addressed the concerns, the convened IRB may lift the suspension. If the concerns are not addressed, the IRB may terminate the research or take other action to protect the rights and welfare of subjects or others (e.g., make a finding of serious or continuing noncompliance).

The suspension is promptly reported by the HPA to appropriate IOs and federal agencies.

2.14.3 Termination of IRB Approval

Termination of IRB approval is a directive of the convened IRB to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review. Terminations of protocols approved under expedited review must be made by the convened IRB.

Termination of approved research by the IRB may arise from an evaluation of unanticipated problems involving risks to subjects or others, findings of serious or continuing noncompliance, or findings arising from continuing review or monitoring of research activities.
The review process depends on the event (i.e., unanticipated problem/event, noncompliance) triggering the determination of termination. The IRB notifies the PI in writing of the termination. The communication contains:

1. Reason for the termination;
2. Corrective actions mandated by the IRB;
3. A request for the number of currently active subjects and any measures needed to protect their rights and welfare if some or all research activities are stopped;
4. Timelines for implementing the proposed actions and follow-up reporting to the IRB;
5. Notification that any request by the investigator for the IRB to reconsider the termination should be submitted within 30 days.
6. If the investigator wishes to pursue re-starting the research, he/she must address all concerns noted by the IRB and then re-submit a new proposal for IRB review and approval.

The termination is promptly reported by the HPA to appropriate IOs and federal agencies.

The IRB will ask the PI to notify any subjects currently participating that the study has been terminated. The IRB, in consultation with the PI, will consider whether procedures for withdrawal of enrolled subjects are necessary to protect their rights and welfare of subjects, such as: transferring participants to another investigator; making arrangements for care or follow-up outside the research; allowing continuation of some research activities under the supervision of an independent monitor; or requiring or permitting follow-up of participants for safety reasons.

Investigators must notify the IRB in writing of proposed actions to be taken to protect current participants.

### 2.14.4 Investigator Hold

An investigator may request an investigator hold on a protocol when the investigator wishes to temporarily or permanently stop some or all approved research activities. An administrative hold is initiated by an investigator. Investigator holds are not suspensions or terminations.

1. Investigators must notify the IRB in writing that:
   a. They are voluntarily placing a study on administrative hold
   b. A description of the research activities that will be stopped
   c. Proposed actions to be taken to protect current participants
Actions that will be taken prior to IRB approval of proposed changes in order to eliminate apparent immediate harm

2. Upon receipt of written notification of the investigator the IRB Specialist places the research on the agenda for review.

3. The IRB Chairs determine whether any additional procedures need to be followed to protect the rights and welfare of current participants.

4. The IRB Chair determines how and when currently enrolled participants will be notified of the administrative hold.

5. Investigators may request a modification of the administrative hold by submitting a request for a modification to previously approved research.

Section 3: The HSPP: Institutional Responsibilities

3.1 Institutional Commitment: Research Ethics

UICOMP requires that all research involving human subjects be guided by the ethical principles delineated in the report of the National Commission for the Protection of Human Subjects of Clinical and Behavioral Research titled: Ethical Principles and Guidelines for the Protection of Human Subjects of Research (i.e., the “Belmont Report”). All research in which UICOMP is “engaged” in must adhere to these principles, regardless of the source of research funding, in order to assure that the rights and welfare of subjects are protected.

UICOMP adheres to these principles as summarized below and as detailed in the Belmont Report:

- **Respect for Persons**: UICOMP ensures that the autonomous decision-making of individuals is respected through processes of informed consent, parental permission and assent (except when it is appropriate to waive those processes) and with the provision of additional safeguards to protect individuals who have diminished capacity of autonomy.

- **Beneficence**: UICOMP is committed to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm related to participation in research, and ensuring that the risks of research are reasonable in relation to the expected benefit to individuals or from the knowledge that is likely to be gained.

- **Justice**: UICOMP ensures that the risks of research and the proposed benefits are not distributed differently along lines of race, culture or other

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social divisions, but that the groups who bear the potential burden of research are the same groups who stand to benefit.

3.2 Shared and Individual Institutional Responsibilities for the Oversight of Human Subjects Research at Affiliated Community Institutions

The PEORIA IRB will continue to serve the mission for which it was originally created; to be a Community IRB in Central Illinois. The IRBs are established and maintained within the UICOMP OHRO. Through the OHRP FWA system, the oversight authority of PEORIA IRB has been extended to cover the affiliated community institutions (based on IRB Use Agreements or MOUs). Each of these participating Institutions hold their own Assurance and share the responsibility for ensuring that PEORIA IRB functions in compliance with the federal regulations. Each Institution, likewise, must assume responsibility for overseeing the conduct of each research project in which it becomes engaged through receipt of a direct award, by virtue of executing a clinical trial agreement or other agreement to conduct research, as well as by the actions of its employees and agents. In this manner, each Institution retains independent responsibility and a shared responsibility for ensuring regulatory compliance in the conduct and oversight of human subject research in which that Institution is engaged.

This manual will address issues related specifically to UICOMP and its institutional responsibilities under its FWA. The manual will elaborate the policies and procedures of PEORIA IRB, which apply to the UICOMP, but are also applicable to the other Affiliated Community Institutions that have entered into IRB Authorization Agreements or MOUs to designate PEORIA IRB under their own Assurances. The currently affiliated community institutions include University of Illinois, College of Medicine Peoria (UICOMP), UnityPoint Methodist and Proctor, OSF Saint Francis Medical Center in Peoria, OSF St. Mary in Galesburg, OSF St. Joseph in Bloomington, OSF St. Anthony in Rockford, OSF Heart of Mary in Urbana, OSF Sacred Heart in Danville, Illinois CancerCare, St. Jude Midwest Affiliate, and Galesburg Cottage Hospital, Other institutions may be added.

3.3 Required Training in Human Subject Protections

Principal Investigator (PI). The individual who is responsible and accountable for conducting the clinical trial. The PI assumes full responsibility for the treatment and evaluation of human subjects, and for the integrity of the research data and results.

Authorized study personnel. PI and other individuals who contribute to the scientific development or execution of a project in a substantive, measurable way, whether or not they receive salaries or compensation under a grant.

It is the policy of PEORIA IRB that all individuals engaged in research using human subjects be familiar with PEORIA IRB policies, procedures and related federal

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regulations. Investigators should maintain an on-going relationship with the OHRO and PEORIA IRB to gain assistance in following policy and procedures during the conduct of their studies. This will help assure that both investigators and the PEORIA IRB remain in compliance with all local, state and federal regulations regarding research involving human subjects.

PEORIA IRB requires CITI training of all investigators. All investigators and authorized study personnel must complete either the Biomedical or the Social/Behavioral Basic Human Subjects Course [depending on the type of research they intend to perform (UICOMP options)] or the Human Subject Research (HSR) Course (OSF option). Additionally, all investigators must complete the Conflict of Interest minicourse, the Good Clinical Practice (GCP) and Responsible Conduct of Research (RCR) courses. Certificates of Training are collected by the OHRO staff. While all investigators need education in the basics of human subjects research, some may require additional education if their work involves especially difficult topics or special populations. It is the responsibility of the PI to ensure all authorized study personnel are adequately trained to carry out their responsibilities.

The PI and any authorized study personnel engaged in research involving protected health information (PHI) must successfully complete training involving the HIPAA privacy rule and protected health information. This module is located within the required CITI Basic Human Subjects courses (UICOMP’s Biomedical or Social/Behavioral or OSF’s Human Subject Research Course).

New research protocols will not be accepted from PIs who have not completed the initial education requirement. A new protocol may be reviewed and approved if the PI holds current certifications of training. However no authorized study personnel listed on the application may participate in any human subject research until they have completed the initial education requirements. This means the individual may not have any contact with research subjects or their private identifiable information. Upon completion of the initial education requirements, a Change in Research Form may be submitted and approved to add individuals as authorized study personnel on the study.

Who is required to obtain initial education under this policy?

- The Principal Investigator
- All co-investigators or sub-investigators
- All authorized study personnel, research staff, study coordinators, and others who will have contact or interactions for research purposes with subjects or with their private identifiable information
- Faculty supervisors of student research projects
3.3.1 Waiver of Initial Education

If the PI or authorized study personnel can verify that they have successfully completed a human subjects research training equivalent to that required by UICOMP, they may request a waiver of the requirement for initial education. However, the PI and all authorized study personnel must complete the requirements of Continuing Education.

3.3.2 Continuing Education and Recertification

The PI and all authorized study personnel must meet the UICOMP continuing education requirement every three (3) years after certification of initial education for as long as they are involved in human subject research. There is no exception to this requirement. The CITI Refresher Course in the Protection of Human Research Subjects (Biomedical, Social/Behavioral or HSR) is required, as well as CITI refresher courses in Conflict of Interest, GCP and RCR.

Investigators must submit evidence of refresher training prior to the expiration of their initial training certification. New research protocols and applications for continuing review from PIs who have not submitted satisfactory evidence of continuing education will require re-assignment of the PI to an appropriate coinvestigator or other authorized study personnel that have completed his/her continuing education. The PI will be removed from the study until refresher training is completed and a Change in Research Form requesting that the PI be added back to the study is submitted and approved.

Other authorized study personnel who have not submitted evidence of refresher training after their initial training has expired will be administratively removed from studies at the time of continuing review. All contact or interactions with subjects or their identifiable private information by the research team member must cease. Once all refresher trainings are completed, a Change in Research Form requesting that the individual be added back to the study must be submitted and approved before the individual may participate in the study.

3.4 Resources for Training in Research Ethics

Investigators may look to the following resources for information and training opportunities.

https://www.primr.org/KnowledgeCenter_SubPage.aspx?id=4736

https://www.irbforum.org/


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3.5 Training for PEORIA IRB Members

There is a comprehensive on-going education program for PEORIA IRB members that include both initial and continuing education. The program focuses on the ethical principles and the regulatory requirements underpinning human subject protections and how to apply those to the initial and continuing review of research protocols. These certifications are valid for three years.

All IRB members must complete the CITI Biomedical Research Course, IRB Board Member Training (UICOMP options) or the Human Subject Research (HSR) Course (OSF option). Additionally, all IRB members must complete the Conflict of Interest mini-course, the Good Clinical Practice (GCP) and Responsible Conduct of Research (RCR) courses.

3.5.1 Initial Education Program

All PEORIA IRB Chairs, members, and alternates must attend one-on-one training (or its equivalent) before they may review research protocols and vote with the IRB. The initial education program includes some of the following:

- History of Human Subject Protections.
- Ethical Principles and *The Belmont Report*.
- Regulatory Requirements. [DHHS regulations 45CFR46 and FDA Human Subject Regulations (including but not limited to 21 CFR 50, 56, 312, 600 and 812);
- IRB’s Role and Responsibilities.
- Application of the Principles and Regulations to the Initial and Continuing Review of Research.
- Vulnerable Populations; Pregnant Women, Fetuses, Prisoners, Children and Others.
- Investigator Responsibilities.

3.5.2 Continuing Education Program

The PEORIA IRB requires its IRB Chairs, members and alternates to complete the CITI Biomedical Research Refresher Course, IRB Member Refresher Course.
or the Human Subject Research (HSR) Refresher Course (OSF option), as well as refresher courses for Conflict of Interest, GCP and RCR every three years following the initial education program requirement. In order to ensure IRB members are well educated in all aspects of human subject protections and prospective review of research involving humans, quarterly education modules will be written and made available to members via IRBNet under the Library Manager – Documents for Committee Members. Education modules will include a PowerPoint or other type of presentation which highlights important content. These education modules will strive to provide timely information on regulatory requirements pertinent to IRB review responsibilities as well as present current thinking on topics which have ethical implications for IRB review.

PEORIA IRB members attend regional and national educational conferences as appropriate.

3.6 IRB Member Liability

The Organization has a program of funded self-insurance covering its employees and other IRB members authorized to act on behalf of the Organization for acts or omissions within the scope of their employment or authorized activity. Said coverage provides coverage for legal defense as well as damages. The program of insurance has limits on liability and other terms, conditions, and exclusions that are applicable. Is this in our agreements with our other participants? Language should match that which is in our IRB agreements a copy of the Organization’s program of insurance is available by contacting the University of Illinois Office of Risk Management, Urbana, IL.

3.7 Review of IRB Member Performance

The IRB Members’ performance will be reviewed on an annual basis by the IRB Executive Committee. Members who are not acting in accordance with the IRB’s mission or policies and procedures or who have an undue number of absences may be removed.

Section 4: The HSPP: PEORIA IRB/OHRO Responsibilities and Duties

4.1 The Role of the University of Illinois, College of Medicine Peoria Institutional Review Board (PEORIA IRB)

The role of the PEORIA IRB is to ensure the adequacy of proposed research plans and to minimize risks and maximize the potential for benefit from human subjects’ participation in research. It is also PEORIA IRB’s role to oversee ongoing conduct of the research. PEORIA IRB oversight includes the maintenance of protections for subjects when UICOMP is engaged in the research and ensures that human subjects are only allowed to participate in research after providing legally effective, fully informed consent.
consent (except when it is ethically appropriate to approve a waiver of this requirement).

PEORIA IRB’s decisions are based on the ethical principles in the Belmont Report. The rules of conduct under which PEORIA IRB functions are established from the Code of Federal Regulations, most frequently 45 CFR 46, 21 CFR 50, and 21 CFR 56, and from this policy.

The authority to create, change and implement policy is shared by the IRB and OHRO. New policies or changes to policies may be presented to the IRB to solicit input from the committee members. The Liaison Committee may also be asked to review and comment on new or changed policies and to advise the IRB/OHRO regarding policy decisions.

All IRBs must be autonomous in their decision-making and determinations. As such, the OHRO and the HSP at UICOMP uphold the independence of the PEORIA IRB from external influences. Additionally, the IRB Chairs foster an environment that encourages the free and full participation of all members in the deliberations of the committee. As an integral component of the HSPP, the IRBs maintain an open line of communication with the HPAs, who are the primary contact person between the IRBs and the federal oversight agencies that have jurisdiction over the IRB (including OHRP for HHS funded research and FDA for research involving drugs, biologics, and medical devices). The IRBs also have a direct relationship with the UICOMP Regional Dean, who is the IO with final responsibility over the PEORIA IRB and the HSPP.

Any attempts to unduly influence any member of the IRB or OHRO staff threaten the independence of the IRB and the integrity of the HSPP; and require prompt reporting by individuals who experience or are aware of occurrences of undue influence. Undue influence with regards to the IRB refers to any attempt to interfere with the standard procedures of the IRB or to inappropriately place pressure on an IRB member, IRB Chair or OHRO staff member in order to obtain a specific outcome from the IRB or one of its members or staff. Any attempt or occurrence of undue influence should be promptly reported to the IRB Chair or OHRO Director. Such reports will be evaluated as potential serious or continuing noncompliance.

Additionally, the PEORIA IRB functions as a Privacy Board for UICOMP and the Affiliated Community Institutions as described in Section 5.

4.2 PEORIA IRB Authority

The PEORIA IRB is vested with the authority to approve, require modifications to research protocols in order to obtain approval, or to disapprove research. The PEORIA IRB has the authority to require progress reports or other information from investigators in order to effectively oversee the conduct of the research and the informed consent
process. The PEORIA IRB has the authority to place restrictions on research activities, suspend or terminate the approval of research that is not being conducted in accordance with PEORIA IRB requirements or that has been associated with unexpected serious harm to subjects.

The PEORIA IRB ensures the adequacy of human subject protections through policies and procedures when they:

- Conduct the initial and continuing review of research protocols,
- Report the PEORIA IRB’s determinations and decisions, electronically, to investigators and the institution,
- Determine which research protocols require review more frequently than once per year,
- Determine which research protocols require verification from other sources, other than the investigator, that no material changes have occurred since the most recent PEORIA IRB review and approval,
- Require that proposed changes in research are promptly reported, and ensure that changes in approved research are not initiated without prior PEORIA IRB review and approval, *except* when necessary to eliminate apparent immediate hazards to subjects,
- Require that any unanticipated problems involving risks to subjects or others are promptly reported to the PEORIA IRB, the Human Protections Administrator (HPA) and appropriate federal agencies,
- Require that any serious or continuing noncompliance with HSPP Policies and/or federal regulations, or the requirements or determinations of the PEORIA IRB, are promptly reported to the PEORIA IRB, the HPA, the Regional Dean and appropriate federal agencies,
- Require that any suspension or termination of PEORIA IRB approval be promptly reported to the Regional Dean, the HPA and any appropriate federal agencies.

Additional authorities of the IRB are outlined in the Institutional Assurance and Oversight document.

4.3 PEORIA IRB Purview

To be ethical, clinical research must involve the community in which it occurs. This requires community participation in planning, conducting and overseeing research, and integrating research results into the health system. Members of these collaborative partnerships must consider how the research will improve health of participants in the research and the community in which research is conducted.

Every effort will be made by the University to achieve collaborative partnerships by ensuring that the IRBs are sufficiently qualified through the experience and expertise of
its members. The IRBs shall be composed of a diversity of members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects pursuant to 45 CFR § 46.107(a). In acknowledgement of this regulation and in recognition of the importance and spirit of community support, the Institution shall exercise preference for local IRB review over non-local IRB review.

The Institution has a profound responsibility to ensure that all IRBs designated under its OHRP approved Federal Wide Assurance (FWA) possess sufficient knowledge of the local research context to satisfy these requirements. This responsibility endures regardless of the IRB's geographic location relative to the institution and the research. It is particularly critical where the research involves greater than minimal risk to subjects or vulnerable categories of subjects.

1. The University maintains interest in the following categories of research when that research involves human subjects, including identifiable private data or tissues derived from human subjects.

   a. Research conducted by UICOMP paid full or part-time faculty, staff or students.
   b. Research performed on the premises of UICOMP, or using equipment belonging to UICOMP.
   c. Research involving UICOMP patients, students, staff or faculty as a cohort.
   d. Research conducted by affiliated faculty, such as volunteer faculty, in their role as an affiliated faculty member when UICOMP is engaged in the research. This intent will be evaluated and communicated by the Institution to the University upon submission to the IRB.

4.4 Commercial IRBs

Investigators wishing to conduct research NOT covered in Section 4.3 may choose between the IRB services provided locally by PEORIA IRB or those provided by a commercial IRB.

If an investigator wishes to utilize the services of a commercial IRB, he/she must submit an IRB jurisdiction waiver form to the OHRO for signature. The investigator will be instructed to update his/her FWA to include the name of the commercial IRB.

4.5 Number, Qualification and Diversity of PEORIA IRB Members

Each PEORIA IRB member will meet the membership requirements as specified in the regulations [45 CFR 46.107, 21 CFR 56.107]. PEORIA IRB will maintain an IRB membership of at least five members as required by the federal regulations. At least one
member will be a non-scientist. PEORIA IRB members will have varying and diverse backgrounds, and will be sufficiently qualified through their experience to promote respect for their advice and counsel in safeguarding the rights and welfare of human subjects.

PEORIA IRB requires a diversity of members (for example, representatives from scientific disciplines, administrative staff, legal professions, clergy, the community, and minority groups) and federal regulations require that the membership be represented by both sexes, multiple professions, scientific and non-scientific member(s), and not otherwise affiliated members.

The members of the PEORIA IRB include individuals with varying backgrounds and appropriate professional competence to review the diverse types of protocols that are received. All members must be committed to the principles of human subject protection. The PEORIA IRB members are also qualified to ascertain the acceptability of the research in terms of institutional commitments and regulations, applicable state and local laws, and standards of professional conduct and practice. In order to ensure that the integrity of the review process is not compromised by competing business interests, individuals involved in research development, do not serve as members of the IRB or carry out day-to-day operations of the review process.

All PEORIA IRB members agree to maintain confidentially regarding all Board deliberations and related documents, information, and institutional actions.

The members of PEORIA IRB are appointed by the Regional Dean of UICOMP in consultation with the administration of the Liaison Committee. The individuals are selected to provide the diversity of representation as required under FDA, DHHS regulations and the Common Rule. There is no set term for members of PEORIA IRB. However, if a member has been unable to attend at least 70% of the meetings in one year, the Chair of PEORIA IRB may ask for the resignation of that member and a new member will be appointed.

On an annual basis, the IRB Chairs and the Director of the HSPP Office will review the membership and composition of the IRB to assess their knowledge of ethical principles and basic regulatory requirements, attendance at, preparedness for and participation in meetings; reviews conducted; and participation in continuing education/training opportunities through an evaluation and self-evaluation process. The entire campus has annual faculty evaluations beginning in April each year. The IRB Chair Evaluations (completed by the IRB Members) and the Member Evaluation of the Director of the OHRO (completed by the IRB Chairs) will coincide with the regularly scheduled Annual Faculty Performance Reviews performed by the IO.

The IRB Chair Evaluation Form will be utilized by the IRB Chairs to self-evaluate in February and by each IRB member to evaluate the IRB Chairs in April as a supplement.
to be used in their faculty evaluations. The IRB Member Evaluation Form will be utilized by the IRB Member to self-evaluate in February and by the Director of the OHRO to evaluate each member in April as a supplement to be used in the faculty evaluation of an IRB Member that is also a faculty member. The IRB Chairs will evaluate the Director of the OHRO using the Member Evaluation Form in April as a supplement to be used in her faculty evaluation.

Each IRB Chair and IRB member will receive a copy of his or her evaluation with face-to-face feedback. If necessary, the Director of the HSPP, IRB Chairs and OHRO staff will work with each IRB Chair or Member to develop a plan to improve the individual’s knowledge, skills, and performance. An anonymized summary of the annual evaluations will be shared with the IO. Outcomes of the evaluation process will be used to make determinations regarding training, development, overall improvement of the HSPP, and the composition of the IRB itself.

As part of the required IRB registration process, PEORIA IRB’s membership rosters are registered with the Office of Human Research Protections (OHRP) (45CFR46.501) and the Food and Drug Administration (FDA) (21CFR56.106).

PEORIA IRB members are responsible for ensuring that the proposal for conducting research and the ongoing conduct of research includes adequate protections for the rights and welfare of research subjects. In order to fulfill this responsibility, it is important for each and every PEORIA IRB member to be well versed in the Belmont Report, federal regulations on IRB requirements, the requirements for legally effective informed consent (including 45 CFR 46, 21 CFR 50, and 21 CFR 56), the privacy of protected health information (45 CFR 160, 45 CFR 164), as well as the Good Clinical Practices for Research as it is consistent with FDA regulations. PEORIA IRB members should take an active role in keeping up with current events in research, for example, by taking membership in IRB forums and news groups that are available on the Internet, or printed updates available by subscription.

Members review the material they are given for each meeting, documenting any questions or concerns they may have on review guides to prepare for the convened meetings or as documentation of expedited review. The primary reviewer checklists and member documentation will be attached with each protocol in IRBNet. PEORIA IRB members are required to know and understand the policies and procedures they are required to follow, with particular attention to the scope of authority and the limitations of PEORIA IRB.

The responsibilities of PEORIA IRB members include but are not limited to: reviewing the application form, the protocol, the grant form (if applicable), recruitment materials, study instruments (i.e., scripts, questionnaires), and the consent form, discussing the forms and materials at the meeting, and voting on the proposal. During a convened IRB meeting, motions are made, and votes taken on such motions, only in the absence...
of investigators or those with a vested interest in a protocol. Voting is by show of hands. The OHRO staff records all member discussions, questions and answers from the board to the investigator, votes, and all votes are reflected in the minutes according to the will of the member to support the motion, vote against it, or abstain (names of abstainers are also recorded). Any member recused from the discussion and voting for a particular protocol will be noted in the minutes.

4.6 PEORIA IRB Chairs and Co-Chairs

PEORIA IRB Chairs are selected by the Regional Dean of UICOMP in consultation with the Liaison Committee. The Chair and Co-Chair of PEORIA IRB must be a clinician and affiliated with one of the Institutions participating in the Liaison Committee. The Chair and Co-Chair may come from different participating institutions, and the term of their appointment will be three years. They will be re-appointed as deemed appropriate. The IRB Chair may appoint one or more designees as having signatory authority for IRB correspondence, and may appoint designees from amongst the qualified IRB members for conducting expedited reviews and determinations of exemption.

The Chairperson’s responsibilities include: serving as presiding officer at meetings of PEORIA IRB, and assuming such other duties as are assigned by PEORIA IRB, including the review of any proposals that, following initial review by PEORIA IRB or pre-review by OHRO staff, require additional review in order to determine compliance with PEORIA IRB conditions of approval.

4.7 PEORIA IRB Member Alternates

PEORIA IRB may also utilize alternate members. Alternate members have all the rights and responsibilities of standing voting members. Alternate members must have similar qualifications to the standing member on the board in order to be in a position to replace a member in the discussion and voting process. They function as a full IRB member in place of the standing member who was unable to attend a particular meeting. The designation is made in advance of the convened meeting, to allow sufficient time for the alternate member to receive and review the meeting materials. Alternate members are included in the IRB Registration roster that is submitted to OHRP.

4.8 Use of Ad Hoc Consultants

If the Chair or Co-Chair determines that there is not sufficient content expertise within the PEORIA IRB for satisfactory review, an outside ad hoc consultation will be obtained from within the institution or in the community at large. The consultant will not have any conflict of interests and will be familiar with process of ethical review of human research. The consultant may attend the meeting to present their information and contribute to preliminary discussions or they may submit a written review. When
the consultant provides a written review it will be utilized by the entire board as a resource for its review of the research protocol. Written reviews of consultants will be kept in IRB records. Key information provided by consultants at meetings will be documented in the minutes. Written reviews provided by the outside reviewer will be filed with the protocol/research record in IRBNet.

4.9 Compensation of PEORIA IRB Members

Regular and alternates members of PEORIA IRB are not compensated for their service.

4.10 PEORIA IRB Meetings

PEORIA IRB meetings are scheduled one year in advance and notification of the dates are distributed by the OHRO staff to all PEORIA IRB members and made available on the PEORIA IRB website. The members will receive the place and time of meetings, the agenda, and the study materials to be reviewed via IRBNet at least one week prior to each individual meeting.

IRBNet access is made available to all present IRB members through the use of a laptop computer, LCD and projection screen. IRB Specialists navigate IRBNet as questions arise regarding agenda items. Reminder aids for the Common Rule’s Criteria for Approval and Subpart D’s four categories of children’s research are provided at each convened meeting of the IRB.

4.10.1 Pre-Meeting Distribution of Documents

All required materials needs to be submitted (in full) 2 weeks prior to the convened meeting for inclusion on the following IRB agenda. The OHRO creates an agenda for each of the PEORIA IRB meetings utilizing IRBNet. The agenda includes all research protocols awaiting action by the PEORIA IRB and informs the members about research that has been approved by the Chair or other designated reviewers through expedited review procedures. The agenda will also inform the PEORIA IRB of any research determined to be exempt.

All IRB members receive their review materials via IRBNet including the IRB agenda, prior month’s meeting Minutes, applicable business items, appropriate continuing education materials and protocol review materials no later than one week before the scheduled meeting to allow sufficient time to review the research protocols and contact investigators, if they wish, for any clarifications or other relevant information.

For an initial review, each PEORIA IRB member has access to the following:
• Initial review application form, with any supporting documents including appendices;
• Informed consent documents, assent documents;
• Full copy of the protocol;
• Investigator’s Brochure;
• Advertisements;
• Responsibilities of Investigator Form;
• Conflict of interest disclosure and management plan (if applicable);
• Completed grant proposal or grant application (if applicable), and any recruiting materials.

The Primary and Secondary Reviewers have access to and complete the New Study Wizard Reviewer Checklist.

4.10.2 Primary and Secondary Reviewers

The IRB Director assigns Primary and Secondary Reviewers to new study reviews paying close attention to the scientific content of the protocol, the potential reviewer’s area of expertise and representation for vulnerable populations involved in the research.

Two reviewers will be assigned to each new protocol and a reviewer may be assigned several protocols or other research items for review. Reviewers are assigned to all protocols requiring initial review, continuing review, and modifications.

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

The primary and secondary reviewers are responsible for:

1. Having a thorough knowledge of all of the details of the proposed research.
2. Performing an in-depth review of the proposed research.
3. Leading the discussion of the proposed research at the convened meeting, presenting both positive and negative aspects of the research, and leading the IRB through the regulatory criteria for approval (See Section 5.10.1).
4. Making suggestions for changes to the proposed research, where applicable.
5. Completing all applicable IRB reviewer forms.

If both the primary and secondary reviewer are absent from the meeting, a new reviewer may be assigned, providing the new reviewer has reviewed the materials prior to the meeting. Additionally, an absent reviewer can submit their written comments for presentation at the convened meeting, as long as there is another reviewer present at the convened meeting, who can serve as the primary reviewer. It should be noted that all of the IRB members receive and are expected to review all studies, not just the ones they are responsible for reviewing.

The IRB Chair with assistance of the IRB Specialist(s) determines that quorum is established and maintained. The IRB Chair convenes a meeting only if a quorum (i.e., greater than 50% including a nonscientist) is present. Quorum is documented by the IRB in the minutes using the Minutes Builder and the IRB Specialists monitor and note the continued presence of quorum for all votes, including a member whose primary concern is in a nonscientific area.

Once a quorum is reached and the IRB meeting is convened, announcements are made and continuing education may be offered. The IRB Chair will poll the IRB members, any ad hoc consultants and OHRO staff for self-declaration of their conflicting interests in advance of convened IRB review. The minutes from the previous meeting are referenced and a discussion of the minutes takes place. If there are corrections to the minutes, they are noted. If no corrections are noted, the minutes are approved in the form presented.

The IRB Chair may order the agenda to accommodate those members who may need to leave early or to accommodate a principal investigator’s time constraints when they are in attendance to present their study.

OHRO staff ensures all items are discussed. Notes taken by staff are used in collaboration with Reviewer Checklists to create the PEORIA IRB meeting minutes and revision letters notifying investigators of the Board’s determinations. All votes, actions, member discussions, questions from the board to the investigators are noted in the minutes and all checklists are attached with each protocol in IRBNet.

4.10.3 IRB Guests

The Principal Investigator of a full board new study is welcome to present their study to the convened IRB. At its discretion, the IRB may also invite the Principal Investigator to the IRB meeting to answer questions about their proposed or ongoing research. The Principal Investigator may not be present for the deliberation or vote on their research.
Other guests may be permitted to attend an IRB meeting at the discretion of the IRB Chairs and the Director of the IRB Office. Guests may participate in the IRB discussion and deliberations, but may not vote. Guests must sign a confidentiality agreement.

4.11 Quorum and Voting Procedures

IRBs meet as often as necessary to consider research applications submitted for review. With the exception of applications eligible for exempt and expedited review, the PEORIA IRB membership reviews the research protocols at convened meetings where a quorum has been established.

Voting members are permitted to attend convened meetings of the PEORIA IRB via teleconference or videoconference, but only if they have been provided access to copies of all of the items for review in advance of the meeting, and only if the equipment allows real time interaction that they can meaningfully participate in the discussion and voting. There are no provisions for any other kind of proxy or written vote, since PEORIA IRB members must be in attendance to vote. However, PEORIA IRB members are permitted to submit written comments or questions via IRBNet for consideration of the Board in its review of the research protocol.

A majority of the members shall constitute a quorum (greater than 50%) for the transaction of business at any meeting of PEORIA IRB, providing that the majority includes at least one member whose primary concerns are in nonscientific areas. In the event a quorum is not present, no official business may be conducted. The IRB Chair will poll the IRB members, any ad hoc consultants and OHRO staff for self-declaration of their conflicting interests in advance of convened IRB review. Members with a conflict of interest will recuse themselves from the meeting room during final discussion and voting on any submission. These members cannot be counted towards the quorum for the motion and the recusal will be documented in the official minutes of the meeting. Each member of PEORIA IRB is entitled to one vote on all official actions (with the exception that an alternate cannot vote if the standing voting member is present). All motions require a simple majority of the votes of the members present (which must satisfy the requirements for quorum), in order to approve a protocol. Voting occurs by a show of hands. The IRB Specialists note the total amount of votes for a particular motion, the number of votes approving the motion, the number of votes opposing the motion and the number of abstentions in the minutes.

When PEORIA IRB reviews a new protocol involving prisoners as subject, the composition of the IRB must satisfy the following requirements pursuant to 45 CFR 46.304(a) and (b):

a) A majority of the IRB (exclusive of prisoner members) shall have no association with the prison(s) involved, apart from their membership on the IRB.
b) At least one member of the IRB must be a prisoner, or a prisoner representative with appropriate background and experience to serve in that capacity, except where a particular research project is reviewed by more than one IRB, only one IRB need satisfy this requirement.

PEORIA IRB will meet special composition requirements for all types of review of the protocol, including original review, continuing review, review of protocol amendments and review of reports of unanticipated problems involving risks to subjects.

4.12 Calculating Approval and Expiration Dates

At the time of initial review and at continuing review, the IRB will make a determination regarding the frequency of review of the research protocols. All protocols will be reviewed by the IRB at intervals appropriate to the degree of risk but no less than once per year. In some circumstances, a shorter review interval (e.g. semi-annually, quarterly, or after accrual of a specific number of participants) may be required. The meeting minutes will reflect the IRB’s determination regarding review frequency and will be reflected in the approval and expiration dates.

It is the policy of the PEORIA IRB to stamp all IRB-approved informed consent documents with the Date of IRB Approval and the Date of IRB Expiration. The Office for Human Research Protections (OHRP) recommends that IRBs require approval and expiration dates on all approved informed consent documents and that only those documents bearing approval and expiration dates be used when obtaining informed consent from human participants.

OHRO staff must affix the approval and expiration dates to all approved informed consent documents. Copies of the current, date-stamped approved documents are the only versions that may be used by Investigators in obtaining consent for research activities. This procedure helps assure that only the current IRB-approved informed consent documents are presented to participants and serves as a reminder to the Investigators of the need for continuing review.

1. Date of IRB Approval. The approval date is the date that the IRB application and informed consent documents were granted final approval by the IRB, unless one of the following applies:

   a. If the Application has received a continuing review and approval of the research activities and informed consent documents, the date of the last continuing review approval is used;

   b. If the IRB has approved a modification to the informed consent documents, the date of the IRB’s consent form approval is used; or
c. The “Date of IRB Approval,” which appears on the informed consent documents, is the date of approval for the most recent version of the informed consent documents.

2. **Date of IRB Expiration.** The expiration date is the date of the convened meeting at which the research was approved or approved with modification plus the approval interval, not to exceed one year.

   The expiration date is the last date that the protocol is approved (i.e., if the approval period is January 1, 2007-December 31, 2007, December 31, 2007 will be the last day that the protocol is approved). The Federal 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 before or on the date when IRB approval expires.

   The approval interval for new expedited studies will always be shorter than one year since expiration dates are set according to convened meeting dates (i.e. a study approved May 19, 2011 will not be set to expire in one year on May 18, 2012, but May 10, 2012, the 2nd Thursday of the month and regularly scheduled IRB meeting. This expiration default aims to deter late submissions of Continuing Reviews for expedited studies.

### 4.13 PEORIA IRB’s On-line Submission System

PEORIA IRB utilizes IRBNet as its on-line submission system. IRBNet was built on the back of a 2001 NIH Enhancement Grant, driven by Researchers and Administrators and guided by industry leaders such as Elizabeth Bankert (Co-Chair, PRIMR, and Dartmouth College) and Skip Nelson (FDA, formerly at the Children’s Hospital of Philadelphia).

IRBNet is a workflow management system, providing a connected submission, review and oversight tool set. The system is made available to investigators, and qualified administrative staff and committee reviewers as per policy. The system utilizes Smart Forms and “attachment” methodologies, and houses Forms Libraries including Training Energizers, IRB forms and resources for its users and select resources for committee members. The system contains a secure audit record of activity, and provides a robust reporting architecture.

UICOMP utilizes IRBNet electronic signatures, streamlined Agenda and Minutes Builders, and many other features.

Electronic signatures are time and date stamped.
Electronic Signatures

All PEORIA IRB submissions via IRBNet require the electronic signature of the PI, or designee. All UICOMP new study submissions require the electronic signature of the department chair/head, and/or research advisor (if applicable) and hospital/clinic research administrator prior to submission to OHRO. The signature action is time and date stamped in IRBNet and serves as documentation of the department chair/head’s, research advisor’s and/or hospital research administrator’s approval for submission in lieu of a physical signature.

An action by the reviewer is captured when a comment is posted in the “Comments” section and/or the reviewer’s checklist is attached. The action is time and date stamped in IRBNet and serves as documentation of the reviewer’s determination in lieu of a physical signature. When an approval is granted by this mechanism, this time and date stamp serves as the official date of approval. Subsequent correspondence to the investigator related to the acknowledgement or approval of an action will be generated by the UICOMP OHRO staff utilizing the date captured in the “comments” section.

IRBNet User List serve

An IRBNet user must become a registered user by following a registration process that includes provision of the registrant’s e-mail address. IRBNet compiles an e-mail list of PEORIA IRBNet users that the OHRO uses as a list serve to disseminate new information that may affect the HSPP. Communication of new policies occurs through emails to users of IRBNet and articles in the quarterly HSPP newsletter sent via IRBNet user list serve. The list serve is the primary means of communication for new policies, procedures and announcements.

4.14 PEORIA IRB Meeting Minutes

PEORIA IRB meeting minutes are written in compliance with FDA regulation 21 CFR 56.115(a) (5), and HHS regulations 45 CFR 46, including: attendance at the meetings, actions taken by PEORIA IRB, the vote on these actions including the number of members voting for, against and abstaining, the basis for requiring changes in or disapproving research, and a written summary of the discussion of controverted issues and their resolution. The minutes also reflect any changes in membership. The minutes will be distributed to all members prior to the next scheduled convened meeting via IRBNet. The OHRO prepares minutes of each meeting of the PEORIA IRB, documenting the Board’s review of research protocols, policy discussions and continuing education. The minutes are recorded in sufficient detail and include the following:

- PEORIA IRB member attendance.

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• PEORIA IRB members document their attendance on a Signature sheet and their attendance is marked on a cumulative attendance chart.
• The attendance chart notes which members are non-affiliated, which members have primary concerns in non-scientific areas, the alternates for primary members, the non-voting members and the Chair.
• The presence of any invited investigators or guests is also documented.
• Research protocol summary including the research objectives, procedures, subject population(s), risks, benefits, and research site.
• Summary of the discussion, in particular discussion of controverted issues and their resolution for each research protocol reviewed.
• Decisions reached on each research protocol reviewed.
• Votes on the decisions, documenting the number of votes for, against, abstaining and total present for the vote. Recusal of members due to conflicting interests is also documented and the quorum reflects the recusal.
• Reasons for requiring modifications to secure approval of a research protocol, for disapproving a research protocol, or suspending or terminating a research protocol.
• If vulnerable groups of subjects are included in the research, the justification for their inclusion, and discussion of the adequacy of special precautions, safeguards, or alternatives taken to minimize risks.
• If pregnant women, fetuses, prisoners, or children are involved in the research protocol specific findings about their inclusion, the additional specific safeguards, the procedures for consent, parental permission or assent of children and other determinations required by the federal regulations.
• If an investigational device is included in the research, the device must be categorized as either a Significant Risk (SR) device or a Non-Significant Risk (NSR) device.
• If a waiver or alteration of informed consent or a waiver of documentation of informed consent is granted, the specific findings supporting the PEORIA IRB’s determination.
• If a waiver/alteration of Authorization is granted, the specific findings supporting the PEORIA IRB’s determination.
• The level of risk involved in the research.
• The review frequency for the next continuing review.
• Disclosure of any COI with any of the proposed protocols prior to review.

A copy of the minutes is provided to the PEORIA IRB members for review via IRBNet before the next meeting. At the actual PEORIA IRB meeting, members have an opportunity to request clarifications or suggest changes to the minutes. Suggested modifications to the minutes are discussed at a convened meeting and agreed to by consensus, and the minutes are subsequently modified according to the Committee’s recommendations by OHRO staff, with the committee providing a final review and approval. When the committee approves the minutes, they become the official minutes for that PEORIA IRB meeting.

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4.15 Confidentiality of the Review Process

At the time of PEORIA IRB member appointment, all PEORIA IRB members, including PEORIA IRB Chairs and Co-Chairs, are provided a Statement of Confidentiality form. This statement provides a written assurance that activities related to research protocol review or other PEORIA IRB related activities performed during the time of a PEORIA IRB member’s appointment will be conducted in strict confidence and not discussed outside of the context of these duties. By accepting the appointment to the PEORIA IRB, each member is agreeing to the terms of confidentiality statement.

4.16 Reporting of PEORIA IRB Findings to Investigators and the Institution

The OHRO staff is charged with attending convened meetings of the PEORIA IRB, and working with IRB members who conduct expedited reviews and reviews of claims of exemption in order to facilitate the communication of the PEORIA IRB’s findings and actions to the investigator and the Institution. All communication of the PEORIA IRB’s findings and actions is done electronically via IRBNet. When federally funded projects are approved, OHRO staff will prepare a form 310, which will be signed by the IRB Chair or his or her designed (OHRO Director or OHRO staff) at UICOMP and scanned into IRBNet for access by the investigator after approval of the protocol. In order to communicate the PEORIA IRB’s findings and actions, the Human Protections Administrators at UICOMP and all affiliated community institutions are provided with a copy of all PEORIA IRB minutes via IRBNet.

The OHRO Director conveys determinations/decisions made by the IRB to the institution’s administration by forwarding the PEORIA IRB’s approved minutes to the IO (SOP: Conveying IRB Determinations to the Institutional Official.)

OHRO will report, by letter posted on IRBNet, to the investigator any findings and actions of PEORIA IRB. The investigator is responsible for communicating any findings to the sponsor. The following information, exclusive of PEORIA IRB members’ names, is documented in an approval notice:

- Protocol or amendment identification (title, number),
- List of documents being approved (protocol, consent, advertisements, etc.),
- Version numbers for protocol, consent form, amendments,
- Approval date,
- Statement of Approval,
- Expiration date of approval,
- Adverse event reporting expectations, and
- Protocol deviation/noncompliance issues reporting expectations.
4.17 PEORIA IRB Membership Roster

OHRO maintains the membership roster for each PEORIA IRB; including a listing of voting members by name, gender, earned degree(s), and primary scientific or nonscientific specialty. The member’s affiliation status to any participating institution or organization will be noted on the roster. The roster also provides information regarding PEORIA IRB alternate members.

The OHRO maintains an education file for each IRB member. The file includes verification of CITI training, curriculum vitae containing evidence of qualifications and expertise, PEORIA IRB Board Member Statement of Confidentiality, Notice of UICOMP IRB Member, Ad Hoc Consultant and OHRO Staff Conflict of Interest Policy and any other applicable educational certificates.

When the roster is updated with OHRP, each Institution participating in the Liaison Committee will receive notification that the roster has been updated.

4.18 PEORIA IRB Records

A unique IRBNet identification number is assigned to each protocol submitted into IRBNet. Subsequent study actions are submitted as packages under the unique identification number and assigned a -2, -3, -4, etc. IRBNet is used to prepare, document, maintain and store the following IRB records:

a. Research project proposals, modifications, continuing review reports and reportable events
b. Approved consent, assent and HIPAA authorization documents and recruitment materials
c. Investigator Brochure or Tech Manual, if applicable
d. IRB reviewer forms
e. Scientific evaluations, when provided by an entity other than the IRB
f. Reportable events of unanticipated problem involving risk to subjects or others and related review determinations (UIRPSO)
g. Data and Safety Monitoring Reports
h. Significant new findings
i. Documentation of noncompliance
j. Documentation of type of IRB review.
k. For expedited review, documentation of any determinations required by the regulations and protocol-specific findings supporting those determinations, including: waiver or alteration of the consent process, research involving pregnant women, fetuses, and neonates, research involving prisoners, and research involving children.
1. Documentation of all IRB review actions.

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

n. Minutes of convened IRB meetings including attendance; actions taken by the IRB; the vote on these actions; the number of members voting for, against, and abstaining; the basis for requiring changes in or disapproving research; and a written summary of the discussion of controverted issues and their resolution.

o. Minutes of expedited items including a written summary of the submission; the action(s) taken by the reviewer(s); the basis for requiring changes in or for referring to the convened board.

p. Copies of approval letters and forms that describe what Principal Investigator must have before beginning the study.

q. Correspondence between the IRB and the research project team

r. Emergency Use submission and correspondence

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

t. Investigator's Conflict of Interest records


v. Member and Researcher Forms Library

w. IRB Member Education Presentations

x. All other IRB correspondence related to the research.

OHRO staff members are also responsible for maintaining the following information:

• All educational credentialing for investigators, research staff, OHRO staff, board members, and any persons engaged in research reviewed and approved by PEORIA IRB,

• CVs/resumes for investigators, research staff, OHRO staff and board members,

• Confidentiality Agreements for OHRO staff, board members and IRB guests.

• All electronic and physical copies of the PEORIA IRB rosters and accompanying documentation,

• Corresponding original IRB Authorization Agreements or MOUs created and maintained through OHRP and Federal Wide Assurances,

• All documentation in reference to UICOMP’s Federal Wide Assurance,

• Physical copies of the agenda, minutes, IRB meeting sign-in sheets and IRB Jurisdiction Waivers.

4.19 Access to IRB Records

The IRB has policies and procedures to protect the confidentiality of research information:
1. All IRB paper records are kept secure in locked filing cabinets.

2. Ordinarily, access to paper IRB records is limited to the Director, IRB Chairs, IRB members, OHRO staff, authorized institutional, and officials of Federal and state regulatory agencies (OHRP, FDA). Electronic IRB records are maintained with IRBNet hosted at a secure, enterprise-class data center that supports the strict requirements of the US Government. IRBNet offers Encryption, password authentication and strict authorization rules for access to IRB records. Research investigators are provided reasonable access to files related to their research through IRBNet. Appropriate accreditation bodies are provided access and may recommend additional procedures for maintaining security of IRB records. All other access to IRB records is limited to those who have legitimate need for them, as determined by the IO and Director.

3. Records are accessible for inspection and copying by authorized representatives of Federal regulatory agencies during regular business hours.

4. Records may not be removed from the IRB Office; however, the IRB staff will provide copies of records for authorized personnel if requested.

5. All other access to IRB study files is prohibited.

4.20 Record Retention

All records are maintained for at least six years after completion of the research or as required by the Illinois State Record Act (5 ILCS 160), other applicable state requirements and regulations or federal regulations. The records are accessible for inspection and copying by authorized representatives of federal agencies or departments at reasonable times and in a reasonable manner in accordance with 21 CFR 56.115(b) and 45 CFR 46.115(b).

PEORIA IRB retains copies of the following items for a minimum of six years following completion or termination of the research:

- All research proposals reviewed, scientific evaluations (if any) that accompany the proposals, approved sample consent documents, recruitment materials, and progress reports submitted by investigators, and reports of injuries to subjects or others,
- All correspondence between PEORIA IRB and the investigators including but not limited to: adverse reaction reports, amendments, and records of continuing review,
- Statements of significant new findings developed during the course of the research that may relate to the subject’s willingness to continue participation.

4.21 ClinicalTrials.gov Administration
The Department of Health and Human Services (DHHS) published a Final Rule updating requirements for submitting registration and summary results information, including adverse event information, for specified clinical trials to ClinicalTrials.gov. The regulation impacted is “Clinical Trial Registration and Results Information Submission”, at 42 CFR Part 11. This Final Rule applies to “Applicable Clinical Trials” of FDA regulated drug, biological, and device products and pediatric post-market surveillance studies of devices required by the FDA.

OHRO staff members are registered as UICOMP’s institutional PRS Administrators.

1. In this oversight capacity, PRS Administrators:
   a. establish user accounts and temporary passwords;
   b. reset a password when the original is lost or forgotten;
   c. with assistance from PRS, change ownership of a study; or
   d. transfer a study to another institution.

2. The Administrator monitors the system and notifies the researcher when updates and/or problems are not addressed in a timely manner.

3. The Administrator offers basic training on the use of the PRS interface and assists with basic tasks of clinical trial registration.

4. The Administrator is not responsible for reviewing, editing, or verifying the accuracy of the clinical trial record posted on ClinicalTrials.gov.

This is not a new regulation as researchers have been required to register and submit results for Applicable Clinical Trials to ClinicalTrials.gov since September 2009 under Section 801 of the Food and Drug Administration Amendments Act, known as FDAAA 801 (please see Section 10: ClinicalTrials.gov Registration for a detailed description of the Final Rule Update for ClinicalTrials.gov).

Section 5: Initial PEORIA IRB Review of a Research Proposal Involving Human Participants

5.1 Initial Review Policy

Investigators who intend to conduct research involving human subjects are responsible for submitting a research protocol, the application form, any research grant application (if applicable), and any other supporting documentation to the OHRO via IRBNet for initial review and approval. PEORIA IRB cannot issue approvals until the submission has received a complete review and approval has been documented. No research with
human subjects may begin (no data may be collected or subjects recruited) until the PEORIA IRB has approved the research and the OHRO has provided written approval.

PEORIA IRB deadlines are posted on the UICOMP website at:
https://peoria.medicine.uic.edu/research/institutional-review-board/meeting-dates/

The investigator will provide PEORIA IRB, two weeks prior to the meeting, the study protocol, typewritten, which includes.addresses:

- Title of the study,
- Purpose of the study (including expected benefits obtained by doing the study),
- Sponsor of the study,
- Results of previous related research,
- Subject inclusion/exclusion criteria,
- Justification for use of any special/vulnerable subject populations (e.g., the decisionally impaired, children),
- Study design (including, as needed, a discussion of the appropriateness of research methods),
- Description of procedures to be performed,
- Provisions for managing adverse reactions,
- The circumstances surrounding consent procedure, including setting, subject autonomy concerns, language difficulties, and vulnerable populations,
- The procedures for documentation of informed consent, including any procedures for obtaining assent from minors (using a witness), translators, and document storage,
- Compensation (if applicable) to subjects for participation,
- Any compensation for injured research subjects,
- Provisions for protection of subject’s privacy and confidentiality,
- Extra costs to subjects for their participation in the study, and
- Extra costs to third party payers because of subject’s participation.
- Summary of necessary support for the research (i.e., services and facilities).
- Investigator’s professional qualifications:
  - Current curriculum vitae (CV),
  - Copy of completed CITI course certifications.

The investigator will provide to PEORIA IRB (if applicable) the Investigator’s Brochure and case report forms, if applicable.

The investigator will provide to PEORIA IRB the proposed informed consent. PEORIA IRB provides a consent form template in the IRBNet Forms Library that includes all the elements as listed below (45 CFR 46.116). Use of this template is not mandatory.

- All requirements of 21 CFR 50.25(a),

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• Requirements of 21 CFR 50.25(b) that are appropriate to the study,
• Requirements of 21 CFR 50.20,
• If applicable, the requirements of ICH-GCP 4.8, and
• Translated consent documents, as necessary, considering likely subject population(s).

The submission should include recruitment materials (i.e., phone screening scripts, patient information sheets). If applicable, advertisements, grant, all data collection tools (i.e. surveys, interview scripts, or established instruments), consent form/cover letter will be submitted by the investigator to PEORIA IRB.

Investigators submitting research for initial review are given the option of presenting their research proposals to the convened IRB. Presentation may be mandated for first time investigators or for highly complex or sensitive research proposals.

5.2 Clinical and/or Research Supervisor Sign-Off

All PEORIA IRB submissions via IRBNet require the electronic signature of the PI, or designee. All UICOMP new study submissions require the electronic signature of the Clinical and/or Research Supervisor prior to submission to OHRO. Studies performed by residents require the electronic signature of his/her Program Director (PD). The signature action is time and date stamped in IRBNet and serves as documentation of the Clinical and/or Research Supervisor’s/Program Director’s (PD for residents only) approval for submission in lieu of a physical signature. The Clinical and/or Research Supervisor/Program Director may designate another person to sign PEORIA IRB submissions in his/her absence.

The person signing as “Clinical and/or Research Supervisor/Program Director (PD for residents only)” should be the individual who has the necessary professional credentials to act as the principal investigator’s supervisor and hold him/her accountable for job performance. The person signing on the line above attests to the following:

1) As the employer or supervisor of the principal investigator, I will hold him/her accountable for compliance with human subjects protection policy and procedures;
2) The resources and environment required for satisfactory completion of this project are available to the investigator; and
3) This project has been reviewed for scientific merit and meets the expectations of our discipline.

5.3 Research Site Designation

An institution or locale (i.e., school, hospital, and doctor’s office) cannot be designated as a research site unless the investigator has a written agreement with the institution or
locale that they agree to be a research site. This agreement represents a declaration that the research is feasible at that site and there are sufficient resources appropriate to the conduct of research at the site. The agreement will include disclosure of any potential or actual conflicts of interest by the institution or locale regarding the conduct of the research.

All UICOMP new study submissions or additions of a new study site require the electronic signature of the hospital/clinic research administrator at that site. The electronic signature of the hospital research administrator acknowledges that the facilities and equipment necessary to conduct the research study are adequate and appropriate for the type of research proposed to the IRB. The signature action is time and date stamped in IRBNet and serves as documentation of the hospital/clinic research administrator’s approval for submission in lieu of a physical signature.

When adding an investigative site to a previously approved research study, a Change in Research Form and an updated Project/Protocol Review Form (PPRF) indicating the new investigative site must be submitted into IRBNet. If the signatory official or designee at the new institution or locale is not a registered user of IRBNet, a letter of support must accompany the Change in Research Form and updated PPRF. The addition of an investigative site may be considered a “minor” modification to the research if the IRB is familiar with the institution or locale at which the clinical investigator has proposed to conduct the research.

If the IRB is unfamiliar with a new proposed institution or locale, the IRB may need additional information to assess the site where the proposed research will take place to ensure it can adequately execute the protocol requirements. Depending upon the nature and risks of the proposed research and the IRB’s prior knowledge of or relationship to the institution or other site at which the research will take place, this may be relatively simple and straightforward or it may entail a more involved assessment.

5.4 Pre-review by OHRO Staff

OHRO staff will pre-review all PEORIA IRB submissions prior to board member review. Submissions will be checked for completeness and accuracy as applicable to all federal regulations and policies as outlined in this manual. OHRO staff will contact investigators and/or research coordinators when additional materials are needed to complete the submission.

5.5 Determinations of Research and Human Subjects Research

When reviewing Research, the PEORIA IRB will use the following definitions taken from the HHS Regulations (45 CFR 46):
• **Research** is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

• **Human subject** means a living individual about whom an investigator (whether professional or student) conducting research obtains: 1) data through intervention or interaction with the individual or (2) identifiable private information.

• **Intervention** includes 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. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

Activities that meet these definitions constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.

In addition to the HHS definition (45CFR) of research and human subject, the UICOMP HSPP also applies the FDA definition.

The FDA defines research (or clinical investigation) as any experiment that involves a test article, one or more human subjects, and that is subject FDA regulations. Reflecting the regulatory purview of the FDA, test article refers to any drug for human use, biological product for human use, medical device for human use, human food additive, color additive, electronic product, or any other article subject to FDA regulations.

Human Subject is defined by the FDA as an individual who is or becomes a participant in research, either as a recipient of the test article or as a control. A subject may be either a healthy individual or a patient. For research involving medical devices, a human subject is also an individual on whose specimen an investigational device is used.

When medical device research involves in vitro diagnostics and unidentified tissue specimens, the FDA defines the unidentified tissue specimens as human subjects.

**5.6 Not Human Subjects Research Determination Process**
At least one qualified member of the PEORIA IRB and a staff member of the OHRO reviews the proposed activity to determine whether the research meets the definition of research and/or does not involve human subjects. The reviewers may:

- Determine that the proposed activity does not meet the definition of research and/or does not involve human subjects,
- Request further information before a determination can be made,
- Determine that the research meets the definition of research and/or involves human subjects and must be reviewed by the PEORIA IRB under exempt, expedited or convened review procedures.

Decision Chart 1 is utilized by OHRO to make the determinations regarding whether or not a protocol involves research and/or human subjects. Using this chart, the reviewer will determine where the protocol falls and document this decision in the IRBNet Comments Box. An action by the reviewer is captured when a comment is posted in the “Comments” section. The action is time and date stamped in IRBNet and serves as documentation of the reviewer’s determination in lieu of a physical signature. When a determination is granted by this mechanism, this time and date stamp serves as the official date of the determination.

Correspondence to the investigator related to the “not research” determination will be generated by the PEORIA IRB staff utilizing the date captured in the “comments” section.

The results of the review will be communicated in a letter posted in IRBNet to the investigator.

The Office for Human Research Protections (OHRP) provides graphic aids as a guide for institutional review boards (IRBs), investigators, and others who decide if an activity is research involving human subjects that must be reviewed by an IRB under the requirements of the U.S. Department of Health and Human Services (HHS) regulations at 45 CFR part 46.

Chart 1 addresses decisions on whether an activity is research that must be reviewed by an IRB: [https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c1](https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c1)
Chart 1: Is an Activity Research Involving Human Subjects?
5.7 Review of Claims of Exemption

February 16, 2016

Activity is not research, so 45 CFR part 46 does not apply.

Start here.

Is it research?

Is the activity a **systematic** investigation **designed** to develop or contribute to **generalizable** knowledge? [45 CFR 46.102(d)]

**YES**

Activity is research. Does the research involve human subjects?

Does the research involve **obtaining information about living individuals**? [45 CFR 46.102(f)]

**YES**

Does the research involve **intervention or interaction** with the individuals? [45 CFR 46.102(f)(1), (2)]

**NO**

Activity is research involving human subjects. Is it covered by the regulations?

Is it **conducted or supported by HHS**? [45 CFR 46.101(a)(1)]

**YES**

Does the institution hold an FWA under which it applies 45 CFR 46 to all of its human subjects research regardless of the source of support?

**YES**

The research involving human subjects is covered by the regulations.

The research involving human subjects is **NOT** covered by the regulations.

Go to Chart 2

**AND**

Other Federal, State and local laws and/or regulations may apply to the activity. [45 CFR 46.101(f)]

**BUT**

Unless exempt under 45 CFR 46.101(b), 45 CFR part 46, subpart A applies to the research, and as appropriate subparts B, C, and D also apply.

**NO**

The research is not research involving human subjects, and 45 CFR part 46 does not apply.

Is the information **individually identifiable** (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information)? [45 CFR 46.102(f)(2)]

**NO**

Is the information **private**? (About behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, or provided for specific purposes by an individual and which the individual can reasonably expect will not be made public.) [45 CFR 46.102(f)(2)]

**NO**

**BUT**
According to Federal Guidelines (45 CFR 46), research that presents little or no risk to human subjects does not require review by a convened PEORIA IRB.

Based on federal regulations UICOMP policy allows, research to be eligible for exemption from the Common Rule. The six categories of exempt research are listed at 45 CFR 46.101(b) and can be found in the Request for Exemption Section of the Project/Protocol Review Form. This form must be completed and submitted by the investigator and submitted via IRBNet.

In some instances, research involving sensitive topics or vulnerable populations cannot be certified as exempt:

- **Children:** The Exemption for research involving survey or interview procedures or observations of public behavior does NOT apply to research in children, except for research involving observations of public behavior when the investigator does not participate in the activities being observed.
- **Prisoners:** Exemptions do NOT apply. IRB review is required.

The OHRO staff will help investigators determine what level of PEORIA IRB review may be necessary for their proposed research by discussing plans for the research study.

**5.7.1 Exempt Review Process:**

The IRB Chair or designee of the PEORIA IRB and a staff member of the OHRO reviews the request for exemption and determines whether the research meets criteria for exemption. The reviewers may:

- Grant the Exemption,
- Request further information before a determination can be made,
- Determine that the proposed activity does not meet the definition of research and/or does not involve human subjects, or
- Determine that the research does not meet exemption criteria and must be reviewed by the PEORIA IRB under expedited or convened review procedures.

Reviewers will document all necessary criteria for consideration in the “Comments” box and/or attach the reviewer’s checklist. An action by the reviewer is captured when a comment is posted in the “Comments” section and/or the reviewer’s checklist is attached. The action is time and date stamped in IRBNet and serves as documentation of the reviewer’s determination in lieu of a physical signature. When an exemption is granted by this mechanism, this time and date stamp serves as the official date of approval.
Correspondence to the investigator related to the acknowledgement or approval of an action will be generated by the PEORIA IRB staff utilizing the date captured in the “comments” section and/or the date captured when the reviewer’s checklist was attached in IRBNet.

The results of the review will be communicated in a letter posted in IRBNet to the investigator. If the exemption is approved, the letter to the investigator in IRBNet will include the exemption categories that the research has met.

5.7.2 Categories of Human Subject Research that May Be Approved as Exempt

UICOMP policies and the federal regulations allows human subject research meeting the requirement of one or more of the following categories to be approved as exempt from PEORIA IRB review and approval and other requirements in the Common Rule.

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 subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Guidance on this category: This means that data must be collected without names or other identifiers. Identifiers include birth dates, addresses, phone numbers, medical record numbers, SSN, license numbers, IP addresses (internet protocol), photographs, unique identification numbers, codes or other identifiers. (i.e., once you collect your data, you should have no way of linking that data back to the individual or the original data source.)

Observation of public behavior means that the researcher has no contact with the subjects. For example, watching children play jump rope on a city playground and recording their rhymes and songs but without talking with the children or approaching them. Exemption for survey and interview research does not apply to research in which the subjects are children,
except for research involving observation of public behavior if the investigator does not participate in the activities being observed.

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.

Guidance on this category: An example of this category would be interviewing persons running for office about their views on a topic.

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.

Guidance on this category: One factor to be considered is what access the researcher may have to the identifiers. Often researchers propose that their research assistant will de-identify the data for the researcher. This would not be considered truly de-identified because the researcher could access the links, as the employer of the research assistant. De-identification must be done by a party who has no interest or involvement in the study. For example, a tissue bank can truly provide de-identified samples to a researcher as the bank is set up as the gatekeeper of the samples.

Publicly available data sets such as Medicare data and other data for secondary analysis fall in this category.

Additional guidance on the "Research Use of Stored Samples or Data" is available at:

Additional guidance is available if your research is in the social science/behavioral area at:

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.

Guidance on this category: This is a fairly narrow category. A researcher cannot declare his/her study a demonstration study unless it is officially classified and funded in that manner. This means that a research study to find out whether the local YMCA is delivering useful services to the homeless is not a demonstration study unless it is funded by HHS or other federal agencies. Though the program may provide public benefit, it is not funded by the federal programs that define "public benefit."

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.

Guidance on this category: Surveys of college students about the dining hall experience and taste testing in the college dining hall probably would be exempt under this category.

General considerations in making a determination of a request for exemption.

- The research cannot involve prisoners as participants. (45 CFR 46.101(i)).
- Exemption categories 1-5 do not pertain to FDA-regulated research. (21 CFR 56.104).
- Exemption categories 1-6 apply to research involving pregnant women, fetuses and neonates [45 CFR 46.201(b)]
- Exemption categories 1 and 3-6 apply to research involving children. Research activities in category 2 are exempt for children only when limited to educational tests or observation of public behavior when the investigators do not participate in the activities being observed. (45 CFR 46.401(b)).

5.7.3 Exemption Certification Guidelines

The review of an IRB exemption requires the following documents:

- Project/Protocol Review Form
- Protocol summary
- Responsibilities of Investigators Form

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• Non-sponsored Conflict of Interest Disclosure Form
• Any applicable advertising, grant proposals, etc.
• Current CITI certifications and current CV for all those listed in section 5 of the Project/Protocol Review Form
• Any applicable questionnaires, surveys, data extraction sheets

All materials required for review must be submitted via IRBNet along with the “Project/Protocol Review Form.” Reviews of exemption requests are often delayed due to incomplete submissions. OHRO staff will contact the investigator and request additional materials.

Although the category of exemption means that the research is exempt from the federal regulations, this research is not exempt from ethical considerations such as the principles of the Belmont Report. The individual making the determination of exemption will determine whether to require additional protections for subjects in keeping with ethical principles.

Additionally, changes that may be made to the study might affect the exempt status. When changes or amendments are proposed for the research, the investigator should submit an amendment application via IRBNet explaining the proposed changes to the study. The amendment will be reviewed by the Chair or OHRO staff designated by the Chair and is attached with each protocol in IRBNet. If the changes do affect the exempt status, the investigator will be notified via IRBNet and the appropriate action will be taken. Changes in the research should not be initiated until the investigator receives notification from OHRO. If the change alters the exempt status of the research, the investigator will be instructed to re-submit the research for the appropriate level of review.

Investigators are expected to notify the PEORIA IRB when the study is completed by submitting the Final Report form via IRBNet.

The convened board is informed of all research protocols granted an exemption determination through inclusion of this information on the next available meeting agenda. Additionally, this information is documented in the meeting minutes in accordance with 45 CFR 46.110(c) and 21 CFR 56.110(c).

The decision charts (charts 2-7) below are utilized for determinations of exemptions. They are available at: https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c1

Chart 2: Is the Human Subjects Research Eligible for Exemption?
Chart 3: Does Exemption 45 CFR 46.101(b)(1) (for Educational Settings) Apply?

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From Chart 1

Has HHS prohibited exemption of the human subjects research? (All research involving prisoners, some research involving children.) [Footnote 1 to 45 CFR 46.101(i), 45 CFR 46.101(b)]

**NO**

Will the only** involvement of human subjects be in one or more of the following categories?

Research conducted in established or commonly accepted educational settings, involving normal education practices?

If not exempt under (b)(1)

Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior?

If not exempt under (b)(2) or (b)(3)

Research involving collection or study of existing data, documents, records, or pathological or diagnostic specimens?

If not exempt under (b)(4)

Research studying, evaluating, or examining public benefit or service programs?

If not exempt under (b)(5)

Research involving taste and food quality evaluation or consumer acceptance studies?

If not exempt under (b)(6)

No exemptions to 45 CFR part 46 apply. Provisions of 45 CFR subpart A apply, and subparts B, C and D also apply if subjects are from covered vulnerable populations.

**"Only" means that no non-exempt activities are involved. Research that includes exempt and non-exempt activities is not exempt.**
Chart 4: Does exemption 45 CFR 46.101(b)(2) or (b)(3) (for Tests, Surveys, Interviews, Public Behavior Observation) Apply?

**From Chart 2**

Is the research only\*\* conducted in *established or commonly accepted* educational settings? (Including but not limited to schools and colleges. May include other sites where educational activities regularly occur.)

**“Only” means that no non-exempt activities are involved. Research that includes exempt and non-exempt activities is not exempt.**

- **NO**
  - Research is not eligible for 45 CFR 46.101(b)(1) exemption.
  - Next
- **YES**
  - Does the research study involve only *normal education practices*? (Such as research on regular and special education instructional strategies, or research on effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.)
  - **NO**
    - Return to Chart 2 and consider whether 45 CFR 46.101(b)(2) exemption applies.
  - **YES**
    - Research is eligible for 45 CFR 46.101(b)(1) exemption from 45 CFR part 46 requirements.

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Chart 5: Does Exemption 45 CFR 46.101(b) (4) (for Existing Data, Documents, Records and Specimens) Apply?

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Chart 6: Does Exemption 45 CFR 46.101(b) (5) (for Public Benefit or Service Programs) Apply?

* Note: See OHRP guidance on research use of stored data or tissues and on stem cells at http://www.hhs.gov/ohrp/regulations-and-policy/guidance/guidance-on-research-involving-stem-cells/index.html, and on coded data or specimens at http://www.hhs.gov/ohrp/regulations-and-policy/guidance/research-involving-coded-private-information/index.html for further information on those topics.

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Chart 7: Does Exemption 45 CFR 46.101(b) (6) (for Food Taste and Acceptance Studies) Apply?


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5.8  Review of Research Through Expedited Review Process

**Review of Research Through Expedited Review Process**

Does the research involve only** a taste and food quality evaluation or a food consumer acceptance study?

**Yes**

Are wholesome foods without additives consumed?

**Yes**

Research is eligible for exemption under 45 CFR 46.101(b)(6) from 45 CFR part 46 requirements.

Other Federal, State and local laws and/or regulations may apply to the activity. [45 CFR 46.101(f)]

**No**

Is food consumed that contains a food ingredient, 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?

**Yes**

Research is not eligible for exemption under 45 CFR 46.101(b)(6).

**No**

Go to Chart 8

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5.8.1 Expedited Review Guidelines

There is no deadline to follow for expedited submissions; they may be submitted at any time in IRBNet. The investigator must submit the documents:

• Project/Protocol Review Form
• Consent/assent forms, if applicable
• Protocol summary or full protocol
• Responsibilities of Investigators Form
• Conflict of Interest Disclosure Form
• Any applicable advertising, grant proposals, etc.
• Current CITI certifications and current CV for all those listed in section 5 of the Project/Protocol Review Form, (if not already submitted to the IRB) and
• Any applicable questionnaires, surveys, data extraction sheets

5.8.2 Categories of Research that may be Approved through Expedited Procedures

Certain types of research protocols may be eligible for review under expedited review procedures. The research must involve no more than minimal risk and fit one or more of the categories for expedited review procedures as specified in the regulations [45 CFR 46.110, 21 CFR 56.110].

Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

If an investigator feels his/her proposed research study meets the criteria for expedited review, the study may be submitted to PEORIA IRB for review.

In order to be reviewed and approved under expedited review procedures, the research must pose no more than minimal risk to subjects, and must meet the criteria in one of the categories below. The first seven categories apply to an initial review of a research protocol. The last two categories apply to the continuing review of a research protocol. Inclusion in one of the categories below is not sufficient in and of itself, as the PEORIA IRB must also determine the research to be no more than minimal risk.

1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
(a) Research on drugs for which an investigational new drug application (21 CFR 312) is not required. (NOTE: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)

(b) Research on medical devices for which (i) an investigational device exemption application (21 CFR 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
   (a) From healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or
   (b) From other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

3) Prospective collection of biological specimens for research purposes by noninvasive means.
   Examples: (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

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

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

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

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

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

8) Continuing review of research previously approved by the convened IRB as follows:
   (a) Where (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.
9) Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

The OHRP decision chart (chart 8) below is utilized for determinations of expedited review. It is available at:
5.8.3 Expedited Review Procedures for an Initial Review

At least one (1) member of the PEORIA IRB is assigned as a primary reviewer. The IRB Chair may designate qualified members from each Committee to conduct these expedited reviews. The designees must be experienced (having

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served on the IRB for at least one year) voting members of the IRB. IRB members with a conflict of interest in the research will not be selected. IRB members will be assigned to review research protocols based on the nature of the research itself and on the expertise and experience of the IRB member.

PEORIA IRB members review the research applications to determine if the research meets the definition of minimal risk and meets the criteria for one or more of the eligible categories. The research is considered to be no more than minimal risk when it is determined that “the probability and magnitude of harm or discomfort anticipated in their search are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests” [45 CFR 46.102(i)]. IRB members may contact the Principal Investigator to ask questions or seek clarification about the research before making a final determination regarding the research.

The reviewer(s) exercise the authority of the PEORIA IRB in approving or requiring modifications to research in order for it to be approved when reviewed under expedited procedures. If the reviewer(s) believe that there is reason for disapproval, or the nature of the project is not suitable for expedited review, then the reviewer(s) must defer any decision and refer the application for review at a convened PEORIA IRB meeting.

The reviewer(s) have access to the initial review application form, with its supporting documents, informed consent/assent documents or requests for waivers of informed consent and/or authorization, protocol summary and recruitment materials.

Under expedited review procedures, the IRB Chair, or designated experienced member may make the following determinations:

• **Approved**: Approved in the form presented.
• **Modifications**: Modifications are required to secure approval.
• **Refer to the convened IRB** for review.

The PEORIA IRB Chair//member may not disapprove a research protocol under expedited review procedures.

The reviewer(s) utilize the “Reviewer’s Checklist for Expedited New Studies” to ensure all criteria for pre-review are considered, met and documented. An action by the reviewer is captured when a comment is posted in the “Comments” section and/or the reviewer’s checklist is attached. The action is time and date stamped in IRBNet and serves as documentation of the reviewer’s determination in lieu of
a physical signature. When an approval is granted by this mechanism, this time and date stamp serves as the official date of approval.

Correspondence to the investigator related to the acknowledgement or approval of an action will be generated by the PEORIA IRB staff utilizing the date captured in the “comments” section and/or the date captured when the reviewer’s checklist was attached in IRBNet.

Documentation of the actions is presented in a formal letter via IRBNet to the investigator to communicate the determinations of the IRB to the investigator.

The PEORIA IRB convened board is informed of all research protocols reviewed and approved under expedited review procedures through inclusion of this information on the next available meeting agenda, which is documented in the meeting minutes in accordance with 45 CFR 46.110(c) and 21 CFR 56.110(c). An approval of research by expedited procedures is complete by itself and does not require any ratification by the convened PEORIA IRB. However, the PEORIA IRB does have opportunity and the authority to raise questions about any research that was previously approved under expedited procedures, and to rereview those research protocols at a convened meeting if it chooses to do so.

The PEORIA IRB is not able to review “Classified research” or research involving prisoners by expedited review procedures.  

5.8.4 Expedited Review of Requested Modifications to Secure Expedited Approval

When an expedited reviewer requests specific revisions to the research protocol, informed consent document, or other research protocol documents, and the investigator concurs with those specific requests, the investigator’s response and corresponding revised documents may be reviewed under expedited review procedures.

Investigators will have ninety (90) days to make the required changes and return them to the IRB Office. If revisions are not received after ninety (90) days, the protocol will require re-submission to the IRB as a new study.

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2 University of Illinois policy forbids the conduct of classified research on any UI property, but it is possible that a UIC faculty member would require IRB approval for classified research conducted off-site. It is also possible the PEORIA IRB would review classified research that does not engage UICOMP.

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Once received in IRBNet, an initial pre-review is performed by OHRO staff. The submission is reviewed by an IRB Chair or designated IRB member to ensure that all requirements of the PEORIA IRB have been met and documented. The OHRO staff will communicate the determinations, in writing via IRBNet, to the investigator.

The PEORIA IRB will be informed about the use of expedited review procedures to review and approve minor modifications to research protocols and this information will be included on the next available meeting agenda. This is also documented in the meeting minutes in accordance with 45 CFR 46.110(c) and 21 CFR 56.110(c).

5.8.5 Minor Modifications to the Research That May Be Reviewed and Approved through Expedited Procedures

The PEORIA IRB may review minor changes in previously approved research during the period for which approval has been given, under expedited review procedures. A ‘minor change’ is defined in this policy as a change in the research plan that does not increase the risks or decrease the benefits related to the study (including risks related to procedures and methods, and to modifications that might negatively impact the statistical analysis of the research). If the change affects two of the following three aspects of the research, (i) the purpose, (ii) the population or (iii) the procedures, the change cannot be considered ‘minor’ and must be reviewed by the convened IRB unless the research itself is no greater than minimal risk and is limited to the categories of research eligible for expedited review.

- Adding qualified authorized study personnel – PLEASE NOTE: Documentation of CITI Certifications must be submitted with a Change in Research for each individual added to the project (unless already on file with the IRB). The Change in Research Form requires that the role of the added individual be specified. The individual must submit his/her CV for the review of their qualifications (education and training) to conduct the research in the specified role. Depending on the sponsorship of the project, the appropriate Conflict of Interest Disclosure Forms must also be submitted in the IRBNet package;
- Specific additions or subtractions to consent forms, Project Protocol Review form, or additional materials, that lower the risks for subjects or clarify procedures;
- Spelling or grammatical errors or changes of technical terms to lay language in consent forms;
- Adding an investigative site – PLEASE NOTE: An institution or locale (school, hospital, and doctor’s office) cannot be designated as a research site unless the new institution’s signatory official or designee has signed the
IRBNet package electronically. The electronic signature represents a declaration that the research is feasible at that site and there are sufficient resources appropriate to the conduct of research at the site. A Change in Research Form and an updated Project/Protocol Review Form (PPRF) indicating the new investigative site must be submitted into IRBNet. If the signatory official or designee at the new institution or locale is not a registered user of IRBNet, a letter of support must accompany the Change in Research Form and updated PPRF. The addition of a new investigative site may be considered a “minor” modification to the research if the IRB is familiar with the institution or locale at which the clinical investigator has proposed to conduct the research;

- Changes in funding;
- Deletion of questions from a survey or questionnaire;
- Changes in contact names, addresses, telephone numbers, advisers, end date, and researchers;
- Changes in the title of the proposal;
- Addition of subjects from the same population as indicated in the original proposal; or
- Additional advertisements or changes to approved advertisements.

Allowing minor changes to be reviewed by expedited means helps to decrease the administrative burdens on the convened IRB without undermining the protection of human research participants.

Under expedited review procedures, the review may be carried out by the PEORIA IRB Chair or by one or more qualified IRB members designated by the Chair. After a pre-review by OHRO staff, the PEORIA IRB Chair or designated IRB member will use the review checklist to ensure all criteria for review are considered, met and documented. The checklist includes the information about the results of the review that the OHRO will communicate, electronically, to the investigator.

An action by the review is captured when a comment is posted in the “Comments” section and/or the reviewer’s checklist is attached. The action is time and date stamped in IRBNet and serves as documentation of the reviewer’s determination in lieu of a physical signature. When an approval is granted by this mechanism, this time and date stamp serves as the official date of approval.

Correspondence to the investigator related to the acknowledgement or approval of an action will be generated by the PEORIA IRB staff utilizing the date captured in the “comments” section and/or the date captured when the reviewer’s checklist was attached in IRBNet.
5.9 Amendments

The investigator must conduct the research in accordance to the specific methods that were proposed in the application and/or protocol that was approved by the PEORIA IRB, however, an IRB may use expedited review procedures to review minor changes in ongoing previously approved research. UICOMP policy and the federal regulations require that the investigator report promptly to the PEORIA IRB when there are proposed changes in a previously approved research project. In addition, it is required that any proposed changes in approved research, during the period for which PEORIA IRB approval has already been given, are not initiated without PEORIA IRB review and approval except when necessary to eliminate apparent immediate hazards to the subject. The investigator should submit amendments to the PEORIA IRB via IRBNet using the appropriate amendment form, being sure to include any revised documents that are necessary to initiate the amendment changes (i.e., revised consent, surveys, questionnaires, recruitment materials, etc.).

All amendments, modifications or any other changes in the conduct of a study or the informed consent process (e.g., document) must be reviewed and approved by PEORIA IRB prior to implementing the change unless a modification is needed to eliminate an apparent immediate hazard to subjects. If possible, the investigator should obtain the concurrence of the PEORIA IRB Chair before making even these kinds of changes and then promptly submit an amendment for PEORIA IRB review. The investigator is required to submit any changes on the Change in Research Protocol Form via IRBNet.

All amendments or changes to the research protocol must be incorporated into the protocol with revision dates noted on each revised page and the first page of the protocol itself. Failure to comply with this policy will result in the inability of the IRB to review the revised materials. Properly completed applications will be forwarded to the Chairman in IRBNet, who will determine if the materials can be expedited or if they require full board review by the committee at the next convened meeting.

An expedited review may be carried out by the IRB Chair or designated IRB member. Amendments that involve minor changes to the research may be reviewed by expedited review procedures. The amendment’s changes will be assessed by an IRB Chair or designated IRB member, who has the option of referring the change to full board review if the amendment involves significant changes or new risks.

The PEORIA IRB member conducting the review of the amendment under expedited review procedures may make one of the following determinations:

- Approve amendment for implementation,
- Request modifications or revisions to secure approval,
- Refer for review by convened PEORIA IRB.
The PEORIA IRB member may not disapprove an amendment to a research protocol under expedited review procedures.

The PEORIA IRB is informed of all amendments to previously approved research protocols reviewed and approved under expedited review procedures on the next available meeting agenda and this is documented in the PEORIA IRB meeting minutes in accordance with 45 CFR 46.110(c) and 21 CFR 56.110(c).

The approval of an amendment does not change the original approval period or the expiration date by which the regularly scheduled continuing review of the research project should be done. Any revised informed consents will be stamped with the appropriate approval date and the expiration date of the most recent initial or continuing review. All other materials such as recruitment materials, surveys or questionnaires will be stamped with the appropriate IRB approval date.

5.10 Convened Review of Research

Convened review is required for any research study involving greater than minimal risk or that does not meet the criteria for expedited review. Applications for consideration of convened review are made available to PEORIA IRB members in IRBNet one week prior to the meeting.

Each PEORIA IRB member has access to the following initial review documents:

- Project/Protocol Review Form
- Consent/assent forms
- Protocol summary or full protocol
- Responsibilities of Investigators Form
- Conflict of Interest Disclosure Form
- Any applicable advertising, grant proposals, etc.
- Current CITI certifications and current CV for all those listed in section 5 of the Project/Protocol Review Form, (if not already submitted to the IRB) and
- Investigator’s Brochure or Tech Manual

All members are required to familiarize themselves with the application in advance of the meeting in order to participate in discussion and voting.

When research is reviewed at a convened meeting, two of the voting members of the PEORIA IRB are assigned to be primary and secondary reviewers. PEORIA IRB members are assigned to review research protocols based on the nature of the research itself and the expertise and experience of the PEORIA IRB member.
PEORIA IRB requests that the federal grant applications be submitted with protocols for review by the primary and secondary reviewers. The Department of Health and Human Services (DHHS) regulations at 45 CFR 46.103(f) require that each application or proposal for HHS-supported human subject research be reviewed and approved by PEORIA IRB. Investigators must submit a copy of the entire proposal (exclusive of appendices). If a grant is linked to multiple IRB protocols, then the PEORIA IRB needs to know which protocols are linked so that they can all be reviewed.

PEORIA IRB members who are reviewing the research protocol are encouraged to contact the Principal Investigator to ask questions, or seek clarification about the research prior to the convened meeting. The primary and secondary reviewers are responsible for guiding the discussion of the protocol at the convened meeting. After sufficient discussion, the members vote on each research protocol (by a hand vote), and the votes are recorded in the meeting minutes.

The convened PEORIA IRB may make the following determinations:

- **Approved**: Approve as submitted.
- **Modifications**: Modification(s) are required to secure approval. The investigator’s response may be reviewed through expedited review procedures.
- **Deferred**: Defer for further review at a subsequent convened IRB meeting. Reasons for deferral include scientific merit concerns, requests for substantial revisions to the protocol and/or consent document.
- **Tabled**: Table the discussion of the research.
- **Disapproved**: The research protocol cannot be approved as proposed.

The decisions will be based on the votes of the majority (more than 50%) of the voting members present at a convened PEORIA IRB meeting.

At meetings of the IRB, a quorum must be established and maintained for the deliberation and vote on all matters requiring a vote. If a quorum is not maintained, the pending action item must be deferred or the meeting terminated. In order to affect a vote, a motion must be made by a voting member of the PEORIA IRB. The motion should include a summary of the modifications or revisions required and the proposed IRB determination (i.e., approved, modifications, deferred, etc.). The motion may go forward for a vote unless the person who made the motion withdraws it. If a motion does not pass, then the Chair will ask for another motion, and so on, until a motion passes.

PEORIA IRB members should complete the “New Study Primary Reviewer Checklist Wizard” to document their protocol review to ensure that all of the criteria for approval have been considered, met and documented. PEORIA IRB members serving as primary and secondary reviewers are responsible to ensure their comments about the research are
addressed during the convened discussion. Members must use the “New Study Primary Reviewer Checklist Wizard” to document their review.

In advance of the meeting, when the OHRO staff, primary or secondary reviewer or Chair believes that a specific proposal may be disapproved, an effort is made to discuss the perceived issues with the investigator prior to the meeting and to identify potential solutions. In the event that such issues cannot be resolved and the proposal is subsequently disapproved at the meeting, the investigator is informed in writing.

5.10.1 Approval Criteria

For research approved through expedited or convened procedures, the PEORIA IRB must make determinations regarding the protocol in order to approve the research. PEORIA IRB approval requires the IRB to determine that:

- Risks to subjects are minimized: (1) by using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to the risk, and (2) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.
- Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects and the importance of the knowledge that may be expected to result. In evaluating risks and benefits, PEORIA IRB considers only those risks and benefits that may result from the research. PEORIA IRB does not consider possible long-range effects of applying knowledge gained in the research.
- Selection of subjects is equitable. In making this assessment, PEORIA IRB takes into account the purposes of the research and the setting in which the research will be conducted and of the special problems of research involving vulnerable populations.
- The informed consent from each prospective study or the subject’s legally authorized representative is obtained, in accordance with and to the extent required by 21 CFR 50 and 45 CFR 46.
- The informed consent is properly documented, in accordance with and to the extent required by 21 CFR 50.27 and 45 CFR 46.
- Where appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.
- Research studies have the resources necessary to protect participants – In most instances, the electronic signature of the hospital research administrator acknowledges that the facilities and equipment necessary to conduct the research study are adequate and appropriate for the type of research proposed to the IRB. Taking this acknowledgement into consideration, the IRB determines that:
• Adequate time for the researchers to conduct and complete the research - All UICOMP new study submissions require the electronic signature of the Clinical and/or Research Supervisor prior to submission to OHRO. Studies performed by residents require the electronic signature of his/her Program Director (PD). The Clinical and/or Research Supervisor/Program Director holds the Principal Investigator (PI) accountable for his/her job performance relating to compliance with human subjects protection policy and procedures and the availability of resources for satisfactory completion of the project.

• Adequate number of qualified staff - In many cases, the IRB may have previous experience with an authorized study person that would allow the IRB to readily determine that the individual is appropriately qualified to conduct the research in their specified role. If the IRB has no experience with the authorized study person, the IRB has access to the individual’s CV for the review of their qualifications (education and training). If the IRB needs additional information, the IRB should be able to obtain a statement confirming the individual’s qualifications from an administrator of his/her institution.

• Adequate facilities - In the majority of instances, an IRB will be familiar with the institution or locale at which the clinical investigator has proposed to conduct the research. If the IRB is unfamiliar with the site, the IRB may need additional information to assess the site where the proposed research will take place to ensure it can adequately execute the protocol requirements.

• Access to a population that will allow recruitment of the necessary number of participants - The study protocol must have an adequate sample size, relative to the goals and the possible variabilities of the study.

• Availability of psychosocial resources that participants might need as a consequence of the research - To minimize the psychological harms presented by some types of research, the IRBs should make sure that the protocol addresses the potential need for counseling services to subjects.

• Direct advertising for research subjects is considered the start of the informed consent process. The IRB reviews proposed subject recruitment methods, advertising materials, and participant payment arrangement, and permits them when they are equitable, fair, honest, and appropriate. The IRB reviews advertising to ensure that advertisements do not:

• State or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and the protocol – In research, the value of a treatment or intervention is often unproven. A clinical trial is
one of the most exact ways to test which treatment/intervention is the best. This uncertainty must be made clear in research advertising. The final version of advertisements in any format; print, audio, video or internet must be reviewed.

- Include exculpatory language - Inclusion of exculpatory language is not permissible. According to 45 CFR 46.116 and 21 CFR 50.20, language that provides a waiver or release or appearance of making the sponsor, researcher or others free from malpractice, negligence, blame fault or guilt is representative of exculpatory language. The IRB Chair, designated IRB member, or the convened IRB review recruitment materials to ensure the rights and welfare of the prospective subjects are protected and not waived.

- Emphasize the payment or amount to be paid, by such means as larger or bold type - Recruitment materials are evaluated for the relative size of the type used and other visual effects. Therefore, materials should be submitted in their final format for review and approval. The PI is responsible for accurately disclosing all information as to payment and including a prorated schedule of payments, as applicable, in the protocol application and the informed consent document. The PI must disclose any changes to the payment terms and submit changes to the IRB.

- Promise “free treatment” when the intent is only to say participants will not be charged for taking part in the investigation. “Free treatment” can be used as a means of drawing attention to the lack of demand for payment, thus giving it greater emphasis.

5.11 Additional Considerations during the IRB Review and Approval of Research

5.11.1 Scientific Merit

In order to assess the risks and benefits of the proposed research, the IRB must determine that:

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

In making this determination, the IRB may draw on its own knowledge and disciplinary expertise, or the IRB may draw on the knowledge and disciplinary expertise of others, such as reviews by a funding agency, or departmental review. When scientific review is conducted by an individual or entity external
to the IRB, documentation that the above questions were considered must be provided to the IRB for review and consideration.

A reviewing individual or entity external to the IRB will not have any conflict of interests and will be familiar with process of ethical review of human research. They may attend the meeting to present their information and contribute to preliminary discussions or they may submit a written review.

Departmental scientific review is documented by the signature of the department chair/head, Clinical and/or Research Supervisor or Program Director (PD for residents only) responsible for the investigator’s research unit on new protocol applications.

5.11.2 Privacy and Confidentiality

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

Definitions

Privacy - having control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others.

Confidentiality - methods used to ensure that information obtained by researchers about their subjects is not improperly divulged.

Private information - 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 information – information where the identity of the subject is or may readily be ascertained by the investigator or associated with the information.

Privacy

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

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

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

Confidentiality

Confidentiality and anonymity are not the same. If anyone, including the investigator, can readily ascertain the identity of the subjects from the data, then the research is not anonymous and the IRB must determine if appropriate protections are in place to minimize the likelihood that the information will be inappropriately divulged. Safeguards designed to protect confidentiality should be commensurate with the potential of harm from inappropriate disclosure.

At the time of initial review, the IRB ensures that the privacy and confidentiality of research subjects are protected. The IRB assesses whether there are adequate provisions to protect subject privacy and maintain confidentiality. The IRB does this through the evaluation of the methods used to obtain information:

   a. About subjects,
   b. About individuals who may be recruited to participate in studies
   c. The use of personally identifiable records and
   d. The methods to protect the confidentiality of research data.

The PI will provide the information regarding the privacy and confidentiality of research subjects at the time of initial review through the completion of the application, any necessary HIPAA Forms, research protocol, and/or other submitted, applicable materials. The IRB will review all information received from the PI and determine whether or not the privacy and confidentiality of research subjects are sufficiently protected. In some cases, the IRB may also require that a Certificate of Confidentiality be obtained to additionally protect research data (See Section 7.5).
In reviewing confidentiality protections, the IRB shall consider the nature, probability, and magnitude of harms that would be likely to result from a disclosure of collected information outside the research. It shall evaluate the effectiveness of proposed de-identification techniques, coding systems, encryption methods, storage facilities, access limitations, and other relevant factors in determining the adequacy of confidentiality protections. In reviewing confidentiality protections, the IRB shall consider the nature, probability, and magnitude of harms that would be likely to result from a disclosure of collected information outside the research.

5.11.3 Determination of Risk

At the time of initial review, the IRB will make a determination regarding the risks associated with the research protocols. Risks associated with the research will be classified as either “minimal” or “greater than minimal”. The meeting minutes will reflect the Committee’s determination regarding risk levels.

5.12 Review of Request Modifications to Secure Approval

In the event that a project requires modification to secure PEORIA IRB approval, the modifications required by the Board are documented in a letter from the PEORIA IRB Chair to the investigator via IRB Net. The PEORIA IRB Chair or designated IRB member has the authority to review the investigator’s response and corresponding revised documents under expedited review procedures (if directed by the convened IRB at the time of the IRB motion) on behalf of the IRB to ensure consistency with the PEORIA IRB requests.

Investigators will have ninety (90) days to make the required changes and return them to the IRB Office. If revisions are not received after ninety (90) days, the protocol will require re-submission to the IRB for a full board review as a new study.

The Board will be notified of the investigator’s response and of the subsequent determination made by a PEORIA IRB member under expedited review procedures, on the next set of meeting minutes/agenda. The determinations will also be noted in the minutes for that meeting corresponding with the agenda.

If a proposal is deferred because the PEORIA IRB requires more than minor modifications or further information to take action on the proposal and/or modifications, the investigator is informed in writing via IRBNet as to the specific additional information required. The deferral response will be reviewed at a later PEORIA IRB meeting.
5.13 Greater Than Minimal Risk Modifications to Previously Approved Research

Proposed amendments that reflect greater than minor modifications to an approved project must be reviewed by the convened PEORIA IRB at one of its regularly scheduled meetings. The PEORIA IRB may make one of the following determinations:

- Approved for implementation,
- Defer for further review at a subsequent convened IRB meeting,
- Disapprove: Amendment cannot be implemented.

The decisions are based on the votes of the majority (more than 50%) of the voting members present at a convened PEORIA IRB meeting. PEORIA IRB members are requested to use the “Primary Reviewer Checklist Changes in Research,” to ensure all criteria for approval are considered, met and documented. The Reviewer Checklist includes the information about the results of the review that the OHRO will communicate, in writing via IRBNet, to the investigator.

The approval of an amendment does not change the original approval period or the expiration date by which the regularly scheduled continuing review of the research project should be done.

Section 6: Continuing Review of a Research Project

6.1 Continuing Review of Human Subjects Research

The IRB will conduct a continuing review of ongoing research at intervals that are appropriate to the level of risk for each research protocol, but not less than once per year. Continuing review must occur 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 of research must occur even when the remaining research activities are limited to the analysis of private identifiable information. Continuing review of research must occur even if enrollment into a study is suspended for any reason.

Initial review of research that is approved by the convened PEORIA IRB requires a determination regarding the period of approval based on an assessment of several factors, primarily involving the kind and degree of anticipated risk for subjects and/or others. Depending on the type of research and the degree of risk, the PEORIA IRB may conduct continuing review of research at a convened meeting or under expedited review procedures (when it is determined there is no more than minimal risk, and the research meets the criteria for approval under expedited procedures).
6.2  Content of Continuing Review

The PEORIA IRB reviews the Continuing Review form and the research protocol. The content of the Continuing Review package includes the following:

- The research protocol, including access to any amendments approved since the last review (Study History);
- Recruitment materials, consent documents, surveys or questionnaires that require re-approval
- The Continuing Review Form that includes:
  - The study status
  - The total number of subjects accrued since the initial approval or the last continuing review and the total number of subjects enrolled to date,
  - A summary of participant withdrawals, the reason for the withdrawals and any complaints about the research,
  - A summary of research subject demographic information,
  - A summary of recruitment and informed consent process information,
  - The number of any unanticipated problems involving research subjects or others (UPIRSOs) that have occurred since the initial review or the most recent continuing review,
  - Information regarding any recent Data Safety Monitoring Board/Data Monitoring Committee Reports, if applicable,
  - A description of any significant amendments to the research protocol or informed consent documents that have been reviewed and approved by the PEORIA IRB since the most recent initial or continuing review approval;
  - Any revisions to the Conflict of Interest Disclosure Forms for Authorized Study Personnel
  - A summary of any preliminary results or findings from this research at UICOMP and other sites,
  - A summary of any recent literature, findings, or other relevant information that might affect the risks associated with the research, the risk-benefit analysis, or a subject’s willingness to continue participation, and
  - The currently approved informed consent document(s), if enrollment is open.

Any proposed amendments to the research protocol or informed consent documents should be submitted as separate packages.

6.3  Continuing Review Approval Criteria
The PEORIA IRB makes the following determinations in order to re-approve the research:

- That the research continues to satisfy the criteria set forth in 45 CFR 46.111 and 21 CFR 56.11 (if applicable) regarding minimizing risks, and that the anticipated risks remain reasonable in light of the potential for benefit, that there is a plan for an equitable selection of subjects, an adequate informed consent process and documents, provisions for monitoring the data for safety, and provisions to ensure the privacy of subjects and confidentiality of data collected.
- Where applicable, the additional protections for the inclusion of vulnerable subjects such as pregnant women, fetuses, prisoners, and children as specified by regulations and the PEORIA IRB are still in place and remain adequate.
- The research satisfies the criteria set forth in 45 CFR 46.116 and 21 CFR 50 (if applicable). That the current informed consent document(s) are accurate and complete, and that any significant new findings that may affect a subject’s willingness to continue participation have been incorporated into the documents and have been communicated to research subjects in active treatment if the PEORIA IRB determines such information might affect their willingness to continue in the research.
- That the HIPAA authorization for the use/disclosure of PHI within the consent form document, meets the regulatory requirements as outlined in 45 CFR 164.508(b)(3), (b)(4), (c)(1), (c)(2), and (c)(3).
- Whether the research requires verification from sources other than the investigator (e.g., other IRBs, the FDA, sponsors, or institutional sources or committees such as Radiation Safety Committee, IBC, Cancer Center Committee, RDRC, etc.) that no material changes in the research have occurred since the previous review. The PEORIA IRB may request an audit of study files to ensure adequate protections if there are concerns that there may have been material changes without prospective PEORIA IRB review and approval.

At the time of continuing review, the IRB will make a determination regarding the risks associated with the research protocols. Risks associated with the research will be classified as either “greater than minimal” or “minimal” in IRBNet. The meeting minutes will reflect the Committee’s determination regarding risk levels.

6.4 Continuing Review Under Convened Review Procedures

For research that was initially approved by the convened PEORIA IRB, continuing review will also be conducted by the convened PEORIA IRB using the same procedures used during initial review unless the research is eligible for expedited review as outlined in section 5.10, “Convened Review of Research.”
Continuing review will be as meaningful and substantive as an initial review. This is especially true since once research has begun, unexpected risks and benefits can emerge that may affect the safety and welfare of subjects.

The PEORIA IRB conducts continuing review of research covered by this policy at intervals appropriate to the degree of risk, but not less than once per year. This means that continuing review will occur on or before the 1-year anniversary date of the previous PEORIA IRB review, even though the research activity may not begin or support for the research may not be received until after the PEORIA IRB approval date. When the PEORIA IRB has approved the research for a period less than one year, continuing review must occur before the end of the approval period to prevent a lapse in PEORIA IRB approval.

The PEORIA IRB may make the following determinations for a convened continuing review:

- Approved for continuation,
- Modifications are required to secure approval for continuation,
- Defer for further review at a subsequent convened IRB meeting,
- Suspend. No new subjects may be enrolled and the investigator must justify to the IRB why it is in the best interest of the currently enrolled subjects to continue,
- Terminate the research in its entirety, no continuation allowed.

The decisions will be based on the votes of the majority (more than 50%) of the voting members present at a convened PEORIA IRB meeting.

The primary reviewer should attach his or her reviewer checklists in IRBNet to serve as written documentation of protocol review to ensure all criteria for approval are considered, met and documented. The reviewing member may use the “Reviewer’s Checklist for Full Board Continuing Reviews” to determine their review.

6.5 Continuing Review under Expedited Review Procedures

For research protocols the PEORIA IRB initially approved under expedited procedures, the PEORIA IRB may conduct continuing review under expedited procedures, unless new risks or information have been identified to warrant the research be reviewed by the convened PEORIA IRB. In some cases, research protocols previously approved by the convened PEORIA IRB may be eligible for review under expedited review procedures in accordance with 45 CFR 46.110 and 21 CFR 56.110 under Categories (8) or (9) as follows:

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.

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

The OHRP decision chart (chart 9) below is utilized for determinations of continuing review by expedited procedures. It is available at:
https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c9
Chart 9: May the IRB Continuing Review be Done by Expedited Procedures?

From Chart 8

Has the research been previously reviewed and approved by the IRB using expedited procedures?

Yes

Have conditions changed such that the research is no longer eligible for expedited review (e.g., protocol change, or experience shows research to be of greater than minimal risk)?

Yes

Review by convened IRB is required.

No

Go to Chart 10


Have conditions changed to make the research eligible for expedited review under the applicability criteria and categories 1 through 7 on the list of categories that may be reviewed by expedited procedures (e.g., research is within those categories and experience confirms research to be of no greater than minimal risk)? [45 CFR 46.110(a)]

No

Research is eligible for IRB review through expedited procedures.

Yes

Has any additional risks been identified since IRB review at a convened meeting?

Yes

Has the IRB determined and documented at a convened meeting that the research involves no greater than minimal risk?

No

Does the research at this site remain active only for long-term follow-up of subjects?

Yes

Is the research conducted under an IND or IDE?

No

(c) Are the remaining research activities at this site limited to data analysis?

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The primary reviewer should attach his or her reviewer checklists in IRBNet to serve as written documentation of protocol review to ensure all criteria for approval are considered, met and documented.

An action by the IRB Chair or designated IRB member is captured when a comment is posted in the “Comments” section and/or the reviewer’s checklist is attached. The action is time and date stamped in IRBNet and serves as documentation of the Chairman’s determination in lieu of a physical signature. When an approval is granted by this mechanism, this time and date stamp serves as the official date of approval.

Correspondence to the investigator related to the acknowledgement or approval of an action will be generated by the PEORIA IRB staff utilizing the date captured in the “comments” section and/or when the reviewer’s checklist is attached.

### 6.6 Lapsed Continuing Reviews as New Studies

A continuing review must occur before the end of the approval period to prevent a lapse in PEORIA IRB approval. If a study lapses, the protocol is administratively closed and requires submission to the IRB for a full board review.

Once a study has lapsed, no additional patients may be entered into this research and research activities must cease. Enrollment of any subjects past the posting of an administrative closure letter will be an act of serious noncompliance.

A lapse in IRB approval is noncompliance, and continuation of research activities after a lapse in IRB approval is serious noncompliance. The PEORIA IRB retains final authority in determining whether the lapse in IRB approval represents serious or continuing noncompliance.

If an investigator submits the lapsed continuing review as a new study within ninety (90) days of its administrative closure date by the IRB, the PI may submit a new package, using the original IRBNet number, containing materials described in Section 6.2: Content of Continuing Review.

The UICOMP primary reviewer assigned to the “new study” may attach the “Reviewer’s Checklist for Full Board Continuing Reviews.”

If the Continuing Review is received after ninety (90) days of its administrative closure date, the PI must submit according to convened review procedures outlined in Section 5.12: Convened Review of Research. UICOMP primary reviewers should complete the “New Study Primary Reviewer Checklist Wizard” to document their protocol review to ensure that all of the criteria for approval have been considered, met and documented.
6.7 Determining When Research Requires Continuing Review More Often than Annually

Research that meets any of the following criteria may require review more often than annually:

1. Significant risk to research subjects (e.g., death, permanent or long lasting disability or morbidity, severe toxicity) without the possibility of direct benefit to the subjects;
2. The involvement of especially vulnerable populations likely to be subject to coercion (e.g., terminally ill)
3. A history of serious or continuing noncompliance on the part of the PI.

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

1. The probability and magnitude of anticipated risks to subjects.
2. The likely medical condition of the proposed subjects.
3. The overall qualifications of the PI and other members of the research team.
4. The specific experience of the Responsible Investigator and other members of the research team in conducting similar research.
5. The nature and frequency of adverse events observed in similar research at this and other institutions.
6. The novelty of the research making unanticipated adverse events more likely.
7. Any other factors that the IRB deems relevant.

In specifying an approval period of less than one year, the IRB may define the period with either a time interval or a maximum number of subjects either studied or enrolled. If a maximum number of subjects studied or enrolled is used to define the approval period, it is understood that the approval period in no case can exceed one year and that the number of subjects studied or enrolled determines the approval period only when that number of subjects is studied or enrolled in less than one year. If an approval period of less than one year is specified by the IRB the reason for more frequent review must be documented in the minutes.

PEORIA IRB approval is given for up to one year (365 days), commencing with the approval date. Research activities may not continue past the expiration date unless the protocol is renewed. For certain projects (depending on level of risk, the subject population being recruited, or the research design), PEORIA IRB may specify a period of approval that is shorter than one year. The approval period will be clearly noted in the approval letter to the investigator.

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6.8 Determining When Research Projects Need Verification from Sources Other than the Investigator that No Material Changes Have Been Made Since the Last PEORIA IRB Review

Changes in approved research may not be initiated without prior PEORIA IRB review and approval except where necessary to eliminate apparent immediate hazards. In its continuing review of research that requires documentation of informed consent, the PEORIA IRB will review copies of the last two signed consent documents (assuming at least two subjects have been enrolled since the last continuing review approval) in order to ensure that the consent document used is the same as the last one approved by the PEORIA IRB.

In addition, in cases where the PEORIA IRB believes, or has found, that an investigator has not conducted the research according to the PEORIA IRB-approved protocol, the PEORIA IRB may require additional verification from sources other than the investigator(s) that no material changes have occurred since previous PEORIA IRB review and approval (e.g., auditing or monitoring of consent documentation). The additional verification must be provided and should be submitted via IRBNet for PEORIA IRB review as required by the Committee. Any information regarding the verification will be communicated to the investigator by the PEORIA IRB, in writing via IRBNet, with an approval or re-approval notification for the research.

6.9 Review of Final Reports

When investigators have either successfully completed their research or have decided to stop (terminate) the research prior to achieving the objectives of the research, they are responsible for notifying the PEORIA IRB by submitting a Final Report via IRBNet. The PEORIA IRB reviews the Final Report under an expedited review procedure. Final reports are required at the completion of studies for all three levels of IRB review:

- Exempt Studies
- Expedited Studies
- Full Board Studies

The UICOMP Chair or designated IRB member conducting the review of the final report and will acknowledge its acceptance unless further information/clarification.

The PEORIA IRB is informed of all final reports reviewed and approved under expedited review procedures on the next available meeting agenda and this is documented in the PEORIA IRB meeting minutes in accordance with 45 CFR 46.110(c) and 21 CFR 56.110(c).
Section 7: Informed Consent, Parental Permission and Assent

7.1 Informed Consent

Respect for persons is one of the three principles identified in the Belmont Report. This principle requires that potential subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. The informed consent process is the primary mechanism by which respect for persons is ensured. The PEORIA IRB reviews the informed consent documents that investigators will use to obtain legally effective informed consent from human subjects or their legally authorized representatives.

The PEORIA IRB must be assured that when obtaining informed consent, the investigators shall, at a minimum:

- Provide the subject (or representative) sufficient information about the research and how the research may affect the subject (risks and benefits).
- Deliver the information in a comprehensible manner, using language and methods readily understandable by the subject.
- Assure voluntariness of participation, by providing sufficient opportunity to consider whether or not to participate, and minimizing the possibility of coercion, undue influence, or harassment.
- Disclose significant financial conflicts of interest to potential research subjects as required by the IRB.
- Assure that the process of informed consent is ongoing throughout the duration of the research.

The PEORIA IRB has the authority to observe or have a third party observe the consent process and the research at any time.

7.2 Determining a Potential Adult Subject’s Ability to Consent to Research

For the purpose of this section, a subject has the capacity to consent to his or her own participation in a research activity if he/she demonstrates an appreciation:

a. that the activity is research, not standard treatment
b. of the risks and benefits of a study
c. of the alternatives that are available if he/she does not participate
d. that, if he/she chooses not to participate, this decision will be accepted without penalty, i.e., without jeopardizing clinical care

In reaching a decision about participation, it is essential for the potential subject to demonstrate an ability to use this information in a rational manner. Thus, in considering risks, benefits, and available alternatives, subjects must show they understand the aspects of these factors that are unique to them as individuals. To highlight this
distinction, a person who is suffering with severe depression may be able to demonstrate an appreciation of a, b, c and d above, but may not care, or may actually want to take risks. Such individuals should not be considered able to provide consent for themselves.

See Section 13 for further discussion regarding adults who cannot consent for themselves.

7.3 Consent Monitoring

In reviewing the adequacy of informed consent procedures for proposed research, the IRB may on occasion determine that special monitoring of the consent process by an impartial observer (consent monitor) is required in order to reduce the possibility of coercion and undue influence, ensure that the approved consent process is being followed, or ensure that subjects are truly giving informed consent.

Such monitoring may be particularly warranted where the research presents significant risks to subjects, or if subjects are likely to have difficulty understanding the information to be provided. Monitoring may also be appropriate as a corrective action where the IRB has identified problems associated with a particular investigator or a research project. If the IRB determines that consent monitoring is required, the IRB Chair and the Director will develop a monitoring plan and submit it to the IRB for approval. The consent monitoring may be conducted by IRB staff, IRB members or another party, either affiliated or not with the institution. The PI will be notified of the IRB’s determination and the reasons for the determination. Arrangements will be made with the PI for the monitoring of the consent process for a specified number of subjects. When observing the consent process, the monitor will determine:

- Whether the informed consent process was appropriately completed and documented;
- Whether the participant had sufficient time to consider study participation;
- Whether the consent process involved coercion or undue influence;
- Whether the information was accurate and conveyed in understandable language; and
- Whether the subject appeared to understand the information and gave their voluntary consent.

Following the monitoring, a report of the findings will be submitted to the IRB, which will determine the appropriate action to be taken.

7.4 Parental Permission and Assent

Decision-making involving the enrollment of minors in research should be consistent with the manner in which minors are allowed or solicited to participate in other activities including medical care. Investigators should seek the informed permission of
parents or legal guardians before enrolling minors in research, unless the PEORIA IRB has granted a waiver of parental permission requirements.

The federal research regulations define children as individuals who have not attained the legal age for consent to treatments or procedures involved in the research, under the State or local law of the jurisdiction in which the research will be conducted. In Illinois, individuals under the age of 18 are considered minors (325 ILCS 45/2(c)) with the exceptions described below.

Circumstances When Minors Can Consent for Themselves:

A. Emancipated or Mature Minor. If a minor has been adjudicated as a “mature minor” or an “emancipated minor” by an Illinois court with jurisdiction over such minor, such minor would also be able to consent to medical treatment and research relating to such treatment under Illinois law. Note that if a minor has only been partially emancipated under the Emancipation of Minors Act, such minor will only have those rights and responsibilities as specified in the court order. When research involves subjects who claim that they are “emancipated” or “mature” minors, the investigator must review and document in the research record the court order that provides such designation before allowing such subject to consent as an adult for the research. An individual aged 17 who is enrolled in the military is also not considered a minor under some circumstances in Illinois.

B. Illinois law also grants minors the legal capacity to consent to medical treatment in certain situations. The Illinois Consent by Minors to Medical Procedures Act (410 ILCS 210/1) permits:

1. A married minor, a minor parent, or a pregnant minor to provide his or her own informed consent to the performance of a medical or surgical procedure performed by: (i) a physician licensed to practice medicine and surgery, (ii) an advanced practice nurse who has a written collaborative agreement with a collaborating physician that authorizes provision of services for minors, or (iii) a physician assistant who has been delegated authority to provide services for minors.

2. A minor parent to provide the informed consent for performance on his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery, an advanced practice nurse who has a written collaborative agreement with a collaborating physician that authorizes provision of services for minors, or a physician assistant who has been delegated authority to provide services for minors, or a dental procedure by a licensed dentist.
3. Other instances where the Minors Medical Procedures Act deems a minor to have the same legal capacity to consent as an adult include:
   a. Emergency treatment or first aid or emergency dental treatment. (410 ILCS 210/3(a)).
   b. Medical care or counseling related to the diagnosis or treatment of any disease or injury arising from predatory criminal sexual assault of a child, aggravated criminal sexual assault, criminal sexual assault, aggravated criminal sexual abuse or criminal abuse of a child. (410 ILCS 210/3(b)).
   c. Medical care or counseling related to the diagnosis or treatment of a minor 12 years of age or older who may have come into contact with any sexually transmitted disease (STD), or may be determined to be an addict, an alcoholic or an intoxicated person, or who may have a family member who abuses drugs or alcohol. (410 ILCS 210/4).

The PEORIA IRB extends the provisions of the Minors Medical Treatment Act to research. Specifically, under the circumstances or for the conditions stipulated in the Act, the PEORIA IRB views the minor to have the same legal capacity to act and has the same powers and obligations as has a person of legal age to consent for research involving such medical or surgical procedures. The minor is not deemed to be able to provide consent for research involving conditions not stipulated by the Act or involving medical or surgical procedures not covered by the Act. Thus, a 13 year old male seeking medical treatment for alcohol addiction can consent to participate in research involving addiction treatment. The research may not however involve additional activities unrelated to clinical management of the addiction, such as genetic research.

PEORIA IRB considers methods for obtaining the assent of the children as well as the permission of the parents or legal guardians. PEORIA IRB’s policy with respect to obtaining permission from the parents or legal guardians and assent from minors is specified below:

- **Parental Permission:** Parental permission or consent must be obtained in writing if the proposed research will recruit minors under the age of 18 years (unless excluded above). One or both parents must sign the parental permission form, depending on the degree of risk and whether there is a potential for direct benefit.

- **Children who are Youth in Care (Previously Wards of the State):** A ward means any child who is placed in the legal custody of the state or other agency, institution, or entity, consistent with the
applicable federal, state, and local laws and regulations. (21 CFR 50.3(g). In Illinois, children placed in foster care are wards of the state.

If an investigator wishes to conduct a study involving children who are wards, and IRB submission must be made to the Illinois Department of Children and Family Services (DCFS) “Research Review Board.” The DCFS “Research Review Board” must first approve the research before the PIRB can review the research.

- **Adolescent’s Written Assent:** In addition to parental permission, written assent must be obtained from children capable of understanding the material presented in the consent form. Assent is obtained by having the child sign on an “assent line” of the consent form. In addition to a written consent form, the child should be given verbal explanation regarding the procedures to be used, procedural meaning in terms of discomfort, inconvenience, and general purpose of the research. This should be done at a level appropriate for the child’s age, maturity, and condition.

- **Child Assent:** PEORIA IRB encourages the investigator to make every effort to engage young children in the decision process regarding whether or not to participate in a research study. A written assent document with language simplified for the child may be provided. Children too young to understand a written consent/assent form should be given a verbal explanation in a manner understandable to the child and at a level appropriate for the child’s age, maturity, and condition. When a verbal assent process is used, the investigator must document in some manner that the assent process occurred and that the child provided assent.

A child may not be involved in the decision process to participate if:

- The child is incapable, mentally or emotionally, of being consulted. PEORIA IRB specifically waives this requirement. PEORIA IRB determines that the research meets the requirements of 45 CFR 46.408(a) such that the nature of the research is an intervention or procedure that holds a prospect of direct benefit that is important to the health or well being of the child and is only available in the context of the research, the assent of the children is not a necessary condition for the research to proceed.

An expanded discussion of the “Inclusion of Children in Research” is present in Section 13.5.
PEORIA IRB shall and approve only research which satisfies the following conditions:

**Research not involving greater than minimal risk** [45 CFR 46.404]
(permission of only one parent is required)

**Research involving greater than minimal risk, but presenting the prospect of direct benefit to an individual subject.** Research in this category is approvable provided: (a) the risk is justified by the anticipated benefit to the subject; and (b) the relationship of risk to benefit is at least as favorable as any available alternative approach [45 CFR 46.405] (permission of only one parent is required)

**Research involving greater than minimal risk with no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject’s disorder or condition.** Research in this category is approvable provided: (a) the risk represents a minor increase over minimal risk; (b) the intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational settings; and (c) the intervention or procedure is likely to yield generalizable knowledge about the subject’s disorder or condition that is of vital importance for the understanding or amelioration of the subject’s disorder or condition [45 CFR 46.406] (permission of both parents required, unless, one parent is deceased, unknown, incompetent, not reasonably available or when only one parent has custody.)

**Research that is not otherwise approvable, but which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children.** Research that is not approvable under 45 CFR 46.404, 46.405, or 46.406 may be conducted or funded by DHHS provided that PEORIA IRB, and the Secretary, after consultation with a panel of experts, finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a significant problem affecting the health and welfare of children. The panel of experts must also find that the research will be conducted in accordance with sound ethical principles [45 CFR 46.407] (permission of both parents required, unless, one parent is deceased, unknown, incompetent, not reasonably available or when only one parent has custody.)

There may be special circumstances when parental permission may not be appropriate and the PEORIA IRB may waive the requirement (in cases such as research on child abuse). PLEASE NOTE: FDA regulations do not allow waiving the requirement for a signed consent form for studies involving FDA regulated products.
7.5 Elements of a Consent / Authorization Using Personal Health Information (PHI)

Elements of a Consent

Current informed consent templates with recommended section headings and boilerplate language can be found on the OHRO web page. The sample consent forms contain all the required consent elements outlined in the federal regulations. The following are the basic required elements (extracted from 45 CFR Part 46.116 and 21 CFR 50.25):

- A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental;
- A description of any reasonably foreseeable risks or discomforts to the subject;
- A description of any benefits to the subject or to persons that may reasonably be expected from the research;
- A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject;
- A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained;

For Example, if the research is subject to FDA regulation, the statement also must note the possibility that the Food and Drug Administration will inspect the records.”

For Example, a Certificate of Confidentiality, issued by the National Institutes of Health (NIH), can be obtained to protect the privacy of research subjects by protecting investigators and institutions from being compelled to release information that could be used to identify subjects.

- For research involving more than minimal risk, an explanation as to whether any compensation and an explanation as to whether any medical treatments are available if injury occurs and, if so, what they consist of, or where further information may be obtained;
- An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject; and
- A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.
• A statement that clinical trial information will be entered into a databank; Clinicaltrials.gov (please see note below).

Whenever appropriate, one or more of the following elements of information shall also be provided to each subject:

• If the risks of any research procedure are not well known, for example because of limited experience in humans: A statement that the particular treatment or procedure may involve risks to the participant, which are currently unforeseeable;
• If the research includes women of child bearing potential or pregnant women, and the effects of any research procedures on embryos and fetuses is not well known: A statement that the particular treatment or procedure may involve risks to the embryo or fetus, if the participant is or may become pregnant, which are currently unforeseeable.
• If there are anticipated circumstances under which the participant’s participation will be terminated by the investigator without regard to the participant’s consent: Anticipated circumstances under which participation may be terminated by the investigator without the participant’s consent.
• If there are costs to the participant that may result from participation in the research: Additional costs associated with study participation.
• If there are adverse consequences (e.g., physical, social, economic, legal, or psychological) of a participant’s decision to withdraw from the research: Consequences of a participant’s decision to withdraw from the research.
• If there are adverse consequences (e.g., physical, social, economic, legal, or psychological) of a participant’s decision to withdraw from the research: Procedures for an orderly termination of participation.
• If significant new findings during the course of the research that may relate to the participant’s willingness to continue participation are possible: Statement that new findings developed during the course of the research that may relate to the participant’s willingness to continue in the research study will be provided to the participant.
• If the approximate number of participants involved in the study might be relevant to a decision to take part in the research: Approximate number of participants involved in the study.

The informed consent requirements in this policy are not intended to preempt any other applicable Federal, State, or local laws which require additional information to be disclosed in order for informed consent to be legally effective. 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.

NOTE: Clinicaltrials.gov
The Food and Drug Administration (FDA) amended the current informed consent regulations (21 CFR Part 50) to require that informed consent documents and processes for applicable drug (including biological products) and device clinical trials include a specific statement that clinical trial information will be entered into a databank. The databank referred to in this final rule is the clinical trial registry databank maintained by the National Institutes of Health/National Library of Medicine (NIH/NLM) which was created by statute. The submission of clinical trial information to this data bank also is required by statute. This amendment to the informed consent regulations is required by the Food and Drug Administration Amendments Act of 2007 (FDAAA) and is designed to promote transparency of clinical research to participants and patients.

Elements of a HIPAA Authorization

The PEORIA IRBs serve as a Privacy Boards under the HIPAA Regulations for uses and disclosures of PHI for a particular protocol. When using PHI in the research, an authorization must be obtained from the subject, unless the PEORIA IRB has waived the requirement.

The authorization may be a separate document or may be combined with the consent document. The PEORIA IRBs offer a combined authorization and consent form template in the IRBNet Forms Library. The use of the combined template is not mandatory for PIRB review, however it is recommended. If the research involves the use of psychotherapy notes, the authorization must be a separate document.

The federal regulations at 45CFR164.508(c) (1) defines the following core elements for an authorization to disclose protected health information (PHI):

- A specific and meaningful description of the PHI to be used or disclosed
- The identification of the persons or class of persons authorized to make the use or disclosure of PHI (who do you want to get information from including your own hospital, practice group, etc.)
- The identification of the persons or class of persons to whom the covered entity is authorized to make the disclosure (what internal or external persons or entities will be getting the information)
- Description of each purpose for which the specific PHI identified earlier is to be used or disclosed (when individual initiates an authorization for their own purposes, the purpose may be stated as “at the request of the individual.”)
- An expiration date or event (this must be a certain date or an event tied to the individual)
- The individual’s signature and date, and if signed by a personal representative, a description of his or her authority to act for the individual

164.508(c) (2) requires these statements for an authorization to disclose PHI:
• A statement that the individual may revoke the authorization in writing, and instructions on how to exercise such right (who does the individual need to write, name and address)
• A statement that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule or, if conditioning is permitted, a statement about the consequences of refusing to sign the authorization
• A statement about the potential for the PHI to be re-disclosed by the recipient and no longer protected by the Privacy Rule

An authorization is not valid unless it contains both the required core elements, and all of the required statements. This is the minimum information needed to ensure individuals are fully informed of their rights with respect to an authorization and to understand the consequences of authorizing the disclosure. The required statements must be written in a manner that is adequate to place the individual on notice of the substance of the statements.

Please see Section 8: “Health Insurance Portability and Accountability Act (HIPAA)” for more information related to the HIPAA Privacy Rule.

7.6 Significant New Findings

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

7.7 Subject Withdrawal or Termination

For a variety of reasons, a subject enrolled in a research study may decide to withdraw from the research, or an investigator may decide to terminate a subject’s participation in research regardless of whether the subject wishes to continue participating. In these circumstances, questions sometimes arise about: (1) whether the investigator may use, study, or analyze already collected data about the subject who withdraws from the research or whose participation is terminated by the investigator; and (2) whether the investigator can continue to obtain data about the subject and if so, under what circumstances. The following addresses these and related questions. Investigators must
plan for the possibility that subjects will withdraw from research and include a discussion of what withdrawal will mean and how it will be handled in their research protocols and informed consent documents.

Regulatory requirements regarding the retention and use of data after subject withdrawal or termination differ between research subject to FDA regulations and that not subject to FDA regulations. Under applicable FDA law and regulations, data collected on human subjects enrolled in an FDA-regulated clinical trial up to the time of subject withdrawal must remain in the trial database in order for the study to be scientifically valid. For research not subject to FDA regulations, investigators, in consultation with the funding agency, can choose to honor a research subject’s request that the investigator destroy the subject’s data or that the investigator exclude the subject’s data from any analysis.

When seeking informed consent from subjects, the following information regarding data retention and use must be included:

- For FDA-regulated clinical trials, when a subject withdraws from a study, the data collected on the subject to the point of withdrawal remain part of the study database and may not be removed. The consent document cannot give the subject the option of having data removed.

- For research not subject to FDA regulations, the investigator should inform subjects whether the investigator intends to either: (1) retain and analyze already collected data relating to the subject up to the time of subject withdrawal; or (2) honor a research subject’s request that the investigator destroy the subject’s data or that the investigator exclude the subject’s data from any analysis.

Sometimes, a subject wants to withdraw from the primary interventional component of a study, but is willing to allow the investigator to continue other research activities described in the IRB-approved protocol and informed consent document that involve participation of the subject, such as: (1) obtaining data about the subject through interaction with the subject (e.g., through follow-up interviews, physical exams, blood tests, or radiographic imaging); or (2) obtaining identifiable private information from the subject’s medical, educational, or social services agency records or from the subject’s healthcare providers, teachers, or social worker. When a subject’s withdrawal request is limited to discontinuation of the primary interventional component of a research study, research activities involving other types of participation for which the subject previously gave consent may continue. Investigator should ask a subject who is withdrawing whether the subject wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through noninvasive chart review, and address the maintenance of privacy and confidentiality of the subject’s information.
If a subject withdraws from the interventional portion of the study, but agrees to continued follow-up of associated clinical outcome information as described in the previous paragraph, the investigator must obtain the subject’s informed consent for this limited participation in the study (assuming such a situation was not described in the original informed consent form). IRB approval of informed consent documents would be required.

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

### 7.8 Waiver or Alteration of Informed Consent

In accordance with HHS regulations [45 CFR 46.116(d)], the PEORIA IRB may waive the requirements for obtaining informed consent or approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent ordinarily required, provided that all of the following conditions are met:

- The research involves no more than minimal risk to the subjects;
- The waiver or alteration will not adversely affect the rights and welfare of the subjects;
- The research could not practicably be carried out without the waiver or alteration;
- Whenever appropriate, the subjects will be provided with additional pertinent information after participation; and
- The study is not FDA regulated.

### Deception

The investigator must obtain an alteration of the informed consent process from the IRB when deception is involved in the research. When the IRB reviews research involving deception, the minutes must document that the IRB made the findings in accordance with 45 CFR 46.116(d). In some fields of research, for example the study of human behavior, there may be exceptional circumstances where studies cannot be conducted without deception, concealment or covert observation of participants. Before approving a research proposal which involves any degree of deception, concealment or covert observation, the IRB must be satisfied that:

(a) the provision of detailed information to prospective participants about the purpose, methods and procedures of the research would compromise the scientific validity of the outcome of that research;

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(b) the precise extent of deception, concealment or covert observation is defined;

(c) there are no suitable alternative methods, not involving deception, concealment or covert observation, by which the desired information can be obtained;

(d) participants are not exposed to an increased risk of harm as a result of the deception, concealment or covert observation;

(e) adequate and prompt disclosure is made and de-briefing provided to each participant as soon as practicable after the participant’s participation is completed;

(f) participants will be able to withdraw data obtained from them during the research without their knowledge or consent; and

(g) such activities will not corrupt the relationship between researchers and research in general with the community at large.

The OHRP decision chart (chart 10) below is used to determine if consent can be waived or if consent elements can be altered. It is available at:
https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c1
Chart 10: May Informed Consent Be Waived or Consent Elements Be Altered under 45 CFR 46.116(d)?

**(Note: If subjects include children to whom 45 CFR part 46, subpart D applies, an alternative provision for waiver of parental permission might apply. See 45 CFR 46.408(c)).**

From Chart 8 or 9

- Will the research or demonstration project be conducted by or subject to the approval of state or local government officials? [45 CFR 46.116(c)(1)]
  - **YES**
  - *Is the project designed to study, evaluate, or otherwise examine: (i) Public benefit of 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? [45 CFR 46.116(c)(1)]
  - **NO**

- Will the research involve greater than minimal risk, as defined in Section 46.102(i)? [45 CFR 46.116(d)(1)]
  - **NO**
  - Is it practicable to conduct the research without the waiver or alteration? [45 CFR 46.116(d)(3)]
    - **YES**
    - No waiver of informed consent or alteration of consent elements is allowed.*
    - **NO**
      - Will waiving or altering the informed consent adversely affect the subjects’ rights and welfare? [45 CFR 46.116(d)(2)]
        - **YES**
        - Go to Chart 11
        - **NO**
          - Will pertinent information be provided to subjects later, if appropriate? [45 CFR 46.116(d)(4)]
            - **YES**
            - Waiver of informed consent or alteration of consent elements is allowed if IRB documents these findings and approves waiver or alteration.
            - **NO**

* Note: See OHRP guidance on informed consent requirements in emergency research at http://www.hhs.gov/ohrp/regulations-and-policy/guidance/emergency-research-informed-consent-requirements/index.html for further information on emergency research informed consent waiver.
7.9 Documentation of Informed Consent

Federal regulations governing the use of human subjects in research activities require written documentation of informed consent unless the research meets the criteria for Waiver of Documentation of Consent. The participant and investigator should sign and date the IRB approved consent form. PEORIA IRB does not ordinarily permit use of the "short form of consent documentation." Confusion sometimes arises as to who can obtain consent and who can be designated to sign the consent form. The following are the acceptable methods for obtaining and documenting informed consent of human research subjects to the PEORIA IRB:

- The IRB must be made aware of the person(s) who will be conducting the consent interviews and obtaining informed consent from participants. These faculty/staff members should be listed in the IRB application and research proposal, and unless indicated otherwise, are the only personnel allowed to conduct the consent interview.
- Each subject (or their legally authorized representative) must be provided adequate time to read and review the consent form, in addition to being advised of the procedures, risks, potential benefit, alternatives to participation, etc. This is frequently accomplished using the consent form as an outline for the interview process.
- After completing the consent interview and assuring that the subject (or their representative) has no further questions and agrees to participate in the research activity, the interviewer should instruct the subject to sign and date the consent form in the appropriate spaces.
- The person conducting the consent interview must then sign and date the consent form in the appropriate spaces (PI or designee). It is assumed that in most cases, all persons signing the consent form will do so at the conclusion of the consent interview.
- Each subject (or their representative) must be given a copy of the consent form. The original consent form should be filed in such a manner as to ensure immediate retrieval when required by auditing entities, e.g., FDA, IRB, or sponsor monitors.
- The regulations are clear that written documentation of informed consent is required, unless that requirement is waived by the IRB. Therefore, obtaining consent via the telephone or the use of “passive consent” is not acceptable unless the IRB waives the requirement to document the informed consent process.
- The regulations also include provisions for approval of a waiver or alteration of part or all of the consent process. The IRB will consider written requests for waiver or alteration of the process when accompanied by sufficient justification.
- Obtaining informed consent from subjects must be accomplished prior to performing the research activity and using only an IRB approved and stamped consent form. Written requests for amendments to an existing consent form must
be approved prior to implementation, at which time the PEORIA IRB office will provide a formal approval letter of the amendment to the consent form.

Upon receipt of an IRB approved consent form, all older versions should be archived (except for original copies in the study binder or files) to prevent inadvertent use of an outdated consent form. Copies of the most recently approved consent form may be made and should be used until replaced by an amended consent form. The currently approved consent form must be reviewed at least annually as part of the continuing review process.

7.10 Waiver of Documentation of Informed Consent

The PEORIA IRB can waive the requirements that the consent process include a signed consent form. Investigators desiring to not obtain a signed consent form may still provide participants with a written consent document disclosing all the required elements necessary for informed consent unless granted a waiver of the entire informed consent by the IRB under the 45 CFR 4.116(d) process. In such cases, the IRB encourages investigators to use the consent templates and remove the signature section. Investigators are free to format the consent document as necessary. According to 45 CFR 46.117 and/or 21 CFR 56.109(c) (1) an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds:

1. The research presents no more than minimal risk; and
2. The research involves procedures that do not require written consent when performed outside of a research setting [45 CFR 46.117; 21 CFR 56.109 (c) (1)].

Or

1. The principal risks are those associated with a breach of confidentiality concerning the subject's participation in the research; and
2. The consent document is the only record linking the subject with the research (45 CFR 46.117); and
3. Each participant will be asked whether the participant wants documentation linking the participant with the research, and the participant’s wishes will govern; and
4. The study is not FDA regulated.

The OHRP decision chart (chart 11) below is used to determine if documentation of Informed Consent can be waived. It is available at:
https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts/index.html#c11
Chart 11: May Documentation of Informed Consent Be Waived Under 45 CFR 46.117(c)?

From Chart 10

Would the consent document be the only record linking the subject and the research and would the principal risk be potential harm resulting from a breach of confidentiality? [45 CFR 46.117(c)(1)]

NO

Does the research present no more than minimal risk and involve no procedures for which written consent is normally required outside the research context? [45 CFR 46.117(c)(2)]

YES

IRB may waive the requirement for a signed consent form for some or all subjects.

AND

IRB may require investigator to provide subjects with a written statement regarding the research. [45 CFR 46.117(c)]

END

NO

IRB may NOT waive the requirement for a signed consent form for any subjects.

If IRB Allows Waiver of Documentation Under 45 CFR 46.117(c)(1)

Investigator will ask each subject if he or she wants documentation linking the subject with the research. [45 CFR 46.117(c)(1)]

Subject’s wishes will govern whether informed consent is documented. [45 CFR 46.117(c)(1)]

February 16, 2016
7.11 IRB Review of Recruitment Materials

The IRB must review, approve, and stamp (if applicable) all recruitment procedures and materials prior to their use by an investigator, since recruitment materials (e.g., advertisements, flyers, phone scripts, newspaper ads, radio and television announcements, bulletin board tear offs, Internet postings, and posters) are part of the informed consent process.

A. Items that Must Be Included in Recruiting Materials

- the name and address of the clinical investigator and/or research facility;
- the condition under study and/or the purpose of the research;
- in summary form, the criteria that will be used to determine eligibility for the study;
- a brief list of participation benefits, if any (e.g., a no-cost health examination);
- the time or other commitment required of the subjects; and
- the location of the research and the person or office to contact for further information;
- compensation or reimbursement, but specific dollar amounts should not be a major feature of the advertisement.

B. What Does Not Require IRB Review

- communications intended to be seen or heard by health professionals, such as "dear doctor" letters and doctor-to-doctor letters
- news stories and
- publicity intended for other audiences, such as financial page advertisements directed toward prospective investors.

Failure to obtain IRB approval for recruitment materials is noncompliance. The PEORIA IRB retains final authority in determining whether the use of unapproved recruitment materials represents serious or continuing noncompliance.

Serious or continuing noncompliance is reportable to unit heads, institutional officials, federal regulatory authorities and sponsors.

7.12 Payment to Research Subjects

Payment to research subjects may be an incentive for participation or a way to reimburse a subject for travel and other experiences incurred due to participation. However, payment for participation is not considered a research benefit. Regardless of the form of remuneration, investigators must take care to avoid unduly influencing subjects. The Version 3.4
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amount of compensation must be proportional to the risks and inconveniences posed by participation in the study. Investigators who wish to pay research subjects must indicate in their research project application the justification for such payment. Such justification should:

a) Substantiate that proposed payments are reasonable and commensurate with the expected contributions of the subject;

b) State the terms of the subject participation agreement and the amount of payment in the informed consent form; and

c). Substantiate that subject payments are fair and appropriate, and that they do not constitute (or appear to constitute) undue pressure on the veteran patient to volunteer for the research study.

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

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

The consent form must describe the terms of payment and the conditions under which subjects would receive partial payment or no payment (e.g., if they withdraw from the study before their participation is completed).

Sites that offer payment will require identifying information to issue checks, cash, or gift certificates to subjects. The consent form must inform subjects that they will be asked to provide their Social Security Number and verification of U.S Citizenship or Permanent Resident Status to receive payment. In addition, the consent must inform subjects that total payments to any one subject during the course of a study totaling $600 or more in a calendar year will be reported to the IRS, and a Form 1099-MISC, Miscellaneous Income, will be sent to the payee at the end of the calendar year in which the payment(s) were made.

Section 8: Health Insurance Portability and Accountability Act (HIPAA)

Protected Health Information obtained by researcher may not be used internally or disclosed to any outside person or organization for research purposes without prior approval of the IRB. Researchers must also abide by all corporate HIPAA policies regarding HIPAA privacy and security.
8.1 Definitions

**Access.** Access is the mechanism of obtaining or using information electronically, on paper, or other medium for the purpose of performing an official function.

**Authorization.** An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual.

**Covered entity.** Covered entity is the term applied to institutions that must comply with the Privacy Rule. These include:
- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

**Common Rule.** Common Rule is a federal Policy on human subject protection that provides for the primary source of regulation of research.

**De-Identified Information.** De-Identified Information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. If information is de-identified it no longer is subject to the Privacy Rule and exempt from HIPAA.

**Deletion.** Deletion is the removal, erasing, or expunging information or data from a record.

**Disclosure.** Disclosure is the release, transfer, provision of access to, or divulging in any other manner information outside of the covered entity.

**Health Information.** Health Information is any information created or received by a health care provider or health plan that 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 payment for the provision of health care to an individual.

**Identifiable Health Information.** Identifiable Health Information is a subset of health information including demographic information collected from an individual.

**Limited Data Set.** Limited Data Set is protected health information that excludes specific direct identifiers of the individual or of relatives, employees or household members of an individual. A limited data set can only be used for the purposes of Version 3.4
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research, public health, or healthcare operations, and disclosed for the purpose of research.

**Minimum Necessary.** Minimum Necessary refers to the principle that any access should be limited to the minimum amount of information needed to accomplish the intended purpose of the use or disclosure.

**Privacy Board.** Privacy Board is the term used to describe a board comprised of members of varying backgrounds and appropriate professional competencies, as necessary, to review individual’s private rights. It is an alternative to an IRB for privacy issues only. It cannot replace the IRB for Common Rule purposes.

**Privacy Act.** Privacy Act is an act that provides for the confidentiality of individually identified and retrieved information about living individuals that is maintained in a system of records and permits the disclosure of records only when specifically authorized by the statute. The Act provides that the collection of information about individuals is limited to that which is legally authorized, relevant, and necessary.

**Privacy Rule.** Privacy Rule provides guidance on the use of protected health information in the conduct of research. It imposes requirements on those involved in research, both individuals and institutions. Privacy refers to a person’s desire to control the access of others to themselves. The evaluation of privacy involves consideration of how the investigator will access information from or about participants. The IRB members should know strategies to protect privacy interests relating to contact with potential participants, and access to private information.

**Protected Health Information.** Protected Health Information is individually identifiable health information transmitted or maintained electronically or in any other form or medium, except for education records or employment records, as excluded in the Privacy Rule.

**Preparatory Research.** Preparatory Research is the method applied to developing or designing a research study.

**Waiver of Authorization.** Waiver of Authorization is a means of requesting approval from an IRB or Privacy Board rather than asking each research subject for an authorization to access protected health information.

**8.2 Historical Background**

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) required the creation of a Privacy Rule for identifiable health information. The resulting Privacy Rule, finalized in August 2002, set a compliance date of April 14, 2003. While the main impact of the Privacy Rule will be on the routine provision of and billing for health care, the
Rule will also affect the conduct and oversight of research. Researchers, IRB staff and members as well as research administration must be aware of these changes.

### 8.3 Effects of HIPAA on Research

The final Privacy Rule published on August 14, 2002 included a number of changes in how the Rule applies to research. See the NIH HIPAA Privacy Rule Booklet for Research and the NIH fact sheet on Institutional Review Boards and HIPAA for more information on how HIPAA applies to research. See also Impact of the Privacy Rule on Academic Research, a white paper published by the American Council on Education.

The Privacy Rule does not make any changes to the Common Rule. However, it does contain several provisions that resemble provisions of the Common Rule and does make reference to those provisions. The Common Rule contains specific requirements for a composition of an IRB and the Privacy Rule contains specific requirements for a Privacy Board. The composition of a Privacy Board is similar to that of an IRB.

Researchers who are working with “Protected Health Information” (PHI) will be required to comply with the rules on HIPAA. UICOMPIRB acts as the Institution’s Privacy Board.

The Privacy Rule permits covered entities to use or disclose protected health information for research purposes when the individual who is the subject of the information authorizes the use or disclosure. For clinical trials, authorization must be sought in addition to informed consent. Authorization must also be sought for other research uses or disclosures of protected health information that do not qualify for an IRB waiver of authorization (discussed below).

The Privacy Rule has several special provisions that apply to research authorizations for uses and disclosures of PHI for research purposes. These requirements are as follows:

1. An authorization for a research purpose may state that the authorization does not expire, that there is no expiration date or event, or that the authorization continues until the end of the research study; and

2. An authorization for the use or disclosure of protected health information for research may be combined with a consent to participate in the research, or with any other legal permission related to the research study (except for research involving the use or disclosure of psychotherapy notes, which must be authorized separately); and

3. Research authorization forms must be filled out completely and accurately by the investigator, to ensure that all parties who require access to protected health information for the research (including sponsors, CROs, DSMBs,
IRBs, etc.) are identified in the form and may receive the information. The IRB combined authorization/consent form should be completed by the investigator and submitted to the IRB for review and approval.

8.4 Research under HIPAA

HIPAA defines research as "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." This definition is identical with the one used in the “Common Rule”, separate federal legislation designed to protect human subjects involved in research. HIPAA describes privacy standards for protecting PHI and so only applies to research that involves humans' (not animals’) health information.

8.5 Waiver of Authorization for Use or Disclosure of Protected Health Information in Research

Under the Privacy Rule, covered entities are permitted to use and disclose protected health information for research with individual authorization, or without individual authorization under limited circumstances. A covered entity may use or disclose protected health information for research when presented with documentation that an IRB has granted a waiver of authorization [see 45 CFR 164.512(i) (1) (i)]. This provision of the Privacy Rule might be used, for example, to conduct records research, epidemiological studies, or other research where de-identified data is unavailable or not suited to the research purpose. For these types of research, it is impracticable for researchers to obtain written Authorization from research participants. Under the Privacy Rule, an IRB (or Privacy board) may waive or alter, in whole or in part, the Privacy Rule’s Authorization requirements for the use and disclosure of PHI in connection with a particular research project [45 CFR 164.512(1)].

The PEORIA IRBs serve as a Privacy Boards (as defined under the HIPAA Regulations) to act upon requests for a waiver or an alteration of the Authorization.

A waiver in whole occurs when the IRB determines that no Authorization will be required for a covered entity to use or disclose PHI for a particular research project because certain criteria set forth in the Privacy Rule have been met.

If the IRB approves such a waiver, the receipt of the requisite documentation of the approval permits a covered entity to use or disclose PHI in connection with a particular research project without Authorization.

Criteria for a waiver or alteration of a HIPAA Authorization

The Privacy Rule establishes the criteria to be evaluated by an IRB in approving an Authorization waiver or alteration. For a researcher within a covered entity to use or

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disclose PHI under a waiver or an alteration of Authorization, he or she must receive documentation from the IRB or Privacy Board that the following criteria have been met:

- The PHI use or disclosure involves no more than minimal risk to the privacy of individuals based on at least the presence of (1) an adequate plan presented to the IRB to protect PHI identifiers from improper use and disclosure; (2) an adequate plan to destroy those identifiers at the earliest opportunity, consistent with the research, absent a health or research justification for retaining the identifiers or if retention is otherwise required by law; and (3) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity except (a) as required by law, (b) for authorized oversight of the research study, or (c) for other research for which the use or disclosure of the PHI is permitted by the Privacy Rule.
- The research could not practicably be conducted without the requested waiver or alteration.
- The research could not practicably be conducted without access to and use of the PHI.

**Documentation of a waiver or alteration of a HIPAA Authorization**

The waiver documentation presented to the covered entity must include the following:

1. Identification of the IRB or Privacy Board and the date on which the alteration or waiver of authorization was approved;
2. A statement that the IRB or Privacy Board has determined that the alteration or waiver of authorization, in whole or in part, satisfies the three criteria in the Rule;
3. A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or Privacy Board;
4. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
5. The signature of the chair or other member, as designated by the chair, of the IRB or the Privacy Board, as applicable.

**8.6 Partial Waiver of HIPAA Authorization for Screening Purposes**

A partial waiver of HIPAA Authorization for screening purposes should be requested if a researcher does not yet know “who” his/her study population is. A partial waiver of the Authorization requirements of the Privacy Rule might be requested, for instance, to allow a researcher to obtain PHI as necessary to recruit potential research subjects. For example, even if an IRB does not waive the Authorization requirement for the entire research study, an IRB may partially waive the Authorization requirement to permit a covered entity to disclose PHI to a researcher for the purposes of contacting and recruiting individuals into the study.
Requests for a partial waiver of HIPAA Authorization for Screening Purposes are commonly requested when a researcher will:

1. Access existing medical records or a database (paper or electronic) to obtain potential subjects’ PHI him/herself;
2. Make a request to OSF Healthcare Analytics or UPH Data Warehouse to access existing medical records or a database to obtain potential subjects’ PHI;
3. Access patient schedules/logs (ex: clinic, surgery, admission) to obtain potential subjects’ PHI.

Criteria for a PartialWaiver of HIPAA Authorization for Screening Purposes

The Privacy Rule establishes the criteria to be evaluated by an IRB in approving a partial waiver of HIPAA Authorization for screening purposes. For a researcher within a covered entity to use or disclose PHI under a partial waiver, he or she must receive documentation from the IRB or Privacy Board that the following criteria have been met:

- The PHI use or disclosure involves no more than minimal risk to the privacy of individuals based on at least the presence of (1) an adequate plan presented to the IRB to protect PHI identifiers from improper use and disclosure; (2) an adequate plan to destroy those identifiers at the earliest opportunity, consistent with the research, absent a health or research justification for retaining the identifiers or if retention is otherwise required by law; and (3) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity except (a) as required by law, (b) for authorized oversight of the research study, or (c) for other research for which the use or disclosure of the PHI is permitted by the Privacy Rule.

- The research could not practicably be conducted without the requested waiver or alteration.
- The research could not practicably be conducted without access to and use of the PHI.

Documentation of a Partial Waiver of HIPAA Authorization for Screening Purposes

The partial waiver documentation presented to the covered entity must include the following:

1. Identification of the IRB or Privacy Board and the date on which the partial waiver of authorization was approved;
2. A statement that the IRB or Privacy Board has determined that the partial waiver of authorization, in whole or in part, satisfies the three criteria in the Rule;
3. A brief description of the protected health information for which use or access has been determined to be necessary by the IRB or Privacy Board;
4. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures; and
5. The signature of the chair or other member, as designated by the chair, of the IRB or the Privacy Board, as applicable.

8.7 Review Preparatory to Research

The Privacy Rule permits a covered entity to use or disclose protected health information to a researcher without authorization or waiver for the limited purpose of a “review preparatory to research.” Such reviews may be used to prepare a research protocol, or to determine whether a research site has a sufficient population of potential research subjects. Prior to permitting the researcher to access the protected health information, the covered entity must obtain representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purposes preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research purpose. Researchers should consult the covered entity and the IRB regarding any forms or applications necessary to conduct a review preparatory to research.

Researchers conducting a review preparatory to research may not record information in identifiable form, nor may they use the information that they receive to contact potential subjects, unless the investigator is also the subject’s treating physician. Because the Privacy Rule permits a covered entity to disclose protected health information to the individual who is the subject of the information, covered health care providers and patients may continue to discuss the option of enrolling in a clinical trial without patient authorization. Even when permitted by the Privacy Rule, however, any use of patient information for recruitment must comply with IRB recruitment policies.

IRB Privacy Board review and approval is required prior to initiating this research. Investigators are not authorized to contact potential research subjects identified in reviews preparatory to research unless they are directly responsible for care of the potential subject and entitled to PHI as a result of that duty.

Investigators who have previously obtained full consent and authorization to contact a research subject as a result of a previously approved research project, may contact his or her former research subjects provided that the subject agreed to be contacted for information on future research conducted by the same principal investigator or coinvestigator (s).

8.8 Research on Protected Health Information of Decedents

The protections of the Common Rule apply only to living human beings; by contrast, the Privacy Rule also protects the identifiable health information of deceased persons (“decedents”). The Privacy Rule contains an exception to the authorization requirement.
for research that involves the protected health information of decedents. A covered entity may use or disclose decedents’ protected health information for research if the entity obtains representations from the researcher that the use or disclosure being sought is solely for research on the protected health information of decedents, that the protected health information being sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is being sought. Researchers should submit the applicable IRB form for IRB approval when they intend to conduct research involving decedents’ protected health information.

8.9 Limited Data Sets with a Data Use Agreement

When a researcher does not need direct identifiers for a study but does require certain data elements that are not permitted in de-identified data, the Privacy Rule permits a covered entity to disclose a “limited data set” to the researcher without authorization or waiver, provided that the researcher has signed a data use agreement. The limited data set is still considered to be protected health information, but it must exclude only specified direct identifiers of the individual or of relatives, employers, or household members of the individual.

If the research involves a limited data set, defined as removing the following 16 identifiers:

1. Names
2. Postal address info. (if other than city, state and zip)
3. Telephone and fax #s
4. Email addresses
5. Social Security #s
6. Medical record, prescription numbers
7. Health plan beneficiary #s
8. Account #s
9. Certificate/license #s
10. Vin and serial #s, license plate #s
11. Device identifiers, serial #s
12. Web URLs
13. IP address #s
14. Biometric identifiers (finger prints)
15. Full face, comparable photo images

The Privacy Rule requires that the data use agreement used in conjunction with the limited data set contain provisions that:

1. Establish the permitted uses and disclosures of the limited data set by the recipient, consistent with the purposes of the research, and which may not include any use or disclosure that would violate the Rule if done by the covered entity;
2. Limit who can use or receive the data; and require the recipient to agree to the following:
3. Not to use or disclose the information other than as permitted by the data use agreement or as otherwise required by law;
4. Use appropriate safeguards to prevent the use or disclosure of the information other than as provided for in the data use agreement;
5. Report to the covered entity any use or disclosure of the information not provided for by the data use agreement of which the recipient becomes aware;
6. Ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set; and
7. Not to identify the information or contact the individual.

Researchers who will be receiving limited data sets must submit a signed copy of the covered entity’s data use agreement to PEORIA IRB for approval, prior to initiating the research.

The Privacy Rule contains certain grandfathering provisions that permit a covered entity to use and disclose protected health information for research after the Rule’s compliance date of April 14, 2003, if the researcher obtained any one of the following prior to the compliance date:

1. An authorization or other express legal permission from an individual to use or disclose protected health information for the research;
2. The informed consent of the individual to participate in the research; or
3. An IRB waiver of informed consent for the research.

Even if informed consent or other express legal permission was obtained prior to the compliance date, if new subjects are enrolled or existing subjects are re-consented after the compliance date, the covered entity must obtain the individual’s authorization. For example, if there was a temporary waiver of informed consent for emergency research under the FDA’s human subject protection regulations, and informed consent was later sought after the compliance date, individual authorization must be sought at the same time.

The transition provisions apply to both uses and disclosures of protected health information for specific research protocols and uses or disclosures to databases or repositories maintained for future research.

8.10 Patient Rights and Research

Under HIPAA, patients have certain rights. Those that may affect research include the right to receive a Notice of Privacy Practices, the right to access, inspect, and receive a
copy of one’s own PHI, the right to request an amendment to one’s own PHI, and the right to an accounting of certain disclosures of PHI that occur outside the scope of treatment, payment and health care operations that have not been authorized.

8.11 HIPAA and Existing Studies

Any research subject enrolled in a study that uses PHI from a covered entity must sign a HIPAA-compliant authorization form. The authorization may be a separate document or may be combined with the consent document. The PEORIA IRBs offer a combined authorization and consent form template in the IRBNet Forms Library. The use of the combined template is not mandatory for PIRB review, however it is recommended.

Section 9: When Problems Occur

Problems occur during research. Having a uniform system for classifying and reporting problems will help protect the safety of human subjects and others, as well as the overall integrity of the study.

It is the responsibility of the PI and research team members to address and record any problems that occur during the course of research. For the research team member who encounters a study problem, it is recommended that they report the problem to the PI in a timely or immediate manner.

9.1 Unanticipated Problems Involving Research Subjects or Others (UPIRSO)

The PEORIA IRB is responsible for ongoing monitoring of the safety and welfare of human subjects. Part of this monitoring is on-going review and assessment of unanticipated problems involving risks to human subjects or others (UPIRSOs) related to participation in the research. Investigators are required by federal regulations and UICOMP policies to promptly report to the PEORIA IRB all unanticipated problems in research involving research subjects or others (UPIRSOs). An unanticipated problem, in general, includes any incident, experience, or outcome that meets all of the following criteria:

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

The PEORIA IRB will accept local events that have been identified as UPIRSOs by the Principal Investigator (as evidenced by his/her signature on the Investigator’s Assessment section of the Unanticipated Problems Form.)

The PEORIA IRB will accept ONLY non-local events that have been identified as UPIRSOs by the monitoring entity (e.g., the research sponsor, a coordinating or statistical center, or a DSMB/DMC) as evidenced by a determination report issued to the investigator by the monitoring entity.

In the absence of a letter from the sponsor or monitoring entity identifying the event as a UPIRSO, or by identifying that the event has met the above referenced three criteria, it is the responsibility of the local PI to determine the meaningfulness of the reported event. If the investigator determines that the report is not useful or meaningful in the form presented, the IRB recommends contacting the sponsor and communicating this to them for further instruction. If the local PI does not contact the sponsor, it will be his/her responsibility to judge the meaningfulness of the report by relying on the sponsor’s assessment and his/her own judgment as to whether the event meets the definition of a UPIRSO.

An incident, experience, or outcome that meets the three criteria above may 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.

Relationship Between Adverse Events and Unanticipated Problems

The term adverse event in general is used to include any event meeting the following definition:

- Any untoward or unfavorable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject’s participation in the research, whether or not considered related to the subject’s participation in the research (modified from the definition of adverse events in the 1996 International Conference on Harmonization E-6 Guidelines for Good Clinical Practice).

Which adverse events are unanticipated problems (UPIRSOs)?
Only a small subset of adverse events occurring in human subjects participating in research will meet the criteria for prompt reporting as an unanticipated problem. The key question regarding a particular adverse event is whether it meets the three criteria for an UPIRSO. To determine whether an adverse event is an UPIRSO, the following questions should be asked:

- Is the adverse event unexpected?
- Is the adverse event related or possibly related to the research?
- Does the adverse event suggest a greater risk of harm than was previously known or recognized?

If the answer to all three questions is yes, then the adverse event is an unanticipated problem and must be reported to appropriate entities.

**Assessing whether an adverse event is unexpected**

An unexpected adverse event is defined as any adverse event occurring in one or more subjects participating in a research protocol, the nature, severity, or frequency of which is not consistent with either:

1. the known or foreseeable risk of adverse events associated with the procedures involved in the research that are described in (a) the protocol related documents, such as the IRB-approved research protocol, any applicable investigator brochure, and the current IRB-approved informed consent document, and (b) other relevant sources of information, such as product labeling and package inserts; or

2. the expected natural progression of any underlying disease, disorder, or condition of the subject(s) experiencing the adverse event and the subject’s predisposing risk factor profile for the adverse event.

(Modified from the definition of unexpected adverse drug experience in FDA regulations at 21 CFR 312.32(a).)

The vast majority of adverse events occurring in the context of research are expected in light of (1) the known toxicities and side effects of the research procedures; (2) the expected natural progression of subjects’ underlying diseases, disorders, and conditions; and (3) subjects’ predisposing risk factor profiles for the adverse events. Thus, most individual adverse events do not meet the first criterion for an unanticipated problem and do not need to be reported under the HHS regulations 45 CFR part 46.103(a) and 46.103(b)(5) and the corresponding FDA regulations 21 CFR 56.108(b)(1), 21 CFR 312.53(c)(1)(vii), and 21 CFR 312.66.
Assessing whether an adverse event is *related* or *possibly related* to participation in research

Adverse events may be caused by one or more of the following:

- the procedures involved in the research;
- an underlying disease, disorder, or condition of the subject; or
- other circumstances unrelated to either the research or any underlying disease, disorder, or condition of the subject.

In general, adverse events that are determined to be at least partially caused by (1) would be considered related to participation in the research, whereas adverse events determined to be *solely* caused by (2) or (3) would be considered unrelated to participation in the research.

**Does an adverse event place subjects or others at a greater risk of harm than was previously known or recognized**

The first step in determining if the adverse event meets the third criteria of an UPIRSO is to determine whether the unanticipated problem is *serious*.

A *serious adverse event* is generally defined as any adverse event that:

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

**Reporting of local adverse events by investigators to IRBs**

In the written approval letter, the PEORIA IRB ensures that the investigator is aware of their responsibility to submit a written report of local unexpected, related adverse events that suggest that the research places subjects or others at a greater risk of harm or discomfort than was previously known or recognized. If the investigator determines that the local adverse event represents an UPIRSO, the investigator must report it promptly to the IRB [45 CFR 46.103(b) (5) and 21 CFR 56.108(b) (1)].
Upon receipt of an Unanticipated Event Reporting Form from a Principal Investigator, the IRB support staff checks the form for completeness. If any applicable sections of the form are incomplete or have been answered unsatisfactorily, the IRB staff will contact the investigator or the designated contact person to obtain additional information.

All UPIRSO Reports are initially assessed by OHRO staff in a timely manner and may be referred to a designated member of the PEORIA IRB to be reviewed. If there are multiples occurrences of a certain event determined to be a UPIRSO, the OHRO will notify the investigator that more information is needed by posting an “information required” letter in IRBNet.

(Regardless of whether the local adverse event is determined to be an unanticipated problem and reportable to the IRB, the investigator must ensure that the adverse event is reported to a monitoring entity (e.g., the research sponsor, or a DSMB/DMC) if required under the monitoring provisions described in the IRB-approved protocol or by institutional policy. )

(If the investigator determines that a local adverse event is not an unanticipated problem, but the monitoring entity subsequently determines that the adverse event does in fact represent an unanticipated problem, the monitoring entity should report this determination to the investigator, and such reports must be promptly submitted by the investigator to the IRB.)

Reporting of non-local adverse events by investigators to IRBs

In the written approval letter, the PEORIA IRB will also ensure that the investigator is aware of their responsibility to submit a written report of non-local adverse events that meet the criteria for an unanticipated problem as determined by the monitoring entity and communicated to the investigator for prompt reporting to the IRB.

In accordance with the monitoring plan described in the IRB-approved protocol, adverse events occurring in a multicenter study should be submitted for review and analysis to a monitoring entity that will assess whether the adverse event represents an unanticipated problem by applying the criteria for a UPIRSO as described above. The monitoring entity should report such a determination to the investigator for prompt reporting to the IRB.

PLEASE NOTE: The PEORIA IRB will ONLY review non-local events that have been determined to meet the definition of an UPIRSO by the monitoring entity.

When non-local adverse events are received by the investigator, he/she should assess whether the monitoring entity has identified the adverse event as being an UPIRSO.
In the absence of an assessment from the sponsor or monitoring entity identifying the event as a UPIRSO, it is the responsibility of the local PI to determine the meaningfulness of the reported event.

Only non-local adverse events identified by the monitoring entity or the local PI to be a UPIRSO must be reported by the investigator to the IRB.

All UPIRSO Reports are initially assessed by OHRO staff in a timely manner and may be referred to a designated member of the PEORIA IRB to be reviewed. If there are multiples occurrences of a certain event determined to be a UPIRSO, the OHRO will notify the investigator that more information is needed by posting an “information required” letter in IRBNet.

**Reporting of other LOCAL unanticipated problems (not related to adverse events) by investigators to IRBs**

Unanticipated problems are incidents or experiences that occur during the research and are not expected based on information about the study provided to the IRB. Similar to adverse events, not all unanticipated problems are research-related or result in real or potential additional risks to subjects or others. Unlike adverse events, which occur primarily in biomedical research, unanticipated problems occur in both biomedical and social or behavioral research.

Upon becoming aware of any other incident, experience, or outcome that may represent an unanticipated problem, the investigator should assess whether the incident, experience, or outcome represents an unanticipated problem by applying the criteria for a UPIRSO as described above. If the investigator determines that the incident, experience, or outcome represents an unanticipated problem, the investigator must report it promptly to the IRB (45 CFR 46.103(b) (5)).

Unanticipated problems need not be adverse events to be considered UPIRSOs. Examples of unanticipated problems that are UPIRSOs (i.e., meet three criteria in section 5a), but not adverse events, are a breach of confidentiality, stolen laptop computer with identifiable study data, a research assistant suffers an injury from faulty research equipment, research assistant is accosted in the housing project where they are interviewing residents for a study, and a subject’s child accidentally takes a dose of the study medication without any harmful effects.

**Reporting of other NON-LOCAL unanticipated problems (not related to adverse events) by investigators to IRBs**

In accordance with the monitoring plan described in the IRB-approved protocol, an incident, experience, or outcome that may represent an unanticipated problem (not related to an adverse event) occurring in a multicenter study should be reviewed and analyzed by
a monitoring entity that assesses whether the incident, experience, or outcome represents an unanticipated problem. The monitoring entity should report such a determination to the investigator for prompt reporting to the IRB.

PLEASE NOTE: The PEORIA IRB will ONLY review non-local incidents, experiences, or outcomes that have been determined to meet the definition of an UPIRSO by the monitoring entity.

When non-local reports of incidents, experiences, or outcomes are received by the investigator, he/she should assess whether the monitoring entity has identified the incident, experience, or outcome as being an UPIRSO.

In the absence of a letter from the sponsor or monitoring entity identifying the event as a UPIRSO, it is the responsibility of the local PI to determine the meaningfulness of the reported event.

Only non-local incidents, experiences, or outcomes identified by the monitoring entity or the local PI to be a UPIRSO must be reported by the investigator to the IRB.

**Adverse Event Reporting for Clinical Investigations of Devices Under Investigational Device Exemptions (IDE)**

Investigators are required to submit to the IRB and the sponsor a report of any unanticipated adverse device effect (UADE) occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect (21CFR812.150(a)(1)). An UADE also meets the definition of an UPIRSO and is defined as follows:

- “any serious adverse effect on health or safety or any life threatening problem or death caused by, 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, or any other unanticipated serious problem associated with the device that relates to the rights, safety, or welfare of subjects (21CFR812.3(s)).

**Events That Do Not Require Reporting to the IRB**

A. Local adverse event or problem that is expected or is not associated with a greater risk of harm to participant or others than previously known;

B. External adverse event or problem that is expected or is not associated with a greater risk of harm to participant or others than previously known; and
C. Minor protocol violations.

9.1.1 The timeframe for reporting UPIRSOs to the IRB

In accordance with OHRP guidance, the PEORIA IRB has adopted the following guidelines in order to satisfy the requirement for prompt reporting:

- Unanticipated problems that are serious adverse events should be reported to the IRB within 1 week of the investigator becoming aware of the event.
- Any other unanticipated problem should be reported to the IRB within 2 weeks of the investigator becoming aware of the problem.
- All unanticipated problems should be reported to appropriate institutional officials (as required by an institution’s written reporting procedures), the supporting agency head (or designee), and OHRP within 30 days of the IRB’s receipt of the report of the problem from the investigator.

In some cases, the requirements for prompt reporting may be met by submitting a preliminary report to the IRB, appropriate institutional officials, the supporting HHS agency head (or designee), and OHRP, with a follow-up report submitted at a later date when more information is available.

9.1.2 UPIRSO or AE Review Process

All UPIRSO Reports are initially assessed by OHRO staff in a timely manner, and will be referred to a Chairman as a designated member of the PEORIA IRB to be reviewed.

The reviewer will have access to the following:

1. Unanticipated Problem Involving Research Subjects or Others (UPIRSO) Form;
2. Protocol summary;
3. Current approved consent document; and

When designated OHRO staff and the IRB Chairman review UPIRSO Reports, they should consider whether the affected research protocol still satisfies the requirements for IRB approval under HHS regulations at 45 CFR 46.111.

- Whether risks to subjects are still minimized and reasonable in relation to the anticipated benefits, if any, to the subjects and the importance of the knowledge that may reasonably be expected to result.
Additionally, designated OHRO staff and the IRB Chairman reviewing the UPIRSO/AE Reports should consider:

- The effect of the AE on the risk-benefit relationship associated with the research, (i.e., no change in risks or benefits; increased risks with no change in benefits; or increased risk and decreased benefits).
- Whether the research protocol requires modifications.
- Whether the informed consent process and/or informed consent document requires modification to inform currently enrolled subjects or subjects who have completed their research participation.
- Whether frequency of continuing review should be increased.
- Whether the UPIRSO/AE Report should be referred to the Convened IRB for review.

If the reviewer determines that the event does not meet the definition of a UPIRSO or the UPIRSO involves no more than minimal risks to participants or others, the reviewer may acknowledge the report with no further action required.

If the reviewer finds that the event meets the definition of a UPIRSO and is more than minimal risk, it may be referred to the Convened IRB for review. IRB members will receive and review at a minimum:

A. Unanticipated Problem Form;
B. Supplementary or follow-up information provided about the event;
C. Protocol summary;
D. Current approved consent document; and
E. All IRB members are provided access to the complete protocol file.

The Convened IRB will consider the following actions:

1. Suspension or termination of the research;
2. Modification of the information disclosed during the consent process;
3. Notification of current participants when such information may relate to the subject’s willingness to continue participation;
4. Providing additional information to past subjects;
5. Requiring current subjects to re-consent to participation;
6. Alteration of the frequency of continuing review;
7. Monitoring of the research or the consent process;
8. Referral to subcommittee of the PEORIA IRB or to other organizational entities; and
If the convened IRB decides a protocol or consent modification is warranted, the Convened IRB must also determine:

- Whether or not previously enrolled subjects must be notified of the modification and, if so,
- When such notification must take place and how such notification must be documented.

The OHRO notifies the investigator, in writing, of the PEORIA IRB’s determination and decisions. If the PEORIA IRB Chair and/or convened UICOMP IRB determine that research activities should be suspended or terminated, the PEORIA IRB will notify the UICOMP H HPA. The suspension or termination is reported promptly by the HPA to the Office for Human Research Protections (OHRP), the Sponsor, and the Food and Drug Administration (FDA), if appropriate. Appropriate reporting must occur within 30 days.

If the PEORIA IRB Chair/Reviewer and/or convened PEORIA IRB determine the event should be referred for review as potential noncompliance, the UICOMP IRB will notify the UICOMP HHPA. The HPA will be responsible for notifying OHRP, the Sponsor, and FDA, if appropriate. Appropriate reporting must occur within 30 days.

### 9.2 Protocol Deviations and Violations

**Deviations**

A protocol deviation is a departure from the approved protocol’s procedures made without prior IRB approval.

Examples of deviations include, but are not limited to the following:

- any emergent deviation from the IRB protocol made without prior IRB review to eliminate apparent immediate hazard to a research subject;
- implementation of unapproved recruitment procedures;
- use of an incorrect informed consent version;
- Missing original signed and dated consent form or missing pages from executed consent form;
- Inappropriate documentation of consent, including:
  - Missing signatures
  - Individual obtaining consent not listed on IRB approved application;
Subject visit/procedure falls outside of the window of time indicated by the protocol, or is not done per protocol, and there is no increased potential for risk to the subject or any damage to the integrity or completeness of the data.

A deviation becomes reportable to the IRB as a protocol violation when the event occurs frequently enough to suggest a pattern or a process problem. Deviations do not typically negatively affect the participant’s safety, rights, or welfare and/or the completeness, accuracy and integrity of the study data, however, frequent deviations of the same nature may be indicative of a pattern or a process problem. Frequent deviations of the same nature are unanticipated problems that must be reported to the IRB on the Unanticipated Problem Form.

Frequent deviations of the same nature may include but are not limited to:

1. More than 3 subjects signing an outdated or unstamped version of the consent form;
2. More than 3 subjects with missing protocol-required lab tests;
3. More than 3 subjects having “out-of-window” visits; and
4. More than 3 subjects deviating from specific protocol eligibility requirements (i.e. enrolling subjects with a blood pressure or a laboratory value slightly higher or lower than dictated by the protocol when all other criteria are met.)

“Frequent” is defined as occurring in more than 3 subjects in a single research study.
Frequent deviations of the same nature are reportable to the IRB when the PI or a member of the research team becomes aware of the occurrences.

Violations

A protocol violation is any deviation that may adversely affect the subject’s rights, safety, or welfare, and/or the completeness, accuracy and integrity of the study data. A protocol violation is often considered a major, more serious, variance from an approved protocol than a deviation.

Examples of violations include, but are not limited to the following:

• Intentional deviation from the protocol or regulations in a non-emergency setting
• any unintended or intended deviation from the IRB approved protocol that involves potential risks or has the potential to recur;
• enrollment of subjects not meeting the inclusion/exclusion criteria of an IRB approved protocol;
• failure to withdraw a subject meeting withdrawal criteria;
• inadvertent loss of samples or data;
• failure to obtain informed consent prior to initiation of study-related procedures;
• improper consent procedure;

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• failure to follow federal and/or local regulations and policies;
• working under an expired professional license/certification, debarred or disqualified status;
• frequent minor deviations;
• any medication error involving dosing, administration and/or preparation of the study drugs;
• any lapse in study approval where there is a continuation of research activities (i.e. recruitment, enrollment, procedures, data analysis); or
• failure to report unanticipated problems to the IRB and/or the sponsor.

9.2.1 The timeframe for reporting Protocol Violations/Frequent Deviations of the Same Nature

Protocol violations may be considered as noncompliance and are to be reported on the UICOMP Unanticipated Problems Form and submitted to the IRB within 2 weeks of the investigator becoming aware of the problem.

9.2.2 Reporting of a Protocol Violation/Frequent Deviations of the Same Nature on the UICOMP Unanticipated Problems Form

Upon receipt of a Protocol Violation/Frequent Deviations of the Same Nature report, OHRO staff will assess the report and refer it to an IRB Chairman for review. The IRB Chair may request additional information in order to appropriately evaluate the event.

Following review, the IRB Chair may:

1. Acknowledge the report
2. Take prompt action and refer to the convened IRB
3. Determine prompt action is not necessary and refer to the convened IRB

Acknowledge the Report

If the IRB Chairman reviews the report and determines that an act of noncompliance has clearly NOT occurred or that an act of noncompliance has occurred, BUT the act is clearly neither serious or continuing, OHRO staff will notify the investigator, in writing, of the PEORIA IRB’s determination and decisions.

9.2.3 Protocol Violations/Frequent Deviations of the Same Nature as Noncompliance

If the IRB Chair reviews the report and determines that there are issues or actions that 1) create an increase in the risks to subjects; 2) adversely affect
the rights, welfare and safety of research subjects; and/or 3) adversely affect the scientific integrity of the study, prompt action may be necessary to eliminate apparent immediate hazards to the subject or the integrity of the study.

**Prompt Action Necessary and Referral to the Convened IRB**

Prompt action typically requires a suspension of enrollment that may be directed by the reviewing IRB Chair. At the IRB Chair’s discretion, this determination can be referred to the Regional Dean/IO or HPA.

Any prompt action directed by the IRB Chair, Regional Dean/IO or HPA will be communicated to the investigator, in writing and the UICOMP HPA (if not already contacted). The UICOMP HPA is responsible for prompt notification to other institutional officials including the HPAs and/or RCOs of each engaged institution, to the appropriate department heads, clinical and/or research supervisors and relevant federal oversight agencies.

**No Prompt Action Necessary and Referral to the Convened IRB**

If the IRB Chairman reviews the report and determines that 1) an act of noncompliance has occurred and 2) the act is potentially serious or continuing, but determines that prompt action is not required to eliminate apparent immediate hazards to the subject or the integrity of the study, the report will be referred to the convened IRB.

**Convened IRB Review of Protocol Violations/Frequent Deviations of the Same Nature as Potential Serious or Continuing Noncompliance**

If the Chairman or designated member of the PEORIA IRB determines that there is potential for serious or continuing noncompliance, the Protocol Violation/Frequent Deviations of the Same Nature report will be referred to the convened IRB for a formal determination of serious or continuing noncompliance.

**Convened IRB Review of Potential Serious and/or Continuing Noncompliance**

Following their review, the IRB may make any of the following determinations:

1. Noncompliance has not occurred;
2. Noncompliance has occurred, but the noncompliance is neither serious nor continuing;
3. Noncompliance has occurred that is serious and/or continuing.
If the convened IRB determines noncompliance has not occurred or that noncompliance has occurred, but it is neither serious or continuing, OHRO staff will notify the investigator, in writing, of the PEORIA IRB’s determination and decisions.

When the noncompliance is determined by the convened IRB to be serious and/or continuing, the IRB will determine if prompt action is required (if not already enacted):

1. Prompt action of suspending enrollment into the research study; or
2. Prompt action of termination of research approval;

When prompt action is required or it has already been enacted, the convened IRB will consider whether to implement one or more of the following actions:

1. IRB-directed corrective action plan;
2. PI-initiated corrective action plan; and/or
3. IRB Directed Monitoring Visit for further investigation (Please see section 18.1 “Assessing Compliance – Monitoring” for a detailed discussion of IRB-directed monitoring.

An IRB-directed corrective action plan could involve one or more of the following:

1. Imposition of ethics and/or human subjects research education for the investigator and/or research staff;
2. Modification of the protocol;
3. Modification of the consent process;
4. Providing information to past participants;
5. Requiring notification to and re-consent of current participants;
6. Modification of the continuing review schedule; and/or
7. Monitoring of the consent process

The OHRO staff will notify the investigator, in writing, of the PEORIA IRB’s determination and decisions.

9.2.4 Potential Serious and/or Continuing Noncompliance Received as an Audit Findings

As stated in Section 2.13, the convened IRB may consider implementing an IRB Directed Monitoring Visit to further investigate serious and/or continuing noncompliance. Likewise, a Research Compliance Officer at a PIRB Affiliate may conduct an investigation and report its findings to the OHRO.
If an IRB-Directed Monitoring Visit identifies additional serious or continuing noncompliance with the federal regulations or UICOMP policy, a report of the findings will be shared with the UICOMP HPA and the directing IRB. The IRB will follow the “Convened IRB Review of Potential Serious and/or Continuing Noncompliance” process described above until an IRB-directed corrective action plan or a PI-initiated corrective action plan is proposed. The plan will be shared with the convened IRB. The PEORIA IRB retains final authority in determining whether the corrective action plan is adequate.

If the action plan is deemed adequate the investigated case of serious and/or continuing noncompliance can be closed.

If an Affiliate’s audit report identifies potential serious or continuing noncompliance in a PIRB-approved research study, the HPA, in consultation with the IRB Chairs and the Regional Dean/IO will make an assessment whether the allegation has any merit through initial fact-finding. If the allegation requires further investigation, the UICOMP HPA will work with the Affiliate’s RCO/HPA to allow the PIRB to have access to the necessary study documents for review.

The HPA will make an assessment whether the allegation requires prompt action to eliminate apparent immediate hazards to the subjects. At the HPA’s discretion, this determination can be referred to the IRB Chair or Regional Dean/IO. Prompt action typically requires a suspension to temporarily halt enrollment into a research study.

Any prompt action will be communicated to the investigator, in writing. The UICOMP HPA is responsible for prompt notification to the HPAs and/or RCOs of each engaged institution, to the appropriate department heads, clinical and/or research supervisors and relevant federal oversight agencies (including OHRP, FDA, and any funding agency). Suspension directives will be reported at the next available meeting of the convened IRB.

Whether prompt action is warranted or is not warranted, the UICOMP HPA will work with the Affiliate’s RCO to establish a hierarchy with the HPAs at the RCO’s institution and the RCOs/HPAs of other engaged sites in order to designate which is the “lead” site. The lead site RCO/HPA will take the initiative in any investigation into allegations or reports of noncompliance and will assume responsibility for updates, as reasonable and upon request, and a copy of the report of its findings to the PEORIA IRB Chairs and the RCOs/HPAs of other engaged sites. Nothing prevents UICOMP or any other engaged Affiliate site from conducting its own investigation, however any findings made by any other site will be shared promptly with the PEORIA IRB.
Chairs and the UICOMP HPA to ensure the safe and appropriate performance of the study.

Any information gathered and/or a formal report rendered during an investigation into an allegation of serious or continuing noncompliance will be referred to the IRB Chairs.

In the absence of any findings of serious or continuing noncompliance, the IRB Chairs will determine whether any follow up with the convened IRB is necessary. The OHRO staff will notify the investigator, in writing, of the PEORIA IRB’s determination and decisions.

If information gathered and/or a formal report indicate(s) the likelihood of serious or continuing noncompliance, the IRB Chairs will refer the information and/or report to the convened IRB. Please refer to the section above entitled: “Convened IRB Review of Potential Serious or Continuing Noncompliance” for a full explanation of the review process.

If a finding/report requires a PI-initiated corrective action plan, the plan will be shared with the convened IRB. The OHRO staff will notify the investigator, in writing, of the PEORIA IRB’s determination and decisions.

Section 10: ClinicalTrials.gov Registration

ClinicalTrials.gov is a public database containing information about federally and privately supported clinical trials for an array of diseases and conditions. A service of the U.S. National Institutes of Health (NIH) in collaboration with the Food and Drug Administration (FDA), ClinicalTrials.gov requires registration and results reporting for clinical trials. Background information regarding history, policies, and laws can be found on ClinicalTrials.gov

Section 801 of the Food and Drug Administration Act (FDAAA 801) specifies registration and results reporting requirements for clinical trials (for full documentation describing the law, see FDAAA 801).

Final Rule Update

The U.S. Department of Health and Human Services has issued a final rule (42 CFR 11) about ClinicalTrials.gov. A checklist-based tool to assist responsible parties in evaluating whether a study is an applicable clinical trial based on 42 CFR 11.22(b) for studies initiated on or after 1/18/17 is available here.
10.1 Definitions

1. **Applicable Clinical Trial (FDAAA 801 definition)** is a trial that generally includes interventional studies (with one or more arms) of FDA-regulated drugs, biological products, or devices that meet one of the following conditions:
   a. the trial has one or more sites in the United States;
   b. the trial is conducted under a U.S. FDA Investigational New Drug application (IND) or Investigational Device Exemption (IDE)
   c. the trial involves a drug, biologic, or device that is manufactured in the United States or its territories and is exported for research.

The following trials are generally excluded:

a. (Non-serious/life-threatening) Phase 1 drug trials, including studies in which drugs are used as research tools to explore biological phenomena or disease processes
b. Small clinical trials to determine the feasibility of a device or a clinical trial to test prototype devices where the primary outcome measure relates to feasibility and not to health outcomes
   c. Trials that do not include drugs, biologics, or devices (e.g., behavioral interventions)
   d. Non-interventional (observational) clinical research, such as cohort or case control studies Trials that were ongoing* as of September 27, 2007, and reached the Completion Date before December 26, 2007

2. **ClinicalTrials.gov** is a registry and results database of publicly and privately supported clinical studies of human participants conducted around the world; service provided and maintained by the NIH.

3. **Clinical Trial (NIH definition)** is a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.
   a. "Prospectively assigned" refers to a pre-defined process (e.g., randomization) specified in an approved protocol that stipulates the assignment of research subjects (individually or in clusters) to one or more arms (e.g., intervention, placebo, or other control) of a clinical trial.
   b. "Intervention" is defined as a manipulation of the subject or subject's environment for the purpose of modifying one or more health-related biomedical or behavioral processes and/or endpoints. Examples include: drugs/small molecules/compounds; biologics; devices;
procedures (e.g., surgical techniques); delivery systems (e.g.,
telemedicine, face-to-face interviews); strategies to change health-
related behavior (e.g., diet, cognitive therapy, exercise, development of
new habits); treatment strategies; prevention strategies; and, diagnostic
strategies.

c. "Health-related biomedical or behavioral outcome" is defined as
the pre-specified goal(s) or condition(s) that reflect the effect of one
or more interventions on human subjects' biomedical or behavioral
status or quality of life. Examples include: positive or negative
changes to physiological or biological parameters (e.g.,
improvement of lung capacity, gene expression); positive or
negative changes to psychological or neurodevelopmental
parameters (e.g., mood management intervention for smokers;
reading comprehension and/or information retention); positive or
negative changes to disease processes; positive or negative changes
to health-related behaviors; and, positive or negative changes to
quality of life.

4. **Clinical Trial (ICMJE definition)** is any research study that prospectively
assigns human participants or groups of humans to one or more health-related
interventions to evaluate the effects on health outcomes.

   a. Health-related interventions include any intervention used to
modify a biomedical or health-related outcome (for example,
drugs, surgical procedures, devices, behavioral treatments, dietary
interventions, and process-of-care changes).

   b. Health outcomes include any biomedical or health-related measures
obtained in patients or participants, including pharmacokinetic
measures and adverse events.

5. **Ongoing Clinical Trial** is any Clinical Trial that has enrolled one or more
subjects and the final subject has not been examined or received an
intervention for the purpose of collecting data on the primary outcome.

6. **Protocol Registration and Results System (PRS)** is a web-based data entry
system used to register the clinical studies and submit results information for
registered studies. Researchers must have a PRS account to register study
information on ClinicalTrials.gov.

7. **Qualifying Clinical Trial** is a clinical trial qualified for coverage by the
Center for Medicare and Medicaid Services (CMS) as specified in the

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8. **Responsible Party** refers to the entity or individual who is responsible for registering a clinical trial and submitting clinical trial information to the Clinical Trial Registry Data Bank, according to FDAAA 801.

### 10.2 Purpose of Registration

Registering clinical trials when they begin, providing timely updates, submitting summary results, and making this information publicly available fulfills a number of purposes and benefits a variety of people.

#### Trial Registry Purposes for Various Groups

<table>
<thead>
<tr>
<th>Registry Purpose</th>
<th>Group That Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fulfill ethical obligations to participants and the research community</td>
<td>Patients, the general public, the research community</td>
</tr>
<tr>
<td>Provide information to potential participants and referring clinicians</td>
<td>Patients, clinicians</td>
</tr>
<tr>
<td>Reduce publication bias</td>
<td>Users of the medical literature</td>
</tr>
<tr>
<td>Help editors and others understand the context of study results</td>
<td>Journal editors, users of the medical literature</td>
</tr>
<tr>
<td>Promote more efficient allocation of research funds</td>
<td>Granting agencies, the research community</td>
</tr>
<tr>
<td>Help institutional review boards (IRBs) determine the appropriateness of a research study</td>
<td>IRBs, ethicists</td>
</tr>
</tbody>
</table>

### Results Database Purposes for Various Groups

<table>
<thead>
<tr>
<th>Results Database Purpose</th>
<th>Group That Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a public record of basic study results in a standardized format</td>
<td>Researchers, journal editors, IRBs, ethicists</td>
</tr>
<tr>
<td>Promote the fulfillment of ethical obligations to participants and the overall contribution of research results to medical knowledge</td>
<td>Patients, the general public, the research community</td>
</tr>
<tr>
<td>Reduce publication and outcome reporting biases</td>
<td>Users of the medical literature</td>
</tr>
<tr>
<td>Facilitate systematic reviews and other analyses of the research literature</td>
<td>Researchers, policymakers</td>
</tr>
</tbody>
</table>


### Required by Law

Section 801 of the Food and Drug Administration Amendments Act (FDAAA 801) (PDF) requires Responsible Parties to register and submit summary results of clinical trials with ClinicalTrials.gov. The law applies to certain clinical trials of drugs (including biological products) and medical devices.

### Required for Journal Publication

The International Committee of Medical Journal Editors (ICMJE) requires trial registration as a condition of the publication of research results generated by a clinical trial. ClinicalTrials.gov is a registry where organizations and individuals can provide the World Health Organization (WHO) Trial Registration Data Set required by ICMJE.

### Section 10.3 Policy Requirements

1. It is the policy of UICOMP that new or Ongoing Clinical Trials which meet any of the following criteria are registered on http://www.clinicaltrials.gov/:
a. Applicable Clinical Trials (ACTs) as defined in the Department of Health and Human Services (HHS) regulation "Clinical Trial Registration and Results Information Submission", at 42 CFR Part 11.
b. Trials funded in whole or in part by the National Institutes of Health (NIH) that meet the clinical trial definition in the "NIH Policy on the Dissemination of NIH-Funded Clinical Trial Information".
c. Trials that meet the clinical trial definition in the International Committee of Medical Journal Editors (ICMJE) clinical trial registration policy.
d. Qualifying Clinical Trials, as defined in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1, which will render claims for items and services to the Center for Medicare and Medicaid Services (CMS).

10.4 Responsibility

1. For each clinical trial subject to this Policy, UICOMP Principal Investigators (PIs) are responsible for:
   a. ensuring the clinical trial is registered on ClinicalTrials.gov in a timely manner by the Responsible Party (Sponsor or PI);
   b. reviewing the content of the clinical trial record posted on ClinicalTrials.gov for accuracy;
   c. notifying the Responsible Party (Sponsor or PI) and the UICOMP PRS Administrator of any inconsistencies and/or errors in the clinical trial record;
   d. reviewing the clinical trial record to verify that required information is submitted timely; and
   e. assisting the Responsible Party (Sponsor or PI) in reporting clinical trial results as appropriate.

10.5 Oversight

1. To serve in the oversight capacity, UICOMP has appointed an Institutional PRS Administrator ("Administrator"). The Administrator assists Responsible Parties with:
   a. establishing user accounts and temporary passwords;
   b. resetting a password when the original is lost or forgotten;
   c. working with PRS to change ownership of a study; or
   d. transferring a study to another institution.

2. The Administrator monitors the system and notifies Responsible Parties when updates and/or problems are not addressed in a timely manner.
3. The Administrator offers basic training on the use of the PRS interface and assists with basic tasks of clinical trial registration.

4. The Administrator is not responsible for reviewing, editing, or verifying the accuracy of the clinical trial record posted on ClinicalTrials.gov.

10.6 Registration Process

Identifying a Clinical Trial Needing Registration

1. Use the following criteria to assess a new or Ongoing Clinical Trial to determine whether it must be registered:
   a. Clinical Trials funded either in whole, or in part by NIH. Apply this criteria to all NIH-funded studies independent of whether the study meets the definition of an Applicable Clinical Trial.
   b. Clinical Trials that meet the clinical trial definition of The International Committee of Medical Journal Editors (ICMJE) that the investigator may wish to publish.
   c. Qualifying Clinical Trials which will render claims for items and services to the Center for Medicare and Medicaid Services (CMS).
   d. "Applicable Clinical Trials (ACT)" which include the following:
      i. Trials of Drugs/Biologics: Controlled, clinical investigations of a product subject to FDA regulations. This includes preliminary studies or phase I trials to be published in an ICMJE journal.
      ii. Trials of Devices: Controlled trials with health outcomes, other than small feasibility studies, and pediatric post-market surveillance.
      iii. Applicable Clinical Trials generally include interventional studies (with one or more arms) of FDA regulated drugs, biological products, or devices that meet one of the following conditions:

1. the trial has one or more sites in the U.S.;
2. the trial is conducted under an FDA Investigational New Drug Application (IND) or Investigational Device Exemption (IDE) application; or
3. the trial involves a drug, biologic, or device that is manufactured in the U.S. or its territories and is exported for research.
Determining the Responsible Party for Registering a Clinical Trial

1. The Responsible Party is either:

a. The Sponsor of a clinical trial; or
b. The PI of such clinical trial, if so designated by a sponsor, grantee, contractor, or awardee, so long as the PI is:
   i. responsible for conducting the trial;
   ii. has access and control over the data from the clinical trial;
   iii. has the right to publish the results of the trial; and
   iv. has the ability to meet all of the FDAAA's requirements for the submission of clinical trial information.

2. For clinical trials that are being performed at multiple institutions, the lead sponsor is responsible for registering the trial. If the PI is not the lead sponsor, he or she works with the other investigators and sponsors to ensure that the trial is registered only once for the entire project.

3. For investigator-initiated trials, the "Responsible Party" is the PI, who is designated as the "Sponsor-investigator."

Registering a Clinical Trial

1. Clinical Trials subject to this policy are registered in ClinicalTrials.gov by the designated Responsible Party within 21 days of enrollment of the first subject. "Enrolled" is defined in 42 CFR 11.10(a) as a human subject's, or their legally authorized representative's, agreement to participate in a clinical trial following completion of the informed consent process, as required in 21 CFR Part 50 and/or 45 CFR Part 46, as applicable. The regulation explains that, for the purposes of this part, potential subjects who are screened for the purpose of determining eligibility for a trial, but do not participate in the trial, are not considered enrolled, unless otherwise specified by the protocol.

Updating a Registered Clinical Trial

Responsible Parties should update their records within 30 days of a change to any of the following:

- Individual Site Status (the recruitment status of each participating facility in a clinical study) and Overall Recruitment Status (the recruitment status for the clinical study as a whole, based upon the status of the individual sites) data elements on ClinicalTrials.gov
• Primary Completion Date (defined as the date the final participant was examined or received an intervention for purposes of final collection of data) data element on ClinicalTrials.gov.

As described in 42 CFR Part 11, additional information must also be updated within 15 or 30 days of a change. Other changes or updates to the record must be made at least every 12 months. It is recommended that the Record Verification Date be updated at least every 6 months for studies that are not yet completed, even if there were no changes to the record.

**Submitting Results for a Registered Clinical Trial**

Submit results for all registered clinical trials no later than 12 months after the Primary Completion Date, defined as the date the final participant was examined or received an intervention for purposes of final collection of data for the primary outcome.

**Section 11: Investigator Responsibilities**

Principal Investigators (PIs) are ultimately responsible for the conduct of research. PIs may delegate research responsibility. However, investigators must maintain oversight and retain ultimate responsibility for the conduct of those to whom they delegate responsibility.

**11.1 Responsibilities**

In order to satisfy the requirements of this policy, investigators who conduct research involving human subjects must:

1. Develop and conduct the project within the framework described in Federal Regulations (45 CFR § 46; 21 CFR § 50,56) as well as the Belmont Report.
2. Develop a research plan that is scientifically sound and minimizes risk to the subjects;
3. Have sufficient resources necessary to protect human subjects, including:
   a. Access to a population that would allow recruitment of the required number of subjects.
   b. Sufficient time to conduct and complete the research.
   c. Adequate numbers of qualified staff.
   d. Adequate facilities.
   e. A process to ensure that all persons assisting with the research are adequately informed about the protocol and their research-related duties and functions.
   f. Availability of medical or psychological resources that subjects might require as a consequence of the research.

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4. Assure that all procedures in a study are performed with the appropriate level of supervision and only by individuals who are licensed or otherwise qualified to perform such under the laws of Illinois and the policies of PEORIA IRB;

5. Assure that all authorized study personnel are educated in the regulatory requirements regarding the conduct of research and the ethical principals upon which they are based;

6. Protect the rights and welfare of prospective subjects;

7. Ensure that risks to subjects are minimized: (i) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes

8. Recruit subjects in a fair and equitable manner

9. Obtain and document informed consent as required by the IRB and ensuring that no human subject is involved in the research prior to obtaining their consent;

10. Have plans to monitor the data collected for the safety of research subjects;

11. Protect the privacy of subjects and maintain the confidentiality of data;

12. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, include additional safeguards in the study to protect the rights and welfare of these subjects;

13. Have a procedure to receive complaints or requests for additional information from subjects and respond appropriately,

14. Ensure that pertinent laws, regulations, and institutional procedures and guidelines are observed by participating investigators and research staff;

15. Ensure that all research involving human subjects receives IRB review and approval in writing before commencement of the research;

16. Comply with all IRB decisions, conditions, and requirements;

17. Ensure that protocols receive timely continuing IRB review and approval;

18. Report unanticipated problems involving risk to subjects or other and any other reportable events to the IRB (see Section 9)

19. Obtain IRB review and approval in writing before changes are made to approved protocols or consent forms

20. Seek IRB assistance when in doubt about whether proposed research requires IRB review.

Investigators are notified of their responsibilities as listed above through the submission of the Responsibilities of Investigator Form and through the attestation that is required for affixing their electronic signature to submissions in IRBNet.
11.2 Investigator Concerns

Investigators who have concerns or suggestions regarding UICOMP’s human research protection program should convey them to the Institutional Official or other responsible parties regarding the issue, when appropriate. The investigator may complete the PEORIA IRB Complaint Form to communicate concerns regarding a research protocol, a specific PEORIA IRB or a research site. The form may be completed with complainant details or anonymously.

The Institutional Official will research the issue, and when deemed necessary, convene the parties involved to form a response for the investigator or make necessary procedural or policy modifications, as warranted. In addition, the Chair of the IRB or the IRB Director will be available to address investigators’ questions, concerns and suggestions.

Section 12: Sponsored Research

It is PEORIA IRB policy that any sponsored research conducted under the auspices of the Organization is conducted in accordance with federal guidelines and ethical standards.

The following describe the procedures required to ensure that all sponsored research meets this requirement.

12.1 Definitions

Sponsor. Sponsor means the company, institution, individual donor, or organization responsible for the initiation, management or financing of a research study. Sponsored research. Sponsored research means research funded by external entities through a grant or contract that involves a specified statement of work (e.g., the research proposal) with a related transfer of value to the sponsor, including clinical trials involving investigational drugs, devices or biologics.

12.2 Responsibilities

1) Sponsor contracts that are reviewed by UIC’s Office of Research Services:  
   a. UIC’s Office of Research Services will review contracts and the IRB and the Office of Research Services will share study information as necessary for each sponsored protocol to ensure that protocol, consent, and contract language are consistent.
2) Sponsor contract NOT reviewed by UIC’s Office of Research Services:  
   a. When a contract is not reviewed by UIC’s Office of Research Services, but is reviewed by another entity in which the investigator reports, the other entity and the IRB will share study information as necessary for each sponsored protocol to ensure that protocol, consent, and contract language are consistent.
3) Sponsor Contracts that are reviewed by UIC’s Office of Research Services will be reviewed for the following

a. All sponsor contracts will indicate that PEORIA IRB will follow the protocol, applicable law, regulations and its ethical standards.

b. The contract or funding agreement documents the financial aspects of the research

c. If the research involves more than minimal risk, the contract or funding agreement indicates who will provide medical care and who is responsible to pay for it in the event a research participant has a research-related injury.

d. If the sponsor will monitor the conduct of the research, the contract or funding agreement obligates the sponsor to promptly report to the organization any findings of on-site study monitors that could affect the safety of subjects, or influence the conduct of the study.

e. If the research has a data and safety monitoring plan, or someone other than the sponsor that is responsible for the data and safety monitoring plan, the contracts or funding agreements state that data and safety monitoring plans will be provided to the organization prior to IRB approval of the research.

f. If the research involves more than minimal risk of injury, the research has a data and safety monitoring plan, or someone other than the sponsor that is responsible for the plan, the contract or funding agreement obligates the sponsor to promptly report to the organization, investigator, or IRB within specified time-frames, but not less frequently than annually, routine and urgent data and safety monitoring reports.

g. The contract or funding agreement includes a description of the plans for disseminating findings from the research, and the roles the researchers and sponsors will play, that are consistent with the organization’s policy regarding the publication of findings from sponsored research.

h. The contract or funding agreement requires the Sponsor to notify the researcher or the organization after the study has ended if study results could directly affect subject safety.

i. The contract or funding agreement obligates the organization to comply with procedures for data recording/reporting.

j. The contract or funding agreement obligates the organization to permit monitoring, auditing and inspection.

k. The contract or funding agreement obligates the organization to retain the trial related essential documents until the sponsor informs the investigator or organization these documents are no longer needed.

l. The description of payments to subjects in terms of amount, method and timing in the contract or funding agreement and associated budgets is consistent with the informed consent document.

m. The description of compensation to investigators and research staff in the contract or funding agreement and associated budgets is at fair market value for their efforts and expenses. Payment in exchange for referrals of prospective participants from researchers (physicians) (“finder’s fees”) is not permitted.
Similarly payments designed to accelerate recruitment that are tied to the rate or timing of enrollment ("bonus payments") are also not permitted.

Section 13: Procedures for Research with Vulnerable Populations

13.1 Enrolling Vulnerable Populations

PEORIA IRB requires the investigator to provide sufficient justification for conducting research involving a vulnerable population. The IRB must ensure that all of the regulatory requirements for the protection of vulnerable subjects are met and that appropriate additional protections for vulnerable subjects are in place. Human subjects research should never be conducted using a vulnerable population for the convenience of the research, but only when the vulnerable population at risk in the research activity will also be one of the populations with the potential for benefit from the knowledge gained by the research. Likewise, vulnerable populations should not be excluded from the potential for benefit from research only because there is not a clear statutory rule for obtaining informed consent or the permission of a legally authorized representative.

When the IRB reviews research that involves categories of participants vulnerable to coercion or undue influence, the review process will include one or more individuals who are knowledgeable about or experienced in working with these participants.

45 CFR 46 has additional subparts designed to provide extra protections for vulnerable populations which also have additional requirements for IRBs.

- 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

DHHS-funded research that involves any of these populations must comply with the requirements of the relevant subparts. Research funded by other federal agencies may or may not be covered by the subparts.

PEORIA IRB limits the application of the FWA to federally funded research. Consequently under UICOMP’s FWA the subparts only apply to DHHS-funded research and research funded by another federal agency that requires compliance with the subparts (FDA regulations include Subpart D, which applies to all FDA-regulated research). The following policies and procedures, which are based on the subparts, apply to all research regardless of funding. The individual sections describe how the subparts apply to DHHS funded research.
13.2 Responsibilities

1. The PI is responsible for identifying the potential for enrolling vulnerable subjects in the research proposal. The PI is responsible for identifying subjects who are at risk for impaired decisional capacity as a consequence of psychiatric illness, and who are being asked to participate in a research study with greater than minimal risk.

2. The IRB shall include representation, either as members or ad hoc consultants, individual(s) interested in or who have experience with the vulnerable populations involved in the research proposal under review.

3. The IRB reviews the PI’s justifications for including vulnerable populations in the research to assess appropriateness of the research proposal.

4. The IRB must ensure that additional safeguards have been included in each study to protect the rights and welfare of vulnerable subjects as needed at the time of initial review of the research proposal.

5. The IRB evaluates the proposed plan for consent of the specific vulnerable populations involved. If the research involves adults unable to consent, the IRB evaluates the proposed plan for obtaining permission from legally authorized representatives.

6. The IRB evaluates and approves the proposed plan for the assent of participants.

7. The IRB evaluates the research to determine the need for additional protections and considers the use of a data and safety monitoring board or data monitoring committee as appropriate.

8. Information reviewed as part of the continuing review process should include the number of participants considered as members of specific vulnerable populations.

9. The IRB should be knowledgeable about and experienced in working with populations who are vulnerable to coercion and undue influence. If the IRB requires additional qualification or expertise to review a protocol, it should obtain consultation.

13.3 Inclusion of Pregnant Women, Human Fetuses, and Neonates in Research (In Vitro Fertilization)
When the proposed research involves fetuses, pregnant women, neonates, or human in vitro fertilization, the PEORIA IRB will ensure the presence of IRB members who are uniquely qualified by their experience and training to review and approve the research. The PEORIA IRB’s discussions, findings and determinations are documented in the PEORIA IRB meeting minutes and review guides for each specific research protocol.

13.3.1 Research Not Funded by DHHS

For research not funded by DHHS, no additional safeguards are required and there are no restrictions on the involvement of pregnant women in research where the risk to the fetus is no more than minimal.

Pregnant women or fetuses may be involved in research not funded by DHHS involving more than minimal risk to fetuses if all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;

2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus;

3. Any risk is the least possible for achieving the objectives of the research;

4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent;

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

6. Each individual providing consent under paragraph 4 or 5 of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;

7. For pregnant women under 18 years of age, consent may be obtained from the minor subject when the research relates to expected medical or surgical procedures performed in pregnant women by the individuals and under the circumstances stipulated Illinois Consent by Minors to Medical Procedures Act (410 ILCS 210/1). When the research does not fall within the Act, assent from the pregnant minor and permission from the parent or guardian
must be obtained as described in the PEORIA IRB policy and procedure Research Involving Children.

8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;

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

10. Individuals engaged in the research will have no part in determining the viability of a neonate.

13.3.2 Research Funded by DHHS

For DHHS-funded research, 45 CFR Subpart B applies to all research involving pregnant women. The two primary considerations of the IRB in evaluating research involving pregnant women or fetuses are (1) whether the research is directed to the mother’s or fetus’ health and (2) the risk to the woman and fetus. Pregnant women or fetuses may be involved in research if the IRB determines and documents in a protocol specific manner in the meeting minutes or review guide (as appropriate) that all of the following conditions are met:

1. Where scientifically appropriate, pre-clinical studies, including studies on pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;

2. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus;

3. Any risk is the least possible for achieving the objectives of the research;

4. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, then the consent of the pregnant woman is obtained in accord with the provisions for informed consent;

5. If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the provisions for informed consent, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.
6. Each individual providing consent under paragraph 4 or 5 of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;

7. For pregnant women under 18 years of age, consent may be obtained from the minor subject when the research relates to expected medical or surgical procedures performed in pregnant women by the individuals and under the circumstances stipulated Illinois Consent by Minors to Medical Procedures Act (410 ILCS 210/1). When the research does not fall within the Act, assent from the pregnant minor and permission from the parent or guardian must be obtained as described in the UICOMP IRB policy and procedure Research Involving Children.

8. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;

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

10. Individuals engaged in the research will have no part in determining the viability of a neonate.

13.3.3 Research Involving Neonates.

a. Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:
   i. Where scientifically appropriate, pre-clinical and clinical studies have been conducted and provide data for assessing potential risks to neonates;
   ii. Each individual providing consent is fully informed regarding the reasonable foreseeable impact of the research on the neonate;
   iii. Individuals engaged in the research will have no part in determining the viability of the neonate; AND
   iv. The requirements of paragraph B or C of this section (refer below) have been met as applicable.

b. Neonates of uncertain viability. Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this policy unless the following additional conditions have been met:
   i. The IRB must determine that:
      1. The research holds out the prospect of enhancing the probability of survival of the neonate to the point of
viability, and any risk is the least possible for achieving that objective: or

2. The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and

3. The legally effective informed consent of either parent of the neonate, or if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent’s legally authorized representative is obtained in accord with 45 CFR 46 Subpart A, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.

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

i. Vital functions of the neonate will not be artificially maintained;

ii. The research will not terminate the heartbeat or respiration of the neonate;

iii. There will be no added risk to the neonate resulting from the research;

iv. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means; and

v. The legally effective informed consent of both parents of the neonate is obtained in accord with 45 CFR 46 Subpart A, except that the waiver and alteration provisions of §46.116 (c) and (d) do not apply; however, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice, except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements of this paragraph.

d. Viable Neonates. A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of 45 CFR 46 Subparts A and D.
13.3.4 Research Involving, After Delivery, the Placenta, the Dead Fetus, or Fetal Material.

A. Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissues, or organs excised from a dead fetus, shall be conducted only in accord with any applicable Federal, State, or local laws and regulations regarding such activities, which may include the Illinois Anatomical Gift Act (755 ILCS 50).

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

13.3.5 Research Not Otherwise Approvable

13.3.5.1 Research Not Funded by DHHS

For research which is not federally funded and the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates and the research is not approvable under the above provisions (sections 9.3.2 and 9.3.3), the IRB will provide copies of the protocol and the IRB minutes to the HPA for a determination regarding whether an ad hoc panel of experts should be convened to review the research. In this case, PEORIA IRB approval will not be released until either the HPA determines that an ad hoc panel is not necessary or the ad hoc panel issues a recommendation that the research is acceptable based on either:

1. That the research in fact satisfies the conditions above, as applicable; or
2. The following:

   a. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates;
   b. The research will be conducted in accord with sound ethical principles; and
   c. Informed consent will be obtained in accord with the provisions for informed consent and other applicable sections of this manual.
13.3.5.2 Research Funded by DHHS

DHHS-funded research that falls in this category must be approved by the Secretary of Health and Human Services. If the IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of pregnant women, fetuses or neonates; and the research is not approvable under the above provisions, then the research will be sent to OHRP for DHHS review. The secretary will determine the approvability based on the criteria stated in 45 CFR 46.207 (b).

13.4 Inclusion of Prisoners in Research

When the proposed research involves prisoners, the PEORIA IRB considers the additional protections outlined in Subpart C of 45 CFR 46, in their review. In addition, the PEORIA IRB will only review and approve research involving prisoners when there are members present who are uniquely qualified by their experience and training to represent the interests of prisoners in the review and approval of this research. The PEORIA IRB’s discussion, findings and decisions in regard to the requirements of 45 CFR 46.305 and 45 CFR 46.306 are documented in the PEORIA IRB meeting minutes and review checklists for each specific research protocol.

The provisions of subpart C apply to research for which (1) prisoners are intended subjects; (2) prisoners are incidental subjects; and (3) when a human subject becomes incarcerated after the research has begun.

When faced with a protocol involving the use of prisoners as research subjects, PEORIA IRB must question the issue of “mere convenience” of population selection. Research in the past took advantage of the environmental circumstances involved in the life of a prisoner, that was relatively routine and subjects were confined to one place. The environmental circumstances common in prisons may create undue influence in favor of participation, (i.e., advantages may be offered to participants via better living conditions, paid participation, parole or reduction in sentencing, social interaction outside the prison, etc.)

In addition to problems of coercion, the involvement of prisoners in research raises the question of burden and benefit. PEORIA IRB reviews carefully the research to ensure that prisoners do not bear an unfair share of the burden of participating in research, nor should they be excluded from its potential benefits.

The following applies to all research involving prisoners, regardless of funding source. The requirements in this section are consistent with Subpart C of 45 CFR 46, which applies to DHHS-funded research.
13.4.1 Applicability

This policy applies to all biomedical and behavioral research conducted under the auspices of PEORIA IRB involving prisoners as subjects. Even though the PEORIA IRB may approve a research protocol involving prisoners as subjects according to this policy, investigators are still subject to the Administrative Regulations of the Illinois Department of Corrections and any other applicable State or local law. [45 CFR 46.301]

13.4.2 Minimal Risk

The definition of minimal risk in the Subpart C is different than in the rest of the federal regulations. According to 45 CFR 46.303, minimal risk is the probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

13.4.3 Composition of the IRB

When PEORIA IRB reviews a new protocol involving prisoners as subject, the composition of the IRB must satisfy the following requirements pursuant to 45 CFR 46.304(a) and (b):

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

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

c) The prisoner representative must be a voting member of the IRB. The prisoner representative may be listed as an alternative member who becomes a voting member when needed. (HRP SOP 6.6.3)

PEORIA IRB will meet special composition requirements for all types of review of the protocol, including original review, continuing review, review of protocol amendments and review of reports of unanticipated problems involving risks to subjects.

13.4.4 Review of Research Involving Prisoners

1. The prisoner representative must review research involving prisoners, focusing on the requirements in Subpart C.
2. The prisoner representative must receive all review materials pertaining to the research (same as primary reviewer).

3. The prisoner representative must be present at a convened meeting when the research involving prisoners is reviewed. If the prisoner representative is not present, research involving prisoners cannot be reviewed or approved. The prisoner representative may attend the meeting by phone, video-conference, or webinar, as long as the representative is able to participate in the meeting as if they were present in person at the meeting. 4. The prisoner representative must present his/her review either orally or in writing at the convened meeting of the IRB when the research involving prisoners is reviewed.

5. Modifications.
   a. Minor modifications to research may be reviewed using the expedited procedure described below, using either of the two procedures described based on the type of modification.
   
   b. Modifi cations involving more than a minor change reviewed by the convened IRB must use the same procedures for initial review including the responsibility of the prisoner representative to review the modification and participate in the meeting (as described above).

6. Continuing review. Continuing review must use the same procedures for initial review including the responsibility of the prisoner representative to review the continuing review materials and participate in the meeting (as described above).

7. Expedited Review
   a. Research involving interaction with prisoners may be reviewed by the expedited procedure, if a determination is made that the research involves no greater than minimal risk for the prison population being studied. The prisoner representative must concur with the determination that the research involves no greater than minimal risk. The prisoner representative must review the research as a reviewer, designated by the chair, or consultant. This may be as the sole reviewer or in addition to another reviewer, as appropriate. Review of modifications and continuing review must use the same procedures for initial review using this expedited procedure including the responsibility of the prisoner representative.
   
   b. Research that does not involve interaction with prisoners (e.g. existing data, records review) 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.

In addition to the other requirements under 45 CFR 46, subpart A, PEORIA IRB ensures that following additional criteria are met under 45 CFR 46.305(a):

- The research under review represents one of the categories of research permissible under section 46.306(a);
- Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired;
- The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers;
- Procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides to the Board justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;
- The information is presented in language which is understandable to the subject population;
- Adequate assurance exists that parole boards will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole; and
- Where the Board finds there may be a need for follow-up examination or care of participants after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences, and for informing participants of this fact.

13.4.5 Incarceration of Enrolled Subjects

If a participant becomes a prisoner while enrolled in a research study that was not reviewed according to Subpart C and Subpart C applies, the IRB must:

1. Confirm that the participant meets the definition of a prisoner.
2. Terminate enrollment or review the research study under Subpart C if it feasible for the participant to remain in the study.
3. Before terminating the enrollment of the incarcerated participant the IRB should consider the risks associated with terminating participation in the study.
If the participant cannot be terminated for health or safety reasons, one of two options are available:

a. Keep the participant enrolled in the study and review the research under Subpart C. If some the requirements of Subpart C cannot be met, but it is in the best interests of the participant to remain in the study, keep the participant enrolled and inform OHRP of the decision along with the justification.

b. Remove the participant from the study and keep the participant on the study intervention under an alternate mechanism such as compassionate use, off label use, etc.

4. If a participant is incarcerated temporarily while enrolled in a study:

5. If the temporary incarceration has no effect on the study, keep the participant enrolled.

6. If the temporary incarceration has an effect on the study, handle according to the above guidance.

### 13.4.6 Additional Duties of the IRB

In addition to all other responsibilities prescribed for IRB in other sections of this manual, the IRB will review research involving prisoners and approve such research only if it finds that:

- the research falls into one of the following **permitted categories** [45 CFR 46.306]:
  
  a. study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

  b. study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;

  c. research on conditions particularly affecting prisoners as a class (for example, research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults);

  d. research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or wellbeing of the subject.

- any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his or her ability to weigh the risks of
the research against the value of such advantages in the limited choice environment of the prison is impaired;

- the risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers;

- procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides to the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;

- the information is presented in language which is understandable to the subject population;

- adequate assurance exists that parole Board will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in advance that participation in the research will have no effect on his or her parole; and

- where the IRB finds there may be a need for follow-up examination or care of subjects after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences, and for informing subjects of this fact.

13.4.7 Certification to DHHS

Under 45 CFR 46.305(c), the institution responsible for conducting research involving prisoners that is supported by HHS shall certify to the Secretary (through OHRP) that the IRB has made the seven findings required under 45 CFR 46.305(a). For all HHS conducted or supported research PEORIA IRB will send to OHRP a certification letter to this effect, which will also include the name and address of the institution and specifically identify the research protocol in question and any relevant HHS grant application or protocol. HHS conducted or supported research involving prisoners as subjects may not proceed until OHRP issues its approval in writing to OX on behalf of the Secretary under 45 CFR 46.306(a)(2).

Under its authority at 45 CFR 46.115(b), OHRP requires that the institution responsible for the conduct of the proposed research also submit to OHRP a copy of the research proposal so that OHRP can determine whether the proposed research involves one of the categories of research permissible under 45 CFR 46.306(a)(2), and if so, which one. The term "research proposal" includes the IRB-approved protocol, any relevant HHS grant application or proposal, any IRB application forms required by the IRB, and any other information requested or required by the IRB to be considered during initial IRB review.
The above requirement does not apply to research that is not HHS conducted or supported.

13.5 Inclusion of Children in Research

When the proposed research involves children, the PEORIA IRB considers the additional protections and the parental permission and assent procedures outlined in Subpart D of 45 CFR 46 in their review. Additional FDA regulations [21 CFR 50 (d)] are followed when applicable. The PEORIA IRB discussion, findings and determinations in regard to the requirements of 45 CFR 46.404 through 45 CFR 46.408 and 21 CFR 50.51 through 21 CFR 50.55 are documented both in the Member Review Checklist and in the IRB meeting minutes for each specific research protocol.

The PEORIA IRB considers children a vulnerable research population due to their limited intellectual and emotional capabilities and are therefore legally incompetent to give valid consent. Special procedures and consideration are required by the federal regulations for the review of research involving children as provided in 45 CFR 46 and 21 CFR 50, subpart D. The federal regulations require the IRB to classify research involving children into one of four categories and to document their discussions of the risks and benefits of the research study. The categories are as follows:

1) Research not involving greater than minimal risk [45 CFR 46.404, 21 CFR 50.51].

2) Research involving greater than minimal risk, but presenting the prospect of direct benefit to an individual subject. Research in this category is approvable provided: the risk is justified by the anticipated benefit to the subject; (b) The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and (c) Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in §46.408.

3) Research involving greater than minimal risk with no prospect of direct benefit to individual subjects, but likely to yield generalizable knowledge about the subject’s disorder or condition. Research in this category is approvable provided: (a) the risk represents a minor increase over minimal risk; (b) the intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational settings; (c) the intervention or procedure is likely to yield generalizable knowledge about the subject’s disorder or condition that is of vital importance for the understanding or amelioration of the subject’s disorder or condition: and (d) Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as set forth in [45 CFR 46.406, 21 CFR 50.53].
4) Research that is not otherwise approvable, but which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children. Research that is not approvable under 45 CFR 46.404, 45 CFR 46.405, or 45 CFR 46.406 may be conducted or funded by DHHS provided that PIRB, and the HHS Secretary, after consultation with a panel of experts, finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a significant problem affecting the health and welfare of children. The panel of experts must also find that the research will be conducted in accordance with sound ethical principles and adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians [45 CFR 46.407].

Research (a clinical investigation) subject to the FDA regulations that is not approvable under 21 CFR 50.51, 21 CFR 50.52, or 21 CFR 50.53, will send to the FDA Commissioner. After consultation with a panel of experts in pertinent disciplines (for example: science, medicine, education, ethics, law) and following opportunity for public review and comment, the Commissioner will determine either:

(1) That the clinical investigation in fact satisfies the conditions of 50.51, 50.52, or 50.53, as applicable, or

(2) That the following conditions are met: (i) The clinical investigation presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; (ii) The clinical investigation will be conducted in accordance with sound ethical principles; and (iii) Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians as set forth in 50.55.

The PEORIA IRB requires that all human subject research include adequate provisions for parental/guardian permission and assent unless the IRB has approved appropriate waivers for those requirements. The investigator is responsible for ensuring that the IRB approved documents or procedures are used, and that any deviation from the approved process and documents is reported promptly to the IRB. Unless the requirement of assent is waived for a particular study, the investigator may not enroll a minor without obtaining the affirmative assent of each minor who is enrolled.

13.6 Inclusion of Individuals who Lack Decision-Making Capacity in Research

The requirements in this section apply to all research involving persons with mental disabilities or persons with impaired decision-making capacity regardless of funding source.
Definitions

COGNITIVELY IMPAIRED: Having either a psychiatric disorder (e.g., psychosis, neurosis, personality or behavior disorders), an organic impairment (e.g., dementia) or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional functions to the extent that capacity for judgment and reasoning is significantly diminished. Others, including persons under the influence of or dependent on drugs or alcohol, those suffering from degenerative diseases affecting the brain, terminally ill patients, and persons with severely disabling physical handicaps, may also be compromised in their ability to make decisions in their best interests. (Penslar RL, Porter JP. Institutional Review Board Guidebook, Chapter 6: Special Classes of Subjects, OHRP, 1993).

COMPETENCE: Technically, a legal term, used to denote capacity to act on one's own behalf; the ability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice. (See terms Incompetence, Incapacity) Competence may fluctuate as a function of the natural course of a mental illness, response to treatment, effects of medication, general physical health, and other factors. Therefore, mental status should be re-evaluated periodically. As a designation of legal status, competence or incompetence pertains to an adjudication in court proceedings that a person's abilities are so diminished that his or her decisions or actions (e.g., writing a will) should have no legal effect. Such adjudications are often determined by inability to manage business or monetary affairs and do not necessarily reflect a person's ability to function in other situations. (Penslar RL, Porter JP. Institutional Review Board Guidebook, Chapter 6: Special Classes of Subjects, OHRP, 1993).

CLOSE FRIEND: In Illinois, “Any person 18 years of age or older who has exhibited special care and concern for the patient and who presents an affidavit to the attending physician stating that he or she (i) is a close friend of the patient, (ii) is willing and able to become involved in the patient's health care, and (iii) has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious and moral beliefs. The affidavit must also state facts and circumstances that demonstrate that familiarity.” (Health Care Surrogate Act 755 ILCS 40/10).

DECISIONAL CAPACITY: In Illinois, “the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or forgoing lifesustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician.” (755 ILCS 40/10).

GUARDIAN: DHHS and the FDA define a guardian as an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care. In Illinois, the term Guardian “means a court appointed guardian of the person who serves as a representative of a minor or as a representative of a person under legal disability.” In Illinois, a variety of guardianship appointments exist and the investigator
should take care to document that the guardian’s representation of the ward is within the scope of their authority: limited guardianship, plenary guardianship, guardian of the person, guardian of the estate, and temporary guardianship (755 ILCS 40/10).

INCAPACITY: Refers to a person’s mental status and means inability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice. Often used as a synonym for incompetence. (Penslar RL, Porter JP. Institutional Review Board Guidebook, Chapter 6: Special Classes of Subjects, OHRP, 1993).

INCOMPETENT: A legal term meaning inability to manage one's own affairs. Often used as a synonym for incapacity.

LEGALLY AUTHORIZED REPRESENTATIVE (LAR): DHHS and the FDA define a legally authorized representative as “an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research.” (46.102(c); 21 CFR 50.3). The Illinois Statutes include several different provisions for Legally Authorized Representatives (LARs). Only the Medical Patients’ Rights Act (410 ILCS 50/3.1) (from Ch. 111 1/2, par. 5403.1) provides a list of defined LARs, and this is only specifically applicable to provision of non-emergency experimental treatments in the context of a Hospital licensed to operate in Illinois. The list provided in Section 3.1. (b) of the Act includes: “the patient's guardian, spouse, parent, or authorized agent.”

Research involving persons with impaired decision-making capability may only be approved when the following conditions apply:

1. Only incompetent persons or persons with impaired decision making capacity are suitable as research subjects. Competent persons are not suitable for the proposed research. The investigator must demonstrate to the PEORIA IRB that there is a compelling reason to include incompetent individuals or persons with impaired decision-making capacity as subjects. Incompetent persons or persons with impaired decision-making capacity must not be subjects in research simply because they are readily available.

2. The proposed research entails no significant risks, tangible or intangible, or if the research presents some probability of harm, there must be at least a greater probability of direct benefit to the participant. Incompetent people or persons with impaired decision-making capacity are not to be subjects of research that imposes a risk of injury, unless that research is intended to benefit that subject and the probability of benefit is greater than the probability of harm.

3. Procedures have been devised to ensure that participant’s representatives are well informed regarding their roles and obligations to protect incompetent subjects or persons with impaired decision making capacity. Illinois State law also requires
that the surrogate act in the patient’s best interest. Thus the research protocol should be something that may treat the subject’s illness or help to discover something about the subject’s specific condition. The surrogate should make decisions based upon the subject’s known preferences. If the subject’s preference is unknown, decisions should be based on a judgment of what the subject’s preference would be in the given situation or based on what is in the subject’s best interest, in general.

13.6.1 Procedures
Initial Review of Research Proposal:

1. The PI identifies the potential to enroll vulnerable subjects in the proposed research at initial review and provides the justification for their inclusion in the study.
2. The IRB evaluates the proposed plan for consent of the specific vulnerable populations involved. If the research involves adults unable to consent, the IRB evaluates the proposed plan for obtaining permission from legally authorized representatives.
3. The IRB evaluates and approves the proposed plan for the assent of participants.
4. The IRB evaluates the research to determine the need for additional protections and considers the use of a data and safety monitoring board or data monitoring committee as appropriate.
5. The PI provides appropriate safeguards to protect the subject’s rights and welfare, which may include the addition of an independent monitor. The independent monitor is a qualified individual not involved in the research study who will determine the subject’s capacity to provide voluntary informed consent.
6. The IRB assess the adequacy of additional protections for vulnerable populations provided by the PI.

Continuing Review and Monitoring. At Continuing review the PI should identify the number of vulnerable subjects enrolled and any that needed an independent monitor in the progress report.

13.6.2 IRB Composition

The IRB membership must include at least one member who is an expert in the area of the research. Consideration may be given to adding another member who is a member of the population, a family member of such a person or a representative of an advocacy group for that population. The IRB may utilize ad hoc members as necessary to ensure appropriate scientific expertise.
13.6.3 Determination of Decision-Making Capacity

The decision-making capacity of a potential research subject should be evaluated when there are reasons to believe that the subject may not be capable of making voluntary and informed decisions about research participation.

The investigator and research staff must have adequate procedures in place for assessing and ensuring subjects’ capacity, understanding, and informed consent or assent. The IRB will evaluate whether the proposed plan to assess capacity to consent is adequate.

For research protocols that involve subjects with mental disorders that may affect decision-making capacity, the IRB may determine that capacity assessments are necessary, unless the investigator can justify why such assessments would be unnecessary for a particular group.

For research that poses greater than minimal risk, the IRB may require investigators to use independent and qualified professionals to assess whether potential subjects have the capacity to give voluntary, informed consent. Even in research involving only minimal risk, the IRB may require that the study include a capacity assessment if there are reasons to believe that potential subjects’ capacity may be impaired. It is not necessary to require a formal capacity assessment by an independent professional for all potential research subjects with mental disorders.

For research protocols involving subjects who have fluctuating or limited decision making capacity the IRB may ensure that investigators establish and maintain ongoing communication with involved caregivers. Periodic re-consent should be considered in some cases. Third party consent monitors may be used during the recruitment and consenting process, or waiting periods may be required to allow more time for the subject to consider the information that has been presented.

It is often possible for investigators and others to enable persons with some decisional impairments to make voluntary and informed decisions to consent or refuse participation in research. Potential measures include repetitive teaching, group sessions, audiovisual presentations, and oral or written recall tests. Other measures might include follow-up questions to assess subject understanding, videotaping or audio-taping of consent interviews, second opinions, use of independent consent observers, interpreter for hearing-impaired subjects, allowing a waiting period before enrollment, or involvement of a trusted family member or friend in the disclosure and decision making process.

Both investigators and IRB members must be aware that for some subjects, their decision-making capacity may fluctuate. For subjects with fluctuating decision
making capacity or those with decreasing capacity to give consent, a reconsenting process with surrogate consent may be necessary.

Although incompetent to provide informed consent, some persons may resist participating in a research protocol approved by their representatives. Under no circumstances may subjects be forced or coerced to participate.

In the event research participants become incompetent or impaired in decision making capacity after enrollment, the PI is responsible for notifying the IRB and Research office. The PI is responsible for developing a monitoring plan which follows the guidelines outlines above for incompetent and impaired decision making research participants.

13.6.4 Procedures for Determining Capacity to Consent

Decisional capacity in the research context has been interpreted by the American Psychiatric Association as requiring:

1. Ability to evidence a choice,
2. Ability to understand relevant information,
3. Ability to appreciate the situation and its likely consequences, and
4. Ability to manipulate information rationally.

A range of professionals and methods may be utilized to assess capacity. In general the consent assessor should be a researcher or consultant familiar with dementias and qualified to assess and monitor capacity and consent in such subjects on an ongoing basis. The IRB will consider the qualifications of the proposed individual(s) and whether he or she is sufficiently independent of the research team and/or institution.

The majority of studies conducted at PEORIA IRB only allow enrolling subjects who have the capacity to consent. For studies that have been approved for enrolling vulnerable populations who may lack capacity to consent, there must be someone who is able to assess capacity of each potential subject to consent. The PI may determine after appropriate medical evaluation that the prospective research subject lacks decision-making capacity and is unlikely to regain it within a reasonable period of time. Additionally, if the reason for lack of capacity is because of mental illness then a psychiatrist or licensed psychologist must confirm this judgment and document in the individual’s medical record in a signed and dated progress note.

A person who has been determined to lack capacity to consent to participate in a research study must be notified of that determination before permission may be
sought from his or her legally authorized representative to enroll that person in the study. If permission is given to enroll such a person in the study, the potential subject must then be notified. Should the person object to participating, this objection should be heeded.

13.6.5 Informed Consent and Assent

Illinois state law [ILCS 50/3.1] notes that no physician may conduct any research program or experimental procedure on a patient without the prior informed consent of the patient or, if the patient is unable to consent, the patient’s guardian, spouse, parent, or authorized agent. This act does not define who is an “authorized agent.” Further, this act does not apply to any research program or medical experimental procedure for patients subject to a life-threatening emergency that is conducted in accordance with 21 CFR 50 or 45 CFR 46. Normally, a guardian is an individual who must be appointed by a court order. The authorized agent may also be a person that the subject gave Durable Power of Attorney for Healthcare under 755 ILCS 45. However, the Illinois Surrogate Act [755 ILCS 40] notes that if a legally appointed representative has not been designated or is not available, then a surrogate from the following list may provide proxy consent for the subject: 1) guardian, 2) spouse, 3) adult son or daughter, 4) parent, 5) adult brother or sister, 6) adult grandchild, 7) close friend, or 8) guardian of the estate.

The consent process, including the use of legally authorized representatives when a subject is not able to provide prospective, legally-effective informed consent, must be outlined in the research protocol and application. The IRB should designate the category of individual, identified in the IL Surrogate Act, who can be recognized as the appropriate authorized agent.

When assessing a potential surrogate, the investigator must evaluate the surrogate to ensure that there are no reasons to disqualify them, such as lack of capacity, unavailability, inattention to the subject’s wellbeing, or unwillingness to accept the responsibility of a surrogate. The investigator should ensure the surrogate is familiar with the subject and the subjects level of impairment, is willing and able to serve as a surrogate for research decisions, understands the risks, potential benefits, procedures and time commitment, and available alternatives to research participation.

If the subject is capable of providing assent, assent should be obtained and documented. Assent may be verbal with the investigator documenting the verbal assent process or the subject may provide written assent. The assent process to be used should be detailed clearly in the research protocol and application form. If at any time during the research the subject regains the capacity to provide consent, the investigator must obtain the participant’s informed consent for continued
participation. If a subject chooses at this time to withdraw from the research, the data already collected may be used for the research, as it was collected with legally effective consent.

Depending upon the focus of the research or specific research procedures, there are other state laws that may need to be considered by the investigator and the IRB, such as the AIDS Confidentiality Act [410 ILCS 305], Consent by Minors to Medical Procedures Act [410 ILCS 210], Genetic Information Privacy Act [410 ILCS 513], and the Mental Health Treatment Preference Declaration Act [755 ILCS 43/]. Additional state laws may apply to the potential subject population or to procedures performed during the research. For example, the abused and neglected child reporting act (325 ILCS 5) and the elder abuse and neglect act (320 ILCS 20) may affect confidentiality limits, especially in instances where a certificate of confidentiality is in place.

However, at times when Illinois law is silent on other scenarios involving the use of Legally Authorized Representatives (LARs) for enrolling subjects into research, the UICOMP would expect the IRB to make provisions for obtaining surrogate permission in accord with other statutory precedents. For instance, in the Consent by Minors to Medical Procedures Act (410 ILCS 210, Chapter 111, part 4501, Section 1), the law allows a minor to give consent for medical or surgical procedures under the following conditions:

The consent to the performance of a medical or surgical procedure by a physician licensed to practice medicine and surgery executed by a married person who is a minor, by a parent who is a minor, by a pregnant woman who is a minor, or by any person 18 years of age or older, is not voidable because of such minority, and, for such purpose, a married person who is a minor, a parent who is a minor, a pregnant woman who is a minor, or any person 18 years of age or older, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age.

The Act goes on to state (410 ILCS 210/2, Ch. 111, par. 4502, Sec. 2.):

Any parent, including a parent who is a minor, may consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of a parent who is a minor shall not be voidable because of such minority, but, for such purpose, a parent who is a minor shall be deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

13.7 Informed Consent for Subjects Whose Primary Language is Not English
The requirements in this section apply to research involving non-English speaking subjects (1) for research targeting a specific subject population that is non-English speaking or that reasonably anticipates that a proportion of the subjects may be non-English speaking and (2) if a non-English speaking subject is unexpectedly encountered.

The federal regulations [45 CFR 46.116 and 21 CFR 50.20] require that informed consent information be presented to a research subject in a language that is understandable to that subject. Illinois state law [110 ILCS 305/20] requires that if a research subject does not understand English, then the informed consent document for the research must be written in a language that the person does understand.

In order to comply with both the federal regulations and state law, if a subject cannot speak English, then special procedures for the consent process must be followed. There are two acceptable methods for enrolling subjects in research when they are non-English speaking.

1) If the research targets a specific subject population that is non-English speaking or it is reasonably anticipated that, based upon the recruitment procedures, a proportion of the subjects may be non-English speaking, then the entire consent document, including recruitment materials, must be translated into the other language(s). The translated document must be approved by the IRB before it is used in the research. The IRB recommends obtaining approval for the English version of the consent document first, then submitting other language translations of the consent as an amendment. The person translating the consent document should be qualified or certified in translation and a description of the qualifications of the person conducting the translation should be submitted with the amendment. The translator (or better yet a different person) should back translate the document, checking for accuracy. The submission of the translated consent document should include an assurance from the translator that back translation has been performed and that the translation has been determined to be accurate. If the investigator is not fluent in the language used to present the consent document, a translator may be used during the consent process. Study records should document the use of a translator. There must be a witness to the translation process and the researcher should include a statement in the research records (and on the English language consent form) to indicate that the translation took place, identify the translator, and document the translator’s belief that the subject understands the research and the consent process. If the subject is a patient, a note about the translation should be made in the subject’s research and medical record as well.

2) An investigator cannot always anticipate needing a consent document in another language. In this instance, the regulations do allow the use of a ‘short form’ consent document [45 CFR 46.117 (b) (2), 21 CFR 50.27 (b) (2)]. The short form is a document written in language understandable to the subject that outlines the
information the subject will be told about the research. The investigator would then have an information sheet read to the subject in their language, usually by a translator. The information sheet may be the IRB approved English version of the consent document or another summary of the research that has been IRB approved. If the information sheet is not the English consent document, then a separate summary document must be IRB approved. Once the information sheet is orally presented to the subject in their language, the short form should be signed by the subject (or the Legally Authorized Representative [LAR]) and then a witness. The summary document should be signed by the person obtaining consent and the witness. The person witnessing the consent process must be fluent in English and the other language and must witness the entire consent process. The translator may serve as the witness. Copies of both the short form and the summary must be given to the subject. The English version and all language versions of the short form that will be used by an investigator must be IRB approved and may be approved via the expedited review procedures as an amendment.

It is important to think about the logistics of enrolling a subject that does not fully understand English. The FDA information sheets caution, “Investigators should carefully consider the ethical/legal ramifications of enrolling subjects when a language barrier exists. If the subject does not clearly understand the information presented, the subject's consent will not truly be informed and may not be legally effective.” Remember that consent is a process and in order for the subject to enroll and continue in the research, the investigator and his/her staff must be able to communicate adequately with the subject throughout the research or it is possible that the subject may be put at risk. It is possible that the subject’s compliance or data integrity may be jeopardized by the subject’s lack of understanding of the research.

When appropriate, the investigator should include the recruitment, consent and continuing participation of non-English speaking subjects in the protocol and/or application when the research is originally reviewed or via an amendment to research. The investigator should discuss how he/she will communicate with the subject throughout the course of the study.

While a translator can be very helpful in aiding with the conversations with a non-English speaking subject, routine on the spot oral translations of the consent document cannot be substituted for a written translation or the use of the short form.

13.8 Illiterate English-Speaking Subjects
If a person who speaks and understands English, but does not read and write is unexpectedly encountered, they can be enrolled in a study by "making their mark" on the consent document, when consistent with applicable state law.

A person who can understand and comprehend spoken English can be entered into a study if they are competent and able to indicate approval or disapproval by other means. The IRB may approve an oral consent process, provided the subject (1) retains the ability to understand the concepts of the study and evaluate the risk and benefit of being in the study when it is explained verbally (still competent) and (2) is able to indicate approval or disapproval to study entry.

For research that is no more than minimal risk, documentation of consent may be waived according to the criteria in Section 7.10.

For more than minimal risk research, the consent form must be read to the subjects and the subjects must be given an opportunity to ask questions. An audiotape approved by the IRB may be used. If capable of doing so, the subject signs, or marks an X to signify consent. If that is not possible, the subject will provide verbal consent. The person obtaining consent and a witness will sign the written study consent form with a statement that documents that an oral process was used and, if necessary, that the subject gave verbal consent. The consent process will also be documented in the medical record or in accord with the Institution’s policy. Signed copies of the consent form are given to the subject and, whenever possible, these documents should be provided to the subject on audio or video tape.

13.9 Informed Consent for Subjects Physically Unable to Talk or Write

An individual who can understand and comprehend spoken English, but is physically unable to talk or write, may be entered into a study if they:

- Retain the ability to understand the concepts of the study and evaluate the risk and benefit of being in the study when it is explained verbally (i.e., are competent), and
- Are able to indicate approval or disapproval to study entry.

The consent form should document the method used for communication with the prospective subject and the specific means by which the prospective subject communicated agreement to participate in the study. An impartial third party should witness the entire consent process and sign the consent document. A video tape recording of the consent interview is recommended.
13.10  Consent in American Sign Language (ASL)

For deaf subjects who are fluent in ASL, the IRB may approve a consent process using ASL and the IRB-approved written consent form. When this process is approved, the individual authorized to consent prospective subjects must use an interpreter fluent in ASL to conduct the consent process and the documentation of the consent process must conform to the requirements set forth in Section 7.7.

13.11  Consent Monitoring in Vulnerable Populations

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

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

See Section 7.3 for a detailed discussion of consent monitoring.

Section 14: PEORIA IRB Conflict of Interest

14.1  Conflict of Interest

Definitions

Financial Conflict of Interest: A financial conflict of interest (FCOI) exists when it is reasonably determines that an investigator’s significant financial interest (SFI) could directly and significantly affect the design, conduct, or reporting of the research.

Investigator: Investigator includes any person who is responsible for the design, conduct, or reporting of research, regardless of title or position.

Authorized Study Personnel (ASP): The Project Director or Principal Investigator and any other person identified as senior/key personnel by the University in the grant application, progress report, or any other report submitted to the PHS. For purposes of this policy, “Authorized Study Personnel” includes the ASP’s spouse and dependent children.

NON-SPONSORED CONFLICT OF INTEREST DISCLOSURE FORM (NSCOIDF): This form is utilized to disclose conflict of interests for any nonsponsored

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research. The PI is allowed to sign on behalf of his/her research team if the study is non-sponsored.

**PART I SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM (SFIDF-I):** This form is utilized by each authorized study personnel to disclose financial interests for any sponsored research. Additionally, this form must be submitted for any non-sponsored greater than minimal risk studies. If a financial interest is disclosed by an authorized study personnel, the Part II SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM must be submitted by that individual.

**PART II SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM (SFIDF-II):** This form is utilized by each authorized study personnel that discloses a financial interest for any sponsored research on the SFIDF-I. This form is used to present a plan for managing the conflict in order to minimize the effect on the design, conduct, or reporting of the research and/or the integrity of the human subject protection program. The OHRO may assist the investigator in the development of a management plan.

**SIGNIFICANT FINANCIAL INTEREST:** An SFI is defined at 42 C.F.R. § 50.603. SFI means a financial interest consisting of one or more of the following interests of the investigator (and spouse and dependent children) related to the Institutional Responsibilities of an Investigator:

a. With regard to any **publicly traded entity**, a significant financial interest (SFI) exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure and the value of any equity interest in the entity as of the date of disclosure, when aggregated, exceeds $5,000.

   i. For purposes of this definition, remuneration includes salary and any payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, paid authorship); equity interest includes any stock, stock option, or other ownership interest, as determined through reference to public prices or other reasonable measure of fair market value;

b. With regard to any **non-publicly traded entity**, a significant financial interest (SFI) exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure, when aggregated, exceeds $5,000, or when the Investigator or Investigator’s family holds any equity interest (e.g., stock, stock options, or other ownership interest); or
c. Intellectual property rights and interests (e.g., patents, trademarks, copyrights, licensing agreements, and royalties from such rights), upon receipt of income related to such rights and interests.

d. HHS/PHS Investigators must also disclose the occurrence of reimbursed or sponsored travel. There is a $5,000 de minimis for reporting sponsored or reimbursed travel.

e. Any other relationships that might present a conflict of interest, such as fiduciary interests (paid or unpaid positions as director, officer, or other management role in a for-profit or not-for-profit entity sponsoring or related to the research) or interests in which compensation or the value of equity or property rights or the combination of interests might affect the outcome of the research.

The following SFIIs and sponsored or reimbursed travel are exempt (42 CFR 50.603) from the disclosure requirements:

a. salary, royalties or other remunerations paid by the Institution; including intellectual property rights assigned to the Institution and agreements to share royalties related to such rights;

b. income from investment vehicles (mutual funds or retirement account that are not managed directly by the individual);

c. income from seminars, lectures, or teaching engagements sponsored by a Federal, state, or local government agency, an Institution of higher education as defined by 20 U.S.C. 1001(a); an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education;

d. income from service on advisory committees or review panels for a Federal, state, or local government agency, an Institution of higher education as defined by 20 U.S.C. 1001(a). (e.g., NIH review panel)

**ORGANIZATIONAL CONFLICT OF INTEREST:** A situation in which the financial investments or the significant financial or proprietary interests of the Institution or of a Key Institutional Leader, either compromise or reasonably appear to compromise the integrity of research related business transactions or the design, conduct, reporting, review, or oversight of the research, which includes but is not limited to sponsored research and human subjects research.

**MANAGEMENT PLAN:** A written plan describing the mechanisms and techniques by which known or apparent conflict of interest related to the research may be
managed, reduced, or eliminated. Depending on the nature of the conflict and the management plan, reviewing bodies of the management techniques may include the Department/Unit Head, Dean and/or other institutional officials as relevant. The COI is described and the management plan is operationalized through the completion of the SFIDF-I and SFIDF-II. The OHRO may provide a recommendation for a management plan found to be acceptable by the IRB. If the COI involves an UICOMP investigator or University official, the UIC COI office will be notified and be involved in the development of the management plan. The IRB has final authority to approve the research, including the management mechanisms being implemented in the research protocol.

**APPARENT CONFLICT OF INTEREST** (also called perceived conflict of interest or appearance of conflict of interest): The possibility that a conflict might adversely affect the credibility of the research or the UICOMP HSPP if the conflict were publicly exposed.

**REBUTTABLE PRESUMPTION:** An assumption that an investigator with a significant financial interest may not be involved in research that uses human subjects. The rule is not intended to be absolute; an investigator with a significant financial interest may rebut the presumption by demonstrating facts that constitute compelling circumstances, in the opinion of the reviewing bodies (Department/Unit Head, Dean and IRB). If compelling circumstances are found, the individual is allowed to design, conduct, report, or manage the research under conditions specified in an approved management plan and in accordance with regulatory and ethical requirements. An investigator with a significant financial stake in the outcome of the research will need to provide both a sufficient reason detailing his/her unique contribution to the research and a reasonable plan that will protect human subjects, the research data, and the integrity of the HSPP.

Conflicts of interest must be disclosed through the submission of the appropriate completed Conflict of Interest Disclosure Forms into IRBNet at:

1. Initial review whether the research is eligible for exempt, expedited, or full review;
2. If the Principal Investigator (PI) changes or authorized study personnel are added to a project via Change in Research;
3. At continuing review; or
4. Whenever a conflict changes, arises or is discovered (via Change in Research).

PIs, and authorized study personnel must monitor whether new conflicts change or arise on a continuous basis until a final report is approved by the PEORIA IRB.

A PI is reminded of the COI regulation and the PEORIA IRB Investigator Conflict of Interest Disclosure Policy at initial review through the completion of the Conflict of Interest Disclosure Forms regardless of sponsorship.

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Non-Sponsored Projects [Utilize the NON-SPONSORED CONFLICT OF INTEREST DISCLOSURE FORM (NSCOIDF)]

The PI is required to complete and submit the Non-Sponsored Conflict of Interest Disclosure Form (NSCOIDF) to attest that his/her research team has no financial conflicts of interest. The PI must electronically sign the IRBNet initial submission package.

If a PI changes or authorized study personnel are added to a non-sponsored project via Change in Research, the new or existing PI must re-submit a NSCOIDF to attest that his/her new research team has no financial conflicts of interest. The PI is required to electronically sign the IRBNet submission package.

If a project remains non-sponsored at the time of continuing review, an updated NSCOIDF must be submitted into IRBNet and the submission package must be signed electronically by the PI.

Sponsored Project or Non-Sponsored Projects that are Greater than Minimal Risk [Utilize the PART I SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM (SFIDF-I) and PART II SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM (SFIDF-II)]

Sponsored projects or non-sponsored greater than minimal risk projects require the physical signatures of the PI and each authorized study personnel on the Part I Significant Financial Interest Disclosure Form (SFIDF-I)

If a financial interest is disclosed by the PI and/or authorized study personnel, the Part II SIGNIFICANT FINANCIAL INTEREST DISCLOSURE FORM (SFIDF-II) must also be submitted by that individual. A management plan is operationalized through the completion of the SFIDF-II. The IRB has final authority to approve the research, including the management mechanisms described within the SFIDF-II.

If a PI changes or authorized study personnel are added to a sponsored project or non-sponsored greater than minimal risk project via Change in Research, the new PI, and/or authorized study personnel are required to physically sign a new or updated SFIDF-I.

If a financial interest is disclosed by the PI and/or authorized study personnel on the new or updated SFIDF-I, the SFIDF-II must also be submitted by that individual. A management plan is operationalized through the completion of the SFIDF-II. The IRB has final authority to approve the research, including the management mechanisms described within the SFIDF-II.

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Previously reported conflicts must be disclosed by the PI and authorized study personnel at continuing review on the SFIDF-I and through the completion of the SFIDF-II, if applicable. The IRB has final authority to approve the management mechanisms described within the SFIDF-II.

14.1.1 Required Training in Conflict of Interest

All investigators and authorized study personnel must complete the CITI Conflict of Interest mini-course prior to engaging in research and at least every four years per the U.S. Public Health Service (PHS) Financial Conflict of Interest (FCOI) Regulation that was effective August 24, 2012. The UICOMP continuing education requirement, however, stipulates COI training every three (3) years after certification of initial COI education for as long as they are involved in human subject research.

Financial COI training is required when:

- Any Investigator or authorized study personnel is new to using the PEORIA IRB

It is the responsibility of the PI to ensure all authorized study personnel are COI-trained.

New research protocols will not be accepted from PIs who have not completed the initial COI education requirements. No investigator or authorized study personnel listed on the application may participate in any human subject research until they have completed the initial COI education requirements. Upon completion of the initial COI and all other initial education requirements (please see Section 3.3 “Required Training in Human Subject Protections”), a Change in Research Form may be submitted and approved to add individuals as authorized study personnel on the study.

14.1.2 Continuing COI Education and COI Re-Training

Continuing Education

Investigators must submit evidence of refresher training prior to the expiration of their initial COI training certification. New research protocols and applications for continuing review from PIs who have not submitted satisfactory evidence of continuing COI education will require re-assignment of the PI to an appropriate coinvestigator or other authorized study personnel that have completed his/her continuing COI education. The PI will be removed from the study until COI and all other required refresher trainings (see Section 3.3) are completed and a Change in Research Form requesting that the PI be added back to the study is submitted and approved.
Other authorized study personnel who have not submitted evidence of COI refresher training after their initial training has expired will be administratively removed from studies at the time of continuing review. Once COI and all other required refresher trainings (see Section 3.3) are completed, a Change in Research Form requesting that the individual be added back to the study must be submitted and approved before the individual may participate in the study.

**COI-Re-Training**

Financial COI re-training is required when:

- UICOMP revises the “Investigator Conflict of Interest Disclosure Policy for Human Subjects Research” in any manner that affects the requirements of the Investigator to comply with the PHS regulation (changes to this policy will be communicated through articles in the quarterly HSPP Newsletter, emails to users of IRBNet and presentations at seminars, departmental meetings and courses where students will be engaging in research).

- The PEORIA IRB finds that any investigator or authorized study personnel is not in compliance with the UICOMP “Investigator Conflict of Interest Disclosure Policy for Human Subjects Research” or with the PEORIA IRB-approved management plan (please see Section 2.13 “Reporting Policy for Serious or Continuing Noncompliance”).

Investigators found to be out of compliance with the Conflict of Interest Disclosure Policy will be required to complete the National Institutes of Health Financial Conflict of Interest web-based Tutorial. A certification of completion must be submitted to the IRB Office as evidence of COI re-training.

**14.1.3 Policy**

A. Federal regulations (Public Health Service, National Science Foundation, Food and Drug Administration, on) and University policies require that investigators disclose significant financial interests related to the research that in any way could bias the design, conduct or implementation, management, and reporting of research data. The regulations further require that the University have a mechanism for the investigators to disclose real or potential conflicts and for the development of a management plan that manages, eliminates, or reduces the potential conflict. The disclosure and management of the conflict must occur before any funds are released to the grantee institution and contractors (investigator) for expenditure.

B. The IRB must consider in its review the disclosure of conflicts of interest that may affect the human subjects enrolled in the research, the integrity of the research, or the integrity of the HSPP. For the HSPP and the IRB, the disclosure of conflicts goes beyond financial conflicts, and includes
institutional conflicts of interest and other potential conflicts, real or apparent, that could affect the research, the rights or safety of the research subjects, or the integrity of the HSPP. The HSPP standards regarding conflicts of interest apply equally to all research whether the study is sponsored, i.e., funded by an external organization, or non-sponsored.

14.1.4 Procedure

At UICOMP, conflicts of interest are reported through transactional processes. The transactional disclosures are linked to specific research protocols.

A. PEORIA IRB Project/Protocol Review Form.

1. The Principal Investigator is responsible for identifying significant financial conflicts of interest that may exist for all investigators and/or authorized study personnel associated with a research protocol. In addition, other real or apparent conflicts of interest that may affect human subject protections or the integrity of the HSPP, including institutional conflicts of interest, must be disclosed by the PI.

2. The PI must disclose conflicts of interest with the initial review submission into IRBNet. Additionally, conflicts of interest must be disclosed when investigators and/or authorized study personnel are added to a project, at continuing review, or whenever a conflict arises or is discovered, using the appropriate PEORIA IRB forms. Conflicts of Interest must be disclosed whether the research is eligible for exempt, expedited, or full review.

3. The appropriate Conflict of Interest Disclosure Forms must be submitted into IRBNet at the occasions described above. Once submitted into IRBNet, the submission records are maintained as electronic records for perpetuity on IRBNet’s secure, enterprise-class data center.

4. When the submitted SFIDF-I discloses a significant financial conflict of interest, the OHRO will contact the Principal Investigator to complete the SFIDF-II. The IRB office may assist in the development of a management plan for significant financial conflicts, and, potentially, for institutional conflicts of interest. If the COI involves an UICOMP investigator or University official, the Campus (UIC) COI office will be notified and be involved in the development of the management plan.

5. Once a management plan is determined to be acceptable by the OHRO it should be submitted into IRBNet for review by the IRB.

6. The IRB has final authority to approve the research, including the management mechanisms being implemented in the research protocol as described in the management plan. The IRB will make a determination regarding the level of disclosure required in the consent process, as well as other measures to reduce or eliminate the potential conflict. If the IRB determines additional disclosure or measures to protect subjects are necessary,
revisions will be requested to the research protocol, protocol application, and/or consent document/process as part of the review.

B. University Proposal Approval Form (PAF) – (UICOMP Faculty proposals only)

1. In this transactional disclosure mechanism, investigators are required to disclose financial conflicts of interest on each PAF that is submitted to University ORS Grants and Contracts Pre-Awards. All applications for research funding and support are processed using the PAF mechanism. ORS forwards all PAF forms with disclosed conflicts of interest to the campus (UIC) COI Office for review.

2. The UIC COI Office contacts the Principal Investigator and requests the completion of the SIGNIFICANT FINANCIAL INTEREST – DISCLOSURE AND MANAGEMENT PLAN (SFI-DMP): The SFI-DMP has two parts. Part I of the form is utilized to disclose the Significant Financial Interest (SFI) and determine if a SFI represents a Financial Conflict of Interest (FCOI) with an Investigator’s research. Part II is utilized to present a plan specific to the research project for managing the Investigator’s FCOI. The SFI-DMP serves to minimize the effect of FCOIs on the design, conduct, or reporting of the research and/or the integrity of the human subject protection program. The COI Office assists the investigator in the SFI-DMP’s development. Once a SFI-DMP is determined to be acceptable by either the COI-HSR subcommittee or the CRC, the COI Office will communicate the recommendation to OHRO for review by the IRB.

3. When a PAF discloses a conflict of interest and indicates that the research involves human subjects, the campus COI Office will notify the OHRO of the existence of a potential conflict of interest.

4. The OHRO will match the conflict disclosure identified by the campus COI Office with the applicable research protocol. The OHRO will ensure that final IRB approval is not granted until the UIC COI Office has communicated the recommendation for a management plan to the IRB for its review.

Annual Disclosure - (UICOMP Faculty only)

A. Illinois Law and University statutes and regulations require each salaried, member of the University academic staff complete a Report of Non-University Activities (RNUA). The RNUA must be completed at least annually, and updated if activities change during the year.

B. On an as-needed basis, the campus (UIC) COI Office will communicate with the OHRO to ensure that potential conflicts of interest relating to human subjects research are reported to the PEORIA IRB and any information that is pertinent to the IRB’s review of the research is made available to OHRO.
I. Development of Management Plan SFIDF-II and IRB Review.

A. When a potential conflict of interest involving human subject’s research is disclosed, the investigator must respond to the rebuttable presumption in the SFIDF-II. Conflicts of interest need not always be eliminated; however, they need to be managed in order to reduce the potential for the conflict to adversely affect the conduct of the research, including the protection of human subjects or the integrity of the research data. A research protocol with an identified potential conflict of interest will not receive final approval from the IRB until a management plan, SFIDF-II, is received from the investigator.

B. The five main elements of the SFIDF-II include:
   1. Description of conflicted investigator’s role and function in the research.
   2. Description of the nature of the conflict.
   3. Description of how the significant financial interest is related to the research.
   4. Justification for the inclusion of the conflicted investigator/conflict in the research.
   5. Description of the proposed management techniques/mechanisms.

C. The SFIDF-II may include one or more specific techniques or strategies including, but not limited to, the following:
   1. Disclosure of the conflict in writing or orally, as is appropriate, to the public, the sponsor, the IRB, researchers and other participants, publishers, or conference organizers and attendees;
   2. Disclosure of the conflict to potential research subjects through the informed consent process (sample disclosure language for the consent document is available from the UIC COI web page. Monitoring and/or auditing of the conduct of the research by independent overseers or a panel (e.g., data safety monitoring board) who have no professional ties to the research or direct reporting relationships to the investigators;
   3. Modification of the research plan, methodology, or performance to add additional protections or to minimize the role of the conflicted individual;
   4. Disqualification from participation in the conduct of the research or restriction of a researcher’s role in all or a portion of the research (e.g., cannot conduct data analysis, restricted from recruiting human subjects, and/or conducting the informed consent process);
   5. Requirement that a monitor or research subject’s ombudsperson be present during recruitment and/or the informed consent process;
   6. Divestiture or restructuring of the significant financial interest;
   7. Modification of the significant financial interest or severance of relationships that create actual or perceived potential conflicts of interest.
D. The submission (initial review, continuing review, amendment) will not be considered for final approval until a SFIDF-II is submitted to the PEORIA IRB via IRBNet, except when a lapse in IRB approval would increase risk to subjects or affect the integrity of the research.

E. The IRB will evaluate the SFIDF-II in the context of the research protocol. The IRB may approve the research with the management plan as presented in the SFIDF-II, or the IRB may modify the management plan, including the requirement of additional measures to manage, reduce or eliminate a potential conflict in the research.

F. The IRB has final authority to approve the research, including the management mechanisms being implemented in the research protocol as described in the SFIDF-II. The IRB will make a determination regarding the level of disclosure required in the consent process. The IRB may require other measures to manage, reduce or eliminate the potential conflict. If the IRB determines additional disclosure or measures to protect subjects are necessary, revisions will be requested to the research protocol, protocol application, and/or consent document/process.

14.2 PEORIA IRB Member, Ad Hoc Consultant and OHRO Staff Conflict of Interest

The members of PEORIA IRB, ad hoc consultants and OHRO staff must sufficiently manage any potential conflict of interest with their role in protecting the rights of research subjects. This means, they must have no significant financial interest in the sponsor of a study under review or the study site that is engaged in the research [45 CFR 46.107(e)] [21 CFR 56.107(e)] or hold conflicting academic relationships.

No members of the PEORIA IRB committee, ad hoc consultants and OHRO staff may vote or take part in the discussion of a protocol/project in which a vested interest may be present. IRB members, ad hoc consultants and OHRO staff are responsible for the self-identification of their conflicting interests in advance of convened IRB review, review using the expedited procedure, review of unanticipated problems involving research subjects or others and the review of noncompliance with regulations or laws or the requirements of the IRB.

Federal regulations at 45 CFR 46.107(e) and 21 CFR 56.107(e) stipulate that no IRB member may participate in the IRB's initial or continuing review of a project in which the member has a conflicting interest, except to provide information requested by the IRB. This includes the Chairman or any member of the OHRO staff that may be acting as a principal investigator, co-investigator, or research personnel or be involved in the study in any way. IRB members (including the Chair and OHRO staff) recuse themselves from the meeting room when the IRB reviews research in which they have a conflicting interest.
interest, and will be noted in the IRB meeting minutes as absent with an indication that a conflict of interest was the reason for the absence. An IRB member (including the Chair and OHRO staff) with a conflicting interest will not be counted towards quorum.

An IRB member, ad hoc consultant, or OPRS staff member is automatically considered to have a conflicting interest when the member/consultant/staff or the member’s/staff’s or ad hoc consultant’s family has any involvement in the design, conduct, or reporting of the research or a significant financial interest (SFI) related to the research that meets the following thresholds:

A. Remuneration received from an external entity at present or in the 12 months preceding the disclosure that when aggregated for the individual and family members the value totals or exceeds $5,000. The $5,000 threshold also applies to salary, royalties, and other payments aggregated for the individual and family members.

B. Ownership in a publicly-traded equity (plus any remuneration) when the value meets or exceeds $5,000.

C. Any level of ownership in a privately-held equity regardless of the dollar value.

D. Intellectual property rights (e.g., patents, trademarks, copyrights, licensing agreements, and royalties from such rights).

E. Any other relationships that might present a conflict of interest, such as fiduciary interests (paid or unpaid positions as director, officer, or other management role in a for-profit or not-for-profit entity sponsoring or related to the research) or interests in which compensation or the value of equity or property rights or the combination of interests might affect the outcome of the research.

F. Any gift regardless of value from a company or other entity that has an interest in the outcome of the human subject’s research under review.

The following SFIs are exempt (42 CFR 50.603) from the disclosure requirements:

i. salary, royalties or other remunerations paid by the University of Illinois; including intellectual property rights assigned to the University of Illinois and agreements to share royalties related to such rights;

ii. income from investment vehicles (mutual funds or retirement account that are not managed directly by the individual);

iii. income from seminars, lectures, or teaching engagements sponsored by a Federal, state, or local government agency, an Institution of higher education as defined by 20 U.S.C. 1001(a); an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education;

iv. income from service on advisory committees or review panels for a Federal, state, or local government agency, an Institution of higher education as defined by 20 U.S.C. 1001(a). (e.g., NIH review panel)
“Other Interest” includes but is not limited to:

A. Supervision of a project (i.e., an IRB member is the investigator’s Faculty Sponsor, or a situation exists in which any investigator must report to or is under the professional supervision of the IRB member);
B. Personal relationship with investigator (IRB member has an immediate family relationship or other close personal relationship with the investigator);
C. Other personal interests that may be conflicting interests, such as if (a) the IRB member has an interest that he/she believes conflicts with the member’s ability to review a project objectively; or (b) the IRB member is in direct competition with the investigator for limited resources, funding, sponsorship, or research subjects, (c) the IRB member is considered a personal or professional adversary of the investigators, or (d) the IRB member is a subordinate to the investigator. For (b), (c), and (d), the IRB member should disclose the circumstances to the IRB Chair or OPRS Director for a determination of whether a conflicting interest exists; and/or
D. Any other reason for which the member or consultant believes that he or she cannot provide an independent review.

Recruitment Incentives

Payment arrangements among sponsors, organizations, investigators, and those referring research participants may place participants at risk of coercion or undue influence or cause inequitable selection. Payment in exchange for referrals of prospective participants from researchers (physicians) (“finder’s fees”) is not permitted. Similarly payments designed to accelerate recruitment that is tied to the rate or timing of enrollment (“bonus payments”) are also not permitted.

14.3 Organizational Conflict of Interest

Definitions

Organizational Conflict of Interest. A situation in which the financial investments or the significant financial or proprietary interests of an institution, or of a Key Institutional Leader, either compromise or reasonably appear to compromise the integrity of research related business transactions or the design, conduct, reporting, review, or oversight of the research, which includes but is not limited to sponsored research and human subjects research.

Key Institutional Leader: An administrator of an institution at the dean or equivalent level or higher and/or who possesses delegated organizational decision-making authority over personnel appointments, salaries, promotions, and/or allocation of organizational
resources for individuals involved in the design, conduct, reporting, review, or oversight of research.

**Significant Financial Interest**: A financial interest is significant when there is a reasonable probability that the existence of the financial interest could bias research or a research related business transaction. The following financial interests of the Institution or of Key Institutional Leaders are considered significant:

1. The institution holds a patent, license, or other intellectual property interest in a product or technology that is the subject of research.

2. The institution holds investments in a non-publicly traded entity that has a separate financial or business relationship with the institution, such as sponsored research.

3. The institution holds investments in a publicly traded entity valued at $100,000 or more and the entity has a separate financial or business relationship with the institution, such as sponsored research.

4. The institution receives a donation exceeding $100,000 from a donor who also has an interest in the institutional research or a procurement contract.

5. A Key Institutional Leader holds either a financial interest valued at $25,000 or more or a fiduciary responsibility in a company that is reasonably related to a research project or has approval authority over the research project.

PLEASE NOTE: The publicly and non-publicly-traded equity and ownership interests of UICOMP are unknown. UICOMP does not manage an investment portfolio.

Institutional Financial Interests also pertain to the financial or business interests of UICOMP Officials (and those of the UICOMP Official’s spouse or partner). UICOMP Officials are persons holding the following positions, including those persons holding these positions in a temporary or interim capacity:

- UICOMP Institutional Official
- UICOMP Executive Directors
- UICOMP Senior Associate Dean for Research
- UICOMP Department Heads

The financial or business interests of UICOMP Officials are disclosed through the annual Report of Non-University Activities (RNUA) process at UICOMP. The RNUA is a process by which academic staff members disclose and obtain prior written approval for non-university income-producing activities or activities that might conflict with an individual’s university responsibilities. The RNUAs of academic staff members are maintained by the Office of Faculty Affairs at UICOMP.

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The following disclosures are completed at START myDisclosures:
https://myresearch.uillinois.edu/myDisclosures/

• Report of Non-University Activities (COCI Policy)
• Sponsor Specific Questionnaire (sponsored research and federal regulations)

The University COI Officer will review a Significant Financial Interest in consultation with the appropriate UEOs, legal counsel, and the Chair of the Conflict Review Committee to determine if it is reasonably related to University research and, therefore, constitutes an Organizational Conflict. All Organizational Conflicts must be either managed or eliminated.

When the Organizational Conflict involves University officers, the management plan will be referred to the University of Illinois Board of Trustees committee on Governance, Personnel, and Ethics for final approval.

Management or Elimination of Organizational Conflicts

Organizational Conflicts will be either managed or eliminated, as follows:

1. Business transactions: Each university will manage or eliminate Organizational Conflicts in business transactions according to its respective processes and relevant laws. The process is guided by the Office of Business and Financial Services policies on purchasing.

2. Sponsored Programs and Human Subjects Research: Each university will manage Organizational Conflicts in research and sponsored programs according to its respective processes. At a minimum, the management plan will include:

   • a description of the nature of the conflict;
   • justification for research to be carried out at the University of Illinois; and
   • conflict management mechanisms, which may include, for example: disclosure of the conflict to the research sponsor and/or disclosure of the conflict in publications or presentations.

Additional conflict management mechanisms for human subjects research may include, but are not limited to:

   • Disclosure of the conflict to the IRB;
   • Disclosure of the conflict to potential research participants during the informed consent process; and
   • Disclosure to an independent advisory board that will monitor the data.
The IRB has final authority to approve human subjects research and may require additional safeguards to be implemented to guard against research bias, including increased disclosures of Organizational Conflicts to the research participants.

Any Key Organizational Leader with an Organizational Conflict reasonably related to a sponsored project or human subjects research will not be allowed to conduct the review or oversight of the research. A qualified substitute will be appointed by the University administrator that serves at the next higher level of review.

**Section 15: FDA-Regulated Research**

FDA regulations apply to any research that involves a test article in a clinical investigation involving human subjects as defined by the FDA regulations. For FDA regulated research, the IRB must apply the FDA regulations at 21 CFR 50 and 21 CFR 56, as well as, where appropriate, 45 CFR 46.

Use of investigational drugs must be conducted according to FDA IND regulations, 21 CFR Part 312, and other applicable FDA regulations. Use of an investigational device in a clinical trial to obtain safety and effectiveness data must be conducted according to FDA’s IDE regulations, 21 CFR Part 812, and other applicable FDA regulations. The following procedures describe the review of FDA-regulated research conducted under the auspices of PEORIA IRB.

**15.1 Definitions**

**Dietary Supplement.** A dietary supplement is a product taken by mouth that is intended to supplement the diet and that contains a dietary ingredient. The dietary ingredients in these products can include vitamins, minerals, herbs and other botanicals, amino acids, other dietary substances intended to supplement the diet, and concentrates, metabolites, constituents, extracts, or combinations of the preceding types of ingredients. Dietary supplements can be found in many forms such as tablets, capsules, softgels, liquids, or powders. See section 201(ff) of the FD&C Act (21 U.S.C. 321(ff)).

**Investigational Drug.** An investigational drug for clinical research use is one for which the PI or a sponsor has filed an IND application (21 CFR Part 312) or an approved drug that is being studied for an unapproved or approved use in a controlled, randomized, or blinded clinical trial.

**Investigational Device.** A medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. As further stated, a device is any healthcare product that does not achieve its primary intended purpose by chemical action or by being metabolized.
**IND.** IND means an investigational new drug application in accordance with 21 CFR Part 312.

**IDE.** IDE means an investigational device exemption in accordance with 21 CFR 812.

**Emergency Use.** Emergency use is defined as the use of an investigational drug or biological product with a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

**Significant Risk (SR).** Significant risk device means an investigational device that:
1. Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; or
2. Is purported or represented to be for a use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; or
3. Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
4. Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

**Non-Significant Risk (NSR).** A non-significant risk device is an investigational device other than a significant risk device.

**Humanitarian Use Device (HUD).** Humanitarian Use Device is a device intended to benefit patients by treating or diagnosing a disease that affects fewer than 4,000 individuals in the United States per year.

**15.2 FDA Exemptions**

The following categories of clinical investigations are exempt from the requirements of FDA regulations for IRB review:

1. Emergency use of a test article, provided that such emergency use is reported to the IRB within 5 working days. Any subsequent use of the test article at the institution is subject to IRB review. [21 CFR §56.104(c)]

2. Taste and food quality evaluations and consumer acceptance studies, if wholesome foods without additives are consumed or if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural, chemical, or environmental contaminant at or below the level found to be safe, by the 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 [21 CFR §56.104(d)].
15.3 Procedures

A. At initial submission, the PI must indicate whether the research involves a test article and is a clinical investigation involving human subjects on the application form.

B. During the pre-review process, the IRB Director will confirm whether FDA regulations are applicable using the FDA Determination Checklist. If FDA regulations apply and the research is not exempt, the IRB Director will indicate on the agenda that the protocol is an FDA-regulated study.

C. If required by the sponsor, the PI may submit a Statement of GCP Compliance in order to obtain the IRB Chairman’s signature certifying that the IRB is in compliance with GCP Guidelines as consistent with the U.S. FDA regulations (21 CFR Parts 50 and 56) and the DHHS regulations (45 CFR Part 46) pertaining to the protection of human subjects.

15.4 Dietary Supplements

Research involving dietary supplements may or may not fall under FDA regulations. Under the Dietary Supplement Health and Education Act (DSHEA) of 1994, a dietary supplement is not considered a drug and is not subject to the premarket approval requirements for drugs if the intended use for which it is marketed is only to affect the structure or any function of the body (i.e., not intended to be used for a therapeutic purpose). Whether a study falls under FDA oversight is determined by the intent of the clinical investigation. If the clinical investigation is intended only to evaluate the dietary supplement’s effect on the structure or function of the body, FDA regulations do not apply. However, if the study is intended to evaluate the dietary supplement’s ability to diagnose, cure, mitigate, treat, or prevent a disease, FDA regulations to apply. Studies involving the ingestion of dietary supplements that are not subject to FDA oversight are still covered by Office of Human Research Protections (OHRP) regulations, and therefore must be reviewed by the Institutional Review Board (IRB).

Similarly, whether an IND is needed for a study evaluating a dietary supplement is determined by the intent of the study. If the study is intended only to evaluate the dietary supplement’s effect on the structure or function of the body, an IND is not required. However, if the study is intended to evaluate the dietary supplement’s ability to diagnose, cure, mitigate, treat, or prevent a disease, an IND is required under part 312. For example, a study designed to study the relationship between a dietary supplement’s effect on normal structure or function in humans (e.g., calcium and bone mass) or to characterize the mechanism by which a dietary supplement acts to maintain such structure or function (e.g., fiber and bowel regularity) would not need to be conducted under an IND. However, a study designed to evaluate a dietary supplement’s ability to prevent osteoporosis or to treat diarrhea or constipation would need to be conducted under an IND under part 312.

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15.4.1 Researcher Responsibilities

The researcher must submit all of the following with their application to the IRB:

- List all dietary supplements or foods to be used in this study. Include the following:
  a) Name
  b) Chemical formula
  c) Dosage strength(s)
  d) Method/route of administration
  e) Mechanism of action
  f) Known drug interactions
  g) Manufacturer/Sponsor
  h) Name of supplier
  i) IND number if applicable and letter from the FDA or industry sponsor setting forth the IND number.
  j) Documentation of approval for use in humans
  k) Documentation or certification of quality or purity

- The rationale for choosing the supplement and dose.
- Justification and safety information if over-the-counter supplements will be administered for non-approved indications or if doses or routes of administration or subject populations are changed.
- Explain whether the use of the supplement involves a route of administration or dosage level, use in a subject population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with its use.
- Provide a plan for the storage, dispensing, handling, inventory control, and disposal of supplements.
- If there is no IND, confirmation that the study will be limited to evaluation of the dietary supplement’s effect on the structure or function of the body.
IND studies, a summary of preclinical and early human studies. All of the requirements for an IND study described in Section 14.6 below apply.

### 15.5 IND/IDE Requirements

Researchers who employ a test article classified by the Food and Drug Administration as an investigational new drug (IND), biologic, or investigational device (IDE) must assure the IRB that they are complying with the FDA's regulations (including 21 CFR 50, 56, 312, 320 600, and 812). If applicable, the IND or IDE letter from the FDA including the number assigned to the test article/device must be filed with the IRB when the application for review is submitted.

The IRB Director will confirm that the IND/IDE number provided in the IRB submission matches that recorded on the sponsor protocol, communication from the sponsor, or communication from the FDA. Validation of the IND/IDE number is required before IRB approval can be granted.

Please Note: An IND goes into effect 30 days after the FDA receives the IND, unless the sponsor receives earlier notice from the FDA.

If the research involves drugs or devices and there is no IND/IDE, the PI must provide a rationale why it is not required.

The IRB will review the application and determine:

1. Whether there is an IND/IDE and if so, whether there is appropriate supporting documentation.
2. If the research involves drugs or devices with no IND/IDE, and whether the research meets the criteria below.

**Investigational New Drugs (INDs).** With limited exceptions, an IND is required for clinical investigations involving drugs. A “Clinical Investigation” is an experiment in which a drug is administered or dispensed to, or used involving, one or more human subjects. For the purposes of the IND regulations, an experiment is any use of a drug (whether approved or unapproved) except for the use of a marketed drug in the course of medical practice. 21 CFR 312.3(b). “Drugs” include articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease and articles (other than food) intended to affect the structure or any function of the body of man or other animals. 21 USC 321 SEC. 201. Biologic products may be classified as drugs as well as certain cosmetics, nutritional supplements, and foods. Additional information regarding when INDs are required is available in FDA guidance.

**Investigational Devices.** An investigational device is a medical device that is the subject of a clinical investigation. Clinical investigations conducted to evaluate safety and
effectiveness of medical devices must be conducted according to the requirements of the IDE regulations [21 CFR part 812]. Certain clinical studies of devices (e.g., certain studies of lawfully marketed devices) may be exempt from the IDE regulations [21 CFR 812.2(c)].

Unless exempt from the IDE regulations, an investigational device must be categorized as either "significant risk" (SR) or "nonsignificant risk" (NSR). The determination that a device presents a nonsignificant or significant risk is initially made by the sponsor. The proposed study is then submitted either to FDA (for SR studies) or to an IRB (for NSR studies). The FDA and/or the IRB will confirm the categorization of the device.

The IRB's SR/NSR determination has significant consequences for the study sponsor, FDA, and prospective research subjects. SR device studies must be conducted in accordance with the full IDE requirements [21 CFR part 812], and may not commence until FDA and IRB approval are granted. Submission of the IDE application enables FDA to review information about the technical characteristics of the device, the results of any prior studies (laboratory, animal and human) involving the device, and the proposed study protocol and consent documents. Based upon the review of this information, FDA may impose restrictions on the study to ensure that risks to subjects are minimized and do not outweigh the anticipated benefits to the subjects and the importance of the knowledge to be gained.

In contrast, NSR device studies do not require submission of an IDE application to the FDA. Instead, the sponsor is required to conduct the study in accordance with the "abbreviated requirements" of the IDE regulations [21 CFR 812.2(b)]. Unless otherwise notified by the FDA, an NSR study is considered to have an approved IDE if the sponsor fulfills the abbreviated requirements. The abbreviated requirements address, among other things, the requirements for IRB approval and informed consent, recordkeeping, labeling, promotion, and study monitoring. If a sponsor has identified a study as NSR, then the investigator must provide an explanation of the determination. If the FDA has determined that the study is NSR, documentation of that determination must be provided. NSR studies may commence immediately following IRB approval.

Additional information on medical device studies is available at:

15.5.1 IND Exemptions

For drugs, an IND is not necessary if the research falls in one of the following categories:
1. The drug being used in the research is lawfully marketed in the United States and all of the following requirements are met:
   a. The research is not intended to be reported to FDA in support of a new indication for use or to support any other significant change in the labeling for the drug
   b. The research is not intended to support a significant change in the advertising for the product;
   c. The research does not involve a route of administration or dosage level, use in a subject population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product
   d. The research is conducted in compliance with the requirements for IRB review and informed consent [21 CFR parts 56 and 50, respectively]
   e. The research is conducted in compliance with the requirements concerning the promotion and sale of drugs [21 CFR 312.7]
   f. The research does not intend to invoke FDA regulations for planned emergency research [21 CFR 50.24].
2. The research only involves one or more of the following: (a) Blood grouping serum, (b) Reagent red blood cells or (c) Anti-human globulin;
3. For clinical investigations involving an in vitro diagnostic biological product, an IND is not necessary if a) it is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure; and b) it is shipped in compliance with 312.160
4. A clinical investigation involving use of a placebo is exempt from the requirements of this part if the investigation does not otherwise require submission of an IND.

If an investigator believes the research use of a drug is exempt from the IND requirement, the IRB requires a detailed discussion of all the IND exemption criteria with the initial submission of the research application. There may be instances where the IRB does not agree with the sponsor or investigator regarding whether or not the research requires and IND. In these instances, the IRB will request that the investigator obtain written FDA concurrence that an IND is not required for the proposed research. Guidance regarding the IND process can be found at:


15.5.2 Exempted IDE Investigations

For devices, an IDE is not necessary if:
1. The research involves a device, other than a transitional device, in commercial
distribution immediately before May 28, 1976, when used or investigated in
accordance with the indications in labeling in effect at that time;
2. The research involves a device other than a transitional device, introduced into
commercial distribution on or after May 28, 1976, that FDA has determined to
be substantially equivalent to a device in commercial distribution immediately
before May 28, 1976, and that is used or investigated in accordance with the
indications in the labeling FDA reviewed under subpart E of 21 CFR 807 in
determining substantial equivalence;
3. The research involves a diagnostic device, if the sponsor complies with
applicable requirements in 21 CFR 809.10(c) and if the testing:
   a. Is noninvasive,
   b. Does not require an invasive sampling procedure that presents
      significant risk,
   c. Does not by design or intention introduce energy into a subject, and
   d. Is not used as a diagnostic procedure without confirmation of the
diagnosis by another, medically established diagnostic product or
      procedure;
4. The research involves a device undergoing consumer preference testing,
testing of a modification, or testing of a combination of two or more devices
in commercial distribution, if the testing is not for the purpose of determining
safety or effectiveness and does not put subjects at risk;
5. The research involves a device intended solely for veterinary use;
6. The research involves a device shipped solely for research on/or with
   laboratory animals and labeled in accordance with 21 CFR 812.5(c);
7. The research involves a custom device as defined in 21 CFR 812.3(b), unless
   the device is being used to determine safety or effectiveness for commercial
distribution.

15.6 Responsibilities

15.6.1 PI

1. The PI is responsible for ensuring that the research is conducted according to
   all regulatory guidelines and PEORIA IRB policies and procedures
2. The PI must obtain approval from the IRB before initiating any research
   activities.
3. The PI proposing the drug/device research will be required to provide a plan –
to be evaluated by the IRB that includes storage, security, and dispensing of
the drug/biologics/device. The investigator must describe the process for
handling the investigational device in the “Use of Medical Devices
Supplement.”
a. The PI is responsible for the investigational drug/device accountability that includes storage, security, dispensing, administration, return, disposition, and records of accountability.
b. The PI will delegate the responsibility for drugs/biologics accountability to the Pharmacy Service.
c. All devices received for a study must be stored in a locked environment under secure control with limited access. The area must be within an area of PI’s control. Proper instructions on the use of the device must be provided to the subjects. A log must be kept regarding the receipt, use, and/or dispensing of the device and the disposition of remaining devices at the conclusion of the investigation.

4. The PI shall report all unanticipated problems involving risk to subjects or others to the IRB according to the procedures outlined in Section 8.

5. For research involving investigational new drugs:
   a. The PI is required to inform Pharmacy Service that IRB have approved the protocol through submission of the IRB approved protocol or Investigator’s Brochure.
   b. The PI must inform the IRB and Pharmacy Service when a study involving investigational drugs has been terminated by the sponsor.
   c. The PI will report to the sponsor any adverse effect that may reasonably be regarded as caused by, or probably caused by, the drug (21 CFR 312 (b)) according to the procedures in the protocol.
   d. The PI will maintain the following:
      i. Current curriculum vitae (CV)
      ii. Protocol
      iii. Records of receipt and disposition of drugs
      iv. List of any co-investigators with their curriculum vitae
      v. Certification that all physicians and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation, and
      vi. Case histories with particular documentation on evidence of drug effects. Emphasis is on toxicity and possible untoward happenings. All unexpected adverse effects are reportable; even if the investigator considers that the event is not related to the drug. All unexpected adverse effects shall be reported immediately to Pharmacy Service and the IRB if they meet the definition of an unanticipated problems involving risk to subjects or others (UPIRSO).
      vii. IRB letters of approval.

6. For research involving investigational devices:
   a. If a device is considered NSR by the PI or sponsor, but after review the IRB determines the device to have significant risk, upon receipt of written notice the PI is responsible for notifying the sponsor of the IRB’s determination. The PI must provide the IRB with confirmation of this action.
   
   b. If the PI is storing the devices, he/she must maintain a log indicating the identification/serial number of the device, name of subject, date dispensed, by whom it was dispensed, and amount remaining.
   
   c. The PI will maintain the following:
      i. Current curriculum vitae (CV),
      ii. Protocol of the study,
      iii. Records of animal study reports
      iv. Records of receipt and disposition of devices
      v. List of any co-investigators with their curriculum vitae,
      vi. Certification that all physicians and/or nurses responsible in the study have appropriate valid licenses for the duration of the investigation,
      vii. Case histories with particular documentation on evidence of effects. Emphasis is on safety and possible untoward happenings. All adverse device effects are reportable
      viii. IRB letters of approval.
   
   d. Following completion of the study the termination procedure for investigational drugs must be applied if pharmacy control, or if the devices are kept by the investigator the log must be completed regarding the receipt, use and/or dispensing of the device and the disposition of remaining devices at the conclusion of the investigation.

   e. If, after use, the PI keeps the devices, he/she must maintain a log regarding the receipt, use and/or re-dispensing of the device and the disposition of remaining devices at the conclusion of the investigation.

   f. The PI will submit to the sponsor and to the IRB a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect.
7. When a PI files an IND or IDE, the PI is considered the sponsor and as such is accountable for all of the FDA regulatory responsibilities and reporting obligations of both the PI and the sponsor, as described in the FDA regulations. The Research Plan asks the PI if he/she also acts as the sponsor of the research and, if so, asks him/her to affirm that he/she has reviewed the Sponsor-Investigator Holding an IND or IDE policies and will comply with the regulatory responsibilities of a sponsor. The UICOMP Compliance and Education Service will conduct education programs for investigators holding an IND or IDE on the sponsor regulations and periodically conduct random audits of PIs holding an IND or IDE as per the QA/QI Program.

15.6.2 IRB

1. The IRB will review the research in accordance with the following requirements and the same criteria it would use in considering approval of any research involving an FDA-regulated product (21 CFR 56.111).

2. For research involving investigational devices:
   a. The IRB will review the control plan and determine whether it is adequate. If the Chair determines that the IRB does not have the necessary expertise to evaluate the plan, outside consultation will be used.
   b. Unless the FDA has already made a risk determination for the study, the IRB will review NSR studies and determine if the device represents significant or non-significant risk and report the findings to the PI in writing. The IRB will consider the risks and benefits of the medical device compared to the risks and benefits of alternative devices or procedures.
      i. Non-significant risk device studies do not require submission of an IDE application but must be conducted in accordance with the abbreviated requirements of IDE regulations (21 CFR 812.2(b)). When the IRB approves a NSR study, the approval will require that the sponsor will comply with the abbreviated IDE requirements and this will be indicated in the approval letter to the PI.
      ii. If the study that has been submitted as NSR is considered SR, the IRB may approve the study, but the study cannot begin until an IDE is obtained.
      iii. The IRB will not review protocols involving significant risk devices under expedited review.
      iv. The IRB will document in the minutes and provide written documentation to the PI of the rationale for determining whether a device is classified as NSR/SR.
v. If the FDA has already made the SR or NSR determination for the study, the agency’s determination is final and the IRB does not need to make a risk determination.

15.7 Expanded Access to Investigational Drugs

Sometimes, investigational products are used for treatment of serious or life-threatening conditions either for a single subject or for a group of subjects, because there are no comparable or satisfactory alternative treatment options. The expanded access mechanisms allow physicians to use promising therapeutic agents without compromising the protection afforded to human subjects or the thoroughness and scientific integrity of product development and marketing approval. An investigator planning to use any of the expanded access avenues should contact OPRS before submitting an application. The investigator should be familiar with the terminology, so that the OPRS can properly advise the investigator regarding the choice of the correct submission process for the type of treatment protocol the investigator plans to use.

Open Label Protocol or Open Protocol IND
These are usually uncontrolled studies, carried out to obtain additional safety data (Phase 3 studies). They are typically used when the controlled trial has ended and treatment is continued so that the subjects and the controls may continue to receive access to the investigational drug until marketing approval is obtained. These types of protocols are considered research and therefore require the submission of full research application packet, prospective Institutional Review Board (IRB) review and informed consent.

Treatment IND
The treatment IND [21 CFR 312.34 and 312.35] is a mechanism for providing eligible subjects with investigational drugs for the treatment of serious and life-threatening illnesses for which there are no satisfactory alternative treatments. A treatment IND may be granted after sufficient data have been collected in controlled clinical trials to show that the drug "may be effective" and does not have unreasonable risks. Because data related to safety and side effects are collected, treatment INDs also serve to expand the body of knowledge about the drug.

There are four requirements that must be met before a treatment IND can be issued:

1) the drug is intended to treat a serious or immediately life-threatening disease;
2) there is no satisfactory alternative treatment available;
3) the drug is already under investigation, or trials have been completed; and
4) the trial sponsor is actively pursuing marketing approval.

Treatment IND studies require prospective convened IRB review and informed consent. Although the FDA has occasionally granted “waivers of IRB review” for Treatment INDs, the University of Illinois at Chicago's policy on human subject research does not permit a waiver.

Physicians who want to enroll research subjects under a Treatment IND protocol for research purposes as well as for treatment of a possible life-threatening condition must follow the standard research submission process. The investigator should clearly identify the protocol as a Treatment IND protocol, so that the IRB is provided with the accurate regulatory status of the investigational agent. Treatment IND protocols that are submitted through regular channels will be given an approval period and will require continuing review.

Physicians who want to use the Treatment IND protocol to treat a patient for an immediately life-threatening condition can follow One-Time Emergency Use submission procedures. Under the FDA regulations, the emergency use of a test article is defined as a clinical investigation, and therefore is considered research. Likewise, the patient receiving the test article is a research subject. Accordingly, the FDA may require data from an emergency use situation to be reported in a marketing application. However, this activity does not meet the HHS definition of human subject research; and therefore the data obtained from the emergency use of a test article may not be reported as part of a prospective systematic investigation designed to develop or contribute to generalizable knowledge.

**Group C Treatment IND**

The "Group C" treatment IND was established by agreement between FDA and the National Cancer Institute (NCI). The Group C program is a means for the distribution of investigational agents to oncologists for the treatment of cancer under protocols outside the controlled clinical trial. Group C drugs are generally Phase 3 study drugs that have shown evidence of relative and reproducible efficacy in a specific tumor type. They can generally be administered by properly trained physicians without the need for specialized supportive care facilities. Group C drugs are distributed only by the National Institutes of Health under NCI protocols. Although treatment is the primary objective and patients treated under Group C guidelines are not part of a clinical trial, safety and effectiveness data are collected. Because administration of Group C drugs is not done with research intent, FDA has generally granted a waiver from the IRB review requirements [21 CFR 56.105]. Even though the FDA has granted a waiver of IRB review for these drugs, an IRB may still choose to conduct a review under its policies and procedures. UIC policy requires the registration of the Class C drug with the IRB via completion and submission of the Treatment IND application.
Parallel Track
The Agency’s Parallel Track policy [57 FR 13250] permits wider access to promising new drugs for AIDS/HIV related diseases under a separate "expanded access" protocol that "parallels" the controlled clinical trials that are essential to establish the safety and effectiveness of new drugs. It provides an administrative system that expands the availability of drugs for treating AIDS/HIV. These studies require prospective IRB review and informed consent. An investigator treating subject under this type of protocol must follow regular Initial Review submission procedures for convened review.

Emergency Use IND
The need for an investigational drug may arise in an emergency situation that does not allow time for submission of an IND in the usual manner. In such cases, FDA may authorize shipment of the drug for a specified use [21 CFR 312.36]. Such authorization is usually conditioned upon the sponsor filing an appropriate application as soon as practicable. Prospective IRB review is required unless the conditions for an Emergency Use Exemption are met [21 CFR 56.104(c) and 56.102(d)]. Informed consent is required unless the conditions for exception are met [21 CFR 50.23].

15.8 Emergency Use of Investigational Drugs
The stipulation for emergency use of a test article (i.e., investigational drugs, agents, biologics, or medical devices) in the FDA regulations represents an exemption from prospective IRB review and approval for the use in a single patient of an investigational drug, biologic or medical device that does not have premarket approval or other approval. FDA regulations require that any subsequent use of the investigational product at the institution have prospective convened IRB review and approval. FDA acknowledges, however, that it would be inappropriate to deny emergency treatment to a second individual if the only obstacle is that the IRB has not had sufficient time to convene a meeting to review the issue. The IRB Chair (or designee) determines whether or not this condition has been met.

Whenever possible UICOMP policy requires the investigator to notify the IRB and receive acknowledgement of the emergency use from the IRB Chair (or designee) before administering the test article. The IRB Chair (or designee) reviews the application for emergency use and acknowledges whether or not they concur that administering the test article in this situation meets the emergency use requirements at 21 CFR 56.102(d)). The acknowledgement by the IRB does not represent approval as FDA regulations do not allow expedited approval of research in emergency situations. It should be noted that manufacturers’ policies typically require an acknowledgement or approval letter from the IRB before the test article will be shipped.
The emergency use exemption for an investigational drug, biologic or medical device requires that each of the following criteria in 21 CFR 56.102(d) is satisfied:

1. A “life-threatening” situation exists;
2. No standard acceptable treatment is available; and
3. Insufficient time is available to obtain IRB approval at a convened meeting.

The term “life-threatening” encompasses conditions that are either:

- Life-threatening: diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life-threatening do not require the condition to be immediately life-threatening or to immediately result in death. Rather, the subject must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.
- Severely debilitating: diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness; loss of arm, leg, hand or foot; loss of hearing; paralysis or stroke.

PEORIA IRB expects the physician to follow as many subject protection procedures as possible and requires the submission of the following via IRBNet:

1) an independent assessment by an uninvolved physician;
2) informed consent from the patient or a legal representative;
3) notification to institutional officials (signature in IRBNet);
4) notification to the Institutional Review Board (IRB); and
5) authorization from the IND holder, if an approved IND exists.

Requirement for an IND for an Investigational Drug or Biologic. The emergency use of an investigational drug or biologic that does not have premarket approval or other approval requires an IND. The investigator must contact the manufacturer and determine if the drug or biologic can be made available for emergency use under the company's IND. When an IND does not exist and the situation does not allow time for submission of an IND, the FDA may authorize the shipment of the test article in advance of the IND submission. The request for such authorization may be made by telephone or other rapid communication means. (21 CFR 312.36). Contact information for obtaining an emergency IND is available at http://www.fda.gov/RegulatoryInformation/Guidances/ucm126491.htm.
Requirement for Five-Day Follow-up Report. The emergency use of a test article must be reported to the IRB within five working days. (21 CFR 56.104(c)). The report is presented to the IRB at the next convened meeting. The IRB reviews the initial notification, five-day follow-up report, and other relevant information provided by the PI. The IRB Chair (or designee) serves as the primary reviewer on this meeting agenda item. The IRB acknowledges whether or not the emergency use of the test article meets the requirements of 21 CFR 56.102(d) and any further issues related to the protection of the human subject.

15.9 Expanded Access to Investigational Devices

Compassionate Use (or Single Patient/Small Group Access)

The compassionate use provision allows access for patients who do not meet the requirements for inclusion in the clinical investigations currently being conducted for a device, but for whom the treating physician believes the device may provide a benefit in treating and/or diagnosing their disease or condition. Compassionate Use is typically approved for individual patients but may be approved to treat a small group of patients. In order to qualify for Compassionate Use, the following conditions must be met:

- Serious disease or condition
- No standard acceptable alternative is available.

The FDA recognizes that there are circumstances in which an investigational device is the only option available for a patient faced with a serious, albeit not life-threatening, disease or condition. In these circumstances, FDA uses its regulatory discretion in determining whether such use of an investigational device should occur.

Prior FDA approval is needed before compassionate use occurs. In order to obtain FDA approval, the sponsor should submit an IDE supplement requesting approval for a protocol deviation under section 21 CFR 812.35(a) in order to treat the patient. The IDE supplement should include:

- A description of the patient’s condition and the circumstances necessitating treatment
- A discussion of why alternative therapies are unsatisfactory and why the probable risk of using the investigational device is no greater than the probable risk from the disease or condition
- An identification of any deviations in the approved clinical protocol that may be needed in order to treat the patient
- The patient protection measures that will be followed (informed consent, concurrence of IRB chairperson, clearance from the institution, independent assessment from uninvolved physician, authorization from IDE sponsor).
The physician should not treat the patient identified in the supplement until FDA approves use of the device under the proposed circumstances. As part of the Compassionate Use protocol, the attending physician should devise an appropriate schedule for monitoring the patient, taking into consideration the investigational nature of the device and the specific needs of the patient. The patient should be monitored to detect any possible problems arising from the use of the device. Following the compassionate use of the device, a follow-up report should be submitted to FDA as an IDE supplement in which summary information regarding patient outcome is presented. If any problems occurred as a result of device use, these should be discussed in the supplement and reported to the reviewing IRB as soon as possible.

The Compassionate Use category can also be applied when a physician wishes to treat a few patients rather than an individual patient suffering from a serious disease or condition for which no alternative therapy adequately meets their medical need. In this case, the physician should request access to the investigational device through the IDE sponsor. The sponsor should submit an IDE supplement that includes the information identified above and indicates the number of patients to be treated. Such a supplement should include the protocol to be followed or identify deviations from the approved clinical protocol. As with single patient compassionate use, a monitoring schedule should be designed to meet the needs of the patients while recognizing the investigational nature of the device. Follow-up information on the use of the device should be submitted in an IDE supplement after all compassionate use patients have been treated.

The UICOMP physician wishing to treat a patient or a small group of patients under the Compassionate Use Criteria must complete and submit the Treatment Use/Compassionate Use form. The submission must include:

- an informed consent document that clearly explains the compassionate use nature of the treatment and the regulatory status of the device
- an independent assessment from uninvolved physician agreeing that the use of the device is justified and necessary
- authorization from IDE sponsor to use the device (e.g. written verification that an amended IDE has been submitted and that the FDA has approved the proposed use of the device)

The Compassionate Use protocol will be reviewed by the convened IRB. The consent document will be stamped for approval for the number of proposed subjects. The protocol will be given an approval period and will require continuing review.

Treatment Use
If during the course of clinical trials with a device, data suggests the device is effective, then the device may be made available through expanded access to patients with life-threatening or serious diseases [21 CFR 812.36].

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The requirements for Treatment Use of investigational devices are similar to investigational drugs. An “immediately life-threatening” disease means a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment. ``Treatment use” of a device includes the use of a device for diagnostic purposes.

The FDA would consider the use of an investigational device under a treatment IDE if:

1) The device is intended to treat or diagnose a serious or immediately life-threatening disease or condition;
2) There is no comparable or satisfactory alternative device or other therapy available to treat or diagnose that stage of the disease or condition in the intended patient population;
3) The device is under investigation in a controlled clinical trial for the same use under an approved IDE, or such clinical trials have been completed; and
4) The sponsor of the investigation is actively pursuing marketing approval/clearance of the investigational device with due diligence.

It is important to remember that a licensed practitioner who receives an investigational device for treatment use under a treatment IDE is an "investigator" under the IDE and is responsible for meeting all applicable investigator responsibilities under 21 CFR 812, 21 CFR 50, and 21 CFR 56.

Also, if the device is to be sold (billed or charged to the subject), the agreement between the manufacturer and the investigator as well as the consent document must include the price to be charged and a statement indicating that the price is based on manufacturing and handling costs only.

UICOMP physicians wishing to treat a patient under a Treatment Use protocol must complete and submit the Treatment Use application. The application and proposed consent document must be reviewed by the convened IRB. Once approved, the Treatment Use protocol will have an approval period, which means that it will require continuing review.

Physicians who want to use the Treatment IND protocol to treat a patient for an immediately life-threatening condition can follow One-Time Emergency Use submission procedures. Under the FDA regulations, the emergency use of an investigational drug or biologic is defined as a clinical investigation, and therefore is considered research. Likewise, the patient receiving the test article is a research subject. Accordingly, the FDA may require data from this use to be reported in a marketing application.
Continued Access
FDA may allow continued enrollment of subjects after the controlled clinical trial under an IDE has been completed in order to allow access to the investigational medical device while the marketing application is being prepared by the sponsor or reviewed by FDA.

These types of protocols are still research protocols collecting additional safety and efficacy data. Therefore, they require convened IRB review and approval and the completion of the standard research protocol application at UICOMP.

15.10 Emergency Use of Unapproved Medical Devices

Similar to investigational drugs, unapproved medical devices may be used in an Emergency Use situation. In order to meet the requirements for Emergency Use, each of the following conditions must exist:

1. Life-threatening or serious disease or condition;
2. No standard acceptable treatment or alternative is available;
3. Insufficient time is available to obtain FDA approval and IRB approval at a convened meeting.

PEORIA IRB expects the physician to follow as many subject protection procedures as possible and requires the submission of the following via IRBNet:

1) an independent assessment by an uninvolved physician;
2) informed consent from the patient or a legal representative;
3) notification to institutional officials (signature in IRBNet);
4) notification to the Institutional Review Board (IRB); and
5) authorization from the IDE holder, if an approved IDE for the device exists.

Requirement for an IDE for an Investigational (Unapproved) Medical Device. An unapproved device may be used in human subjects only if it is approved for clinical testing under an approved application for an IDE. However, the FDA recognizes that emergencies arise where an unapproved device may offer the only possible life-saving alternative, but an IDE for the device does not exist, the proposed use is not approved under an existing IDE, or the physician or institution is not approved under the IDE. Using its enforcement discretion, the FDA has not objected if a physician chooses to use an unapproved device in such an emergency, provided that the physician later justifies to the FDA that an emergency actually existed.

After an unapproved device is used in an emergency, the physician should:

1) report to the IRB within five days [21 CFR 56.104(c)] and otherwise comply with provisions of the IRB regulations [21 CFR part 56];
2) evaluate the likelihood of a similar need for the device occurring again, and if future use is likely, immediately initiate efforts to obtain IRB approval and an approved IDE for the device's subsequent use; and

3) if an IDE for the use does exist, notify the sponsor of the emergency use, or if an IDE does not exist, notify FDA of the emergency use (CDRH Program Operation Staff 301-594-1190) and provide FDA with a written summary of the conditions constituting the emergency, subject protection measures, and results.

Subsequent emergency use of the device may not occur unless the physician or another person obtains approval of an IDE for the device and its use. If an IDE application for subsequent use has been filed with FDA and FDA disapproves the IDE application, the device may not be used even if the circumstances constituting an emergency exist. Developers of devices that could be used in emergencies should anticipate the likelihood of emergency use and should obtain an approved IDE for such uses.

Under the FDA regulations, the emergency use of an investigational drug or biologic is defined as a clinical investigation, and therefore is considered research. Emergency uses of devices, however, are not conducted for the purpose of determining safety or effectiveness of the device, and therefore are not considered a clinical investigation of a medical device. Regardless, the FDA may require data from an emergency use situation to be reported in a marketing application. However, this activity does not meet the HHS definition of human subject research; and therefore the data obtained from the emergency use of a test article may not be reported as part of a prospective systematic investigation designed to develop or contribute to generalizable knowledge.

15.11 Emergency Use Exception from Informed Consent Requirement

Even for an emergency use, the investigator is required to obtain informed consent of the subject or the subject's legally authorized representative unless both the investigator and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following [21 CFR 50.23(a)]:

- The subject is confronted by a life-threatening situation necessitating the use of the test article.
- Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject.
- Time is not sufficient to obtain consent from the subject's legal representative.
- No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life.

If, in the investigator's opinion, immediate use of the test article is required to preserve the subject's life, and if time is not sufficient to obtain an independent physician's determination that the four conditions above apply, the clinical investigator should make
the determination and, within 5 working days after the use of the article, have the
determination reviewed and evaluated in writing by a physician who is not participating
in the clinical investigation. The investigator must notify the IRB within 5 working days
after the use of the test article [21 CFR 50.23(c)].

15.12 Planned Emergency Use

No planned emergency research is done.

15.13 Off-Label Use of Approved Medications/devices

The UIC human research policies and procedures do not apply to “off-label” uses of
approved medical products in the practice of medicine (i.e., not in a research/clinical trial
context).

15.14 Humanitarian Use Devices (HUDs)

A Humanitarian Use Device (HUD) is a device that is intended to benefit patients by
treating or diagnosing a disease or condition that affects or is manifested in fewer than
4,000 individuals in the United States per year. A device manufacturer’s research and
development costs could exceed its market returns for diseases or conditions affecting
small patient populations. The HUD provision of the regulation provides an incentive for
the development of devices for use in the treatment or diagnosis of diseases affecting
these populations. In order to obtain approval for a HUD, the manufacturer must submit
to the FDA a Humanitarian Device Exemption (HDE) application. The application is
called an exemption because the information about the device provided in the application
is exempt from the effectiveness requirements of a Pre-Market Approval (PMA)
application. The PMA is the standard approval application for medical devices.

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

Although the use of the HUD is for medical treatment purposes, the FDA has mandated
that the use must be monitored by the IRB. In order to meet this mandate, UICOMP
requires that an investigator wishing to use a HUD complete and submit a Humanitarian
Use Device application form. The use of the HUD must be reviewed by the convened
IRB at the time of initial review, but may be reviewed via expedited review procedures
upon continuing review.

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The federal regulations (21 CFR 814, Subpart H) do not require that the physician obtain informed consent for the use of the HUD. However, the regulations indicate that the decision regarding whether or not informed consent will be required may be made by the local IRB. The PEORIA IRBs will evaluate the protocol, informational brochures, and patient informational materials in order to make the final determination regarding whether or not an informed consent document will be required. In general, if the informational materials are sufficient in explaining that the device is a HUD whose efficacy has not been proven, and explaining the potential risks and benefits of the HUD, the IRB may determine that a separate informed consent document is not required. However, the investigator must understand that a consent process should still occur, that clearly explains the HUD device and how it differs from a device approved for use through a PMA. In most cases, the PEORIA IRBs require that a treatment consent specific for the HUD usage be developed and submitted for IRB review.

Section 16: Collaborative Multi-site Research Projects

In the conduct of collaborative multi-site research projects, UICOMP acknowledges that each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with applicable federal regulations. A formal relationship must be established between PEORIA IRB and the affiliated institutions through an Institutional Agreement, a Memorandum of Understanding, or other such written agreement. This relationship must be formalized before the PEORIA IRB will accept any human research proposals from the affiliated institution.

If UICOMP or an affiliated institution serves as the primary site for a research protocol, it is the policy of PEORIA IRB to require the lead PI to have a process for all facilities participating in a human subjects study to receive adequate documentation about the study in order to protect the interests of study participants. Before a collaborative multi-site study can begin, it must be approved by the IRBs of record for each participating facility and, where appropriate, the PEORIA IRB as the IRB of record for the primary site.

When the PEORIA IRB reviews research conducted in whole or in part at another institution, the particular characteristics of each institution’s local research context must be considered, either (i) through knowledge of its local research context by UICOMP or (ii) through subsequent review by appropriate designated institutional officials, such as the Chairperson and/or other IRB members.

The primary site investigator is responsible for serving as the liaison with regulatory and funding agencies, with other participating facilities, and for all aspects of internal review and oversight procedures. The investigator is responsible for ensuring that all participating facilities obtain review and approval from their IRB of record and adopt all protocol modifications in a timely fashion. The investigator is responsible for ensuring that the research study is reviewed and approved by any other appropriate committees.
the coordinating facility and at the participating facilities prior to enrollment of participants.

The PI must follow these procedures when one of UICOMP’s affiliated institutions is the primary research site:

- During the initial IRB submission of the multi-site study, the investigator indicates in writing on the application form or in an application letter that they are the primary site of a multi-site study.
- The investigator submits the name of each participating institution in their IRB application materials.
- The investigator submits approval letters from all the IRB of record for all participating sites.

When a UICOMP affiliate is engaged in only part of a collaborative multi-site research project, the PEORIA IRB only needs to approve the part(s) of the research in which the UICOMP affiliated investigator is engaged. For example, if a UICOMP affiliate is operating the statistical center for a multicenter trial that receives identifiable private information from multiple other institutions, the PEORIA IRB reviews and approves the research activities related to the receipt and processing of the identifiable private information by the statistical center.

### 16.1 Reliance on another Institutional Review Board (IRB)

The substantial growth in the number of multicenter trials has created a greater reliance on a centralized IRB review process in order to reduce duplication of effort, delays, and increased expenses.

Use of a centralized IRB review process is consistent with the requirements of existing IRB regulations at 21 CFR 56.114, stating that, “institutions involved in multiinstitutional studies may use joint review, reliance upon the review of another qualified IRB, or similar arrangements aimed at avoidance of duplication of effort.” An IRB that is at a different location from the research site, which is often the case, can review the research provided that the IRB is competent to understand the local context of the research.

A centralized IRB review process involves an agreement under which multiple study sites in a multicenter trial rely in whole or in part on the review of an IRB other than the IRB affiliated with the research site. Because the goal of the centralized process is to increase efficiency and decrease duplicative efforts that do not contribute to meaningful human subject protection, it will usually be preferable that a central IRB take responsibility for all aspects of IRB review at each site participating in the centralized review process. Other approaches may be appropriate as well.
In order for UICOMP to rely on another institution for IRB review, the other institution must:

1. Have an active federal-wide assurance (FWA) with OHRP (Office of Human Research Protections).

2. Have an inter-institutional Agreement (IIA) signed by the IO’s of both parties.

When UICOMP relies on the services of another institution for IRB review, policies and procedures or a written agreement must define responsibilities.

UICOMP often retains responsibility for:

- Ensuring, through education, that St. Jude Midwest Affiliate researchers understand which activities are eligible for review by another IRB

- Ensuring that St. Jude Midwest Affiliate researchers are knowledgeable about the need to obtain any approvals from their own organization prior to seeking review by another IRB, and that researchers know when to seek guidance.

- Ensuring St. Jude Midwest Affiliate researchers and research staff have appropriate qualifications and expertise to conduct the research, are knowledgeable about laws, regulations, codes and guidance governing their research, and are knowledgeable about the organization’s policies and procedures

- Requiring St. Jude Midwest Affiliate researchers and research staff disclose conflicts of interest according to the process agreed upon between the organization and reviewing IRB, and comply with any conflict of interest management plans that may result.

- Managing organizational conflict of interest related to the research

- Ensuring reporting of noncompliance, participant complaints, protocol deviations or other events according to the requirements specified in the reliance agreement.

- Conducting monitoring in addition to, or in cooperation with, the reviewing IRB, when appropriate.

**16.1.1 National Cancer Institute (NCI) Central IRB (CIRB) for the Review of NCI–Sponsored Research for Pediatric Subjects**

UICOMP relies on the services of the Pediatric CIRB for the review of NCI-sponsored research conducted at the St. Jude Midwest Affiliate.
UICOMP has an Authorization Agreement with the NCI CIRB stating that the NCI CIRB will meet the human subject protection requirements of UICOMP’s OHRP-approved FWA. The NCI CIRB will follow written procedures for reporting its findings and actions to appropriate officials at UICOMP. Relevant minutes of CIRB meetings and supporting documents are available to UICOMP via a secure website at any time. UICOMP remains responsible for ensuring compliance with the NCI CIRB’s determinations and with the terms of UICOMP’s FWA.

16.1.1.1 Establishing Local Context

The CIRB is informed of local context considerations via submission of three worksheets. First, the Annual Signatory Institution Worksheet providing local context considerations for the signatory institutions as well as any component or affiliate institutions. Second, the Annual Principal Investigator Worksheet providing local context considerations relative to the PI within the institutional context. Third, the Principal Investigator submits the Study-Specific Worksheet to open a study with the CIRB in light of the local context considerations provided in the two previous worksheets.

16.1.1.2 The Responsibilities of NCI CIRB

The responsibilities of the NCI CIRB are to:

1) Maintain an NCI CIRB membership that satisfies the requirements of 45 CFR 46 and 21 CFR 56 and provides special expertise as needed to adequately assess all aspects of each study;
   a) Post the roster of NCI CIRB membership on the public side of the NCI CIRB website;

2) Conduct initial, amendment, and continuing review of studies as well as review of any other study-specific documents submitted by the Study Chair to the NCI CIRB;

3) Conduct review of local context considerations as outlined in the following Worksheets:
   a) Annual Signatory Institution Worksheet about Local Context;
   b) Annual Principal Investigator Worksheet about Local Context; and
   c) Study-Specific Worksheet about Local Context;

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4) Conduct review of potential unanticipated problems and/or serious or continuing noncompliance when the Signatory Institution or other entity reports an incident, experience, or outcome to the CIRB;

   a) This review includes reporting any unanticipated problem and/or serious or continuing noncompliance determination to OHRP, the FDA, and the Signatory Official for the NCI;

5) Report any suspension or termination of CIRB approval to OHRP, FDA, and the Signatory Official for the NCI;

6) Conduct review of individual Adverse Event Reports for studies without a Data and Safety Monitoring Board (DSMB) or equivalent monitoring body;

7) Post all study-wide documents related to CIRB reviews to a secure website and notify research staff and institutional designees of the postings;

8) Provide institution-specific documents related to CIRB reviews via email to research staff and institutional designees;

9) Notify the Signatory Institution immediately if there is ever a suspension or restriction of the CIRB’s authorization to review a study; and

10) Post the NCI CIRB Standard Operating Procedures on the public side of the CIRB website.

The responsibilities of UICOMP are to:

1) Comply with the NCI CIRB’s requirements and directives;

2) Report to the NCI CIRB the names of any Component or Affiliate Institutions that meet the following definitions:

   a) Component Institutions are defined by the NCI CIRB as meeting all of the following criteria:
      • The Component Institution operates under a different name than the Signatory Institution, but the Signatory Institution has legal authority for the Component Institution;
      • The FWA number for the Component Institution is the same as the Signatory Institution;
• The local context considerations of the Component Institution are the same as the Signatory Institution;
• The boilerplate language and institutional requirements of the Component Institution are the same as the Signatory Institution; and
• The conduct of research at the Component Institution is monitored by the same office as the Signatory Institution;

b) Affiliate Institutions are defined by the NCI CIRB as meeting all of the following criteria:
• The local context considerations of the Affiliate Institution are the same as the Signatory Institution;
• The boilerplate language and institutional requirements of the Affiliate Institution are the same as the Signatory Institution; and
• The conduct of research at the Affiliate Institution is monitored by the same office as the Signatory Institution;

3) Ensure the safe and appropriate performance of the research at the Signatory Institution and at all Component and Affiliate Institutions. This includes, but is not limited to:
   a) Ensuring the initial and ongoing qualifications of investigators and research staff;
   b) Overseeing the conduct of the research;
   c) Monitoring protocol compliance;
   d) Maintaining compliance with state, local, or institutional requirements related to the protection of human subjects;
   e) Providing a mechanism to receive and address concerns from local study participants and others about the conduct of the research; and
   f) Investigating, managing, and providing notification to the NCI CIRB of any study-specific incidence, experience, or outcome that seems to rise to the level of an unanticipated problem and/or serious or continuing noncompliance. When notifying the NCI CIRB of a potential unanticipated problem and/or serious or continuing noncompliance, the institution must provide a plan to manage the incident, experience, or outcome, including measures to prevent similar occurrences;

NOTE: As part of ensuring safe and appropriate performance of research the Signatory Institution has the authority to observe any aspect of the research process including observing the consent process. The CIRB retains the authority to direct this to be done when necessary.
4) Provide updates in a timely manner to the NCI CIRB whenever a Signatory Institution Principal Investigator is replaced. The CIRB requires submission and approval of the Annual Principal Investigator Worksheet About Local Context prior to finalizing the replacement Principal Investigator;

5) Notify the NCI CIRB when a regulatory deficiency has been cited on an audit that occurred during the time that the NCI CIRB was responsible for study review;

6) Complete and submit the Annual Signatory Institution Worksheet About Local Context, the Annual Investigator Worksheet About Local Context, and any other worksheets/forms required by the NCI CIRB for participation;

7) Have CIRB-approved Principal Investigators complete and submit the Study-Specific Worksheet about Local Context to open a study;

8) Incorporate NCI CIRB-approved boilerplate language into the NCI CIRB approved model consent form to create the consent form to use for a specific study:
   a) Make no language changes to the consent form with the exception of NCI CIRB-approved boilerplate language;
   b) Obtain NCI CIRB approval of changes to the boilerplate language prior to implementation; and
   c) Obtain NCI CIRB approval of translations of the consent form prior to implementation;

9) Maintain a regulatory file for each study under NCI CIRB purview as per local institution and sponsor policy; and

10) Conduct full board review of any study enrolling prisoners, since the NCI CIRB is not constituted to review studies enrolling prisoners.

16.1.2 IRBChoice for the Shared review of St. Jude Studies

IRBChoice is a national IRB reliance platform for multi-site studies that provides a shared reliance model within a single IT platform and master reliance agreement. The goal of IRBChoice is to promote faster and more consistent IRB determinations for multi-site studies. IRBChoice allows institutions to maintain regulatory oversight (shared reliance) on a study-by-study basis. This model involves a single IRB review for a single study resulting in the same IRB determination, model consent and expiration date for all sites.
The St. Jude IRB is the Lead IRB and is responsible for making the regulatory determination for their site and then making their approval available in the IRBchoice System (e.g., meeting minutes, determination letter, IRB application) for the PEORIA IRB, as a Relying Site, to use to give approval for their site via a subcommittee review of St. Jude IRB’s determination and the local site’s institutional reviews (conflict of interest, researcher qualifications, HIPAA, etc.) and local context. This model has been acknowledged by OHRP, FDA, and AAHRPP to be an acceptable alternative IRB review model.

16.1.2.1 Using the Shared Model

When using the Shared Model, the role of the PEORIA IRB is to assess, via IRB subcommittee (i.e., at least 1 IRB member), 1) the accuracy of a study determination from the St. Jude IRB, 2) the suitability of the local context (e.g., in the consent form), and 3) to ensure any non-IRB institutional reviews are completed and incorporated appropriately (e.g., radiation safety, COI, biosafety review, etc.).

16.1.2.2 Relying Site Investigators

For every study, the responsibilities of investigators at the St. Jude Midwest Affiliate to the PIRB is outlined in the IRBchoice Investigator Responsibilities and Submission Instructions Sheet. Investigators at St. Jude Midwest Affiliate are responsible for ensuring they adhere to their PIRB policies and procedures when using the Shared Model.

16.1.2.3 Initial Review

For its own site, the St. Jude IRB will review research involving human subjects in accordance with applicable federal regulations, the local context provided by its local investigator, and its own policies and procedures. The St. Jude IRB shall be responsible for clearly documenting compliance with the Federal Human Research Protections Regulations for each IRB-approved review provided within the IRBchoice System for a given study.

The St. Jude IRB will review all applicable documents including but not limited to the following:

- Protocol
- Documentation of the local context of its local site
- Informed consent, parental permission, and assent forms for its local site
• Investigator’s brochures, package insert, and device manual (as applicable)
• Recruitment procedures
• Grant application for research supported by DHHS
• Participant materials including questionnaires, diaries and instructions

The St. Jude IRB is responsible for making the regulatory determination for their site available in the IRBchoice System (e.g., meeting minutes, determination letter, and IRB application) for Relying Sites’ IRBs.

**Investigators at the St. Jude Midwest Affiliate will submit to PIRB as usual practice.** Investigators should contact their IRBchoice Liaison to clarify anything that is not clear on the Investigator Responsibilities and Submission Instructions Sheet.

The investigator will complete the PEORIA IRB initial review form Project/Protocol Review Form and prepare a submission to the UICOMP IRB that includes:

1) A completed Project/Protocol Review Form
2) St. Jude Approved research protocol
3) St. Jude Approved Informed Consent Document(s)
4) St. Jude Approval letter
5) Local Consent/parental permission/HIPAA Authorization document(s), any applicable child assent(s), and information sheets (if applicable) that include the local contact information and local liability, injury and/or confidentiality language
6) Recruitment materials
7) Other relevant documents available from the St. Jude IRB

Thereafter, the PIRB will utilize the documents submitted by its investigator and the approval documents from the St. Jude IRB in IRBchoice to give approval for their site via a subcommittee (at least 1 IRB member) that verifies 1) St. Jude IRB’s determination, 2) the local site’s local context. The PIRB will be responsible for indicating in the IRBchoice System their reliance on the St. Jude IRB’s approval, documenting this reliance in the IRBchoice System, and sending its determination letter to its local site investigator.

To indicate PIRB’s reliance on St. Jude IRB’s approval following agreement with the St. Jude IRB’s determination and approval of
PIRB’s local context, PIRB will incorporate the following language into its approval letter:

“A sub-Committee of the PIRB reviewed the research application identified above. Based on the acceptance of the [Full Board/Expedited] review conducted by [Lead IRB], the sub-Committee reviewed the submission for issues of local context and determined the study poses [greater than minimal risk/minimal risk] to participants. Approval is extended for the documents listed below with an expiration date of [MM/DD/YYYY] in alignment with the Lead IRB expiration date:

[Locally approved documents will be listed here].”

PIRB maintains regulatory oversight for the study; oversight is not transferred to the St. Jude IRB. Thus, PIRB is responsible for all post-approval monitoring and ongoing oversight until the next study-wide amendment or annual review, when the process of relying on the review of the St. Jude IRB be repeated by a subcommittee. Site-specific amendments that do not apply to all institutions are not uploaded to IRBchoice and are reviewed by the Relying Site’s IRB according to its local policies and procedures.

If anything about the review and approval of St. Jude IRB is not clearly documented or the PIRB’s subcommittee would like to discuss St. Jude IRB’s review, the contact information for the IRBchoice Liaison of the St. Jude IRB is in the IRBchoice System. If the study cannot be approved by the subcommittee of PIRB, it should be sent on to the full board or otherwise reviewed according to local policies and procedures of PIRB.

The St. Jude study team should do the following to ensure efficiency and consistency:

• Submit the study to the St. Jude IRB as soon as the protocol is finalized;
• Submit for continuing review at least 4-8 weeks prior to the expiration date to ensure the St. Jude IRB has time to review and upload approval to IRBshare + allow PIRBs to use the streamlined review;
• Submit study-wide amendments as quickly as possible and disseminate the changed documents to Relying Site investigators and study teams as soon as approval is received. Changes involving patient safety may be reviewed by each IRB separately, outside of IRBshare, if it is more expedient.
• Submit local amendments following local IRB policy and procedures. Local amendments do not go into IRBchoice and should only be submitted to the local IRB where the change occurred.
16.1.2.4  Informed Consent Documents (ICDs)

When informed consent documents (ICDs) are required for a study, the St. Jude IRB-approved ICD(s) will be used for all Relying Sites for that study. Changes should not be made to the ICD approved by the Lead IRB except in the areas including, but not limited to, HIPAA authorizations, conflict of interest, payment for research related injury, differences in research costs to subjects and local study contacts.

Modifications to these sections will be subject to approval of the Relying Site’s IRB only. Outside of approving the ICD for its own site, the St. Jude IRB does not approve the local consent form of Relying Sites.

After initial approval, any changes to a Relying Site’s local language in the ICD is reviewed by the Relying Site’s IRB only.

16.1.2.5  Continuing Review

The St. Jude IRB will review continuing review progress reports from their site only. The St. Jude IRB will conduct continuing reviews in accordance with applicable federal regulations, the local context provided by its local St. Jude investigator, and its own operating procedures. The St. Jude IRB will, upon approval for its site, upload all currently approved documents along with the approval letter to the IRBchoice System. The IRBchoice System will notify Relying Sites’ IRBs when the St. Jude IRB has the continuing review approval for the Lead Site.

After the St. Jude IRB has approval, Relying Sites’ investigators will submit to their local IRB for continuing review approval. At this time, the PIRB will utilize the documents provided in the IRBchoice System in addition to the continuing review progress report from their own site to grant approval for their site via subcommittee.

The investigator will complete the PEORIA IRB Continuing Review Form and prepare a submission to the PEORIA IRB that includes:

- A completed Continuing Review of Research Application form.
- Current St. Jude Approved Research protocol
- St. Jude Continuing Approval letter
- Current local consent/parental permission/HIPAA Authorization document(s), any applicable child assent(s), and information sheets (if

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applicable) that include the local contact information and local liability, injury and/or confidentiality if enrollment will continue at the site

- Recruitment materials
- Other relevant documents available from the St. Jude IRB.

PIRB will be responsible for documenting reliance on the review and approval of the St. Jude IRB in the IRBchoice System, as well as sending the determination letter to its local site investigator.

If the St. Jude IRB determines it cannot reapprove a study, it will notify all relevant Relying Sites of its determination and the reasons for the determination in the IRBchoice System. Relying Sites can make their own determination as to whether they agree with the decision to not reapprove the study or they can review the study according to their local policies and procedures.

If any review and approval of a study that the St. Jude IRB has provided to the IRBchoice System lapses, expires, or the St. Jude IRB otherwise decides not to continue to provide IRB documents to the IRBchoice System, then they will provide notice to all Relying Sites’ IRBs via the IRBchoice System within 10 business days.

16.1.2.6 Amendments (Modifications) to Approved Research

Study-wide amendments are first submitted to the St. Jude IRB for review and approval. The St. Jude IRB will conduct protocol amendment reviews in accordance with applicable federal regulations, its local context, and its own operating procedures. St. Jude IRB will, upon approval, upload all currently approved documents along with the approval letter to the IRBchoice System. The IRBchoice System will notify Relying Sites’ IRBs when it has approved the study-wide amendment.

After the St. Jude IRB has approved the amendment, the Relying Sites’ investigators will submit to their local IRB for approval of the study wide amendment.

1. Study-Wide

The investigator should submit the study-wide amendment that changes the local informed consent to the IRB via IRBNet. The amendment submission will include:
• A completed Change in Research Form that provides a summary of the changes
• All St. Jude IRB approved revised documents (protocol, consent form, etc.), if applicable
• St. Jude IRB approval letter that corresponds to the proposed amendment

The submitted consent should include local contact information, and other local language previously required by the PEORIA IRB.

2. Site-Specific Amendments Only

The investigator should submit the site-specific amendment that changes the local informed consent to the IRB via IRBNet. The amendment submission will include:

• A completed Change in Research Form that provides a summary of the changes
• The locally revised documents (protocol, consent form, etc.), if applicable
• Site-specific amendments that do not apply to all institutions are independently reviewed by the IRB of the institution where the change is occurring and are not uploaded to the IRBchoice System.

At this time, PIRB will utilize the documents provided in the IRBchoice System in addition to any locally submitted documents to grant approval for their site via subcommittee. PIRB will be responsible for documenting reliance on the review and approval of the St. Jude IRB in the IRBchoice System, as well as sending the determination letter to its local site investigator.

16.1.2.7 Reportable Events (unanticipated problems, deviations, noncompliance)

Investigators should follow their local policies and procedures for reporting events to their local IRB in addition to the procedure listed in the study protocol for reporting to other study sites via a coordinating center or sponsor.

Local unanticipated problems involving risks to subjects or others (UPIRSO) and/or serious or continuing noncompliance must be promptly reported to the PEORIA IRB using the Unanticipated Problems
16.1.2.8 Final Reports

When the St. Jude IRB has completed a research protocol (including no further data analysis and any publications are in press with no possibility for requests for additional data analysis), a final report must be submitted to PIRB.

The investigator should submit the “Final Report” form to be reviewed. A final report must be submitted even if the research was never initiated, no subjects were enrolled, or the investigator is terminating the research earlier than originally planned.

16.1.2.9 Suspensions and Terminations of IRB Approval

If any review and approval of a study that has been provided to the IRBchoice System is suspended or terminated due to any study-related event or safety monitoring finding that increases risk to human subjects greater than was previously known, the St. Jude IRB will notify all Relying Sites’ IRBs via the IRBchoice and provide the review and approval documents related to the suspension or termination to all Relying Sites’ IRBs within 72 hours. **PIRB must either (a) accept the decision to suspend or terminate the study or (b) stop using the Shared Model for the study and promptly complete and obtain a review and approval of the study by its own IRB, resuming all review and approval activities at its own site going forward for the remainder of the study.**

If any review and approval of a study provided to the IRBchoice System is suspended or terminated due to any other reason, the St. Jude IRB will notify all Relying Sites’ IRBs via the IRBchoice System and provide the review and approval documents related to the suspension or termination to all Relying Sites’ IRBs within 10 business days. **PIRB must either (a) accept the decision to terminate the study, (b) choose another Lead IRB approval in the IRBchoice System, if available, prior to the next scheduled continuing review date for the study, or (c) stop using the Shared Model for the study and complete and obtain a review and approval of the study by its own IRB sometime prior to the next scheduled continuing review date for the study, resuming all review and approval activities at its own site going forward for the remainder of the study.**
16.1.2.10 IRB Determinations and Meeting Minutes

The St. Jude IRB’s determination/approval letter, including meeting notes (if the protocol was subject to full board review), will be available in the IRBchoice System for all studies using the Shared Model.

16.1.2.11 Investigator Conflicts of Interest

All sites are responsible for assessing its Investigators’ significant financial interest in the research being conducted, and for instituting plans to manage those conflicts. Significant financial interests do not have to be reported to the St. Jude IRB by the Relying Site’s IRB.

16.1.2.12 HIPAA Privacy Board

All sites that are Covered Entities are independently responsible for making determinations regarding authorizations for use of protected health information and requests for waivers or alterations of authorizations under the Federal Privacy Rule.

Section 17: Research Involving Department of Defense Funding

17.1 Background

The purpose of this policy is to outline the laws, regulations, and guidance that the UICOMP HSPP will comply with when conducting, reviewing, approving, overseeing, supporting or managing the human subjects research with the U.S. Department of Defense (“DoD”).

Note – DOD Components (such as Army, Navy, etc.) may have additional requirements regarding human subjects research.

17.2 Policy

A. Application and Scope

This policy applies to all biomedical and social/behavioral research involving human subjects conducted under the auspices of UICOMP when it:

- Conducts, reviews, approves, oversees, supports, manages or otherwise is contractually subject to regulation by the DoD; and/or
- Human subject research performed under the auspices of UICOMP using DoD property, facilities, or assets (hereinafter “DoD Supported Research”).

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In most cases, protocols covered by this DOD requirement also will have review, approval and oversight by the DOD Human Research Protections Program.

UICOMP assures that such DoD Supported Research complies with additional DOD human subjects protection requirements, including but not limited to:

- The Belmont Report
- Title 21 Code of Federal Regulations 50, 56, 312, and 812, Food and Drug Administration (FDA) Regulations
- DoD Directive (DoDD) 3216.02, “Protection of Human Subjects and Adherence to Ethical Standards in DoD-supported Research”
- Title 10 United States Code Section 980 (10 USC 980), “Limitation on Use of Humans as Experimental Subjects”
- DoDD 3210.7, “Research Integrity and Misconduct”
- DoDD 6200.2, “Use of Investigational New Drugs in Force Health Protection”

B. Specific Citations for Key Additional Requirements Not Covered by Title 45 CFR 46, Subparts B, C and D; 21 CFR 50, 56, 312, and 812; and the UICOMP HSPP Written Policies and Procedures

17.3 Special Considerations and Procedures for DoD Research

16.3.1 Minimal Risk – DoDI 316.02, enclosure 3, para 6b]

The definition of minimal risk based on the phrase “ordinarily encountered in daily life or during the performance of routine physical or physiological examination or tests” shall not be 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.)

17.3.2 Undue Influence – [DoDD 3216.2, enclosure 3, para 7e1]

Service members shall follow their command policies regarding the requirement to obtain command permission to participate in research involving human
subjects while on-duty and for approving off-duty employment or activities. Superiors (e.g., military and civilian supervisors, unit officers, and noncommissioned officers (NCOs) are prohibited from influencing the decisions of their subordinates (e.g., junior enlisted personnel and equivalent civilians) regarding participation as subjects in research involving human subjects. Unit officers and senior NCOs in the chain of command shall not 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 afforded the opportunity to participate as research subjects. When applicable, officers and NCOs so excluded shall be afforded the opportunity to participate as research subjects in a separate recruitment session. During recruitment briefings to a unit where a percentage of the unit is being recruited to participate as a group, an ombudsman not connected in any way with the proposed research or the unit shall be present to monitor that the voluntary nature of individual participants is adequately stressed and that the information provided about the research is adequate and accurate.

17.3.3 Education and Training – [DoDD 3216.2, enclosure 3, para 5]

For initial and continuing research ethics education for all personnel who conduct, review, approve, oversee, support, or manage human participant research, there may be specific DoD educational requirements or certification required. The IRB shall use this guidance document as the basis for reviewing any DOD supported research and shall ensure that the PI has received this document before approving the research. 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.

17.3.4 Appointment of a Research Monitor – [DoDI 3216.02, enclosure 3, para 8]

- The IRB considers the appointment of a research monitor:
  - Required for research involving greater than minimal risk, although the IRB or organizational official can require this for a portion of the research or studies involving no more than minimal risk if appropriate.
  - The research monitor is appointed by name and shall be independent of the team conducting the research.
  - There may be more than one research monitor (e.g. if different skills or experience are needed.
  - The monitor may be an ombudsman or a member of the data safety monitoring board. The IRB must approve a written summary of the monitors’ duties, authorities, and responsibilities.
  - The IRB or HSPP official shall communicate with research monitors to confirm their duties, authorities, and responsibilities.
The duties of the research monitor are determined on the basis of specific risks or concerns about the research.

- May perform oversight functions (e.g. observe recruitment, enrollment procedures, and the consent process, oversee study interventions and interactions, review monitoring plans and unanticipated problems involving risks to participants or others, oversee data matching, data collection and analysis).
- May discuss the research protocol with researchers, interview human subjects, and consult with others outside of the study.
- Report observations and findings to the IRB or a designated official.

The research monitor has the authority to:
- Stop a research study in progress.
- Remove individuals from study.
- Take any steps to protect the safety and well-being of participants until the IRB can assess.

17.3.5 Additional protections for pregnant women, prisoners, and children (Subparts B, C and D) of 45 CFR 46) – [DoDI 3216.02, enclosure 3 para 7]

- Research involving pregnant women, prisoners, and children are subject to the DHHS Subparts B, C, and D.
  - For purposes of applying Subpart B, the phrase “biomedical knowledge” shall be replaced with “generalizable knowledge.”
  - The applicability of Subpart B is limited to research involving pregnant women as participants in research that is more than minimal risk and included interventions or invasive procedures to the woman or the fetus or involving fetuses or neonates as participants.
  - Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g.

- Research involving prisoners cannot be reviewed by the expedited procedure.
- When the IRB reviews research involving prisoners, at least one prisoner representative must be present for quorum.

In addition to allowable categories of research on prisoners in Subpart C, epidemiological research is also allowable when:
The research describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor association for a disease.

- The research presents no more than minimal risk
- The research presents no more than an inconvenience to the participant.

When a prisoner becomes a subject, 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 shall require that all research interactions and interventions with the prisoner-subject (including obtaining identifiable private information) cease until the convened IRB can review this request to approve a change in the research protocol. The convened IRB, upon receipt of notification that a previously enrolled human participant has become a prisoner, shall promptly re-review the research protocol to ensure that the rights and wellbeing of the human subject, now a prisoner, are not in jeopardy. 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.

17.3.6 Limitation of Waivers and Exceptions from Informed Consent - [DoDI3216.02, enclosure 3 para 13; 10 U.S.C. 980]

If the research participant meets the definition of “experimental subject,” policies and procedure prohibit a waiver of the consent process unless a waiver is obtained from the Assistant Secretary of Defense for Research and Engineering. The Assistant Secretary of 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.

Research involving a human being as an experimental subject is 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. If the research participant does not meet the definition of “experimental subject,” policies and procedure allow the IRB to waive the consent process.

For classified research, waivers of consent are prohibited.

17.3.7 Limitations on Compensation for U.S. Military Personnel - [Dual Compensation Act and 24 U.S.C. 30]

The Dual Compensation Act prohibits an individual from receiving pay from more than one position for more than an aggregate of 40 hours of work in one calendar week. This prohibition applies to employees paid from either appropriated or non-appropriated funds, or a combination thereof, and includes temporary, part-time and intermittent appointments. This law is not applicable to enlisted off-duty military personnel in relation to their military duty.

When research involves U.S. military personnel, limitations on dual compensation include:

• Federal employees while on duty and non-Federal persons may be compensated for blood draws for research up to $50 for each blood draw.
• Non-Federal persons may be compensated for research participation other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.

17.3.8 Requirement for Reporting - DoDI 3216.02, enclosure 3 para 4(b)(4)

The Institution shall promptly (no longer than within 30 days) notify the DoD Human Research Protection Official (HRPO) of the following: when significant changes to the research protocol are approved by the IRB, the results of the IRB continuing review, if the IRB used to review and approve the research changes to a different IRB, when the institution is notified by any Federal department or agency or national organization that any part of its HSPP is under investigation for cause involving a DoD-supported research protocol, and all substantiated unanticipated problems involving risks to human subjects or others (UPIRTSOs), suspensions, terminations, and serious or continuing noncompliance regarding DoD-supported research involving human subjects.
17.3.9 Recordkeeping Requirements - [DoDD 3216.2, para. 5.3.2; SECNAVINST 3900.39D, para. 8c(18)]

Recordkeeping requirements for DOD-supported research with human subjects are stronger than the Common Rule’s requirement. DOD may require submitting records to DOD for archiving.

Records maintained that document compliance or noncompliance with DoD requirements shall be made accessible for inspection and copying by representatives of the DoD at reasonable times and in a reasonable manner as determined by the supporting DoD component.

17.3.10 Addressing and Reporting Allegations of Noncompliance with Human Research Protections - [DoDD 3216.2, para. 4.10;]

Report the initiation of all investigations and report results regardless of the findings to the Navy Secretary General and appropriate sponsors.

17.3.11 Addressing and Reporting Allegations of Research Misconduct - [DoDD 3216.2, para. 4.8; DODD 3210.7;]

All findings of serious research misconduct under this section shall be reported to the Director, Defense Research and Engineering.

17.3.12 Provisions for Research with Human Subjects using Investigational Test Articles (Drugs, Device and Biologics) - [DoDD 3216.2, para 4.9; DoDD 6200.2]

Principal investigators may not be sponsors for INDs and IDEs.

17.3.13 Prohibition of Research with Prisoners of War (POW) and Detainees - [DoDD 3216.2, para 4.4.2]

Research involving any person captured, detained, held or otherwise under the control of DoD personnel (military and civilian, or contractor employee) is prohibited.

17.3.14 Classified Research[DoDI 3216.02, enclosure 3 para 13]

The involvement of classified information may be limited to information needed for IRB approval and oversight of the research; information needed to inform the human subjects during the consent process; and information provided by the human subjects during the course of the research. Secretary of Defense approval is required for all classified non-exempt research involving human subjects.

Informed consent procedures shall include:
(1) Identification of the Department of Defense as the supporting institution of the research, unless the research involves no more than minimal risk. The Secretary of Defense may grant an exception to this requirement on the grounds that providing this information could compromise intelligence sources or methods.

(2) A statement that the research involving human subjects is classified and an explanation of the impact of the classification.

The IRB shall determine whether potential human subjects need access to classified information to make a valid, informed consent decision.

IRB review shall be conducted using a full board review. Use of an expedited review procedure is prohibited.

17.3.15 Additional Requirements for DoD Sponsored Research

a) New research and substantive scientific amendments to approved research shall undergo scientific review and that the review is considered by the IRB. The IRB may rely on outside experts to provide an evaluation of scientific merit.

b) When conducting research with international populations, additional safeguards for research conducted with international populations: The Organization or Researcher has permission to conduct research in that country by certification or local ethics review and the Researcher follows all local laws, regulations, customs, and practices.

c) Disclosure regarding the provisions for research-related injury follow the requirements of the DoD component.

d) Surveys performed on Department of Defense personnel must be submitted, reviewed, and approved by the Department of Defense after the research protocol is reviewed and approved by the IRB.

e) When conducting multi-site research, policies and procedures indicate that a formal agreement between organizations is required to specify the roles and responsibilities of each party.

f) For DoD supported research, the following shall be promptly (no longer than within 30 days) reported to the DoD human research protection officer:

a. When significant changes to the research protocol are approved by the IRB.

b. The results of the IRB continuing review.

c. Change of reviewing IRB.

d. When the organization is notified by any Federal department, agency or national organization that any part of
the HSPP is under investigation for cause involving a DoD supported research protocol.

g) If consent is to be obtained from the experimental subjects’ legal representative, the research must intend to benefit the individual participant. The determination that research is intended to be beneficial to the individual experimental subject must be made by an IRB.

17.4 Responsibilities

It is the responsibility of the principal investigator to ensure compliance with all additional Department of Defense (DoD) requirements for human subject protection. It also is the responsibility of the IRB to ensure that all additional requirements by Department of Defense Components for human subject protection have been met before IRB approval of the research project.

Section 18: Continuous Quality Improvement (CQI) & Monitoring

The Quality Improvement Program is a part of the UICOMP Human Subjects Protection Program. The goal of the program is to assess, maintain, and improve compliance with local, state, and federal regulations as well as UICOMP Policies and Procedures. The program also evaluates the quality, efficiency, and effectiveness of the Human Subjects Protection Program. The Quality Improvement Program is implemented and managed by the IRB Accreditation and Compliance Specialist or an appropriate designee.

The IRBs have a role in QI from both a policy and review process perspective to ensure that there is general consistency among the IRBs in applying human subject protections. The OHRO Director will meet with IRB Chairs on a regular basis to identify common issues and concerns among the IRBs, and to work towards improvements. When needed to improve the overall performance of the IRB review process, the Director and IRB Chairs will include groups of members or the complete IRB membership in educational and guidance activities.

18.1 Assessing Compliance - Monitoring

Compliance will be assessed primarily through monitoring activities. All UICOMP employed investigators with open studies will be subject to IRB Directed or periodic monitoring of their study post approval.

Monitoring of external studies (research performed at an affiliated community institution or research performed by their staff) for which the PIRB 1 or PIRB 2 serves as the IRB of record will be limited to compliance concerns identified either during IRB meetings or resulting from complaints or concerns reported to the IRB or OHRO by subjects, research team members, or members of the community.
1. **IRB Directed Monitoring** – The IRB will direct the IRB Accreditation and Compliance Specialist or an appropriate designee to conduct a monitoring visit with a specific investigator. The IRB will provide the IRB Accreditation and Compliance Specialist or an appropriate designee with a description of the reason for which the monitoring is being requested. The IRB may ask that only a specific concern be addressed or that a comprehensive post approval monitoring of the study be conducted.

The IRB Accreditation and Compliance Specialist or an appropriate designee will contact the external investigator directly to schedule the visit. The IRB Accreditation and Compliance Specialist or an appropriate designee will provide the IRB, OHRO Director and the PI with a written summary of the visit. The IRB will determine whether any follow up is necessary. If details of possible noncompliance are contained in the report, the IRB will act in accordance with PEORIA IRB Policies and Procedures for dealing with noncompliance, Section 14.1. The PI will be instructed to self-report to his/her institution’s Human Protections Administrator any instances of noncompliance with the institutions Policies and Procedures.

2. **Post Approval Monitoring** - A not for cause, post approval monitoring event will be initiated by the IRB Accreditation and Compliance Specialist or an appropriate designee. The purpose of the visit will be to determine whether or not the study is being conducted in the manner in which it was approved by the IRB. A list of open studies will be consulted to identify studies for monitoring. Only studies being conducted by a UICOMP employed PI will be subject to post approval monitoring. Preference will be given to studies with higher risk or to studies with Principal Investigators who have never been monitored before.

The IRB Accreditation and Compliance Specialist or an appropriate designee will contact the UICOMP investigator directly to schedule the visit. The IRB Accreditation and Compliance Specialist or an appropriate designee will provide the IRB Chairs, the OHRO Director and the PI with a written summary of the visit. In the absence of any findings that require a response, the IRB Chairs will determine whether any follow up with the convened IRB is necessary. If a finding requires a response/corrective action, this will be shared in the report, the report will be shared with the convened IRB and the IRB will act in accordance with PEORIA IRB Policies and Procedures for dealing with noncompliance, Section 14.1. The PI will be instructed to self-report to his/her UICOMP Department Head and IO any instances of noncompliance with the institutions’ Policies and Procedures.

3. **DoD Monitoring Visit** - All UICOMP investigators who receive funding from the Department of Defense will be subject to a DoD Monitoring visit. The purpose of the DoD Monitoring visit is to ensure that the IRB review and investigator conduct of the study is in compliance with DoD regulations. Regulations applicable to
extramural, DoD funded studies found under DoDI 3216.02 as well as component specific requirements will be used to evaluate compliance.

Activities of monitors during any of the three above-referenced compliance visits may include:

a. Examining all research records held by the PI and research team members
b. Access to IRB approved documents as needed
c. Requesting progress reports
d. Observing research sites where human subjects research is being conducted, consent is being obtained, documents containing identifiable information are being stored, study drugs or devices are stored, or specimens are being kept.
e. Requesting Copies of Fully Executed Contracts (UICOMP held contracts only), grants or other funding agreements
f. Reviewing consent form documents
g. Reviewing HIPAA authorizations
h. Contacting Research Subjects
i. Reviewing recruitment material and advertisements
j. Talking with research team members
k. Talking with the Principal Investigator

The IRB Accreditation and Compliance Specialist or an appropriate designee will provide the IRB Chairs, OHRO Director and the PI with a written summary of the visit. The IRB Chairs will determine whether any follow up is necessary. If deficiencies in compliance are discovered, appropriate corrective and preventive actions must be implemented. Investigators will be expected to submit a corrective action preventative action (CAPA) plan to the IRB Chair of record in response to deficiencies identified during a monitoring event.

Additionally, education will be offered both at the time of discovery and if necessary, at a separately scheduled visit in order to ensure the nature of the deficiency is understood and can be effectively corrected (if possible) and prevented from occurring again. The IRB Chair will be responsible for approving the CAPA plan. The Investigator will be responsible for implementing the CAPA plan and reporting back to the IRB Chair once it has been completed. Upon satisfactory completion of the CAPA plan, the IRB Chair will alert the IRB Accreditation and Compliance Specialist or an appropriate designee that the monitoring event may be closed.

If details of possible serious or continuing noncompliance are contained in the report, the IRB Chair will refer the report to the IRB. The IRB will act in accordance with PEORIA IRB Policies and Procedures for dealing with noncompliance, Section 14.1.
In order to evaluate the effectiveness of the Monitoring Program, investigators who have had a monitoring visit will be asked to provide feedback. The feedback will be in an electronic survey format. Feedback will be used to improve the program.

4. **Internal IRB Compliance Review** – An internal review of the IRB review and approval process for specific studies. Studies will be chosen for review randomly.

One or more of the below-listed subgroups of document review areas A, B, C or D will be chosen by the IO for a focused quality improvement assessment. All documents prepared during the three months prior to the assessment will be reviewed for compliance.

The results of the quarterly Internal IRB Review will be presented in an aggregated quality improvement report to the IRB Chairs, the UICOMP HPA, and the IO. Areas with less than 100% compliance will be re-assessed every six months until 100% compliance is attained.

Activities included in an Internal IRB Compliance Review may include, but are not limited to:

A. **Review of IRB Meeting Minutes to assure documentation that:**
   1. Quorum was met and maintained
   2. The criteria for approval were discussed and documented
   3. HIPAA Privacy provisions were adequately reviewed, discussed, and documented
   4. Continuing Review discussions were meaningful and substantive
   5. Sub-part D determinations were discussed and documented
   6. Drug or device statuses were reviewed, discussed and documented
   7. Significant risk/nonsignificant risk determinations were discussed and documented
   8. Consideration of setting review period more often than annually was given

B. **Review of IRB Approval Letters to assure documentation that:**
   1. Sub-part D determinations were documented
   2. Approval period is stated
   3. HIPAA Privacy determinations were documented
   4. A statement is present stating that changes to the protocol or consent must be approved by the IRB prior to implementation
   5. A statement is present stating that events meeting the definition of a UPIRSO are reportable to the IRB
   6. A statement is present stating that each subjects should receive a copy of the consent form
7. Significant risk/non-significant risk determinations documentation for IDE studies

C. Review of Project/Protocol Review Forms to assure that:
   1. Key personnel listed on the protocol have required training and CV on file
   2. The IRB has approved only documented collaborating or external sites

D. Review of specific IRB studies to assure proper documentation to:
   1. Determine whether a lapse in approval occurred
   2. Determine if reporting procedures for unanticipated problems were followed
   3. Review primary reviewer checklists
   4. Verify the IRB has only approved collaborating or external sites
   5. And to verify appropriate record retention policies

18.2 Review metrics related to turn around times between submission and first review

The results of the Internal IRB Review will be presented on a study specific basis in a formal report to the IRB Chairs, the UICOMP HPA, and the IO. Deficiencies discovered during an Internal IRB Compliance Review may require a CAPA plan to be submitted by the Director of the Office of Human Research Oversight to the Institutional Official. The Institutional Official will approve the CAPA plan. The Director of the OHRO will be responsible for implementing the CAPA plan and reporting back to the IO when it has been completed. Upon satisfactory completion of the CAPA plan, the IO will alert the CIRB Specialist that the monitoring event may be closed.

Section 19: Participant Outreach

The UICOMP OHRO is committed to ensuring that educational opportunities are offered to research participants, prospective research participants, and community members which will enhance their understanding of research involving human participants at UICOMP.

The following procedures describe how the UICOMP OHRO fulfills that responsibility.

19.1 Outreach Resources and Educational Materials

The UICOMP OHRO periodically provides standard research presentations to address commonly requested information. Standard presentations include topics such as “The IRB Review Process”, “Using IRBNet”, “What is Human Subjects Research?”, and “The History of Human Subjects Research”. These standard presentations would likely be given on request to classes and possibly community groups who are interested in learning more about what the IRB does, but who are not necessarily researchers.
The UICOMP OHRO has a LibGuide page on UICOMP’s Library of Health Sciences website published under the “Research & Subject Guides” section of the Library homepage. The site will serve as an archive of all presentations provided to the public, as well as old volumes of the PIRB Newsletter. This site will be accessible to the general public so our community of researchers will also have full access to its content.

19.2 Evaluation

Feedback will be gathered on the quality of the standard research presentations in order to continuously improve education efforts. If feedback suggests the proposed format is not effective, changes will be made to enhance effectiveness.

Section 20: Other PEORIA IRB Policies and Procedures

20.1 Noncompliance with PEORIA IRB Policies, Procedures, or Decisions

When the IRB or the OHRO encounters information or allegations suggesting there has been serious or continuing noncompliance with the federal regulations related to human subject research, or to local UICOMP policies, the IRB or the OHRO may choose to refer the information or allegations to the HPA.

The HPA will send any allegations of serious or continuing noncompliance to the IRB for review. The investigator will be notified in writing if more information is required to investigate noncompliance issues. The decisions of the IRB will be communicated in writing to the investigator following completion of the review. A written report of the determinations and any required corrective action plan will be provided in a timely manner to the investigator, and the HPA. These communications will either notify the investigator that the research may continue, that the research may continue once a corrective action plan has been negotiated, or that the research may not continue due to placement of sanctions.

The duties of the IRB when reviewing allegations of serious or continuous noncompliance shall include:

- Receive complaints, review allegations of serious noncompliance or harm,
- Receive and consider recommendations from the HPA concerning instances of noncompliance,
- Communicate directly with investigators and with other institutional and government officials as appropriate and required,
- Consult with legal counsel as appropriate,
- Have direct access to the local Institutional Official for human subject research of the UICOMP and the UIC Vice Chancellor for Research when necessary.
The IRB may also require prompt reporting to sponsoring agencies, OHRP or the FDA (if the protocol involves drugs/devices) any suspension or termination of research protocol.

20.2 Genetic Studies

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 and limits on education options, and may create a social stigma. Knowledge of one's genetic make-up may also affect one's knowledge of the disease risk status of family members.

In studies involving genetic testing, several questions need to be addressed, including:

1. Will test results be given?
2. Will disease risk be quantified, including the limits on certainty of the testing?
3. Will a change in a family relationship be disclosed, such as mistaken paternity?
4. Does the subject or family member have the option not to know the results? How will this decision be recorded?
5. Could other clinically relevant information be uncovered by the study? How will disclosure of this added information occur?
6. Do any practical limitations exist on the subject's right to withdraw from the research, withdraw data, and/or withdraw DNA?
7. Is the subject permitted to participate in the study while refusing to have genetic testing (such as in a treatment study with a genetic testing component)?

For DNA banking studies, several questions need to be addressed, including:

1. Will DNA be stored or shared? If shared, will the subject's identity be known by the new recipient investigator?
2. Will the subject be contacted in the future by the investigator to obtain updated clinical information?
3. How can the subject opt out of any distribution or subsequent use of his/her genetic material?

20.3 Research Involving Coded Private Information or Biological Specimens

PEORIA IRB policy is based on the OHRP guidance document entitled, “Guidance on Research Involving Coded Private Information or Biological Specimens” (August 10, 2004 http://www.hhs.gov/ohrp/humansubjects/guidance/cdebiol.pdf). This document:

1. Provides guidance as to when research involving coded private information or specimens is or is not research involving human subjects, as defined under HHS regulations for the protection of human research subjects (45 CFR part 46).
2. Reaffirms OHRP policy that, under certain limited conditions, research involving only coded private information or specimens is not human subjects research.

3. Provides guidance on who should determine whether human subjects are involved in research.

For purposes of this policy, coded means that: (1) identifying information (such as name or social security number) that would enable the investigator to readily ascertain the identity of the individual to whom the private information or specimens pertain has been replaced with a number, letter, symbol, or combination thereof (i.e., the code); and (2) a key to decipher the code exists, enabling linkage of the identifying information to the private information or specimens.

Under the definition of human subject in Section 2 of this policy, obtaining identifiable private information or identifiable specimens for research purposes constitutes human subjects research. Obtaining means receiving or accessing identifiable private information or identifiable specimens for research purposes. This includes an investigator’s use, study, or analysis for research purposes of identifiable private information or identifiable specimens already in the possession of the investigator. In general, private information or specimens are considered to be individually identifiable when they can be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems. Private information or specimens are not considered to be individually identifiable when they cannot be linked to specific individuals by the investigator(s) either directly or indirectly through coding systems.

Research involving only coded private information or specimens do not involve human subjects if the following conditions are both met:

1. the private information or specimens were not collected specifically for the currently proposed research project through an interaction or intervention with living individuals;

and

2. the investigator(s) cannot readily ascertain the identity of the individual(s) to whom the coded private information or specimens pertain because, for example:
   a. the key to decipher the code is destroyed before the research begins;
   b. the investigators and the holder of the key enter into an agreement prohibiting the release of the key to the investigators under any circumstances, until the individuals are deceased (note that the HHS regulations do not require the IRB to review and approve this agreement); data use agreement
   c. 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

d. there are other legal requirements prohibiting the release of the key to the
investigators, until the individuals are deceased.

In some cases an investigator who obtains coded private information or specimens about living individuals under one of the conditions cited in 2(a)-(d) above may (1) unexpectedly learn the identity of one or more living individuals, or (2) for previously unforeseen reasons now believe that it is important to identify the individual(s). If, as a result, the investigator knows, or may be able to readily ascertain, the identity of the individuals to whom the previously obtained private information or specimens pertain, then the research activity now would involve human subjects. Unless this human subjects research is determined to be exempt (See Section 5.7), IRB review of the research would be required. Informed consent of the subjects also would be required unless the IRB approved a waiver of informed consent (See Section 7.8).

20.4 Who Should Determine Whether Coded Private Information or Specimens Constitutes Human Subjects Research?

The investigator in consultation with the IRB Chair or Director of the IRB Office will determine if the research involving coded information or specimens requires IRB review. If the request is verbal (by phone or in person) or by email, it is the investigator’s responsibility to maintain documentation of such a decision. If the investigator submits a formal submission, the request must include sufficient documentation of the activity to support the determination. Formal submissions will be responded to in writing and a copy of the submitted materials and determination letter/email will be kept on file.

20.5 Training Grants, Center Grants

In accordance with 45 CFR 46.118, UIC recognizes that there are some applications for grants, cooperative agreements, or other applications that are funded by federal departments or agencies with the knowledge that subjects may be involved within the period of support, but these applications do not include the specific plans for human subjects research in order to accomplish the aims of the application.

- “Core” or “Center” grants—these are institutional grants that will support individual research projects that are “yet to be determined” at the time of submission of the grant application, when the Core or Center grant will not enroll subjects directly, but supports separate protocols involving human subjects.
- Training grants—these applications request funding for research fellows or others who will be supported for the purpose of implementing human subject research, but the specific studies on which they participate are not part of the training grant application.
The federal funding agency and UIC policy requires that the grant be reviewed by the IRB prior to the funds being released to the investigator. The investigator must complete the “Development/Center/Training Grant” application, which may be reviewed via expedited review procedures. Because funding agencies are requiring continuing review of such grants, the grant itself will be assigned a continuing review approval period. Regardless of the type of grant, under NO circumstances may an investigator initiate human subjects research funded by the grant/contract, including pilot studies, prior to the review and approval of a separate IRB application or a Claim of Exemption (through OPRS) for the individual human subject research protocols.

When submitting the individual protocols, the investigator should note the parent grant as the source of funding. The OPRS Information system, RISC®, has the ability to link all protocols noted as being funded by the parent grant, to the parent grant for quick reference.

20.6 Policy & Procedures for Data Safety Monitoring Plans (DSMP)

For all research that is more than minimal risk, the investigator must submit a safety monitoring plan. The initial plan submitted to the IRB should describe the procedures for safety monitoring, reporting of unanticipated problems involving risks to subjects or others, descriptions of interim safety reviews and the procedures planned for transmitting the results to the IRB. This description should include information regarding an independent Data and Safety Monitoring Board (DSMB), if one exists, or an explanation why an independent data safety monitor is not necessary.

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

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

1. Monitoring is commensurate with the nature, complexity, size and risk involved.
2. Monitoring is timely. Frequency should commensurate with risk. Conclusions are reported to the IRB.
3. For low risk studies, continuous, close monitoring by the study investigator or an independent individual may be an adequate and appropriate format for
monitoring, with prompt reporting of problems to the IRB, sponsor and regulatory bodies as appropriate.

4. For an individual Safety Monitor the plan must include:
   • Parameters to be assessed
   • Mechanism to assess the critical efficacy endpoints at intervals in order to determine when to continue, modify, or stop a study.
   • Frequency of monitoring
   • Procedures for reporting to the IRB

5. For a Data Safety Monitoring Board, the plan must include:
   • The name of the Data Safety Monitoring Board
   • Where appropriate, is an independent from the sponsor
   • Availability of written reports
   • Composition of the monitoring group (if a group is to be used): experts in all scientific disciplines needed to interpret the data and ensure patient safety. Clinical trial experts, biostatisticians, bioethicists, and clinicians knowledgeable about the disease and treatment under study should be part of the monitoring group or be available if warranted.
   • Frequency and content of meeting reports
   • The frequency and character of monitoring meetings (e.g., open or closed, public or private)

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

20.7 International Research

No International Research is done.

20.8 Community Based Research (CBR)

No Community Based Research is done.
Section 21: Appendix

DEFINITIONS:

ACCRUAL TARGET: The number of required evaluable subjects, plus the number of anticipated inevaluable subjects, as described in the IRB-approved protocol and consent document.

ADVERSE EFFECT: An undesirable and unintended, although not necessarily unexpected, result of therapy or other intervention (e.g., headache following spinal tap or intestinal bleeding associated with aspirin therapy).

APPLICABLE CLINICAL TRIAL: A trial that generally includes interventional studies (with one or more arms) of FDA-regulated drugs, biological products, or devices that meet one of the following conditions:

a. the trial has one or more sites in the United States;
b. the trial is conducted under a U.S. FDA Investigational New Drug application (IND) or Investigational Device Exemption (IDE);
c. the trial involves a drug, biologic, or device that is manufactured in the United States or its territories and is exported for research.

ASSENT: Agreement by an individual not competent to give legally valid informed consent (e.g., a child or cognitively impaired person) to participate in research.

ASSURANCE: A formal written, binding commitment that is submitted to a federal agency in which an institution promises to comply with applicable regulations governing research with human subjects and stipulates the procedures through which compliance will be achieved.

AUTONOMY: Personal capacity to consider alternatives, make choices, and act without undue influence or interference of others.

BELMONT REPORT: A statement of basic ethical principles governing research involving human subjects issued by the National Commission for the Protection of Human Subjects in 1978.

BENEFICENCE: An ethical principle discussed in the Belmont Report that entails an obligation to protect persons from harm. The principle of beneficence can be expressed in two general rules: (1) do not harm; and (2) protect from harm by maximizing possible benefits and minimizing possible risks of harm.

BENEFIT: A valued or desired outcome; an advantage.

CHILDREN: Persons who have not attained the legal age for consent to treatment or procedures involved in the research, as determined under the applicable law of the jurisdiction in which the research will be conducted.

CLINICAL TRIAL: A controlled study involving human subjects, designed to evaluate prospectively the safety and effectiveness of new drugs or devices or of behavioral interventions.

CLINICALTRIALS.GOV: A registry of clinical trials. It is run by the United States National Library of Medicine (NLM) at the National Institutes of Health, and is the
largest clinical trials database, currently holding registrations from over 230,000 trials from 195 countries in the world.

CLOSED TO ACCRUAL: In contrast to a temporary suspension, the closure of a study to accrual typically is a permanent status change which occurs when the Investigator has either reached the target enrollment, or has decided for other reasons to end further accessions. A study that is closed to accrual may involve some subjects still in active treatment, or remain only open for follow-up information.

COGNITIVELY IMPAIRED: Having either a psychiatric disorder (e.g., psychosis, neurosis, personality or behavior disorders), and organic impairment (e.g., dementia) or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional functions to the extent that capacity for judgment and reasoning is significantly diminished. Other disorders include persons under the influence of or depended on drugs or alcohol and those suffering from degenerative diseases affecting the brain. Terminally ill patients, and persons with severely disabling physical handicaps, may also be compromised in their ability to make decision in their best interest.

COMPASSIONATE USE: See Emergency Use

COMPENSATION: Payment or medical care provided to subjects injured in research; does not refer to payment (remuneration) for participation in research.

COMPETENCE: Technically, a legal term, used to denote capacity to act on one’s own behalf; the ability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a “reasoned” choice.

COMPLETED: When all research data have been analyzed, and all subjects have been either enrolled on a long-term follow-up study or have been taken off of a study, the investigator may petition the IRB for completion of the study, usually in the context of a continuing review report. Only the IRB can complete the study, and once the study is completed, no further analysis of the data or any other research activity may be performed, including the recording of long-term follow-up data (without a new approval from the IRB).

CONFIDENTIALITY: Pertains to the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others without permission in ways that are inconsistent with the understanding of the original disclosure.

CONTROL (SUBJECTS) OR CONTROLS: Subject(s) used for comparison who are not given a treatment under study or who do not have a given condition, background, or risk factor that is the object of study. Control conditions may be concurrent (occurring more or less simultaneously with the condition under study) or historical (preceding the condition under study). When the present condition of subjects is compared with their own condition on a prior regimen or treatment, the study is considered historically controlled.

DATA AND SAFETY MONITORING BOARD: A committee of scientists, physicians, statisticians, and others that analyzes data during the course of a clinical trial to
monitor for adverse effects and other trends (such as an indication that one treatment is significantly better than another, particularly when one arm of the trial involves a placebo control) that would warrant modification or termination of the trial or notification of subjects about new information that might affect their willingness to continue in the trial.

**DECLARATION OF HELSINKI:** A code of ethics for clinical research approved by the World Medical Association in 1964 and widely adopted by medical associations in various countries. It was revised in 1975 and 1989.

**DECISIONAL INCAPACITY:** Refers to a person's mental status and means inability to understand information presented, to appreciate the consequences of acting (or not acting) on that information, and to make a choice. Often used improperly as a synonym for incompetence. Decisional incapacity can be determined by a physician.

**DHHS:** A federal agency: U.S. Department of Health and Human Services; formerly the Department of Health, Education and Welfare (DHEW).

**DRUG:** Any chemical compound that may be used on or administered to humans as an aid in the diagnosis, treatment, cure, mitigation, or prevention of disease or other abnormal conditions.

**EMANCIPATED MINOR:** A legal status conferred upon persons who have not yet attained the age of legal competency as defined by state law (for such purposes as consenting to medical care), but who are entitled to treatment as if they had by virtue of assuming adult responsibilities such as being self-supporting and not living at home, marriage, or procreation.

**EMERGENCY USE:** There are situations when a patient may have an indication for the use of an unapproved medical device or drug, but does not meet the criteria for enrollment onto an IRB-approved study. The Clinician must abide by the FDA and local IRB provisions for emergency use, including reporting the use to the IRB prospectively if possible, but at least within 5 days of the emergency use. Patients treated according to emergency use provisions are by definition not research subjects and their data may not be analyzed as part of a study.

**ENROLLMENT:** A subject is considered to be enrolled on a research study when a written informed consent document is signed.

**EXPEDITED REVIEW:** Review of proposed research by the IRB chair or a designated voting member of group of voting members rather than by the entire IRB. Federal rules permit expedited review for certain kinds of research involving no more than minimal risk and for minor changes in approved research.

**EXPERIMENTAL:** Term often used to denote a therapy (drug, device, procedure) that is unproven or not yet scientifically validated with respect to safety and efficacy. A procedure may be considered “experimental” without necessarily being part of a formal study (research) to evaluate its usefulness.

**EXPERIMENTAL STUDY:** A true experimental study is one in which subjects are randomly assigned to groups that experience carefully controlled interventions manipulated by the experimenter according to a strict logic allowing causal inference about the effects of the interventions under investigation.
FDA: Food and Drug Administration; an agency of the federal government established by Congress in 1912 and presently part of the Department of Health and Human Services.

FETUS: The product of conception from the time of implantation until delivery. If the delivered or expelled fetus is viable, it is designated an infant. The term “fetus” generally refers to later phases of development; the term “embryo” is usually used for earlier phases of development.

FULL BOARD REVIEW: Review of proposed research at a convened meeting at which a majority of the membership of the IRB are present, including at least one member whose primary concerns are in nonscientific areas. For the research to be approved, it must receive the approval of a majority of those members present at the meeting.

GRANT: Financial support provided for research study designed and proposed by the principal investigator(s). The granting agency exercises no direct control over the conduct of approved research supported by a grant.

GUARDIAN: An individual who is authorized under applicable state or local law to give permission on behalf of a child to general medical care.

HUMAN SUBJECTS: Individuals whose physiologic or behavioral characteristics and responses are the object of study in a research project. Under the DHHS regulations, human subjects are defined as: living individual(s) about whom an investigator conducting research obtains: (1) data through intervention or interaction with the individual; or (2) identifiable private information. FDA further defines the term as follows: “Human Subject” means an individual who is or becomes a participant in research, either as a recipient of a test article or as a control. A Subject may be either a healthy human or a patient.

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, subjects 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.

INCOMPETENCE: A legal term meaning inability to manage one's own affairs. Often used as a synonym for incapacity (lacking the capacity to make an informed decision), incompetence can only be determined by a judge in a court of law.

INSTITUTIONAL REVIEW BOARD: (IRB) means any board committee, or other group formally designated by an institution to review, to approve the initiation of, and to conduct periodic review of, clinical research involving human subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the human subjects.

INVESTIGATIONAL NEW DRUG OR DEVICE: A drug or device permitted by 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.

INVESTIGATOR: In clinical trials, an individual who actually conducts an investigation. Any interventions (e.g., drugs) involved in the study are administered to subjects under the immediate direction of the investigator.
LEGALLY AUTHORIZED REPRESENTATIVE: A person authorized either by statute or by court appointment to make decisions on behalf of another person. In human subjects’ research, 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.

LIAISON COMMITTEE: The UICOMP Institutional Official and Human Protections Administrator with direct responsibility for the PEORIA IRBs participate in a larger advisory Committee that assists in the oversight and direction for the PEORIA IRB. The Liaison Committee consists of one representative of each Institution appointed by that Institution. The Regional Dean of University of Illinois, College of Medicine-Peoria chairs over this committee. The Committee is consulted with over appointments of PEORIA IRB members and Chairs. In addition, the Liaison Committee may be approached by an investigator if there are complaints regarding a determination by the IRB. The Liaison Committee may choose to appoint subcommittee of PEORIA IRB to review the project or determination in question, and provide a written report of its findings to PEORIA IRB with their recommendations.

MEDICAL DEVICE: A diagnostic or therapeutic article that does not achieve any of its principal intended purpose through chemical action within or on the body. Such devices include diagnostic test kits, crutches, electrodes, pacemakers, arterial grafts, intraocular lenses, and orthopedic pins or other orthopedic equipment.

MINIMAL RISK: A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. For example, the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as part of routine physical examination. The definition of minimal risk for research involving prisoners differs somewhat from that given for non-institutionalized adults.

MONITORING: The collection and analysis of data as the project progresses to assure the appropriateness of the research, its design and subject protections.

NIH: National Institutes of Health: a federal agency within the Public Health Service, DHHS, comprising 21 institutes and centers. It is responsible for carrying out and supporting biomedical and behavioral research.

NUREMBERG CODE: A code of research ethics developed during the trials of Nazi war criminals following World War II and widely adopted as a standard during the 1950s and 1960s for protecting human subjects.

OFFICE FOR Human Research Protections (OHRP): The office within the Department of Health and Human Services, responsible for implementing DHSS regulations (45 CFR 46) governing research involving human subjects.

PHASE I, II, III, IV DRUG TRIALS: Different stages of testing drugs in humans, from first application in humans (Phase I) through limited and broad clinical tests (Phase III), to post marketing studies (Phase IV).
**Phase I Drug Trial** Phase I trials include the initial introduction of an investigational new drug into humans. These studies are typically conducted with healthy volunteers; sometimes, where the drug is intended for use in patients with a particular disease, however, such patients may participate as subjects. Phase I trials are designed to determine the metabolic and pharmacological actions of the drug in humans, the side effects associated with increasing doses (to establish a safe dose range), and, if possible, to gain early evidence of effectiveness; they are typically closely monitored. The ultimate goal of Phase I trials is to obtain sufficient information about the drug’s pharmacokinetic and pharmacological effects to permit the design of well-controlled, sufficiently valid Phase II studies. Other examples of Phase I studies include studies of drug metabolism, structure activity relationships, and mechanisms of actions in humans, as well as studies in which investigational drugs are used as research tools to explore biological phenomena or disease processes. The total number of subjects involved in Phase I investigations is generally in the range of 20-80.

**Phase II Drug Trial** Phase II trials include controlled clinical studies conducted to evaluate the drug’s effectiveness for a particular indication in patients with the disease or condition under study, and to determine the common short-term side effects and risks associated with the drug. These studies are typically well controlled, closely monitored, and conducted with a relatively small number of patients, usually involving no more than several hundred subjects.

**Phase III Drug Trial** Phase III trials involve the administration of a new drug to a larger number of patients in different clinical settings to determine its safety, efficacy, and appropriate dosage. They are performed after preliminary evidence of effectiveness has been obtained, and are intended to gather necessary additional information about effectiveness and safety for evaluating the overall benefit-risk relationship of the drug, and to provide an adequate basis for labeling. In Phase III studies, the drug is used the way it would be administered when marketed. When these studies are completed and the sponsor believes that the drug is safe and effective under specific conditions, the sponsor applies to the FDA for approval to market the drug. Phase III trials usually involve several hundred to several thousand patient-subjects.

**Phase IV Drug Trial** Concurrent with marketing approval, FDA may seek agreement from the sponsor to conduct certain post marketing (Phase IV) studies to delineate additional information about the drug’s risks, benefits, and optimal use. These studies could include, but would not be limited to, studying different doses or schedules of administration than were used in Phase II studies, use of the drug in other patient populations or other stages of the disease, or use of the drug over a longer period of time.

**PLACEBO:** A chemically inert substance given in the guise of medicine for its psychologically suggestive effect; used in controlled clinical trials to determine whether improvement and side effects may reflect imagination or anticipation rather than actual power of a drug.
PRINCIPAL INVESTIGATOR: The scientist or scholar with primary responsibility for the design and conduct of a research project.

PROTOCOL: The formal design or plan of an experiment or research activity; specifically, the plan submitted to an IRB for review and to an agency for research support. 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.

PROTOCOL DEVIATION: Any change, divergence, or departure from the approved study design or procedures of a research protocol that is under the investigator’s control and that has not been approved by the IRB, and does not affect the participant’s safety, rights, or welfare and/or the completeness, accuracy and integrity of the study data. This term is (i) most often used when the variance is an unintended change that is not considered as serious as a violation, (ii) is considered minor or administrative, and (iii) may involve no more than minimal risk to participants or others.

PROTOCOL EXEMPTION: There are situations when an eligibility criterion, or some other aspect of the research protocol would need to be modified in order to enroll a particular research subject on a study. In the circumstances of a medical emergency, with the likelihood of impending permanent morbidity or mortality, the Investigator-Clinician should employ as many prospective human subjects protections as practicable, including informing the IRB Chair, obtaining written informed consent from the patient/parents, and the concurrence of an independent physician (which should be documented in the medical record). Patients who do not meet the eligibility criteria according to the IRB-approved protocol may not be enrolled as research subjects without the written, prospective approval of the IRB and their data may not be collected or analyzed as part of the research.

PROTOCOL VIOLATION: Any deviation that may adversely affect the subject’s rights, safety, or welfare, and/or the completeness, accuracy and integrity of the study data. A protocol violation is often considered a major, more serious, variance from an approved protocol than a deviation.

RESEARCH: A systematic investigation (i.e., the gathering and analysis of information) designed to develop or contribute to generalizable knowledge.

RISK: The probability of harm or injury (physical, psychological, social, or economic) occurring as a result of participation in a research study. Both the probability and magnitude of possible harm may vary from minimal to significant. Federal regulations define only “minimal risk.”

SPONSOR (OF A DRUG TRIAL): A person or entity that initiates a clinical investigation of a drug – usually the drug manufacturer or research institution that developed the drug. The sponsor does not actually conduct the investigation, but rather distributes the new drug to investigators and physicians for clinical trials. The drug is administered to subjects under the immediate direction of an investigator who is not also a sponsor. A clinical investigator may, however, serve as a sponsor-investigator. The sponsor assumes responsibility for investigating the new drug, including responsibility for compliance with applicable laws and
regulations. The sponsor, for example, is responsible for obtaining FDA approval to conduct a trial and for reporting the results of the trial to the FDA.

**SPONSOR-INVESTIGATOR:** An individual who both initiates and actually conducts, alone or with others, a clinical investigation. Corporations, agencies, or other institutions do not qualify as sponsor-investigators.

**SUSPENSION:** Suspension of IRB approval is a directive of the convened IRB or IRB designee either to stop temporarily some or all previously approved research activities, or to stop permanently some previously approved research activities. Suspended protocols remain open and require continuing review.

**TARGET ACCRUAL:** See accrual target.

**TERMINATION:** Termination of IRB approval is a directive of the convened IRB or IRB designee to stop permanently all activities in a previously approved research protocol. Terminated protocols are considered closed and no longer require continuing review.

**VOLUNTARY:** Free of coercion, duress, or undue inducement. Used in the research context to refer to a subject’s decision to participate (or to continue to participate) in a research activity.

**Section 22: Revision Log**

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