



**MISSISSIPPI STATE**  
**UNIVERSITY™**

# Human Research Protection Program

## Operations Manual



# **Quick Reference Guide: Updates to Operations Manual**

## **Version Dated December 2020**

-Added Required Elements regarding Department of Defense requirements at DODI 3216.02 (revised April 2020) per the request of AAHRPP.

# Table of Contents

Section 1: Human Research Protection Program Policies .....	6
Scope of the Human Research Protection Program (HRPP).....	6
Mission of the HRPP .....	6
Engagement in Research .....	9
Categories of Participants.....	10
Ensuring Compliance.....	10
Components of the Organization .....	10
Management of HRPP Documents .....	10
Federal Wide Assurance (FWA) .....	11
Organization of the HRPP/IRB and Personnel .....	11
Consultants to the IRB.....	13
Conflict of Interest (COI) for IRB Members or Consultants.....	14
Undue Influence of the HRPP .....	15
MSU Investigators .....	15
Investigator Responsibilities (PI).....	15
Conflict of Interest for the Institution, Investigators and Research Team.....	15
Determining What Constitutes Research .....	15
Scientific Merit or Scholarly Validity .....	16
Consent, Parental Permission, and Child Assent.....	16
Deception and Incomplete Disclosure.....	16
Participant Incentives.....	17
Appeal of an IRB Decision.....	17
Collaborative Research .....	17
Humanitarian Use of a Device on Human Participants.....	17
Research Data Security.....	17
Significant and Nonsignificant Risk for a Medical Device Study.....	17
Research Participant Pools .....	17
Investigator Separation and Ownership of Human Participants Data.....	18
Special Protections for Vulnerable Participants .....	18
Compliance and Quality Assurance Program .....	18
Federally Funded Research.....	19
Section 2: HRPP / IRB Operations.....	19
Part A. Activities of the HRPP .....	19
Records of the HRPP .....	20
Study Records .....	20

Pre-Review of Protocols .....	21
Developmental Approval.....	21
Exempt Reviews.....	22
Categories for Exemption Determination .....	23
Informed Consent.....	26
Notifications of Determinations .....	26
Part B. IRB Standard Operating Procedures.....	26
IRB Authority .....	26
IRB Records.....	26
Education of IRB Members.....	27
IRB Evaluation.....	28
Membership of the IRB.....	28
Minutes of the IRB .....	28
Conflict of Interest for IRB Members or Consultants .....	29
IRB Review Procedures.....	30
Expedited Review.....	32
CIRB Review .....	34
CIRB Meeting .....	34
Waivers of Consent .....	36
"Passive" Consent and Parental Notification.....	38
Re-consent of Minors who are now Adults.....	38
The "informed consent should be viewed as an ongoing process throughout the duration of a research project. When a child who was enrolled in research with parental or guardian permission subsequently reaches the legal age of consent to the procedures involved in ongoing research, the subject's participation in the research is no longer regulated by the requirements of 45 CFR part 46.408 regarding parental or guardian permission and subject assent." Therefore, when a minor participant reaches the age of 18 and is still undergoing research procedures, re-consent is necessary. The informed consent Federal guidance states "Unless the Institutional Review Board (IRB) determines that the requirements for obtaining informed consent can be waived, the investigators should seek and obtain the legally effective informed consent, as described in 45 CFR 46.116, for the now-adult participants for any ongoing interactions or interventions with the participants." .....	38
Observation of the Informed Consent Process .....	38
Deception and Incomplete Disclosure.....	38
Withdrawal from Clinical Trials.....	40
Amendments to Approved Studies.....	41
Continuing Review of Approved Studies.....	41
Appeal of an IRB Decision.....	43
Collaborative Research .....	43

Multi-Site Research .....	49
Significant Risk (SR) and Non-Significant Risk (NSR) for a Medical Device Study .....	50
Compliance and Quality Assurance Program (CQAP) .....	51
Part C: Responsibilities of MSU Investigators .....	57
Required Human Subjects Training .....	57
Protocol Submissions and Review .....	58
Determining What Requires HRPP/IRB Oversight .....	59
Research Participant Pools .....	62
Research Data Security .....	63
Financial Conflict of Interest for the Institution, Investigators and Research Team.....	64
Investigator Separation and Ownership of Human Participants Data .....	65
Participant Protections.....	66
Vulnerable Participants.....	67
Code of Federal Regulations Definitions.....	67
Mississippi Code of 1972 Definitions .....	67
Section 3: Federally Funded Studies.....	77
Consent, Parental Permission, Child Assent and Waivers .....	78
Continuing Review of Approved Studies .....	81
Data Safety and Monitoring .....	82
Financial Conflict of Interest for the Institution, Investigators and Research Team.....	82
Noncompliance.....	83
Research Data Security .....	83
Requirements for IRB Approval of Non-Exempt Studies .....	83
Scientific Merit or Scholarly Validity .....	86
Suspensions and Terminations of Previously Approved Research .....	86
Unanticipated Problems Involving Risks to Participants or Others .....	86
Section 4: Glossary .....	86

[Merit Merit](#)

# Section 1: Human Research Protection Program Policies

## Scope of the Human Research Protection Program (HRPP)

### Mission of the HRPP

The MSU HRPP (herein referred to as HRPP) will strive toward the highest protection of human research participants and to cultivate, through education, an atmosphere of such protection throughout the entire University research community. We will promote the highest ethical standards for the conduct of human subjects research, and we will make ongoing efforts to identify and implement best practices for those efforts. The HRPP will endeavor to be a cohesive team to provide effective and efficient service to the University research community, and to do so in a supportive and pleasant environment.

The HRPP and the Institutional Review Board for the Protection of Human Subjects (herein referred to as IRB) are the **only** entities delegated the authority to approve, require modification to, or disapprove all research involving human subjects activities performed under the auspices of MSU. Therefore, individuals with questions pertaining to human subject protection issues should contact the HRPP Staff, HRPP Officer, IRB Chair, or Director of the Office of Research Compliance and Security for guidance. The HRPP follows the ethical principles of the [Belmont Report](#) to govern the conduct of all research involving human participants.

MSU predominantly conducts research of a Social/Behavioral nature, as well as some Biomedical research. As such, the organization follows the Department of Health and Human Services (herein referred to as DHHS) regulations, overseen by the Office for Human Research Protections (herein referred to as OHRP), as well as the Food and Drug Administration (herein referred to as FDA) regulations, regarding human subjects research.

In accordance with Subpart A of the Code of Federal Regulations (CFR), also known as the [Common Rule](#), the regulatory definitions are the basis for the criteria used to determine if the research meets the federal definition of “research” and “human subjects” ([§46.102](#)).

**Research** - a *systematic investigation*, including research development, testing, and evaluation, designed to *develop or contribute to knowledge*. Activities that meet this definition constitute research for the purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes.

**For purposes of this part, the following activities are deemed not to be research (that would require HRPP/IRB oversight):**

(1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected.

(2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters).

(3) Collection and analysis of information, biospecimens, or records by or for a

criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes.

(4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

**Human subject** - a living individual about whom an investigator (whether professional or student) conducting research:

- (1) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or
- (2) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.

In addition to the above, the following definitions apply when the research is federally funded by the following agencies:

**FDA (21 CFR 50):**

*Clinical investigation* means any experiment that involves a test article and one or more human participants and that either is subject to requirements for prior submission to the FDA under §505(i) or §520(g) of the Act, or is not subject to requirements for prior submission to the FDA under these sections of the Act, but the results of which are intended to be submitted later to, or held for inspection by, the FDA as part of a protocol for a research or marketing permit. The term does not include experiments that are subject to the provisions of [part 58](#) of this chapter, regarding nonclinical laboratory studies.

*Human subject* means an individual who is or becomes a participant in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient.

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

**Department of Justice (DoJ) Regulations (28 CFR 512)**

For research conducted within the *Bureau of Prisons* (which is under the DOJ) Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.

The investigator must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the investigator.

The investigator must have academic preparation or experience in the area of study of the proposed research.

When submitting a research proposal, the applicant shall provide the following information:

- A summary statement, which includes:
- Names and current affiliations of the investigators
  - Title, purpose, location and duration of the study

- Methods to be employed
- Anticipated results
- Number of participants (staff or inmates) required and amount of time required from each
- Indication of risk or discomfort involved as a result of participation.

A comprehensive statement, which includes:

- Review of related literature
- Detailed description of the research method
- Significance of the anticipated results and their contribution to the advancement of knowledge
- Specific resources required from the Bureau of Prisons
- Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur
- Description of steps taken to minimize any risks.

Description of physical or administrative procedures to be followed to:

- Ensure the security of any individually identifiable data that are collected for the study.
- Destroy research records or remove individual identifiers from those records when the research has been completed.

Description of any anticipated effects of the research study on organizational programs and operations.

Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.

A statement regarding assurances and certification required by [28 CFR 46](#), if applicable.

The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing.

The research design must be compatible with both the operation of prison facilities and protection of human participants. The investigator must observe the rules of the institution or office in which research is conducted.

Any investigator who is a non-employee of the Bureau must sign a statement in which the investigator agrees to adhere to the provisions of [28 CFR 512](#).

The Bureau Research Review Board will review all research proposals.

**Environmental Protection Agency (EPA) Regulations (40 CFR 26 Subparts C and D):**

EPA prohibits research involving the intentional exposure of pregnant women, nursing women, or children to any substance.

The EPA requires additional protections to pregnant women and children as participants in observational research, i.e., research does not involve intentional exposure to any substance.



EPA policy requires submission of HRPP determinations and approval to the EPA human subjects research review official for final review and approval before the research can begin.

For research not conducted or supported by any federal agency that has regulations for protecting human research participants, and for which the intention of the research is submission to the EPA, the EPA regulations protecting human research participants apply, including:

- EPA extends the provisions of the [40 CFR 26](#) to human research involving the intentional exposure to non-pregnant, non-nursing adults to any substance.
- EPA prohibits the intentional exposure of pregnant women, nursing women, or children to any substance.

All activities that meet the above requirements must be submitted to and reviewed by the HRPP to determine the appropriate level of review in accordance with the applicable regulations, regardless of whether the research is conducted within or outside the State of Mississippi. All student-led research must be conducted with direct oversight of a faculty or staff advisor. Any amendments of an approved study cannot be initiated without HRPP approval.

### **Engagement in Research**

The HRPP follows the OHRP guidance entitled "[Engagement of Institutions in Human Subjects Research](#)" to determine when the Institution is "engaged in research."

Individuals considered as agents of MSU include all faculty, staff, and students acting in the capacity of an affiliate of the Institution. MSU faculty and staff engaging in employment (practice of profession, consulting or business) outside of MSU in accordance with Human Resources Management policy 60.415, [Outside Employment and Consulting](#)," are not considered agents of the Institution during such outside employment.

The HRPP expects that all investigators, IRB members, HRPP staff, as well as the Institutional Official (herein referred to as IO) overseeing or conducting research under the auspices of MSU will adhere to the basic ethical principles of respect for persons, beneficence, and justice as outlined in the [Belmont Report](#).

The Institution will include non-employees (such as adjunct faculty, visiting faculty, and visiting scholars) as agents of the Institution (and thereby covered under the auspices of the HRPP) only when they are acting in a capacity directly related to the Institution's business (such as service on a graduate student's committee).

Those individuals not affiliated with MSU will be asked to provide documentation of IRB approval from their home institution or request that MSU will serve as the IRB of record.

Any entities or individuals being asked to participate in a research study may visit our website at [www.orc.msstate.edu/human-subjects/participant-information](http://www.orc.msstate.edu/human-subjects/participant-information) for resources pertaining to their rights as a participant and questions to ask before and after the study.

## Categories of Participants

MSU conducts research involving, but not limited to, the following categories of participants:

1. Adults with and without decision-making impairment
2. Children with and without decision-making impairment Pregnant women
3. Prisoners
4. Students and employees of the institution

MSU does not, by policy, exclude any types of research or research involving any specific categories of participants.

## Ensuring Compliance

The HRPP works with other institutional entities to ensure all required approvals are in place prior to the conduct of human subjects research. The Office of Sponsored Projects (herein referred to as OSP) will not release funding for human subjects research prior to approval of the project by the HRPP. If a sponsor requires that IRB documentation accompany the grant proposal, the researcher can submit a protocol for Developmental Approval until funding is secured and the protocol can be resubmitted for full approval. The HRPP will notify all investigators in writing of their approval status. Additionally, the HRPP provides guidance to investigators and the IRB concerning activities that sometimes are or are not overseen by the HRPP, such as classroom research, quality improvement, case reports, program evaluation, surveillance activities, and routine training regarding required approvals to the campus community.

When contacted by research participants, the HRPP provides information such as, but not limited to: participant rights, any problems, concerns or questions pertaining to the participant's involvement in the research study, and appropriate procedures to reporting any problems or concerns. The HRPP Officer, who maintains an electronic record of the incident, manages participant complaints. Complaints are resolved according to the procedures outlined in the Compliance and Quality Assurance Program (CQAP) section under [Unanticipated Problems](#).

The HRPP communicates with the MSU research community in a variety of methods. Changes in policy and procedures, training opportunities, as well as pertinent information regarding human subjects research are highlighted in emails, the myProtocol system, on the ORCS website, or in face-to-face interactions. The HRPP conducts Post-Approval Monitoring (PAM) activities in accordance with the policy and procedures pertaining to the Compliance and Quality Assurance ([CQA](#)) [Activities Performed by the IRB](#).

## Components of the Organization

MSU has no components of the institution that are viewed as separate organizations.

## Management of HRPP Documents

[§46.115\(b\)](#) states, "The records required by this policy shall be retained for at least 3 years, and records relating to research which is conducted shall be retained for at least 3 years after the completion of the research. The institution or IRB may maintain the records in printed form, or electronically. All records shall be accessible for inspection and copying by authorized representatives of the Federal department or agency at reasonable times and in a reasonable manner." Requests by the public to see IRB records must go through open records request.

The Chair and the HRPP Officer approve and/or rescind new or modified policies and procedures. The HRPP utilizes the myProtocol system for the submission and review of online

protocols, amendments, etc. Other HRPP operational documents are created, approved, updated and revised by the HRPP, and are uploaded into the myProtocol system.

### **Federal Wide Assurance (FWA)**

The IO is the individual authorized to act for and on behalf of the institution, and obligates the institution to the terms of the FWA.

MSU's FWA number with OHRP is FWA00000203.

### **Organization of the HRPP/IRB and Personnel**

The IO is the key Institutional leader authorized by the University President to act on the Institution's behalf, specifically committing the Institution to compliance with all requirements of ([45 CFR 46](#)), and other applicable federal regulations (e.g., [21 CFR 50](#) and [§56](#)). The University Policy and Procedure Statement on Human Subjects at Mississippi State University ([OP 79.03](#)) names the Vice President for Research and Economic Development as the IO.

### **Responsibilities of the IO**

The IO is responsible for the following:

- Designating one or more IRBs that will review research covered by the institution's FWA.
- Providing sufficient resources, space, and staff to support the IRB's review and record keeping duties. To evaluate these needs, the IO regularly meets with the Assistant VP for Research and Director of the Office of Research Compliance and Security, who communicate with the HRPP Officer about the program regarding any potential resources that are needed to facilitate the research enterprise for the University. At least annually, these resources are evaluated to see if any changes need to be made to accommodate the growing research portfolio at MSU.
- In the instance of community outreach, ensures that the HRPP has sufficient resources to carry out the needs to facilitate such research activities;
- Providing training and educational opportunities for the IRB and investigators.
- Setting the tone for an institutional culture of respect for human participants;
- Ensuring effective institution-wide communication and guidance on human subjects research;
- Ensuring that investigators fulfill their responsibilities;
- Encouraging that all staff engaged in the conduct or oversight of human subject research participate in education activities;
- Serving as a knowledgeable point of contact for OHRP, or delegating this responsibility to another appropriate individual.

The IO delegates to the HRPP Officer and the IRB Chair the authority to carry out the activities of the HRPP. The HRPP establishes the policies and procedures, which are carried out by the HRPP staff and the IRB.

### **Responsibilities of the HRPP Officer**

The HRPP Officer serves as the Human Protections Administrator (HPA) at MSU and has the additional responsibilities of:

- Carrying out delegated duties as outlined for the IO
- Conducting reviews of IRB protocols submitted through the myProtocol system

- Provide oversight for and submission of the Association for the Accreditation of Human Research Protection Programs ([AAHRPP](#)) accreditation and Annual Report documents
- Administer policy and procedures for the protection of human participants
- Serve as the institutional point of contact for AAHRPP, OHRP, and any other sponsoring agency
- Ensuring that all collaborations, funded or unfunded, are conducted in accordance with Federal, State, and local laws and institutional policies and procedures
- Serve as a point of contact for the MSU research community

### **Responsibilities of the IRB Chair**

The IO will appoint an individual with appropriate knowledge, skills, and leadership abilities necessary to serve as the IRB Chair. The Chair of the IRB will be appointed for renewable terms of three years, and is responsible for ensuring the safety and welfare of human subjects research participants through the effective implementation of all Federal, State, and local laws, and institutional policies and procedures. Further, they are tasked with ensuring that the matters brought before the board are done so with fairness and impartiality. Additional responsibilities of the Chair include, but are not limited to, the following:

- Carrying out delegated duties as outlined for the IO
- Meeting with the IO (or designee) at least once per semester to discuss the needs, resources and direction of the IRB
- Administer policy and procedures for the protection of human participants
- Reviewing project protocols and related consent forms and evaluating them in terms of criteria for approval
- Convening IRB meetings for full review and chairing the Convened IRB (CIRB) meetings
- Issuing formal decisions on protocols reviewed by the CIRB, in consultation with HRPP Staff
- Maintaining confidentiality regarding the drafts, documents and protocols reviewed and discussions undertaken by the IRB, whether as a current or former member
- Serve as a point of contact for the MSU research community

The Vice Chair is also appointed by the IO to assume the responsibility of the IRB Chair in the event the Chair cannot participate.

### **Appointment and Responsibilities of IRB Members**

The IO appoints members of the IRB for terms up to three years. Appointments are made based on the needs of the IRB to meet regulatory and organizational requirements, including the need for scientific and scholarly expertise appropriate for the review of research in which the Institution is engaged. Membership of the IRB may be comprised of faculty, staff, and students of the Institution, as well as members of the community. Individuals who are responsible for business development are prohibited from serving as members or ex-officio members on the IRB or carrying out day-to-day operations of the review process. IRB membership records are kept and reported according to [Records of the HRPP](#).

Federal Policy [§46.107](#) requires that IRBs must have at least five members with varying backgrounds to promote complete an adequate review of research activities commonly

conducted by the institution. The IRB must be sufficiently qualified through the experience and expertise of its members and the diversity of their backgrounds, including considerations of their racial and cultural heritage and their sensitivity to issues, such as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human participants. Composition of the IRB will be:

1. The IRB must have at least five members with varying backgrounds to promote complete and adequate review of research commonly conducted by the organization.
2. The IRB may not be comprised exclusively of all males or all females.
3. The IRB may not be comprised exclusively of members of a single profession.
4. The IRB must have at least one member whose primary concerns are in scientific areas.
5. The IRB must have at least one member whose primary concerns are in nonscientific areas.
6. The IRB must have at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.
7. The IRB must have at least one member who represents the perspective of research participants.

Additional responsibilities of IRB members include, but are not limited to the following:

- Administering policy and procedures for the protection of human participants
- Reviewing project protocols and related consent forms and evaluating them in terms of criteria for approval
- Attending and participating in IRB meetings
- Voting on formal decisions on CIRB reviewed protocols, in consultation with HRPP Staff
- Maintaining confidentiality regarding the drafts, documents and protocols reviewed and discussions undertaken by the IRB, whether as a current or former member
- Informing the HRPP Officer, IRB Chair, or IO of noncompliance or of any attempts to inappropriately influence the IRB
- Serve as a liaison and ambassador for the MSU research community

### **Consultants to the IRB**

IRB will use consultants for reviews of research when it does not have the appropriate scientific or scholarly expertise to understand and conduct an in-depth review of a protocol, or does not have representation with knowledge about or experience with categories of participants vulnerable to coercion or undue influence. The consultant is responsible for providing the IRB with written concerns and recommendations regarding the research to ensure a complete review. Consultants may attend the CIRB meeting to discuss the research, but they do not vote with the IRB members.

### **HRPP Staff**

The HRPP staff members are trained to support all operations of the HRPP and assist the MSU research community with the conduct of their research.

Additional responsibilities of HRPP Staff include, but are not limited to the following:

- Assisting the HRPP Officer and IRB Chair in the conduct of their duties as outlined above
- Administering policy and procedures for the protection of human participants
- Reviewing and approving Exempt research
- Conducting pre-reviews of all submissions
- Attending IRB meetings
- Serve as a liaison and ambassador for the MSU research community

### **Conflict of Interest (COI) for IRB Members or Consultants**

It is the responsibility of each IRB member or Consultant to reveal any potential conflict of interest to the IRB Chair or HRPP Officer as soon as it is recognized, regardless of the IRB activity. [§46.107\(d\)](#) states, “No IRB may have a member participate in the IRB’s initial or continuing review of any project, in which the member has a conflicting interest, except to provide information requested by the IRB.” COI applies to any matter brought before the IRB.

No IRB member may participate in the review of a protocol in which the member has an actual conflicting interest or the appearance of a conflict exists, except to provide information requested by the HRPP.

When an IRB member works with an investigator prior to submission to the HRPP to help design the protocol and write the consent document to enhance the likelihood of approval, that member is conflicted because that individual is then involved in the design of the research. In instances where an HRPP staff member assists in this manner, another HRPP staff member will conduct the review and approval process for that study.

### **Financial Conflict of Interest (FCOI)**

In order to avoid real or perceived conflicts of interest, (i) no participating IRB member or consultant may hold an equity interest (*e.g.*, partnership, stock, or profit-sharing) in the organization requesting HRPP review; (ii) no participating IRB member or consultant may be paid more than reasonable compensation or receive more than reasonable benefits for IRB-related activities; and (iii) no IRB member or consultant may receive compensation or benefits under arrangements that could impede or discourage objective decision-making on behalf of human participants.

### **Institutional Conflict of Interest Related to Licensing**

When Mississippi State University licenses technology or other intellectual property, it may receive equity in a company as a result of that license and/or a royalty or other fee as compensation for the use of that intellectual property. An institutional conflict of interest is created if an investigator undertakes human subjects research on a drug, device, biologic, or other item on which MSU has a patent, has licensed the intellectual property, or receives royalties or other fees. Cases involving a possible institutional conflict of interest related to licensing will be reviewed by an external IRB per the Memorandum of Understanding (MOU) executed between the two institutions.

### **Major Gifts to Mississippi State University Foundation**

The MSU Foundation receives, invests, and administers private support for MSU consistent with MSU’s priorities and mission. An institutional conflict of interest is created if a Major Donor (> \$10,000) sponsors human subjects research at Mississippi State University. Research involving a possible institutional conflict of interest related to major gifts will be reviewed by an external IRB per the Memorandum of Understanding (MOU) executed between the two institutions.



### **Undue Influence of the HRPP**

MSU policy [OP 79.03](#) states that, "[t]he IRB has the authority to act independently to bind all activities falling under their purview. No other University official or committee may approve human subjects research that has not been approved by the HRPP. Any attempt to inappropriately influence the HRPP will not be tolerated." For reporting and responding to reports see [Undue Influence of the IRB](#).

## **MSU Investigators**

### **Investigator Responsibilities (PI)**

The University Policy and Procedure Statement on Ethics in Research and Other Scholarly Activities at MSU ([OP 80.02](#)) states, "the highest standards of honesty, integrity and ethical behavior are expected of all personnel involved in research and scholarly activities [at] our institution ... [t]hese standards are expected of all administrators, faculty, staff members, and students." Additionally, it is the responsibility of MSU students to refrain from any form of violation of the [Student Honor Code](#).

Investigators play a crucial role in protecting the rights and welfare of human participants and are responsible for carrying out sound ethical research consistent with research plans approved by the HRPP/IRB. It is the responsibility of the investigator to ensure that all Federal, State, local and institutional regulations have been met. This applies to study design through dissemination of results. The process or procedure with which investigators carry this out is at their discretion. Violations of these policies will be reported to the appropriate entities for review.

### **Conflict of Interest for the Institution, Investigators and Research Team**

This policy establishes the process to evaluate a report of a significant financial interest by any investigators or research team involved in the design, conduct, or reporting of human subjects research or an institutional financial interest that is related to human subjects research.

For Public Health Service (PHS)-funded research, there are additional training requirements. See [Financial Conflict of Interest for the Institution, Investigators and Research Team](#).

In addition to the [Requirements for IRB Approval](#) of non-exempt studies, human subjects research that is sponsored by external sources must comply with the MSU Policy and Procedure Statement on Financial Conflict of Interest in Sponsored Activities ([OP 70.09](#)).

### **Determining What Constitutes Research**

The HRPP determines whether or not a research study or project requires HRPP/IRB oversight. Only research, which meets the federal definition of research, will be required to undergo formal review and approval procedures as outlined in [IRB Review Procedures](#). When evaluating a specific project, it is useful to think of this definition as a requirement for two key elements: (1) the project involves a systematic investigation, and (2) the design – meaning goal, purpose, or intent – of the investigation is to develop or contribute to generalizable knowledge (or is universally applicable). Both elements must be met to fall under the purview of the HRPP.

To determine what research requires HRPP oversight, the following criteria are applied to the Summary, Purpose and Procedures section within myProtocol. If any of the following criteria are met, the research will undergo further HRPP review:

- 1) The design of the project involves randomization (i.e., randomly assigning participants to different treatment groups).
- 2) The intent of the project is to draw general conclusions that can be applied beyond a particular program or population.
- 3) The project will impose risks or burdens beyond the standard of practice to make the results generalizable.

The procedures section of this document describes additional considerations for determining oversight specific to various research methods (case studies, oral histories, classroom research, etc.).

### **Scientific Merit or Scholarly Validity**

The HRPP/IRB, as part of the review process of non-Exempt research, will consider if the procedures described are consistent with sound research design and current practice. It will also consider if the protocols described are reasonable and appropriate to answer the research question posed.

### **Consent, Parental Permission, and Child Assent**

It is the policy of the HRPP that all human subjects research will be conducted in accordance with the [Belmont Report](#) principle of respect for persons with regard to obtaining consent. The myProtocol submission system is used to solicit necessary information from the investigator regarding the circumstances surrounding the consent process, in order that the IRB may evaluate whether the consent process meets the relevant regulatory and ethical obligations. (See the definitions for Consent, Parental Permission, and Child Assent in the Glossary).

Research conducted with children utilizing MSU facilities must comply with [OP 01.29 Minor Protection which states](#): *'Covered Programs include private lessons, tutoring, mentoring or other instruction or assistance offered by individuals using MSU facilities and any research involving Minor subjects or in which Minors are participating as researchers or assistants.*' The Office of Compliance and Integrity can assist investigators with any questions about this policy.

### **Deception and Incomplete Disclosure**

The HRPP recognizes that deception and incomplete disclosure may be valuable research methodologies, yet their use presents special challenges to ensure that the research is conducted ethically. At times, especially in social and behavioral research, deception or incomplete disclosure is necessary to avoid study bias or to test a hypothesis that requires the participant's misdirection. On the other hand, the regulations for obtaining informed consent from research participants ([§45 CFR 46.116](#)) in general require full disclosure of all elements relevant to the subject's participation in the research. *Deception and incomplete disclosure raise concern as they may interfere with the ability of the subject to make a fully informed decision about whether or not to participate in the research.*

Thus, proposed research involving deception or incomplete disclosure necessitates special considerations by the HRPP. To determine when certain restrictions apply, the HRPP will consider the extent to which the deception in a given study interferes with the subject's ability to give informed consent. This includes distinguishing whether "deception" or only "incomplete disclosure" (without deception) is involved, whether there is sufficient justification for use of such measures, and whether there is an appropriate consent and debriefing process in place. (This



policy is adopted with permission from University of California, Berkeley's Committee for Protection of Human Subjects).

### **Participant Incentives**

Participant incentives, if used, must be approved by the HRPP/IRB and cannot be coercive (i.e., incentives cannot be of such value that participants would have difficulty choosing not to participate in the research study.) These incentives can take many forms (cash payments, gift cards, course credit/bonus, miscellaneous items such as flash drives, health evaluations, etc.).

Obtaining and disbursing incentives is the responsibility of the investigator and should be documented in such a way to withstand an audit of all disbursements. Investigators are to be aware of, and comply with [MSU's Gift Card Guidelines](#) when using this type of incentive. Credit for payment accrues as the study progresses and must not be contingent upon the participant completing the study.

### **Appeal of an IRB Decision**

[§46.112](#), and [§56.112](#) - "Research covered by this policy that has been approved by an IRB may be subject to further appropriate review and approval or disapproval by officials of the institution. However, those officials may not approve the research if it has not been approved by an IRB."

### **Collaborative Research**

All non-Exempt research in which MSU is engaged, regardless of the location or the involvement of non-MSU investigators, will be reviewed and approved by the HRPP. The procedures for requesting MSU or another institution to serve as the IRB of record for collaborating organizations or to add non-MSU individuals are outlined in the section on [Collaborative Research](#). Please also see the Addendum for SMART IRB at the end of this document for reference on Collaborative Research and requests to rely on a single IRB.

### **Humanitarian Use of a Device on Human Participants**

It is the policy of the HRPP not to approve the humanitarian use of a device on human participants.

### **Research Data Security**

It is the responsibility of investigators to protect research data in order to protect the confidentiality, integrity, and availability of data from unauthorized generation, access, modification, disclosure, transmission, or destruction.

### **Significant and Nonsignificant Risk for a Medical Device Study**

It is the policy of the HRPP that a determination of Significant Risk and Nonsignificant Risk for an investigational device must be made by the IRB prior to consideration of approval of the medical device study. The criteria for approval are the same as for any FDA regulated study. These regulations require, in part, that the IRB approval be obtained and maintained throughout the investigation and that the informed consent must be obtained and documented.

### **Research Participant Pools**

The HRPP will provide guidance and oversight of research participant pools regardless of whether the research is on or off campus. A research participant pool may contain students who are grouped together and identified as potential research participants, even when the exact

nature of the research to be conducted has not yet been determined. Research projects recruiting from research participant pools are reviewed on a project-by-project basis. All participation in student-participant-pool-related research must be completely voluntary; instructors cannot mandate or require student participation. Departments may provide students with class credit to participate in research participant pools.

### **Investigator Separation and Ownership of Human Participants Data**

Data that meets the regulatory definition of human subject in accordance with [§46.102e\(1\)](#) (i.e., identifiable private information or identifiable biospecimens about a living individual) collected in the conduct of research (from the conception of the idea to through data analysis) is jointly owned by MSU and the investigators. The HRRP will not mediate any dispute regarding ownership of or rights to the use of data. Any such dispute will be directed to the Vice President for Research and Economic Development for resolution.

### **Special Protections for Vulnerable Participants**

**Children:** All research involving children ([see Glossary for definition](#)) will be reviewed in accordance with the ethical and regulatory considerations applicable to children under [§46 Subpart D](#) or [§50 Subpart D](#). Research involving children may only be approved if the special protections outlined in the regulations are provided. Compliance with these regulations will in no way render inapplicable pertinent Federal, State, or local laws or regulations. [§56.103\(c\)](#)

**Cognitively Impaired Individuals:** All research involving cognitively impaired participants will be reviewed and approved in accordance with special considerations as determined by the [Belmont Report](#), Federal and State regulations, and as outlined in this Operations Manual.

**Pregnant Women, Human Fetuses and Neonates:** Additional health concerns during pregnancy, and the need to avoid unnecessary risk to the fetus, warrant special consideration from the IRB of research involving women who are, or may become, pregnant. All research involving pregnant women, human fetuses and neonates of uncertain viability or nonviable neonates will be reviewed and approved in accordance with [§46 Subpart B](#) and/or [21 CFR 56](#). All research involving the transplantation of fetal tissue will be reviewed and approved in accordance with [Public Law 103-43](#).

**Prisoners:** All research involving prisoners will be reviewed in accordance with the ethical and regulatory considerations applicable to prisoners under [§46 Subpart C](#). Research involving prisoners is not eligible for Expedited review and must be reviewed by the CIRB.

**Students and Employees of MSU:** MSU students and/or employees will be considered vulnerable participants in MSU research due to their potential subordinate position within the institution. Research involving MSU students and/or employees may be reviewed at the Exempt, Expedited or CIRB level.

### **Compliance and Quality Assurance Program**

**AAHRPP Standard I-5:** “The Organization measures and improves, when necessary, compliance with organizational policies and procedures and applicable laws, regulations, codes, and guidance. The Organization also measures and improves, when necessary, the quality, effectiveness, and efficiency of the Human Research Protection Program.”

The Compliance and Quality Assurance Program is comprised of a variety of activities including, but not limited to: Post-Approval Monitoring (PAM), noncompliance, unanticipated problems,

suspensions and terminations; and is designed to ensure compliance with federal regulations and local policies and procedures are protecting the rights and welfare of human participants who are taking part in research.

### **Federally Funded Research**

The HRPP will ensure compliance with additional regulations required by funding agencies for research conducted with, but not limited to:

- Department of Defense (DoD)
- Department of Energy (DoE)
- Department of Education (DoED)
- Department of Justice (DoJ)
- Environmental Protection Agency (EPA)
- Food and Drug Administration (FDA)

## **Section 2: HRPP / IRB Operations**

### **Part A. Activities of the HRPP**

The HRPP is responsible for the creation, implementation and review of the policies and procedures carried out by the HRPP and IRB. The HRPP Officer and IRB Chair will review the policies and procedures as necessary, but no less than every 3 years.

The MSU HRPP conducts activities designed to enhance the understanding of human research by participants, prospective participants, or their communities, when appropriate. The HRPP office provides several campus training sessions throughout each year that are available to potential research participants to help them understand the process and requirements for researchers. IRB training through the CITI website platform is also available, along with modules for a variety of research activities that they may wish to learn more about. These activities are updated each semester as needs arise for particular topics, or as regulatory information is updated. Evaluations of the outreach activities are conducted after events such as: Post-Approval Monitoring reviews, IRB Annual Retreat, and after any in-person training sessions on campus. A link to an evaluation is available upon approval of an IRB protocol about the researcher's experience with the process and how we can improve. Another evaluation is available on our website for anyone who interacts with our office (if a protocol is not submitted), to provide feedback on improvements, staff, and request any topics for presentation. The results of these evaluations are reviewed by the HRPP Officer and discussed with the IRB Chair, Vice Chair, Director of the Office of Research Compliance, and Assistant VP for Research to assess any needed support or resources to accommodate future needs for the next semester.

## Community-Engaged Research

Community engagement helps facilitate robust research programs and provides a more open line of communication with individuals outside of the University. By increasing these activities, following regulatory requirements, and carrying out meaningful research that benefits our community, it also impacts the community attitudes toward participation in future research. The MSU Center for Community-Engaged Learning (CCEL) also provides information about research and publication opportunities, resources for identifying community partners, and other helpful tips for faculty, staff, and students wanting to pursue these types of activities involving our community. More information can be found at their website: <https://www.ccel.msstate.edu/>. Each year, MSU faculty researchers are invited to participate in the CCEL program as Fellows to facilitate community-engaged research projects. The HRPP Officer meets with each group to educate them on IRB requirements and to facilitate a relationship between community-engaged research and the Institutional Review Board, so that both groups can be informed about community-engaged research needing IRB approval. Through these projects, community members have the opportunity to get involved in the research process to help develop the project and facilitate its completion through the dissemination of results. These individuals take the human subjects training courses to gain a better understanding of regulatory requirements and the processes for approval and data storage.

Additional considerations for community-engaged research are the education of IRB members on topics such as community-based participatory research projects, experience of IRB members with this type of research, and including consultants to the IRB with expertise in this field.

## Records of the HRPP

Confidentiality of HRPP/IRB records means that detailed information regarding the study can only be shared with investigators listed on the project or appropriate institutional officials. The HRPP may confirm or provide the status of IRB approval, study number and/or study title, in addition to providing additional information to participants to clarify concerns, procedures, etc. All other requests for information regarding the study must either be obtained directly from the PI or with written permission from the PI for the HRPP to share. Please note that these records are held by a state entity and therefore are subject to protection and disclosure if required by law. Research information may be shared with the HRPP and OHRP.

## Study Records

Records for each study reviewed by the HRPP will be maintained in accordance with [§46.115\(a\)](#) (1, 3, 4, and 7) in the myProtocol system including the following:

1. Protocol
2. Copy of funding award notice and Scope of Work (if applicable)- not applicable for studies after July 19, 2018 during Delay Period and under 2018 Requirements.
3. Investigator brochure (FDA requirement see [§56](#))
4. Recruitment materials
5. Reports of injuries to participants (if applicable)
6. Justification for Exempt determinations
7. Determinations required by laws, regulations, codes, and guidance and protocol specific findings justifying those determinations
8. Reviewer checklist applicable to the level of review of the study
9. Checklists for vulnerable populations, continuing reviews, amendments (if applicable)
10. Consent and/or assent forms (or waiver thereof) as applicable
11. All correspondence between the HRPP/IRB and the investigator
12. Protocol Violations
13. Data and safety monitoring reports (if applicable)

14. Noncompliance reports (if applicable)
15. Significant new findings (if applicable)
16. All other protocol-specific information submitted to the IRB

Records are accessible for inspection and copying by authorized representatives of federal agencies or departments at reasonable times and in a reasonable manner. When DoD funded, records that document compliance or noncompliance will 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.

If a protocol is cancelled without participant enrollment, IRB records are maintained for at least three years after cancellation.

### **Pre-Review of Protocols**

The HRPP staff reviews all protocols upon receipt for the following:

1. A complete IRB protocol submitted via myProtocol with the required electronic check boxes on the Assurances page, and ensuring all Personnel have current IRB training
2. An informed consent document for non-Exempt studies, or a description of the consent procedures for Exempt studies, or a justification for a waiver of informed consent, or a waiver of documentation of consent.
3. Copies of questionnaires, surveys or similar instruments, if applicable.
4. Site letters, if applicable, for extramural research.
5. Recruitment materials for non-Exempt studies (flyers, posters, web-pages, other advertisements, verbal scripts, email messages, etc.).

If the protocol is incomplete, the HRPP will return the protocol to the investigator until all revisions have been made. Once complete, HRPP staff will review the grant information for congruency with the IRB protocol and determine:

1. Is the Institution engaged in research? Refer to guidance on "[Engagement of Institutions in Human Subjects Research](#)".
2. Does the study meet the regulatory criteria for human subjects and research requiring HRPP oversight?
3. If no, the study is determined to be Not Human Subjects Research (NHSR) and the investigator will be notified via email that the study does not require HRPP oversight and they may proceed with the study.
4. If yes, the HRPP determines the appropriate level of review: Exempt, Expedited or CIRB. Projects eligible for Exempt review, using Exempt categories found at [§46.104](#), or [§56.104](#) may be reviewed and approved by the IRB Chair or HRPP staff.

Submissions to the HRPP wherein no communication has taken place between the HRPP staff and the PI for a period of 2 months will be withdrawn. Researchers will receive a system-generated reminder notice at 20 days and a manual email reminder from HRPP staff at 40 calendar days after comments were last sent to them, and if no response is received after 60 days, the protocol will be withdrawn. If a protocol is withdrawn for this reason, , a new protocol must be submitted for the project to be considered.

### **Developmental Approval**

This is the review and categorization of protocols and proposals lacking definite plans for the involvement of human participants. All federal funding agencies now require IRB approval prior to funding of an awarded grant or contract if they involve human subjects research. Many

times, this funding is needed to develop and finalize instruments and procedures for human participant use. Other times, a sponsor may require an IRB document at the time of proposal to show that they are working with the HRPP/IRB office on developing their protocol. This presents a dilemma regarding the responsibility to thoroughly review human subject research submissions. In accordance with [§46.118](#) (and all correlating federal subparts distinct to each “Common Rule” agency), and [§312](#) and [§812](#) the following procedure is to be used:

1. When a project plans to use human participants in research, it is the responsibility of the PI to ensure that the human subjects field of the Internal Approval Sheet (IAS) is checked. OSP sends an email to the PI when the grant proposal is processed, alerting them to the need for IRB approval before a fund may be established.
2. An IRB protocol should be submitted via myProtocol with all relevant information known at that time. The title of the study must indicate that this is for developmental approval. A timeline for the development of instruments and procedures should be provided.
3. The protocol will be assigned a study number. When necessary, the OSP Administrator will be notified that an IRB protocol has been received. It will not be reviewed or approved, but the PI will receive an email stating that they have been granted developmental approval.
4. The IRB protocol will then be returned to the investigator until the study is funded. When all instruments and procedures have been developed, they should be resubmitted with the full IRB protocol. At that time, the investigator will complete the protocol and resubmit it for review by the HRPP/IRB to get approval. If the IRB box has been checked on the IAS, OSP will not process the award until IRB approval (either developmental approval or full approval) has been obtained.
5. No human participants may be used until IRB approval has been granted. In some cases, a pending notice will be sent monthly reminding the PI that the IRB approval has not been obtained and additional items are needed for review.

If an investigator is found to be conducting human subject research without obtaining HRPP/IRB approval, the IRB Chair will be alerted in accordance with the policy and procedures contained in the CQA section on [Noncompliance](#).

A proper course of action will be pursued and could include the halting of all funds and research associated with the project.

### **Exempt Reviews**

Only the IRB Chair, Vice Chair or HRPP staff may determine which activities qualify for an exemption under [45 CFR 46](#). Investigators do not have the authority to make an independent determination that research involving human participants is Exempt and must submit a protocol to the HRPP using myProtocol. What this means is the study must be reviewed by the HRPP but does not require ongoing IRB oversight. An Exemption determination does not, however, lessen the ethical obligations to subjects as articulated in the Belmont Report and in disciplinary codes of professional conduct. The investigator must receive written notification of this determination prior to initiation of any human subject research activities.

The HRPP requires the following regardless if an Exemption is granted:

1. All personnel associated with the study, including unaffiliated investigators, be listed in myProtocol (see PI training requirements), and
2. All the necessary permissions to conduct research are obtained (see requirements for school-based research).



On the HRPP Checklist, HRPP staff members document the level of review required, state that conflict of interest does or does not exist, and that the determination that a research activity meets one or more of the Exempt categories identified in [§46.104](#) or [§56.104](#). If the study requires non-Exempt review, see the procedures for [IRB Review Procedures](#).

Once the Exemption determination has been granted, the study will be inactivated within the myProtocol system. Personnel and procedural amendments are not required once an Exemption determination is granted. However, if the research changes at any point and the scope of the original exemptions or the risk to participants increases, the PI must contact the HRPP to reactivate the study and submit an amendment.

### **Categories for Exemption Determination**

[§46.104](#) to what do these policies apply?

(a) Except as provided in paragraph (b) of this section, this policy applies to all research involving human participants conducted, supported or otherwise subject to regulation by any federal department or agency which takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by federal civilian employees or military personnel, except that each department or agency head may adopt such procedural amendments as may be appropriate from an administrative standpoint. It also includes research conducted, supported, or otherwise subject to regulation by the federal government outside the United States.

(1) Research that is conducted or supported by a federal department or agency, whether or not it is regulated as defined in [§ 46.103](#), must comply with all sections of this policy.

(2) Research that is neither conducted nor supported by a federal department or agency but is subject to regulation as defined in [§46.103](#) must be reviewed and approved, in compliance with [§ 46.104](#), [§46.103](#), and [§46.107](#) through [§46.117](#) of this policy, by an Institutional Review Board (IRB) that operates in accordance with the pertinent requirements of this policy.

(b) Unless otherwise required by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are Exempt from this policy: **Conditions:** The Exemptions at [§46.104](#) do not apply to research involving prisoners.

(1) Research conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

- (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot be readily ascertained, directly or through identifiers linked to the subjects;
- (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
- (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can be readily ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

(3)

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

- (A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot be readily ascertained, directly or through identifiers linked to the subjects;
- (B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or
- (C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

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

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



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

- (i) The identifiable private information or identifiable biospecimens are publicly available;
- (ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;
- (iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 164.512(b); or
- (iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 4 U.S.C. 3501 *et seq.*

(5) Research and demonstration projects which are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

- (i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal Web site or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

(6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Currently, the MSU HRPP does not utilize Exemption Categories 7 & 8 that include broad consent, as these were optional when the 2018 requirements went into effect.

After the pre-review by the HRPP, projects not meeting the criteria for Exemption will be reviewed to determine eligibility for [Expedited](#) review in accordance with [§46.110](#) or [§56](#), and will also be reviewed and approved by at least one IRB member. All other projects will be referred for [CIRB](#) review.

### **Informed Consent**

Even when a project is Exempt from the regulations governing human subjects research in accordance with [§46.101](#) or [§56.104](#), there may be an ethical obligation to obtain the participants' consent (or parental permission and child assent for research involving children) or at least provide them with information regarding the research.

For Exempt research, there must be a mechanism of disclosure to participants that the project involves research, a description of the procedures associated with the study, contact information for the investigator, and a statement that participation is voluntary. The HRPP provides template consent forms to assist investigators in meeting these required disclosures. These templates can be found in the Information Resources section in myProtocol. If such disclosure is not practicable, the investigator must provide justification for a waiver in that regard.

### **Notifications of Determinations**

The HRPP's determination of a study will be promptly conveyed in writing to the PI and other appropriate institutional offices. Copies of all correspondence and approved documents will be maintained in the IRB file for that project within the myProtocol system.

## **Part B. IRB Standard Operating Procedures**

### **IRB Authority**

The IRB is responsible for all activities outlined in [45 CFR 46](#) except those that are exemptions. Exemption determinations are the responsibility of the HRPP staff. The following sections detail the procedures for how this authority is carried out.

### **IRB Records**

[45 CFR 46](#) requires that IRB records be prepared and adequately maintained. All research records must be maintained for at least 3 years following the cessation of the research activity.

### **Composition of the IRB**

Information pertaining to the composition of the IRB is to be documented on the IRB Composition Checklist by HRPP Staff to ensure requirements of [§46.107](#) are met.

The HRPP Officer, via an update to the IRB Registration, reports changes in IRB membership to OHRP within 90 days of a change in membership.

The IRB roster includes:

- Names
- Earned degrees
- Representative capacities
- Scientific/Nonscientific status
- Affiliation status (whether the IRB member or an immediate family member of the IRB member is affiliated with the organization)
- Indications of experience sufficient to describe each IRB member's chief anticipated contributions
- Employment or other relationship between each IRB member and the organization
- Alternate members and the members for whom each alternate member may substitute

### **Consultants to the IRB**

**When the determination is made by the HRPP Officer and/or IRB Chair that the membership of the IRB does not have the appropriate expertise for the review of a particular protocol, the HRPP will seek a qualified consultant who will be identified using recommendations from the HRPP/IRB, the IO, and/or the investigator submitting the protocol in question. When possible, the consultant will be identified from individuals from the Institution or local community.**

Once identified, prospective consultants will be contacted by the HRPP regarding consultation activities. If he/she is willing to serve, the prospective consultant will be sent a Confidentiality Agreement and Conflict of Interest disclosure form to complete and return to the HRPP. Upon receipt of the Confidentiality Agreement and disclosure of no conflicts, the protocol and relevant attachments will be forwarded to the consultant, along with the Consultant Comment Form. The consultant will be asked to conduct an in-depth review of the protocol and submit a completed Consultant Comment Form. In addition, the IRB member with the closest relevant experience will complete the IRB Reviewer Checklist.

If the protocol requires review by the CIRB, the consultant will be asked to attend the meeting to present the review of the protocol to the Board and to answer any questions, along with the assigned reviewer. However, if unable to attend the meeting, the HRPP will provide the written review of the protocol for distribution to the Board prior to the meeting. The consultant may be available via phone to answer questions raised by the Board.

**Federally funded:** The National Institute on Disability and Rehabilitation Research (NIDRR) requires that when research purposefully requires inclusion of children with disabilities, or individuals with mental disabilities as research participants, the IRB must include at least one person primarily concerned with the welfare of these research participants.

### **Education of IRB Members**

IRB Members must take the mandatory training for investigators before voting privileges will be allowed. Yearly, all IRB members will attend a retreat where they are trained on HRPP policies,

procedures and other relevant topics of interest. Each year, all members will receive an IRB Member Handbook that contains, at a minimum, the following materials:

- a. The [Belmont Report](#)
- b. [The Nuremberg Code](#)
- c. Terms of MSU's FWA
- d. MSU Policy on the Use of Human Subjects in Research ([OP 79.03](#))
- e. [45 CFR 46](#)
- f. [21 CFR](#)

The retreat serves as IRB investigator training and, if attended, is renewed yearly.

At the discretion of the IRB Chair or HRPP Officer, additional training events will consist of education sessions held during a CIRB meeting or the circulation of educational materials prior to or during the meeting.

### **IRB Evaluation**

Members are evaluated per requirements within the [CQA of the HRPP](#).

### **Membership of the IRB**

IRB member files will be maintained in accordance with [§46.108\(a\)\(2\)](#). Individual member files will include the following:

1. Member Information Sheet
2. Curriculum Vitae
3. Confidentiality Agreement
4. Recusal Agreement
5. New Member Orientation Checklist

The HRPP Officer maintains a list of IRB members that are eligible to conduct Expedited and reviews by the CIRB. To be eligible, the IRB member must:

- Have completed new member orientation and have current IRB training,
- Have served as a secondary reviewer on a CIRB protocol or conducted one Expedited review under the guidance of an IRB Member, and/or
- Have previous experience deemed to be sufficient by the HRPP Officer.

The IRB member and the IRB Chair are informed in writing when these criteria have been met.

These records will be maintained safely and confidentially in an electronic form on a secured network.

### **Minutes of the IRB**

CIRB meeting minutes will be recorded in accordance with [§46.115\(a\)\(2\)](#) by the HRPP staff.

Additionally, minutes will include the following:

1. Documentation of separate deliberations for each action
2. Records of when an alternate member, if applicable, replaces a primary member
3. The IRB's determination of the approval period when conducting the pre-review or continuing review of a study
4. Attendance at the meeting
5. The names of IRB members who leave the meeting and the reason for the absence (e.g., conflicting interest)
6. Votes for each protocol as numbers for, against, or abstaining

7. The basis for requiring changes in research and whether those changes are substantive and should be returned to the IRB
8. The basis for disapproving research
9. A written summary of the discussion of controverted issue and their resolution
10. Determinations required by the regulations and protocol-specific finding justifying those determinations for:
  - a. Waiver or alteration of the consent process
  - b. Research involving pregnant women, fetuses and neonates
  - c. Research involving prisoners
  - d. Research involving children
  - e. Research involving participants with diminished capacity
11. The rationale for significant risk/non-significant risk device determinations

Draft minutes will be forwarded for review and approval by the CIRB in the meeting packet for the next meeting. The approved minutes (with any changes requested by the IRB) will be reviewed by the HRPP Officer or IRB Chair. The minutes are maintained by the HRPP staff along with a copy of the meeting packet materials and any relevant documents distributed during the meeting in an electronic file. Copies of the approved minutes will be provided to the IO in a password-protected electronic file stored on a secure server.

#### **Conflict of Interest for IRB Members or Consultants**

It is the responsibility of each IRB member to reveal any potential conflict of interest to the IRB Chair as soon as it is recognized. If the IRB Chair indicates a conflict of interest, then the matter will revert to the IRB Vice Chair. In the event that the IRB Vice Chair also has a conflict of interest, then the HRPP Officer will assign an IRB member to chair the matter. Reviewer comment forms for both Expedited and CIRB reviews will request confirmation that no real or perceived conflict of interest exists for the designated reviewers.

If the investigator submitting a protocol feels that an IRB member has a potential conflict, the investigator is encouraged to contact the HRPP or the IRB Chair requesting that the member be excluded.

For CIRB reviews, IRB members will leave the meeting room before deliberation and voting on research in which they have a conflicting interest. The minutes will reflect the member as being absent with an indication that a conflicting interest was the reason for the absence and will not be counted towards quorum.

#### **Undue Influence of the IRB**

##### **Reporting of Undue Influence**

IRB members, staff, investigators, or research participants have the obligation to report any pressure or undue influence to make decisions that would favor an individual investigator or the institution over the welfare and safety of the research participant.

The manner in which the incident is reported can take various pathways. Reports will be written so as to maintain integrity of the wording, but identity may be withheld if there is a perceived need for anonymity. Reports may be submitted to any of the following people:

- IRB Chair
- HRPP Officer
- HRPP Staff
- IRB Administrator

- Director of the Office of Research Compliance and Security
- IO

### **Response to Reports of Undue Influence**

Regardless of the pathway chosen to report, the IO will be informed and they will choose the manner in which the report is handled. The IO may choose to review the report, delegate the authority to conduct an official investigation to a specific individual or committee, or choose to be directly responsible for an official investigation. If the IO is involved in the allegation, the President will be informed and will be responsible for the manner in which the report is handled. If a committee is delegated the authority to conduct the investigation, they may convene a meeting and/or otherwise obtain additional information as necessary. The person or committee responsible for the review will document the outcome of the review, and the ORCS will maintain a record. The complainant will be provided with a response and the corrective plan if applicable. The CIRB will be informed of the findings.

### **IRB Review Procedures**

#### **Requirements for IRB approval of non-Exempt studies**

In order to approve a research study, the CIRB or Expedited Reviewer must determine that the research satisfies all requirements of [§46.111](#) and [§56.111](#). These requirements apply to pre-review, continuing review, and review of amendments.

1. Risks to participants are minimized
2. Risks to participants are reasonable in relation to anticipated benefits, if any, to participants, and the importance of the knowledge that may reasonably be expected to result
3. Selection of participants is equitable. In making an assessment about whether selection of participants is equitable, the HRPP takes into account:
  - a. The purposes of the research.
  - b. The setting in which the research will be conducted.
  - c. Whether prospective participants will be vulnerable to coercion or undue influence.
  - d. The selection (inclusion/exclusion) criteria.
  - e. Participant recruitment and enrollment procedures.
  - f. The influence of payments to participants.
4. Informed consent will be sought in accordance with [§46.116](#) and [§50](#)
5. Informed consent will be documented in accordance with [§46.117](#) and [§50.27](#)
6. When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of participants.
7. When appropriate, there are adequate provisions to protect the privacy of participants.
  - a. In order for the IRB to assess provisions to protect privacy of participants, investigators must provide information regarding these provisions in the IRB protocol. This information must address any collection of participants' private information without their explicit consent; any physical intervention or manipulation of participants' environment for which they have not given consent; the potential for participants to be publicly identified or embarrassed through their participation, or for their responses to be made known outside the research team; cultural considerations of participants which might affect expectations of privacy; as well as any other information related to participants' privacy and the conduct of the research. In regard to cultural considerations of privacy, the HRPP/IRB may seek outside consultation in accordance with the Consultants to the IRB policy and procedure.

- b. The IRB will consider appropriate the provisions to protect privacy interests of participants if the information provided by the investigator indicates no areas of concern or if any such concerns of the IRB are adequately addressed. Participants must provide their consent for the collection of private information unless consent is waived by the IRB. Additionally, the research setting must be conducive to the protection of participants' privacy (e.g., adequate separation such that survey responses cannot be observed, private room or space such that oral interview responses cannot be overheard). If outside consultation is needed to assess cultural considerations of privacy, any concerns of the consultant must be addressed to the satisfaction of the CIRB or Expedited Reviewer prior to approval of the study.
8. When appropriate, there are adequate provisions to maintain the confidentiality of data.
  - a. In order to approve a study, the IRB must find that there are appropriate provisions to maintain the confidentiality of identifiable data. In order for the IRB to assess provisions to protect confidentiality of data, investigators must provide information regarding these provisions in the protocol. This information must address the identifiability (direct and/or indirect identifiability) of data collected; if identifiable, the purpose of the identifiers; when identifiers will be removed; provisions (physical and electronic) to protect confidentiality during storage, use, and transport/transmission of data; who will have access to the data; where data and consent forms will be stored; and a plan for removing the identifiers from the data for future use of the data, or destruction of the data in accordance with the procedures on [Research Data Security](#).
  - b. The IRB will consider appropriate the provisions to protect confidentiality of the data if the information provided by the investigator indicates no areas of concern, or if any such concerns of the IRB are adequately addressed. Provisions to protect confidentiality must include appropriate mechanisms to control access to the data in accordance with participants' consent (if applicable) and the protocol, and must include plans for removal of identifiers once identifiers are no longer needed. The data security plan must also include information regarding the destruction or maintenance of the data once the study is complete. IRB approval should be maintained for any such dataset that will continue to include identifiable data. If outside consultation is needed to assess confidentiality concerns, any concerns of the consultant must be addressed to the satisfaction of the CIRB or Expedited Reviewer prior to approval of the study.
9. When some or all of the participants are likely to be vulnerable to coercion or undue influence, additional safeguards are included in the study to protect the rights and welfare of these participants. See procedures for requirements related to inclusion of specific [vulnerable participants](#).
10. Payment to research participants is not considered a benefit and should not be based on the risk of study participation. The amount of payment and the proposed method and timing of disbursement of payment must not be coercive or present undue influence.
11. Credit for payment accrues as the study progresses and must not be contingent upon the participant completing the study.
12. Any amount paid as a bonus for completion must be reasonable and not so large as to unduly influence participants to stay in the study when they would otherwise have withdrawn.
13. All information concerning payment, including the amount and schedule of payments must be provided in the protocol including the justification for such payment, and must be set forth in the consent document.



14. Finder's fees and bonus recruitment payments are typically associated with clinical trials and are offered by the sponsor of the research as an incentive to enhance recruitment. The HRPP does not permit the payment of finder's fees and/or bonus recruitment payments, in any form, due to the potential that it may be perceived as causing undue influence. Several professional associations and groups have stated that this practice is unethical (e.g. AMA, APA).

All protocol personnel are notified in writing of the review decision. If the project is externally funded, the OSP will be notified. The approval documents will contain the relevant federal regulation citation, the approval date, the expiration date and the IRB protocol number. If disapproved, the reasons for the action will be detailed in the written correspondence. See the [Federally Funded Studies](#) section for additional requirements.

When following DoD requirements:

Data or information acquired by the DoD Component under a pledge of confidentiality for exclusively statistical purposes must be used exclusively for statistical purposes and may not be disclosed in identifiable form for any other purpose, except with the informed consent of the respondent.

### **Expedited Review**

After the completion of the pre-review, the HRPP staff assigns the protocol to a reviewer (IRB member or Consultant) with relevant expertise and knowledge of the area of investigation. The reviewer is notified via an email from myProtocol that they have been assigned a study to review. All relevant documents are available to the reviewer in myProtocol.

The review process will include an in-depth review of all pertinent documentation, including supplemental conditions for consideration provided by the HRPP. The reviewer will complete the IRB Reviewer Checklist, and if applicable, the Vulnerable Populations Checklist. The reviewer will provide comments to the research team via myProtocol. The reviewer may recommend for approval the protocol or require modifications or clarifications as a condition for approval or refer the protocol to the CIRB; the reviewer may not disapprove the research. Results of the review will be promptly conveyed in writing by the HRPP to the research team. The regulatory requirements for approval by the Expedited procedure are identical to approval by the CIRB procedure.

### **What Qualifies A Study for Expedited Review?**

To qualify for Expedited Review, the research must meet **all** the following criteria:

- Be of minimal risk (see definitions, below) to the participants;
- Must not involve prisoners or mentally impaired persons;
- Involve only procedures listed in one or more of the following categories:



## Categories for Expedited Review

1. **Clinical studies of (a) drugs for which an investigational new drug application 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), or (b) medical devices for which an investigational device Exemption application is not required; or the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.**
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 (Note: amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than two 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 ( Note: amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an eight week period and collection may not occur more frequently than two 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); and (e) Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gum base or wax or by applying a dilute citric solution to the tongue; (f) Placenta removal 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 non-research purposes (such as medical treatment or diagnosis).
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, social behavior), or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

### **CIRB Review**

The CIRB review category is used for all human subjects research that does not qualify for [Exempt](#) or [Expedited](#) review. Each protocol, continuing review, and/or review of an amendment to previously approved research is assigned at least one primary and one secondary reviewer, who are members of the IRB, based on relevant expertise and knowledge. The reviewer is notified via an email from myProtocol that they have been assigned a study to review. All relevant documents are available to the reviewer in myProtocol.

The primary and secondary reviewers will conduct an in-depth review of all pertinent documentation and present the protocol to the CIRB. If a reviewer cannot be present at the meeting, he/she should provide their written review to the IRB Chair or HRPP staff prior to the meeting. If the IRB does not have at least one individual present at the meeting with the appropriate expertise of the area of investigation, or of any populations vulnerable to coercion or undue influence to be included in the study, the IRB will defer review until such expertise can be obtained either through membership or consultation. The regulatory requirements for approval by the CIRB are identical to approval by the [Expedited Review](#).

### **CIRB Meeting**

No official actions may be taken at a meeting without quorum. Should the quorum fail during a meeting (e.g., those with conflicts being excused, early departures, loss of a [non-scientist](#), unaffiliated, or general perspective member), the meeting must be terminated from further votes until the quorum can be restored. The IRB Chair or Vice Chair presides over the meetings, votes as part of the regular membership, and acts in accordance with the policy on [Responsibilities of the IRB Chair](#).

Meetings are scheduled prior to the beginning of each semester for the day and time that accommodates the majority of the members. When there are no items requiring the attention of the CIRB, meetings are canceled. Additional meetings or special sessions may be scheduled as needed. Protocols undergoing review must be individually presented, orally or in writing, and discussed so that they receive a substantive review by the IRB.

Wherever possible, IRB meetings should take place with all participating IRB members physically present. However, circumstances sometimes warrant conducting IRB meetings via telephone and/or video conference call. Each remotely participating IRB member must be able to actively and equally participate in the discussion of all protocols. Minutes of such meetings must clearly document who is participating remotely.

All members are notified approximately one week prior to the meeting that the materials for the upcoming meeting are available for review in myProtocol. Materials will include at a minimum the following:

- Agenda
- Draft minutes from the previous meeting(s) to be voted on for approval at the meeting
- IRB protocols (new, continuing and amendments) scheduled for review, relevant attachments (consent documents, recruitment materials, etc.) and relevant correspondence/notes

Expedited reports are distributed at a minimum of quarterly, and will contain the name of the project, investigator, reviewer, type of review (pre-review, continuing, amendment), and date of approval.

All members scheduled to attend the meeting will review the packet in its entirety and be prepared to discuss each item on the agenda. HRPP staff will invite all PIs of protocols on the agenda to attend the CIRB meeting for the purpose of answering any of the CIRB's questions, though their attendance is not required for approval. The protocol is discussed, and for a protocol to be approved, it must receive the affirmative vote of a majority of those members present at the meeting. The CIRB votes on an appropriate level and interval for future continuing and amendment reviews and on the protocol specific determinations which are recorded in the minutes. The review interval must be appropriate to the degree of risk, and must occur within one year. The IRB Chair, Vice Chair, or designee presides over the vote, which is reflected in the CIRB minutes for that meeting. Once approved, all human participant research activities are subject to audit at any time by the HRPP Staff or IRB Members, in accordance with the CQA requirements for [Post-Approval Monitoring](#).

When the CIRB requests substantive clarifications or modifications that are directly relevant to the determinations required by the CIRB, the protocol must be returned to the IRB for additional review before approval may be granted. The effective approval date of all protocols will be the date on which the IRB Chair (or designee) has reviewed, and accepted as satisfactory, any revised documentation or conditions required by the IRB from the investigator. When the CIRB specifies revisions that only necessitate concurrence by the investigator, the IRB Chair (or designee) may approve the research on behalf of the IRB in accordance with the policy on [Expedited Review](#). The primary and secondary reviewer who will present review summaries at the next meeting will review all other revisions.

The CIRB's decisions and any requirements for modifications will be promptly conveyed in writing to the research team. Written notification from the IRB Chair of decisions to disapprove a protocol will be accompanied by the CIRB's reasons for the decision, and an invitation for the investigators to submit an appeal using the procedure described in the [Appeal of an IRB Decision](#).

### **[Consent, Parental Permission, Child Assent and Waivers](#)**

The HRPP uses a two-stage process for the review of consent, parental permission, assent and waivers: (1) the HRPP Pre-Review Checklist and (2) the IRB Reviewer Checklist and Vulnerable Populations Checklist, when appropriate.

All non-Exempt research must comply with [§46.116](#) and [117](#) with regard to required elements and documentation of consent. Research regulated by the FDA must also meet the criteria of [§50 Subpart B](#). Additionally, research involving children must comply with requirements for parental permission and child assent in accordance with [§46.408](#). The HRPP provides template consent forms to assist investigators in meeting the requirements for informed consent in accordance with these regulations, as well as MSU-specific requirements.

Investigators may elect to document informed consent using the Exempt or the Expedited and Full Board templates provided, or the investigator may request waivers or alterations of the consent process as described in the following sections.

It is recommended by the HRPP that researchers consider their intended participants when completing the informed consent information, and suggested to utilize an 8<sup>th</sup> grade reading level where the information will be easy to understand for the majority of individuals recruited for the study. In studies involving children, the assent document should be age appropriate.

### **Expedited and Full Board Consent**

This consent is the standard consent form template provided in the myProtocol system. This consent document fully describes, in writing, the protocol and includes all required elements of consent. To allow use of this form of consent documentation, the IRB determines:

- The consent document embodies the basic and required additional elements of disclosure.
- The participant or participant's legally authorized representative will sign the consent document.
- A copy of the consent document will be given to the person signing the consent document.
- The investigator will give either the participant or the representative adequate opportunity to read the consent document before it is signed.

### **Exempt Consent**

This form is an abbreviated consent document that can be supplemented by an oral description of the protocol. To allow the use of this form of consent documentation, the IRB determines:

- The consent document states that the elements of disclosure required by regulations have been presented orally to the participant or the participant's legally authorized representative.
- A written summary embodies the basic and required additional elements of disclosure.
- There will be a witness to the oral presentation.
- For participants who do not speak English, the witness is conversant in both English and the language of the participant.
- The participant or the participant's legally authorized representative will sign the consent document.
- The witness will sign both this form and a copy of the summary.
- The person obtaining consent will sign a copy of the summary.
- A copy of the signed consent form will be given to the participant or legally authorized representative.
- A copy of the signed summary will be given to the participant or the legally authorized representative.

### **Waivers of Consent**

To request a waiver of any part of the consent process, an investigator must submit to the IRB the appropriate Waiver Request Form (contained within myProtocol) providing a project-specific justification for the request. Any such waiver will only be approved by the IRB if the project is not regulated by the FDA and the waiver meets the requirements of [§46.116\(e\) or \(f\)](#) in regard to a waiver or alteration of consent, [§46.117\(c\)](#) in regard to a waiver of documentation, and/or [§46.408](#) in regard to a waiver of parental permission and/or child assent. Any such approved waivers will be documented on the IRB Reviewer Checklist and in the CIRB meeting minutes, for CIRB reviewed projects.

### **Waiver of Consent Process**

Investigators may request a waiver or alteration of the consent or parental permission processes when one of the following two sets of conditions is met:

1. Most common set of conditions for a waiver or alteration:
  - a. The research involves no more than minimal risk to the participants.
  - b. The waiver or alteration does not adversely affect the rights and welfare of the participants.
  - c. The research cannot practicably be carried out without the waiver or alteration.
  - d. When appropriate, the participants will be provided with additional pertinent information after participation.
  - e. The research is not FDA-regulated.
2. Less common set of conditions for a waiver or alteration:
  - a. The research is conducted by or subject to the approval of state or local government officials.
  - b. The research or demonstration protocol is 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.
    - iv. Possible changes in methods or levels of payment for benefits or services under those programs.
  - c. The research cannot practicably be carried out without the waiver or alteration.
  - d. The research is not FDA-regulated.

The IRB will not review requests for a waiver of the requirements for consent for planned emergency research.

### **Waiver of Documentation of the Consent Process**

When the IRB considers waiving the requirement to obtain written documentation of the consent process, the IRB reviews a written description of the information that will be provided to participants. In addition to meeting one of the two conditions in the previous section, the requirement to document the consent process may be waived under one of two sets of conditions:

1. Based on Harm
  - The only record linking the participant and the research is the consent document.
  - The principle risk to potential harm resulting from a breach of confidentiality.
  - Each participant will be asked whether he/she wants documentation linking the participant with the research, and the participant's wishes will govern.
  - The research is not FDA-regulated.
2. Based on Risk (for [Expedited review](#) only)
  - The research presents no more than minimal risk of harm to participants.
  - The research involves no procedures for which written documentation of the consent process is normally required outside the research context.

### **Waiver of Consent Process – Parental Permission is not a Reasonable Requirement**

The IRB may waive the requirement for parental permission when the following conditions are met:

- The provisions for a waiver of some or all of the elements of informed consent in [§46.116](#) are met;

OR

- The research is designed for conditions or for a participant population for which parental or guardian permission is not a reasonable requirement to protect the participants.
- An appropriate mechanism for protecting the children who will participate as participants in the research is substituted.
- The research is not FDA-regulated.

### **"Passive" Consent and Parental Notification**

"Passive Consent" has been used in school-based research in response to the challenges of securing prior written permission from parents. For example, researchers collecting survey and behavioral data from children at school provide parents with information regarding the study by mail and ask the parent(s) to return a form if they do not want their child to participate.

Sometimes this practice is referred to as an opt-out procedure, which is not consistent with the regulatory requirement for seeking and obtaining parental permission. The passive consent process is not equivalent to informed consent. **Passive consent is strongly discouraged by the MSU HRPP.** The federal regulations require that parental or guardian permission for children to participate in research must be secured or waived in accordance with the four criteria provided in the regulations. On a very practical level, sending notice does not mean that notice is received for a variety of reasons, including parents' inability to read. The parental notification process can be used to provide parents with the option to remove their children from research, but only if the requirement for parental permission has been **waived** by an IRB.

### **Re-consent of Minors who are now Adults**

The "informed consent should be viewed as an ongoing process throughout the duration of a research project. When a child who was enrolled in research with parental or guardian permission subsequently reaches the legal age of consent to the procedures involved in ongoing research, the subject's participation in the research is no longer regulated by the requirements of 45 CFR part 46.408 regarding parental or guardian permission and subject assent." Therefore, when a minor participant reaches the age of 18 and is still undergoing research procedures, re-consent is necessary. The informed consent Federal guidance states "Unless the Institutional Review Board (IRB) determines that the requirements for obtaining informed consent can be waived, the investigators should seek and obtain the legally effective informed consent, as described in [45 CFR 46.116](#), for the now-adult participants for any ongoing interactions or interventions with the participants."

### **Observation of the Informed Consent Process**

The HRPP/IRB has the authority to observe or have a third party observe the consent process for any research study that has been approved at MSU. The IRB will consider whether the consent process should be observed by someone outside the research team when the study includes participants with diminished decision-making capacity or individuals particularly vulnerable to coercion (such as children or individuals in a subordinate position to the investigator), or when other circumstances warrant as judged by the IRB. See the [Federally Funded Studies](#) section for additional requirements.

### **Deception and Incomplete Disclosure**

In keeping with federal regulations and ethical codes established by the *Belmont Report* and the *American Psychological Association*, the HRPP will consider the following points when reviewing research involving the use of deception or incomplete disclosure:

1. The study must not involve any more than minimal risk to the subjects.



2. The use of deceptive techniques must be justified by the study's prospective value AND there should be no reasonable alternative method that would be equally effective (i.e., the researcher must demonstrate that the deception is necessary to conduct the study).
3. Prospective subjects must not be deceived about research that is reasonably expected to cause physical pain or severe emotional distress.
4. If the study design allows, subjects should be told during the original consent process that some information is being withheld or is incomplete, and that they will receive more information after the research is over. However, researchers often believe that even vague references to hidden purposes will affect subjects' behavior and make the study impracticable. Investigators should either add such language to their consent forms when it is possible or note in their protocols why it is not feasible to do so.
5. In addition, the research must meet the criteria for a waiver of one or more elements of informed consent, as described in *Waiver of Consent Process*.
6. Whenever appropriate, researchers should debrief participants. The debriefing should take place as early in the study as the design permits, preferably at the conclusion of a subject's participation, but no later than the conclusion of the research. (See information about the debriefing process below).

In studies involving deception and/or incomplete disclosure, (see [Glossary](#) for definitions) fully informed consent is not obtained from subjects prior to participation. When the consent process will not disclose pertinent information about the research, the CIRB must consider whether the research meets all of the criteria for a waiver of one or more elements of informed consent as set forth in federal regulations at [45 CFR 46.116\(f\)](#). (See criteria for Waiver of Consent Process).

### **Debriefing**

Debriefing the participant is an important aspect of the informed consent process in deceptive studies. It gives the investigator an opportunity to explain any deception or incomplete disclosure involved, as well as to help the subjects deal with any distress or discomfort prompted by the research. If the study involves deception at the time of subject enrollment or consent that may have influenced the subject's decision about participation, and/or the deception would likely be perceived by subjects as an invasion of privacy (e.g., videotaping without prior consent), *the HRPP may require re-consent for use of data as part of the debriefing process after study participation.*

### **Exceptions to Debriefing Requirement**

There may be rare instances when debriefing would be inappropriate, such as when the debriefing itself may present an unreasonable risk of harm without a countervailing benefit. For example, if an individual were selected for participation in a study about group behavior based on a previously measured "negative" behavior or characteristic, it might not be appropriate for the debriefing to describe the selection process. In such cases, the HRPP would not recommend or require detailed debriefing.

### **Delayed Debriefing**

In certain cases, debriefing immediately after a subject's participation would compromise study results (e.g., the study is ongoing and early subjects might tell others about it, making it impossible for the researchers to obtain valid/unbiased results from later subjects). Under such circumstances the HRPP may approve a delayed debriefing process, such as sending

debriefing information to participants via email or regular mail (if subjects' contact information is kept), or giving subjects a website URL where they can get debriefing information when the study has been completed. (In some cases, it may be sufficient to ask the subject being debriefed to not reveal such information to others).

### **Debriefing as an Educational Tool**

Some University schools or student subject pools recommend that feedback be provided at the conclusion of the study to further the education of the participants (as opposed to giving information that was previously withheld or falsified). In such cases, the original consent may mention this will be done, and the debriefing form may include bibliographical citations advising subjects where they can obtain additional information on the topic if they wish.

In general, the debriefing process should consist of the following:

1. Disclosure of the deceptive aspect(s) of the study, and what the actual study objective was. This should be presented in clear lay terms, similar to the consent document. Extremely technical/ detailed explanations of study hypothesis, intentions of each task, etc., are not typically required.
2. An explanation of the reasons for the deception. The reasons should be clearly explained, in language sensitive to subjects' possible discomfort or embarrassment at having been deceived.
3. An opportunity for the subject to ask questions.
4. *If indicated*, an opportunity for the subject to withdraw the provided data. The HRP will decide on a case-by-case basis whether it is necessary to *re-consent* subjects to use study data obtained under deceptive premises. For example, in cases that involve only incomplete disclosure, a debriefing form that gives additional information about the study but does not ask for re-consent to use data will usually be acceptable. In contrast, when deception at the time of subject enrollment or consent is likely to have influenced the subject's decision about whether or not to participate in the research, or when the deception would likely be perceived by the subject as an invasion of privacy, the subject's signature to permit use of such data will usually be required.

*(This procedure is adopted with permission from University of California, Berkeley's Committee for Protection of Human Subjects).*

### **Withdrawal from Clinical Trials**

When participants withdraw from a clinical trial, the MSU IRB determines:

- When a participant withdraws from a study, the data collected on the participant to the point of withdrawal remains part of the study database and may not be removed. The consent document cannot give the participant the option of having data removed.
- An investigator may ask a participant who is withdrawing whether the participant wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the participant distinguishes between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review, and address the maintenance of privacy and confidentiality of the participant's information.
- The investigator must obtain the participant's consent for this limited participation in the study (assuming such a situation was not described in the original consent document). The IRB must approve the consent document.



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

### **Amendments to Approved Studies**

All changes to a non-Exempt approved study must be submitted as an Amendment in myProtocol and will be reviewed at the level at which it was approved. All changes must be approved prior to their implementation except, when necessary, to eliminate apparent immediate hazards to the participants. (If this happens, please contact the HRPP immediately). If significant new findings are found during the review process that may affect participants' willingness to continue participation, such findings are provided to participants.

For changes to an approved study that are initiated without HRPP approval to eliminate apparent immediate hazards to the participants, an amendment must be submitted within (1) one business day. The change will be reviewed by the HRPP to determine whether the change was consistent with ensuring the participants' continued welfare.

Personnel amendments to studies will be reviewed and approved by the HRPP Staff. IRB training will be verified for individuals being added to the study before the amendment is approved. This type of amendment does not require HRPP staff to complete the IRB Reviewer Checklist. Minor procedural changes to a study that was previously approved at the CIRB level, that do not increase the risk or decrease the potential benefit to participants, may be reviewed and approved at the Expedited level, unless the CIRB has voted otherwise for a specific study. The regulatory criteria used to approve the original protocol should be applied to the amendment.

Amendments involving more than a minor change reviewed by the CIRB must use the same procedures for the review.. When possible, the primary and secondary reviewers will be those assigned to complete the pre-review; otherwise reviewers with relevant knowledge and expertise will be assigned by the HRPP Staff to conduct the review.

### **Continuing Review of Approved Studies**

Under the pre-2018 regulations, approved non-Exempt protocols were subject to continuing review when any of the following were true:

- the research is permanently closed to the enrollment of new participants;
- all participants have completed all research-related interventions; and
- the research remains active only for long-term follow-up of participants;

**OR**

- no participants have been enrolled; and
- no additional risks have been identified;

**OR**

- the remaining research activities are limited to data analysis.

With the transition to the 2018 Requirements, Continuing Reviews are no longer required. Over the course of year 2019, as active non-Exempt studies came up on their expiration date, they were reviewed under the new regulations going forward. After all studies were transitioned

under the new regulations, Continuing Reviews will no longer be required except under certain circumstances where the reasoning has been justified and well-documented by the IRB on the Convened IRB Project Checklist when discussing and voting on the protocol at hand.

Examples of when a study might return for Continuing Review or need to be reviewed more than annually might include the following:

- The sponsor requires Continuing Review
- The research will be conducted internationally or at non-MSU locations
- The project involves additional regulatory oversight, such as Conflict of Interest management plans, biosafety, or export control
- An amendment or protocol violation reveals new findings that require additional oversight for the project
- The investigator has a history of noncompliance or a pattern of non-serious noncompliance that needs to be monitored

\*Continuing review is required for research that is regulated by the FDA.

When continuing review of research is required by law or regulation, IRB members determine:

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

For non-Exempt protocols, at 60 days, 30 days and 15 days prior to the expiration date, myProtocol will notify the investigator that the protocol is expiring. If materials have not been received by the expiration date, a letter is sent to the research team notifying them that the protocol is expired and research is halted. There is no grace period for the conduct of research beyond the approval period specified by the IRB. The expiration date is the last date that the protocol is approved and the last day that research may be conducted unless re-approval is granted.

When renewal of a protocol does not occur prior to the end of the approval period, IRB approval expires automatically and the research must stop unless the CIRB or the IRB Chair finds that it is in the best interest of individual participants to continue participation in the research interventions or interactions. Enrollment of new participants cannot occur under any circumstances after the expiration of IRB approval.

When renewing the protocol, investigators must submit their materials at least 10 calendar days prior to the current expiration date. Materials to be reviewed must be submitted within the myProtocol system and include, but are not limited to:

1. any relevant information not previously submitted, especially information about risks associated with the research,
2. a clean copy of all stamped documents (consent, assent, permission forms, recruitment materials, etc.) unless there has been no change to those documents, and
3. any requested protocol amendments.

Reviewers will access all materials through the myProtocol system. The IRB Chair (or designee) will conduct all Expedited continuing reviews. When possible, the same primary and secondary reviewer will conduct CIRB renewals that completed the pre-review; if unavailable, reviewers with relevant knowledge and expertise will be assigned by the HRPP staff to conduct the review. When a protocol was originally reviewed by the CIRB, the renewal should be conducted by the CIRB unless the protocol has been reclassified by the CIRB as being eligible

for Expedited review in accordance with [§46.110 Category #9 and/or §56.110](#). Such reclassification will be documented in the minutes.

The criteria for renewals are the same as those for [Requirements for IRB Approval](#). Any significant new findings that may relate to the participant's willingness to participate are provided to the participant. If no participants have been enrolled, the research may receive renewal using the Expedited procedure under Expedited category #8. However, if there is under/over 15% of enrollment at the time of renewal, the IRB Chair has the discretion to close the study.

### **When Remaining Activities are Confined to Data Analysis**

IRB approval should generally be maintained throughout completion of data analysis to allow for amendments (such as additional data collection). IRB approval is mandatory when ongoing activities include identifiable data. Protocols previously reviewed by the CIRB may receive renewal at the Expedited level if no participants have been enrolled and no additional risks have been identified, or if the remaining research activities are limited to data analysis in accordance with [§46.110 category #8 and/or §56.110](#). However, with these considerations in mind, an investigator may submit the Final Report for a project where remaining activities are confined to analysis of only non-identifiable data.

### **Appeal of an IRB Decision**

Request for appeal of an IRB decision, regardless of the level of review, must be made to the IRB Chair in writing (within calendar 30 days of notification of disapproval of a protocol or elements of a protocol or amendment and within 14 calendar days of notification of noncompliance, unanticipated problems, suspension, termination or other findings). All appeals will be reviewed by the CIRB. Once a request for appeal has been received, the IRB Chair will schedule a meeting for the appeal. If the person making the appeal wishes to speak directly to the CIRB, he or she may attend a CIRB meeting and do so at a scheduled time and date. If the PI responds only in writing, the appeal will be discussed at the next CIRB meeting. The appeal can be approved or denied. If the appeal is denied, the CIRB may require changes to the decision and any required investigator actions; however, the investigator must comply with the final decisions made by the CIRB. The determination will be communicated in writing to the PI.

Should the person making the appeal wish to bring an attorney to the CIRB meeting, he or she must give the IRB Chair ten (10) business days written notice of his or her intent to do so. An attorney (other than an IRB member or PI) may not attend a CIRB meeting for the purposes of review or appeal unless a representative from MSU's General Counsel office is also present.

If the IRB rejects the appeal, the investigator must comply with the IRB's remediations, or the research will not be approved. Appeal determinations are final and cannot be appealed further. The IO cannot reverse the findings of an appeal determination. However, the IO may ultimately disapprove a study that has not been previously approved by the CIRB.

### **Collaborative Research**

Any other circumstances regarding MSU affiliates and/or MSU locations associated with the conduct of human subjects research not described herein will be considered on their own merits by the HRPP Officer and/or IRB Chair and action will be taken as deemed appropriate.

## **Single Institutional Review Board (IRB) for Multi-Site Federal Grants Policy**

The following is to clarify how the HRPP implements federal agency requirements regarding the use of a single Institutional Review Board (sIRB) for multi-site research.

- I. This policy does not supersede or alter other related Mississippi State University policies.
- II. This policy applies only to federally-funded research.
- III. Unless other requirements must be followed under a specific federal agency's policy and/or guidelines, Mississippi State University will follow the National Institutes of Health ([NIH](#)) [policy and guidance regarding sIRB](#), including the costs associated with IRB review, when a Mississippi State University IRB serves as the Reviewing IRB for a federally-funded multi-site study.
  - A. Reviewing IRB means the "IRB of record" to which authority for IRB review and oversight has been ceded by another institution for one or more research studies.
  - B. Multi-site study means a study that uses the same protocol to conduct non-exempt human subjects research at more than one site.
  - C. The NIH policy applies to the domestic sites of NIH-funded multi-site studies where each site will conduct the same protocol involving non-Exempt human subjects research, whether supported through grants, cooperative agreements, contracts, or the NIH Intramural Research Program.
    1. The NIH policy does not apply:
      - a. to career development, research training or fellowship awards;
      - b. to foreign sites;
      - c. when prohibited by a federal, tribal, or state law, regulation, or policy;
      - d. or, in limited circumstances, when there is a compelling justification for an exception and the NIH grants an exception following an assessment of the need.
  - D. The NIH policy states that the activities of the sIRB will generally fall into two categories, primary activities and secondary activities and defines these activities as follows:
    1. Primary activities refer to the activities associated with conducting the ethical review of the proposed research protocol that will be carried out at all of the participating sites and the review of the template informed consent document describing the study.
    2. Secondary activities refer to the activities associated with the review of site-specific considerations for all of the participating sites, including investigator qualifications, institutional capabilities, state/local regulatory requirements, and community ethos.
      - i. Following initial approval, there are additional activities associated with fulfilling IRB oversight responsibilities, including:
        - 1) reviewing reportable events from all participating sites (e.g., unanticipated problems, protocol deviation) and reporting them as

appropriate to the Office for Human Research Protections (OHRP) and the funding Institute or Center

- 2) receiving and reviewing any complaints that arise with regard to the conduct of the study
- 3) notifying all participating sites of serious or continuing non-compliance and all other determinations
- 4) communicating with participating sites on matters related to sIRB determinations.

E. In general, Mississippi State University will treat primary activities as those costs already included in an organization's Federally-approved indirect cost rate agreement.

1. Secondary activities may be charged for work performed for the relying institutions and paid from direct costs as part of the budget proposal for federal funding with appropriate budget justification.

IV. Proposals submitted to NIH to support human subjects research on or after the NIH implementation date must include a plan describing the use of an sIRB that will be selected to serve as the IRB of record for all study sites.

A. This plan should include:

1. a statement confirming that participating sites will adhere to the sIRB Policy
2. and a description of how communications between sites and the sIRB will be handled.

B. When an investigator plans on submitting a funding proposal to a federal agency that requires the use of an sIRB for the research, the investigator must contact the Mississippi State University HRPP office for assistance with:

1. identification of the Reviewing IRB,
2. budgeting for sIRB review,
3. identifying any other regulatory issues that may need to be addressed as part of the proposal to use an sIRB.

C. The IRB office will review the request to assess the appropriateness and feasibility (e.g. resources and expertise needed) of:

1. the proposed Reviewing IRB (whether an internal or external IRB is proposed)
2. and the plan describing how communications between sites participating and the sIRB will be handled.

#### **Non-MSU Investigator (Outside Investigator- OI) without collaboration of an MSU Investigator**

When an OI proposes to conduct research at an MSU location, they must contact the HRPP for a determination as to whether MSU is engaged in the research. The OI is required to submit documentation of IRB approval from an institution with an existing FWA to the HRPP. The HRPP reserves the right to request and review any materials associated with the research.

If it is determined by the HRPP that MSU **is not** engaged in human subjects research, the activity is allowed to commence. If the OI is wanting to contact a smaller subset of campus participants (ex: instructors in a particular department), they may contact them directly. However, if they wish to send a mass email, the OI must have appropriate MSU VP approval to do so, and must review and follow the ITS Procedure for Mass Electronic Communications, found here: [https://www.its.msstate.edu/files/mec\\_guidelines1.pdf](https://www.its.msstate.edu/files/mec_guidelines1.pdf). The HRPP will not serve as IRB of Record for research in which MSU is not engaged, nor will it seek approval or sponsorships for the conduct of the activity.

If it is determined by the HRPP staff that MSU **is** engaged in human subjects research, the OI will be required to have an MSU faculty or staff member who agrees to serve as PI at MSU to oversee the research conducted at the MSU location. The activities of the MSU Investigator will be reviewed via normal procedures of the HRPP.

### **Unaffiliated Investigator (UI) with collaboration of an MSU Investigator**

When an MSU investigator proposes to collaborate with a UI to conduct human subjects research, the MSU investigator must submit an Unaffiliated Investigator Agreement (UIA) form which describes the activities the UI will be performing, as well as the Unaffiliated Investigator Approval Request Form, so that the HRPP staff may make a determination as to whether the UI is engaged in human subjects research.

If the HRPP determines the UI is **not** engaged in human subjects research, HRPP approval will not be required of the UI. However, if the UI is associated with an institution with its own IRB, the HRPP may suggest or require the UI confer with the IRB of that institution, and may require documentation of any decision.

If the HRPP staff determines the UI **is** engaged in human subjects research, the UI must have the project approved or determined to be Exempt by an IRB. In cases of federally-funded, non-Exempt human subjects research, the research must be reviewed and approved by an IRB designated on an FWA to comply with the regulatory requirement for single-IRB review. The following situations may occur:

1. If the UI belongs to an institution with an FWA, it will be expected that the covered institution will provide IRB review. However, other arrangements may be made for IRB review, including petition of the HRPP to serve as IRB of Record for the UI as described below.
2. If the UI belongs to an institution with an IRB but lacks an FWA, the HRPP will request the approval of that institution's IRB but may require other arrangements for HRPP review of the project, such as the MSU HRPP serving as the IRB of Record.
3. If the UI does not belong to an institution with either an FWA or an IRB, or is acting as an independent consultant apart from any such affiliation, other arrangements must be made for IRB review, such as the HRPP serving as the IRB of Record.
4. In instances where the UI is acting as an independent consultant or otherwise separate from an institution with which he or she normally has an affiliation, the HRPP must receive documentation on that institution's letterhead from the IRB or other appropriate office that the individual is in fact unaffiliated with said institution for the given project.

### **IRB of Record Requests for a UI**

Whenever the MSU HRPP is petitioned to serve as the IRB of Record for a UI or defer to another IRB, such an arrangement will be made at the discretion of the appropriate officials as described below. In such cases, the IRB Authorization Agreement (IAA) and UIA must be

executed to formalize the arrangement. For non-Exempt research, a subcommittee of the CIRB and the IO, or IO's designee, must approve the arrangement. The subcommittee will consist of the HRPP Officer, IRB Chair, and two other members of the IRB. At least three members of the subcommittee must participate to conduct business. If the subcommittee cannot come to a unanimous decision, it will be referred to the CIRB. If the UIA Approval Request Form is approved, the MSU Investigator must also submit a UIA for each UI, to be signed by the IO (or designee) prior to the UI's conduct of any human subjects research.

1. In instances in which a UI is affiliated with an FWA-holding institution, and officials of both institutions agree for the MSU HRPP to serve as the IRB of Record, the IRB Authorization Agreement (IAA) must be executed.
2. In instances in which a UI is not affiliated with an FWA-holding institution, an IAA must be executed for the MSU HRPP to serve as the IRB of Record. Use of the IAA must comply with OHRP Guidance titled "[Extension of an FWA to Cover Collaborating Individual Investigators and Introduction of the Individual Investigator Agreement.](#)"

In either case, when the HRPP is to serve as the IRB of Record, all UIs must have current IRB training. *When an individual investigator will no longer be engaged in study activities, they should be removed via submission of an amendment in myProtocol.*

The HRPP will, in certain circumstances, agree to allow another IRB with a designated FWA to serve as the IRB of record for an MSU Investigator engaged in human subjects research (e.g., when there is minimal involvement by the MSU investigator. Prior to entering into an IAA allowing another institution to serve as the IRB of record, the HRPP will seek to ensure that the designated institution has [AAHRPP](#) accreditation. Whether or not the designated institution has AAHRPP accreditation, the IAA or MOU must describe how the responsibilities are divided between MSU and the other institution's IRB and will ensure that the HRPP will receive documentation pertaining to the study including, but not limited to, IRB minutes, investigator education, and reports such as problems, noncompliance, and closing reports.

### **MSU Investigator engaged in human subjects research at a non-MSU location**

Whenever an MSU Investigator conducts human subjects research at a non-MSU location, the MSU Investigator must list in their protocol all external sites where human subjects research activities will take place. A letter or email of permission from an appropriate entity addressing the items outlined in the protocol form must be included as an attachment. If the site has an IRB, this permission must come from the IRB. If the institution is engaged in research as described above, the IRB approval letter will suffice as the permission letter. If an organization is only passing on information to prospective research participants, no permission letter is required.

If a school is to be involved, the permission letter must come from the school district's Superintendent **and** the Principal or Vice-Principal in accordance with the school's policies. The HRPP will accept the letter or email of permission as indication of compliance with the school's policies.

If a researcher is proposing to include the Starkville Oktibbeha Consolidated School District (SOCSD) in their research, they must first go through their approval process to make this request prior to submitting an IRB protocol for review. To make this request, a researcher can access the online form at <https://www.starkvillesd.com/departments/curriculum-instruction/research-requests> or may contact Brandi Burton, the Director of Educational Enhancement and Innovative Research at the district office at [bburton@starkvillesd.com](mailto:bburton@starkvillesd.com). The



SOCSD has a board that reviews and approves studies and will issue a letter of approval if it is granted. That approval letter should be included as an attachment in the protocol submitted to the HRPP for review.

**For Research NOT Funded by the DoED:**

The IRB must verify compliance with DoED regulations that schools are required to develop and adopt policies in conjunction with parents regarding the following:

- The right of a parent of a student to inspect, upon the request of the parent, a survey created by a third party before the survey is administered or distributed by a school to a parent.
- Any applicable procedures for granting a request by a parent for reasonable access to such survey within a reasonable period of time after the requests are received.
- Arrangements to protect study privacy that are provided by the agency in the event of the administration or distribution of a survey to a study containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):
  - Political affiliations or beliefs of the student or the student's parent.
  - Mental or psychological problems of the student or the student's family.
  - Sex behaviors or attitudes.
  - Illegal, anti-social, self-incriminating, or demeaning behavior.
  - Critical appraisals of other individuals with whom respondents have close family relationships.
  - Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
  - Religious practices, affiliations, or beliefs of the student or the student's parent.
  - Income (other than that required by law) to determine eligibility for participation in a program or for receiving financial assistance under such program.
- The right of a parent of a student to inspect, upon the request of the parent, any instructional materials used as part of the educational curriculum for the student.
- Any applicable procedures for granting a request by a parent for reasonable access to instructional material received.
- The administration of physical examinations or screenings that the school or agency may administer to a student.
- The collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangement to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.
- The right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information before the instrument is administered or distributed to a student.
- Any applicable procedures for granting a request by a parent for reasonable access to such instrument within a reasonable period of time after the requests are received.

### **MSU Investigators Engaged in human subjects research as Part of Outside Employment or Practice of Profession (Including Consulting)**

When an MSU investigator engages in outside employment to conduct human subjects research, they will be considered as an Unaffiliated Investigator and must follow the procedures outlined above.

### **IRB Review of International/Cultural Research**

While we cannot impose our standards for written documentation on other cultures, we do not relax our standards for ethical conduct of non-Exempt research or for a meaningful consent process. The MSU IRB will serve as the IRB of record for all MSU investigators conducting research abroad. However, the investigators should seek approval from the local equivalent of the IRB prior to seeking MSU IRB approval, and provide the HRPP with documentation of that approval as an attachment in their protocol submission in the myProtocol system. It is suggested that investigators contact the HRPP for guidance pertaining to this process. International/Cultural research protocols should consider local culture and customs in their design. As such, requests to waive some or all of the consent procedures should include explanations of the cultural norms or conditions requiring such a waiver.

Reviews of non-Exempt international research protocols will include individuals with relevant expertise and knowledge relating to the culture or group to be studied, including [Consultants to the IRB](#). This is referred to as a Local Context Review. During the pre-review, the [International Compilation of Human Research Standards](#) will be referenced for additional safeguards for research conducted with international populations. See the [Federally Funded Studies](#) for additional requirements.

Exempt research conducted internationally should use best practices but the Local Context Review is not required.

### **General Data Protection Regulation (GDPR)**

In 2018, the European Union (EU) established the General Data Protection Regulation, which regulates the processing by an individual, a company or an organization of personal data relating to individuals in the EU.

OHRP has provided a [Compilation of Guidances on the EU General Data Protection Regulation](#).

Any studies proposing to include any of the listed EU countries must contact the HRPP for further instruction.

### **Multi-Site Research**

When conducting multi-site research, a formal agreement between organizations is required to specify the roles and responsibilities of each party. When the investigator is the lead investigator, the IRB evaluates whether the management of information relevant to the protection of participants is adequate, such as:

- Unanticipated problems involving risks to participants or others.
- Interim results.
- Protocol amendments.

As of January 20,2020, the Common Rule now requires the use of a Single IRB

(sIRB) when more than one institution is involved in a research project funded by a Common Rule agency. Exceptions to the Single IRB Review can be found [here](#).

### **Significant Risk (SR) and Non-Significant Risk (NSR) for a Medical Device Study**

The sponsor (i.e., the provider of the device) will provide the HRPP with an assessment of whether or not a device study represents a SR/NSR. The IRB may agree or disagree with the sponsor's assessment of risk. The determination of the risk status of the device should be based on the proposed use of the device in an investigation. The IRB may review:

1. A description of the device.
2. Reports of prior investigations conducted with the device, to include reported adverse events.
3. The proposed investigational plan.
4. A description of participant selection criteria.
5. Monitoring procedures.
6. The sponsor risk assessment and the rationale used to make the sponsor's risk determination.

The IRB may also:

1. Request additional information if necessary from the sponsor or investigator.
2. Ask the FDA to provide a risk assessment.

If the IRB disagrees with the sponsor's NSR assessment:

1. The sponsor must notify FDA that SR determination has been made by the IRB. The FDA has the ultimate authority to determine if a device study is SR or NSR.
2. If the FDA determines the device study is SR, FDA approval of an Investigational Device Exemption (IDE) application and IRB approval of the study must be obtained prior to conducting the clinical trial.

If the IRB agrees with the sponsor's NSR assessment and approves the study, the study may begin without submission of an IDE application to FDA. However, abbreviated FDA requirements described in [§812.2\(b\)](#) must be adhered to and documented during IRB pre-review and continuing review as appropriate:

1. The sponsor of the investigation must label the device in accordance with [21 CFR 812.5](#);
2. IRB approval must be obtained;
3. Consent must be obtained from each participant in accordance with [§50](#);
4. The sponsor must comply with the monitoring requirements listed in [§812.46](#);
5. The sponsor must maintain records as required under [§812.140 \(b\)\(1\)-\(3\) and \(5\)-\(10\)](#);
6. The sponsor must ensure that participating investigators maintain the records required by [21 CFR 812.140 \(a\)\(3\)\(i\)](#) and
7. The sponsor must file reports as required under [§812.150\(a\)](#):
  - a. Unanticipated adverse device effects,
  - b. Withdrawal of IRB approval,
  - c. Informed consent and
  - d. Others (to include progress reports and final reports).

Progress reports are to include the following:

1. **Basic Elements:** IDE Number, Device name and indication(s) for use, Sponsor's name, address, phone number, and fax and contact person

2. Study Progress (Data from beginning of the study should be reported, unless otherwise indicated.): Brief summary of the study progress in relation to the investigational plan; Number of investigators/investigational sites (attach list of investigators); Number of participants enrolled (by indication or model); Number of devices shipped; Brief summary of results; Summary of anticipated and unanticipated adverse effects; Description of any deviations from the investigational plan by investigators (since last progress report).
3. Risk Analysis: Summary of any new adverse information (since the last progress report) that may affect the risk analysis; this includes preclinical data, animal studies, foreign data, clinical studies, etc.; Reprints of any articles published from data collected from this study; New risk analysis, if necessary, based on new information and on study progress.
4. Other Changes: Summary of any changes in manufacturing practices and quality control (including changes not reported in a supplemental application); Summary of all changes in the investigational plan not required to be submitted in a supplemental application.
5. Future Plans: Progress toward product approval, with projected date of Premarket Approval (PMA) or 510(k) submission; Any plans to change the investigation, e.g., to expand the study size or indications, to discontinue portions of the investigation or to change manufacturing practices (NOTE: Actual proposals for these changes should be made in a separate supplemental application).

Final reports are to include the following:

1. Basic Elements: IDE Number, Device name and indication for use, Sponsor's name, address, phone number, and fax number and contact person.
2. Study Progress (Data from beginning of the study should be reported, unless otherwise indicated.): Brief summary of study progress in relation to investigational plan; Number of investigators/investigational sites (attach list of investigators); Number of participants enrolled (by indication or model); Number of devices shipped; Disposition of all devices shipped; Brief summary of results; Summary of anticipated and unanticipated adverse effects; Description of any deviations from the investigational plan by investigators (since last progress report).
3. Risk Analysis: Summary of any new adverse information (since last progress report) that may affect the risk analysis; this includes preclinical data, animal studies, foreign data, clinical studies, etc.; Reprints of any articles published from data collected from this study.
4. Other Changes: Summary of any changes in manufacturing practices and quality control (including changes not reported in a supplemental application); Summary of all changes in investigational plan not required to be submitted in a supplemental application.
5. Marketing Application or Future Plans: Progress toward product approval, with date (or projected date) of PMA or 510(k) submission; or indication that marketing of device is not planned; any plans to submit another IDE application for this device or a modification of this device.

### **Compliance and Quality Assurance Program (CQAP)**

The CQAP is comprised of a variety of activities that are designed to ensure compliance with federal regulations and local policies and procedures, and are protecting the rights and welfare of human participants engaging in the research.

### **Compliance and Quality Assurance (CQA) of the HRPP**

Multiple mechanisms are used to evaluate the HRPP for compliance, quality, efficiency, and effectiveness. These methods include:

**Investigators.** Investigators are evaluated using routine, targeted or random audits following the procedures outlined in the CQA Activities Performed by the IRB, on [Post-Approval Monitoring \(PAM\)](#). HRPP staff members determine if changes to procedures or training/education are needed, and will review trends in audit results.

**HRPP Staff.** The HRPP staff are evaluated annually using the periodic investigator survey; two metrics: time from submission to Exempt determination and time from assignment to the HRPP panel to initiation of Cycle 1 comments retrieved from the myProtocol system; and random audits of approved studies for process and policy deviations (conducted by the HRPP Officer or IRB Chair). Informal evaluation is conducted continuously by the MSU research community. Results will be provided to the IO (or designee), feedback will be provided to the staff member in writing, and any recurring issues or continuous improvement opportunities identified. Any concerns regarding performance or qualifications should be made to the IO directly, or through the Director of the ORCS.

**IRB Members.** IRB Members are evaluated at the end of the first year for newly appointed members, and at the end of the third year for all others (unless otherwise needed) on their attendance, review turnaround times, responsiveness to HRPP staff, and their interaction with the MSU research community. Results will be provided to the IRB member, the IRB Chair, and the IO (or designee) in writing, and will be used to identify areas for continuous improvement and/or reappointment decisions. Any concerns regarding performance or qualifications should be made to the IO directly, or through the Director of the ORCS.

**HRPP Officer, IRB Chair and IRB Vice Chair.** These individuals are evaluated using the procedures described for IRB members, as well as by the IRB membership for their leadership and performance. Results will be provided to them in writing and to the IO (or designee) for continuous improvement and/or reappointment decisions. Any concerns regarding performance or qualifications should be made to the IO directly, or through the Director of the ORCS.

**Composition of the IRB.** The composition of the IRB is evaluated annually during the spring semester using the IRB Composition Checklist. The composition will be reviewed by the IRB Chair, HRPP Staff and IO (or designee) to assess representation and areas of expertise needed by the IRB. Recommendations will be made to the IO for approval.

**Quality Improvement Activities.** In addition to those above, quality improvement evaluation involves: an HRPP evaluation survey that is available to investigators who have submitted protocols, and is included in their determination or approval email notice. This link is also available 24/7 on the ORCS website. . This survey covers topics such as: interactions with HRPP staff, familiarity with the myProtocol system, and training and communication preferences. These results are used to identify continuous improvement opportunities and develop relevant training modules to meet the specific needs of the MSU research community.

### **CQA Activities Performed by the IRB**

The IRB is responsible for ensuring compliance with the policies and procedures presented in this document, and applicable regulations for all non-Exempt research activities conducted under the auspices of MSU. These activities include:

### **Post-Approval Monitoring (PAM)**

The HRPP and/or IRB may conduct routine, targeted or random audits subject to their jurisdiction. These activities may include, but are not limited to, the following:

- Request progress reports from investigators;
- Examine research records to confirm use of approved materials;
- Contact research participants;
- Observe the informed consent process;
- Review and/or verify from sources other than investigators that no material changes in the study have occurred; and/or
- Other monitoring or auditing activities deemed appropriate by the IRB.

The PAM process is as follows:

1. HRPP staff will solicit 2-3 volunteers from the IRB and provide the PAM members with all relevant protocol documentation.
2. PAM leader contacts the PI to arrange a site visit, and provides the PI with the PAM on-site checklist as a self-auditing process.
3. PAM members meet with the PI and will complete the PAM on-site checklist. The PAM members may request copies of study materials (consent forms, data sheets, etc.) for review during the site visit. Since the IRB is an independent entity that oversees all non-Exempt human subjects research approved at MSU, and the PAM members are a subset of the IRB, their role in the PAM process allows them to request and review all parts of an approved study. If their requests are denied, the IRB Chair and/or HRPP Officer will follow up, and any requested documents must be presented at that time. After conducting the review, the PAM members may provide general comments on best practices, but will refrain from commenting on the details of the reviewed study.
4. After the site visit, the PAM members will review the checklist and prepare a report including praise for good practices, recommendation for any corrective actions to be taken, and, if necessary, a recommendation to the HRPP Officer or IRB Chair that perceived serious issues be investigated accordingly (e.g., adverse event, unanticipated problems, noncompliance, suspension/termination).
5. PAM leader will provide a copy of the report to the IRB Chair and HRPP Officer for review and may request additional information or modifications.
6. The final PAM report will be submitted to the PI within 14 days of completion of the site visit.
7. PAM leader will report the results at the next CIRB meeting.

The PAM process will be conducted at least 4 times per semester (spring and fall) in order to monitor more of the ongoing active non-Exempt studies that have been approved by the MSU HRPP and IRB.

### **Noncompliance**

Noncompliance can range from minor issues to serious and/or continuing (see [Glossary](#) for definitions). Procedures vary depending on the level of noncompliance. Reports of noncompliance may be reported by anyone with such knowledge including, but not limited to, the research team, office staff, research participants, or HRPP staff. Such allegations may include, but are not limited to, complaints, protocol deviations, and audit findings. Any employees aware of noncompliance associated with human subjects research are to report such information to the ORCS, the IRB Chair, an IRB member, any member of the HRPP staff, the ORCS Director, the MSU Ethics Officer, or through the MSU Ethics Line.



Reports of noncompliance should include as much information about the incident as is known, to include the name of the investigator(s), title of the research, IRB protocol number, and a description of the circumstances of the noncompliance, as well as any protocol deviation, if available. Confidentiality of the complainant will be maintained by the HRPP/IRB in accordance with the wishes of the complainant, and to the extent possible, given the circumstances of the noncompliance. Complainants will be protected in accordance with the MSU “Whistleblower” Policy ([OP 01.07](#)).

Information pertaining to the report of noncompliance will be gathered by the HRPP, then forwarded to the IRB Chair who will determine the appropriate course of action, including if the research must halt immediately in accordance with the procedures for [Suspensions and Terminations of Previously Approved Research](#). The IRB Chair (or designee) will contact the investigator in writing of the report of noncompliance and require a response confirming receipt of the notification.

Findings of minor noncompliance, such as exceeding the number of approved participants, will be addressed and corrected at the discretion of the HRPP Officer and/or IRB Chair, unless these issues are continuing. The Noncompliance Subcommittee handles noncompliance of a more serious nature with possible referral to the CIRB.

The Noncompliance Subcommittee will consist of the IRB Chair, Vice Chair, HRPP Officer, and another member of the IRB named by the Chair. At least three members of the Noncompliance Subcommittee must participate to conduct business. The Noncompliance Subcommittee will meet to discuss the report, meet with the investigators involved, and review any relevant documentation held by the HRPP or the investigators to determine whether the allegation has a basis in fact. Alternatively, the Chair (or designee) has the discretion of referring the matter directly to the CIRB for the sake of expediency.

If the Noncompliance Subcommittee decides by unanimous vote that the report of noncompliance has no basis in fact, the matter will be dismissed. If the Noncompliance Subcommittee does not dismiss the report of noncompliance, the following actions will be taken:

1. Noncompliance that is neither serious nor continuing, and for which there are no aggravating circumstances, may be addressed and resolved by the Noncompliance Subcommittee without review by the CIRB. Matters meeting these criteria may also be referred to the CIRB at the discretion of the Noncompliance Subcommittee.
2. All other noncompliance reports will be forwarded to the CIRB along with the determinations and recommended remediations. In preparation for review at the CIRB, IRB members will be provided any materials gathered during the investigation and the investigators involved will be invited to attend the meeting to address questions by the board. The CIRB makes a determination on the report of noncompliance and accepts or amends the remediation recommendations of the Noncompliance Subcommittee.

When determining remediations and required corrective actions, the following will be considered: the nature of the noncompliance, the history of the investigator, whether the noncompliance appears to have been intentional, whether it harmed participants, placed participants at increased risk of harm, or violated the rights of participants. With regard to the history of the investigator, consideration will be given to the investigator’s previous interactions with the HRPP, the level of cooperation exhibited by the investigator with regard to the current matter, and any corrective actions proactively taken by the investigator with regard to the noncompliance issue.



Remediations and corrective actions that may be defined or required include, but are not limited to, the following:

1. Noncompliance that is neither serious nor continuing:
  - a. Additional training in human subjects protections.
  - b. Increased monitoring of an investigator's research.
  - c. A corrective action plan written by the investigator to prevent future noncompliance.
  - d. Amendment of the research protocol, the continuing review schedule, and/or the information disclosed during the consent process.
  - e. Referral to other entities (e.g., legal counsel, HRPP of collaborating institution(s), other institutional officials as appropriate).
  - f. Restrictions on use of data.
  - g. Others as appropriate.
2. Noncompliance that is serious and/or continuing may include those items listed above, as well as the following:
  - a. Suspension of privileges to conduct human subjects research or suspension or termination of the study (indefinitely or for a specific period of time).
  - b. Notification of current participants (required when such information might relate to participants' willingness for continued participation).
  - c. Providing additional information to past participants.
  - d. Requirement that current participants re-consent to participation.

The CIRB should also consider, with regard to matters of noncompliance, whether systematic changes are needed at the institutional level, such as additional training provided to other investigators to prevent such future noncompliance.

### **Unanticipated Problems Involving Risks to Participants or Others Background**

In accordance with [§46.108\(a\)\(4\)](#) and [§56](#), any unanticipated problems involving risks to participants or others must be promptly reported to the IRB, appropriate institutional officials, and the department or agency head. The PI must submit to the HRPP a completed Protocol Violation as soon as possible, but always within 10 calendar days. Serious problems must be reported verbally within (1) one calendar day, in addition to the submission of the written Protocol Violation. Serious problems include, but are not limited to, those that result in any professional medical or psychological intervention. If the PI does not have all relevant information at the end of 10 calendar days, the report should be submitted with the information available. A follow-up Protocol Violation should be submitted any time additional relevant information becomes available after submission of the initial Protocol Violation. If someone other than the PI makes ORCS aware of the problem, the HRPP staff will contact the PI and request submission of the completed Protocol Violation form.

Only those problems that meet all of the following criteria fall under the auspices of this policy:

- Unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the approved protocol; and (b) the characteristics of the participant population being studied; related or possibly related to participation in the research (*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).
- The research places participants or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized. For purposes of this policy, "participants" would include even a single participant for whom

any recognized increased risk of harm is mitigated through corrective actions put in place - either (a) immediately by the PI without prior approval of the IRB in order to prevent such harm, such action must be reported verbally within (1) one calendar day, in addition to the submission of the written Protocol Violation as stated above or (b) at the direction of the HRPP or IRB Chair in response to the unanticipated problem.

The HRPP staff will review Protocol Violations. The HRPP Officer and/or IRB Chair will handle reports that do not involve risks to participants or others. Others will be forwarded to the CIRB for review. The IRB Chair will serve as the primary reviewer and will also choose a secondary reviewer from among the IRB membership, and they will present the Protocol Violation at the next CIRB meeting. The Protocol Violation checklist will be completed by the HRPP Officer or IRB Chair.

The CIRB should consider whether the affected research protocol still satisfies the requirements for IRB approval under HHS regulations at [§46.111](#) and [§56](#). If the CIRB determines that the unanticipated problem requires remediations, these may include, but are not limited to, the following:

- Suspension and/or termination of the research.
- Notification of current participants (required when such information might relate to participants' willingness for continued participation).
- Amendment of the research protocol, and/or the information disclosed during the consent process.
- Referral to the IO, the MSU Ethics Officer, if applicable, the Director of the Office of Research Compliance and Security, the PI, the PI's supervisor, and other institutional officials as appropriate (including the Director of OSP if the research is externally funded).

The CIRB's determinations will be documented in the meeting minutes.

When following DoD requirements:

- Any unanticipated problems involving risks to participants or others for any DoD-supported research must be promptly (no longer than within five days) reported to the DoD Office for Human Research Protections.

### **Suspensions and Terminations of Previously Approved Research**

In accordance with [§46.113](#) and [§56.108\(b\)\(3\)](#), the HRPP has the authority to immediately suspend or terminate approved research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to participants.

When research is suspended or terminated, considerations include:

- Whether procedures for withdrawal of enrolled participants take into account their rights and welfare (e.g., making arrangements for medical care outside of a research study, transfer to another investigator, and continuation in the research under independent monitoring).
- Informing current participants of the termination or suspension.
- Any adverse events or outcomes reported to the HRPP.

Research can be suspended upon first discovery of possible harm to participants. Suspension will be communicated to the PI, in the most expeditious manner possible, but will be followed-up in writing. Suspensions of non-Exempt approved research will be reviewed at the next CIRB meeting to determine the course of action. The decision of whether to continue the suspension,

or terminate the study, or reinstate approval will be decided by the CIRB. The IRB's determinations will be documented in the meeting minutes.

### **Reporting of Noncompliance, Unanticipated Events and Suspensions and/or Terminations**

Within 10 calendar days of determination of serious and/or continuing noncompliance, the CIRB's findings will be reported in writing to the IO, the MSU Ethics Officer(if applicable), the Director of Research Compliance and Security, the PI, the PI's supervisor, and other institutional officials as appropriate (including the Director of OSP if the research is externally funded).

Any serious and/or continuing noncompliance must be reported further as follows:

#### **Non-funded Research:**

Serious and/or continuing noncompliance in research not externally funded will require no further reporting unless regulated by the FDA, in which case the IO will report the problem in accordance with FDA regulations regardless of funding status.

#### **Funded Research:**

Serious and/or continuing noncompliance in research externally funded will be reported within 10 days by the IO to the relevant Department or Agency Head (sponsor), and any applicable regulatory body including, but not limited to, OHRP and FDA. If the research is sponsored strictly by non-federal sources, the issue of noncompliance will be reported within 10 days by the IO to the Sponsor, and the FDA if so regulated.

The report of the IO to any external agency will include the following for the project:

- Title of the research project and/or grant proposal.
- Name of the PI.
- MSU IRB study number.
- Grant, contract, or cooperative agreement number.
- A detailed description of the noncompliance.
- Actions the institution is taking, or plans to take, to address the noncompliance issue (e.g., educate the investigator, educate all research team, suspend the protocol, suspend the investigator, conduct random audits of the investigator or all investigators, etc.).

The maximum time between recognition of a reportable event and fulfilling the reporting requirement will be 60 calendar days. See the [Federally Funded Studies](#) section for additional requirements.

### **Part C: Responsibilities of MSU Investigators**

It is the responsibility of any MSU affiliated investigator to be familiar with and adhere to all HRPP policies and procedures for the conduct of human subjects research. ***ONLY the HRPP can tell an investigator if a protocol is required to be submitted for review (per [OP 79.03](#)).***

### **Required Human Subjects Training**

All investigators who wish to conduct human subjects research at Mississippi State University must receive training in the protection of human research participants. To comply with this mandate, training may be fulfilled through either online CITI training or a requested in-person training session. Information about training options is located on the [HRPP website](#).

Investigators are required to renew their IRB training at least every 5 years. Alternate training may be accepted, but only at the discretion of the HRPP.

The FWA Agreement and the DoN provide to the HRPP the training necessary for investigators when engaging in or overseeing such research activities. Investigators become aware of the specific DoN requirements through routine correspondence with the DoN and/or the HRPP. New requirements are disseminated by the HRPP to the MSU research community.

### **Protocol Submissions and Review**

Prior to beginning a protocol, investigators are strongly encouraged to contact the HRPP for assistance in determining if HRPP/IRB oversight is required. At a minimum, the investigators should provide the following information in an email:

1. Who the intended research participants are,
2. A brief description of the study procedures, and
3. Any foreseeable/potential risks to participants.

The HRPP will communicate whether or not the proposed research requires HRPP/IRB oversight. Some research activities that are not regulated under the [Common Rule](#) may require review only for the purpose of assessing compliance with HIPAA or other regulations or institutional policies. See Table 1 below.

If it is determined that the research does not require HRPP/IRB oversight, investigators are encouraged to complete the Not Human Subjects Research form within myProtocol and an official email detailing the HRPP determination will be sent.

If the research is determined to require HRPP/IRB oversight, the investigator will be instructed to submit a protocol for Exempt or non-Exempt review, as appropriate. All submitted protocols will undergo:

1. Completeness check.
2. Pre-review.
3. [Exempt](#), [Expedited](#), or [CIRB](#) review, based on risk.
4. Notification of the review decision.

At MSU, students conducting human subjects research are not permitted to submit a protocol for review and approval. All student-led research must be submitted for review under the name of the student's advisor. Once the student has been listed in the *Personnel Section* under *Student Researcher* in the myProtocol system, the student can then complete the application. It is, however, the responsibility of the principal investigator (the advisor), to ensure that the protocol is complete and accurate upon submission. This is also indicated by checking appropriate boxes on the Assurances page of the protocol prior to submission by the advisor to the HRPP. The investigator may be requested to modify or provide additional information at each review step. All reviewer comments will be provided to the investigator(s) through the myProtocol system. Reviewers also may elect to contact the investigator directly with any concerns identified during the review process. Investigators are required to respond to all comments and/or correspondence regarding any protocol. Pending PI notices are sent by the HRPP to the investigator(s) 20 calendar days and 40 calendar days after comments were last sent to the PI, if no response has been received by the PI. If 60 calendar days pass with no communication from the research team, the study will be closed without further notice. If the investigator still needs to complete an IRB protocol for that study and it has been withdrawn after that 60 days, then the investigator must submit a new protocol.

***No research activities can begin until approval has been received; this includes recruitment, consent, and other research activities through data analysis.***

For [Exempt](#) approvals, studies are granted an approval period of 5 years, after which the PI would need to contact the HRPP about submitting a new protocol for review and approval. (Investigators are encouraged to clone the original protocol if the procedures have remained relatively unchanged.) Reference the Exemption Determination section for more details on this process.

For Expedited approvals, [studies are granted an approval period of 5 years, after which the PI would need to contact the HRPP about submitting a new protocol for review and approval. \(Investigators are encouraged to clone the original protocol if the procedures have remained relatively unchanged\).](#)

[For studies approved at the Full Board level, they will be granted a one year approval, and will be subject to review by the board at the annual review, unless the review status is voted on by the board to proceed at the Expedited level at that time. This will be determined on a case-by-case basis at the discretion of the CIRB.](#)

For all non-Exempt studies, investigators are required to submit [Amendments](#) for review and approval of any changes to the approved study (i.e., personnel or procedural in nature) prior to their implementation. Any failure to adhere to approved study procedures or implementation of changes prior to approval may result in [noncompliance](#) and/or [suspension/termination](#) of the study, as outlined in the CQAP. Investigators are also required to submit a Final Report when the research is completed. (A study can be closed if data collection is completed and data has been de-identified, even if data analysis has not taken place. If the data collection is not complete, or if the data is not de-identified yet, the study must remain open.)

**[Determining What Requires HRPP/IRB Oversight](#)**

Determining what requires HRPP/IRB oversight is a complicated process. Table 1 below is intended to help investigators in understanding how oversight is determined for specific activities. It is important to note that if the project involves more than minimal risk, vulnerable populations, or sensitive topics, HRPP/IRB approval is always required regardless of the type of activity.

**Table 1:** Research activities requiring or not requiring HRPP review and/or approval.

ACTIVITY	DESCRIPTION	SUBMISSION REQUIRED TO HRPP?
Case Report	Report about experiences or observations associated with one or two individuals.	NO
	Care should be taken, however, to distinguish a case report from an “N-of-1” research study in which there is a systematic manipulation of an intervention to produce generalizable results.	YES

Oral History	Interviews that collect, preserve and interpret the voices and memories of people, communities, and participants in past events as a method of historical documentation. The intent is to document a particular past or unique event in history.	NO <i>(but exercise of professional ethics is expected)</i>
Pilot Testing or Instrument Development	Preliminary activities typically designed to help the investigator refine data collection procedures.	YES
Repositories (e.g., data, specimen, etc.)*	A storage site or mechanism by which <b>identifiable</b> human tissue, blood, genetic material or data are stored or archived for research by multiple investigators or multiple research projects.	YES
Dissemination of Results	Publication and/or presentation of study findings does not in and of itself define an activity as research. If the study was designed specifically so that publication and/or presentation in a specific journal or forum would be possible, then yes the activity is likely research and requires oversight; otherwise it does not.	YES (only if the intent/motive to publish drives the study design)
Research involving Coded Biological Specimens/Coded Private Information*	<p>Analysis of coded human specimens or coded private human data where:</p> <ul style="list-style-type: none"> <li>• The specimens/data were not collected specifically for the proposed study through an interaction or intervention with living individuals,</li> <li>• The investigators cannot readily ascertain the identities of the individuals from whom the specimens/data were obtained either directly or indirectly through a coding system, and</li> <li>• The investigator is not an investigator or collaborator on the specimen or data provider's research.</li> </ul>	NO
Classroom Assignments/ Research Methods Classes	<p>Activities designed for educational purposes that teach research methods or demonstrate course concepts if <b>ALL</b> of the following criteria are met, the project will <b>NOT</b> require HRPP/IRB oversight:</p> <ol style="list-style-type: none"> <li>1. No more than minimal risk</li> <li>2. No sensitive topics or confidential information that could place a participant at risk</li> <li>3. No vulnerable populations.</li> </ol> <p>These activities are not intended to create new knowledge.</p>	NO <i>(but instructors have an obligation to protect students and others)</i>

	<b>Independent Research Projects:</b> Theses, dissertations, and honors research projects involving human participants are considered research as defined by <a href="#">45 CFR 46</a> .	YES
Research Using Publicly Available Data Sets	Use of publicly available data sets that do not include information that can be used to identify individuals. "Publicly available" is defined as information shared without conditions on use. This may include data sets that require payment of a fee to gain access to the data.	NO
Research on Organizations	Information gathering about organizations, including information about operations, budgets, etc. from organizational spokespersons or data sources. Does not include identifiable private information about individual members, employees, or staff of the organization.	NO
Quality Assurance and Quality Improvement Activities - Non-Clinical	Data collected with the limited intent of evaluating and improving existing services and programs or for developing new services or programs. Examples include teaching evaluations or customer service surveys.	NO

\*Investigators must include in the protocol submission a letter of permission to use the data set(s).

For any activity that does not require IRB oversight, investigators are encouraged to use best practices such as informed consent, voluntary participation, procedures for maintaining privacy and confidentiality\*, data security, etc. Additionally, results cannot be distributed outside the institution.

Note: If an investigator's intention changes from that of fulfilling a classroom assignment to that of research and contribution to generalizable knowledge, **IRB review is required (e.g., prior to the submission of a journal or conference paper or presentation)**.

The PI should clearly indicate to the IRB in their protocol that the data were originally collected as part of an educational activity by providing the course name and a copy of the syllabus.

- [Certificates of Confidentiality](#) can be obtained to protect the privacy of research participants by protecting investigators and institutions from disclosing identifying information in proceedings such as civil, criminal, administrative, legislative etc. NIH funded researchers are automatically issued a CoC through their award. Other DHHS agencies (FDA, CDC, SAMSHA, HRSA, HIS) issue CoCs for research they fund. Researchers can also request a CoC from NIH for health-related studies that are not funded by HHS.

### **Responsibility for Oversight of Student Projects/Classroom Activities**

When conducting research involving humans, regardless of whether it requires HRPP/IRB oversight, each course instructor of record and/or faculty advisor of student research has the responsibility for:



- (1) being familiar with and having reviewed all proposed activities;
- (2) overseeing these activities; and
- (3) assuring that ethical principles are adhered to in the conduct of those activities.

For those studies that are submitted for HRPP/IRB for approval, the advisor assumes the responsibility for the project and has read and agrees to abide by the assurances listed on the Assurances page when they check the required boxes.

Failure to meet these responsibilities could result in reporting as described in the CQA on [Noncompliance](#).

### **Research Participant Pools**

Investigators may use participant pools to recruit participants for future research projects. This could include student participant pools used by various departments or external participants that wish to participate in multiple studies, or have unique characteristics of interest to MSU investigators.

Software systems used to provide human participant pool management that contain sensitive data are covered under the [MSU Information Security Policy](#), and it is a requirement that encryption be used. Whole disk encryption is required on mobile devices (e.g., laptops, jump drives, etc.) that store sensitive information, and websites must use encryption to accept passwords or present sensitive data.

### **Registration**

Each pool must have a designated coordinator. The coordinator of the participant pool must complete the Research Participant Pool Registration Form for review and approval by the HRPP. The Registration Form and appended documents must be reviewed by the HRPP on an annual basis, and any changes must be approved by the HRPP prior implementation of the changes.

Coordinators of the participant pool must have a mechanism in place to provide the following information, at a minimum, to participants:

- What it means to be in a participant pool.
- The alternatives to participating in research if applicable.
- How participants opt out of the pool.
- The ramifications for students who miss a scheduled research appointment (student pools only).
- What happens to the data collected.

### **No-Shows**

Any participant who fails to show for scheduled appointments without canceling may not be penalized. [§46.116\(b\)\(8\)](#) requires that participation in research be voluntary and refusal to participate involve no penalty or loss of benefits to which the participant is otherwise entitled. In accordance with this regulation, participants must be free to choose not to participate in research for which they have signed up at any time. Furthermore, participants must be free to communicate their decisions not to participate in whatever way they choose, including by simply not showing up.

### **Requirements for Investigators Using Student Pools**

To ensure students are fully informed about the research requirements for the course and the compensation offered for their participation, a clear explanation of requirements necessary to earn the class credit must be provided. The research protocol and consent forms must specify how many hours or units of credit are available for participation in each research study, including credits that may be awarded for prescreening. Limits on the amount of credit that may be awarded for a particular study or alternative assignment must be clearly stated prior to, or at the time of, enrolling in the research study. Investigators wishing to include participants less than 18 years of age should refer to [Vulnerable Participants – Children Involved in Research](#) for requirements regarding parental permission. Investigators are discouraged from recruiting participants they directly supervise or selecting participants solely on such basis.

### **Research Data Security**

The increasing use of electronic data collection and storage must be addressed in current research protocols in addition to physical security measures. In addition to reviewing the guidelines below, investigators must be familiar with the [MSU Information Security Policy](#), which identifies technologies, procedures, and best practices.

### **Assessing the Security Method Needed**

Based on the type of data involved in the study, the investigator is required to (1) think about the risk to participants and (2) how those risks will be minimized. To assess risk, investigators should consider the type of data collected (identifiable, anonymous, de-identified or coded), whether sensitive information is collected (such as HIPPA), and the risk of harm to the participants or others if the data is compromised. To minimize risk, the investigators should consider data protection measures during collection, transmission and storage.

### **Electronic Data Storage and Security**

Electronic data must be stored on devices that have appropriate security controls installed, such as password protection, firewall protection, anti-virus protection, automatic system patching and system backup. Users who are not involved in an approved specific research project, or are no longer working on particular protocols, must be removed from access to research data. See the Minimum Security Standards information above in [Research Data Security](#) for specific data classification level controls. For example, a folder common to an entire department is not an acceptable storage location for protected research data. Access to the research directory must be restricted to only the investigators listed on a protocol. The HRPP recommends the use of any MSU-supported storage location, such as Microsoft OneDrive that includes a two-factor authentication to access.

Many research protocols contain a coding sheet that links data to personal identifiers. Investigators using coding sheets must store the coding sheet, consent documents, and data separately, and ensure that they are encrypted.

All websites (typically web surveys) that accept Personal Identifying Information (PII) of research participants must be protected by Secure Sockets Layer (SSL) encryption, and all file transfers of data collected must be done by secure protocols such as HTTPS or SFTP. Electronic sharing of files between investigators must also use these same protocols. For those systems that require user authentication (e.g., the use of an MSU NetID and password), users are prohibited from sharing individual usernames or passwords per [OP 01.12](#). While short-term cloud storage in places like Dropbox, Google Docs, or other platforms is permissible, long-term cloud storage is not. If you have questions about this, please contact the HRPP for guidance.

### **Mobile Apps**

Investigators that use existing, or build their own, mobile apps for the purposes of research data collection and/or data storage must consult with ITS for appropriate approvals for usage. Depending on the type of data collected from the app, additional disclosure to potential participants of potential risks is required. For commercially available apps, investigators are required to know and understand the terms of service, to communicate this information to the participants, and monitor these terms for updates.

Investigators who manage their own systems and servers will be held responsible for data protections. Departmental IT staff should be consulted about assistance with data security controls and for assistance in application of data security. Departments vary in the breadth and scope of their local resources and may have specific security procedures. The MSU ITS department is available to assist investigators with data security procedures. See [Federally Funded Studies](#) for additional requirements.

### **Financial Conflict of Interest for the Institution, Investigators and Research Team**

PHS-funded investigators and research team members will receive training related to financial conflict of interest. Training will be conducted prior to conducting research, and at least every four years thereafter. Training will be required immediately when:

- Financial conflict of interest policies are revised in a manner that changes investigator requirements.
- An investigator is new to the organization.
- An investigator is non-compliant with financial conflict of interest policies and procedures.

If any of the questions on the Potential Conflict of Interest section in the protocol form are answered “Yes”, the protocol will be referred to the Director of the Office of Research Compliance and Security / Conflict of Interest Manager. The Director of ORC will work with the investigator to develop an appropriate Management Plan. For PHS-funded studies, the Conflict of Interest Review Committee will develop the Management Plan.

For Expedited studies, the HRPP Officer will determine if the Management Plan is satisfactory. For Full Board studies, the CIRB will determine if the Management Plan is satisfactory. The HRPP Officer and/or CIRB have final authority to accept the Management Plan as presented or make appropriate changes to mitigate the financial conflict of interest.

Management Plans may include (but are not limited to) partial or complete divestment, limiting involvement of the conflicted individual, or additional oversight or disclosure. Disclosure alone cannot be used to manage conflicts of interests that might affect the protection of participants.

Investigators and the research team will be required to submit an annual report describing his or her compliance with their Management Plan. The Director of ORCS and the HRPP Officer will review annual reports. Any deviation from the Management Plan will be handled in accordance with the CQA on [Noncompliance](#).

### **Institutional Conflict of Interest Related to Licensing**

To identify institutional conflict of interest related to licensing, the HRPP requires all new human subjects research protocols to indicate source(s) of all funding to be used in supporting the

research. This information will be compared to a report provided by the Office of Technology Management listing all active institutional start-up companies that have been approved by the Mississippi University Research Authority (MURA) Board.

### **Institutional Conflict of Interest Related to Institutional Officials**

When a University official, with the authority to act on behalf of the Institution and to make decisions that have institution-wide implications or whose decisions could reasonably be seen as affecting the conduct, review, or oversight of research, is found to hold a financial interest related to the research, he or she shall either:

1. Totally divest him or herself of the financial interest; or
2. Resign from the board or other position with the external entity that has a financial interest in the research.

### **Major Gifts to Mississippi State University Foundation**

To identify institutional conflicts of interest related to major gifts, the HRPP requires all new human subjects research protocols to indicate source(s) of funding to be used in supporting the research. When the source of funding is not federal or state, the HRPP staff will communicate with the MSU Foundation to determine if the sponsor is a major donor (a person or entity who has contributed more than \$25,000 lifetime to the University).

### **Investigator Separation and Ownership of Human Participants Data**

When an investigator separates from the institution (faculty, staff or students), they are to contact the HRPP Office regarding any open protocols they are involved with as the PI or other personnel to take appropriate steps to either close the protocol or identify who at MSU will assume responsibility for their role on the project. If the study closes, no further action is required by the investigator. If the study remains open and the investigator wishes to continue collecting data at MSU, they need to follow the procedures in [Collaborative Research](#). If the study remains open and the investigator wishes to continue data collection at their new institution, the investigator must provide a copy of IRB approval from their new institution to the MSU HRPP.

Prior to separating from the institution, the investigator must ensure that all versions of the data remain at MSU and are accessible by the other members of the research team. Investigators can take a copy of the data using the procedures outlined in [Research Data Security](#). Further, investigators must refer to [OP 76.01 Section VI](#) on Intellectual Property at Mississippi State University with regard to maintaining possession of data after leaving MSU. For federally funded projects, the investigator must obtain permission from the sponsor prior to removing any data. A copy of the IRB approval from the new institution with an FWA must be provided to the HRPP. Otherwise, the data must be rendered non-identifiable, or otherwise no longer meet the definition of human participant, such that HRPP/IRB approval is no longer needed.

### **Student-Led Research and Data Ownership**

Any data collected under an HRPP/IRB-approved protocol, including those for theses or dissertations, are the property of MSU. Student investigators must leave a copy of all data set versions (raw, processed, cleaned, coded, etc.) with their advisor. [Section VI of OP 76.01](#) applies to students as well.

## **Participant Protections**

### **Data Safety and Monitoring**

A Data and Safety Monitoring Plan (DSMP) will only be required when the study is greater than minimal risk (i.e., CIRB reviewed protocols). Based on the risk to participants described in the protocol, the primary and secondary reviewers will make a recommendation to the CIRB if they believe that a DSMP is needed for a final determination.

For the CIRB to approve a protocol requiring a DSMP, it might consider provisions such as:

Reporting mechanisms:

1. What safety information will be collected, including serious adverse events.
2. Frequency of monitoring and reporting, such as after a specific number of participants are enrolled, or length of time after the study has begun.
3. If not using a data monitoring committee, and if applicable, statistical tests for analyzing the safety data to determine whether harm is occurring.
4. The entity that will conduct the monitoring, including the qualifications and number of people serving on the monitoring committee/board and whether they have any perceived conflict of interest with the investigator or sponsor.
5. A specific list of the data to be reviewed.
6. Procedures for analyzing and interpreting the data.
7. If specific events or end-points are anticipated in the study, a description of the actions to be taken when such events or end-points are reached.
8. Methods of communication between the data monitor to the IRB and sites (if multi-site study).

Contracts or other funding agreements require the sponsor to promptly (no longer than 30 days) report to the organization any findings that could:

- Effect the safety of participants and/or
- Influence the conduct of the study or alter the IRB's approval to continue the study.

### **Participant Incentives**

Participant incentives, if used, must be approved by the HRPP/IRB and cannot be coercive (i.e., incentives cannot be of such value that participants would have difficulty choosing not to participate.) These incentives can take many forms (cash payments, gift cards, extra course credit/bonus points, items such as flash drives, health evaluations, etc.).

Obtaining and disbursing incentives is the responsibility of the investigator and should be documented in such a way to withstand an audit of all disbursements. Investigators are to be aware of, and comply with [MSU's Gift Card Guidelines](#) when using this type of incentive. Credit for payment accrues as the study progresses and must not be contingent upon the participant completing the study.

When using gift cards or cash incentives, participants must be made aware that the reconciliation process for departments may involve their names being shared with the necessary departmental individuals who process those records, but that their confidentiality will be protected.

## **Class/Course Credit and Alternative Assignment**

Any research study offering class credit to participating students must provide non-research alternative opportunities to earn credit of equal value and time commitment to students declining to participate in the research. Undue influence must not be exerted on students for participation in research. Investigators should clearly and completely describe the alternative assignment in a way and at a time that allows the participants to make an informed choice about which method they will use to earn class credit. To promote fairness and justice, the alternative assignment should require approximately the same time and effort commitment as participation in the research study.

## **Vulnerable Participants**

### **Vulnerable Participants - Children Involved in Research**

[§41-41-17](#). Authorized consent to participate in research conducted in accordance with federal law. Sources: *Laws, 2004, ch. 339, § 1, eff from and after July 1, 2004.*

(1) Any adult, as defined in [§41-41-203\(a\)](#), Mississippi Code of 1972, or emancipated minor, as defined in [§41-41-203\(e\)](#), Mississippi Code of 1972, may consent to participate as a participant in research if that research is conducted in accordance with federal law [45 CFR Part 46](#).

(2) Unemancipated minors may participate as participants in research, if that research is conducted in accordance with federal law, with the consent of a parent or a guardian, as defined in [§41-41-203\(e\)](#), Mississippi Code of 1972.

Code of Federal Regulations Definitions

### **§46.102(i) and §50.3(l): *Legally authorized representative (LAR)*-**

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.

### **§46.402(d-e), §50.3(p), and §50.3(s): *Parent or Guardian***

**(d) Parent** - a child's biological or adoptive parent.

**(e) Guardian** - an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care includes participation in research. For purposes of [subpart D](#) of this part, a guardian also means an individual who is authorized to consent on behalf of a child to participate in research.

**§50.3(o) Children** means persons who have not attained the legal age for consent to treatments or procedures involved in clinical investigations, under the applicable law of the jurisdiction in which the clinical investigation will be conducted.

**§50.3(q) Ward** means a child who is placed in the legal custody of the State or other agency, institution, or entity, consistent with applicable Federal, State, or local law.

Mississippi Code of 1972 Definitions

### **§41-41-203. Definitions.**

The following words shall have the meaning ascribed in this section unless the context shall otherwise require:

(a) "Adult" means an individual who is eighteen (18) years of age or older.

(e) "Emancipated minor" means an individual under the age of eighteen (18) years who:



- (i) Is or has been married;
  - (ii) Has been adjudicated generally emancipated by a court of competent jurisdiction; or
  - (iii) Has been adjudicated emancipated for the purpose of making health-care decisions by a court of competent jurisdiction.
- (f) "Guardian" means a judicially appointed guardian or conservator having authority to make a health-care decision for an individual.

### **§93-13-1. Parental Guardianship of Minor Children**

The father and mother are the joint natural guardians of their minor children and are equally charged with their care, nurture, welfare and education, and the care and management of their estates. The father and mother shall have equal powers and rights, and neither parent has any right paramount to the right of the other concerning the custody of the minor, or the control of the services or the earnings of such minor, or any other matter affecting the minor. If either father or mother die or be incapable of acting, the guardianship devolves upon the surviving parent. Neither parent shall forcibly take a child from the guardianship of the parent legally entitled to its custody. But if any father or mother be unsuitable to discharge the duties of guardianship, then the court, or chancellor in vacation, may appoint some suitable person, or having appointed the father or mother, may remove him or her if it appears that such person is unsuitable, and appoint a suitable person.

Research involving children may be approved at the [Exempt](#), [Expedited](#) or [CIRB](#) level. The Review Checklist for Research Involving Children (contained in the Vulnerable Populations Checklist) must be completed by the reviewer(s) for projects being reviewed at the Expedited or CIRB level.

In order to be approved by the HRPP, research-involving children must fall into one of four categories outlined in [Subpart D](#). The four categories are based on degree of risk and benefit to individual participants.

Categories of Research Involving Children:

1. Research Not Involving Greater than Minimal Risk to Children ([§46.404](#))
2. Research Involving Greater than Minimal Risk but Presenting the Prospect of Direct Benefit to the Individual Child ([§46.405](#))
3. Research Involving Greater than Minimal Risk and No Prospect of Direct Benefit to the Individual Child, but Likely to Yield Generalizable Knowledge about the Child's Disorder or Condition. ([§46.406](#))
4. Research Not Otherwise Approvable, which Presents an Opportunity to Understand, Prevent, or Alleviate a Serious Problem Affecting the Health or Welfare of Children ([§46.407](#))

The HRPP must determine if assent of the child participants must be solicited based on the ages, maturity, and psychological state of the children involved. In general, age 7 is the recommended age to begin seeking assent, but it may be appropriate for younger children depending on their aptitude. If assent is solicited, the HRPP must determine that the language used to explain the procedures is appropriate.

The assent to participate in a research project should be obtained in accordance with the instructions included in the sample Assent Template, which can be found in the Information Resources section of myProtocol. The HRPP must determine whether assent is needed and how it should be documented.



If a waiver of assent is requested by the investigator, the HRPP must determine that at least one of the necessary conditions outlined in [§46.408\(a\)](#) is met.

The permission of each child's parents or legally authorized representative must be solicited unless the HRPP determines that the conditions outlined in [§46.408\(c\)](#) are met.

Permission to participate in a research project should be obtained in accordance with the instructions included in the sample Parental or Legally Authorized Representative Permission Form Template, which can be found in the Information Resources section of myProtocol.

If the investigator requests a waiver of documentation, the HRPP must determine that the requirements outlined in [§46.117](#) are met.

When permission is sought from only one parent, the HRPP must determine that at least one of the conditions outlined in [§46.408\(b\)](#) is met.

When child participants are wards of the state or any other agency, the HRPP must determine that all of the conditions outlined in [§46.409](#) are met.

When child participants have a legally authorized representative or are wards of the state or any other agency, written documentation of the judicial appointment must be provided to the investigator at the time of consent, and a copy maintained by the investigator with the consent/assent documents.

The HRPP must assure that it possesses the expertise necessary to review research-involving children as participants or seek the expertise of a consultant in accordance with [Consultants to the IRB](#).

### **When Following DoED Regulations:**

#### **Definitions:**

*Research or experimentation program or project* means any program or project in any research that is designed to explore or develop new or unproven teaching methods or techniques.

*Children* are persons enrolled in research not above the elementary or secondary education level, who have not reached the age of majority as determined under state law.

Access to instructional material used in a research or experimentation program:

All instructional material—including teachers' manuals, films, tapes, or other supplementary instructional material—which will be used in connection with any research or experimentation program or project must be available for inspection by the parents or guardians of the children engaged in such research.

The process to comply with the [Protection of Pupil Rights Amendment](#):

**For research funded by the DoED:** No student shall be required, as part of any research project, to submit without prior consent to surveys, psychiatric examination, testing, or treatment, or psychological examination, testing or treatment, in which the primary purpose is to reveal information concerning one or more of the following:

- Political affiliations.
  - Mental or psychological problems potentially embarrassing to the student or his or her family.
  - Sex behavior and attitudes.
  - Illegal, anti-social, self-incriminating and demeaning behavior.
  - Critical appraisals of other individuals with whom the student has close family relationships.
  - Legally recognized privileged and analogous relationships, such as those of lawyers, physicians, and ministers.
  - Religious practices, affiliations, or beliefs of the student or student's parent.
- Income, other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under a program.

Prior consent means:

- Prior consent of the student, if the student is an adult or emancipated minor; or
- Prior written consent of the parent or guardian if the student is an unemancipated minor. Schools and contractors obtain prior written parental consent before minor students are required to participate in any ED-funded survey, analysis, or evaluation.

**When following Department of Defense (DoD) requirements:**

- Research involving children is subject to DHHS [Subparts B, C, and D](#).
  - For purposes of applying [Subpart B](#), the phrase “biomedical knowledge” shall be replaced with “generalizable knowledge.”
- Research involving children cannot be Exempt.

**When following EPA regulations:**

- Research involving intentional exposure of children to any substance is prohibited and not approved by the IRB.
- For research intended for submission to the EPA, research involving intentional exposure of children to any substance is prohibited and not approved by the IRB.
- The IRB must review and approve observational research involving children that does not involve greater than minimal risk, only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth in [§26.406](#).
- The IRB may only approve observational research involving children that involves greater than minimal risk, but presenting the prospect of direct benefit to the individual participants if the IRB finds and documents that:
  - The intervention or procedures holds out the prospect of direct benefit to the individual participant or is likely to contribute to the participant's well-being.
  - The risk is justified by the anticipated benefit to the participants.
  - The relation of the anticipated benefit to the risk is at least as favorable to the participants as that presented by available alternative approaches.
  - Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in [§26.406](#).

**Vulnerable Participants - Cognitively Impaired Individuals Involved in Research**  
**§46.102(i) and §50.3(l)**

*Legally authorized representative* means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedure(s) involved in the research.

Research in which cognitively impaired individuals will be considered as participants may be reviewed at the [Exempt](#), [Expedited](#) or [CIRB](#) level. The Review Worksheet for Research Involving Cognitively Impaired Individuals (contained in the Vulnerable Populations Checklist) must be completed by the reviewer(s) for projects being reviewed at the Expedited or CIRB level to ensure appropriate regulatory requirements are met prior to IRB approval.

Research involving cognitively impaired participants may not be approved by the IRB when all of the following conditions apply:

1. There is no advance directive (completed before cognitive impairment) which provides evidence of willingness to participate in the research;
2. Participants are too intellectually impaired to give consent;
3. The research involves greater than minimal risk; and
4. Offers no prospect of direct benefit to the individual participant.

For participants who lack decision-making capacity, the permission of the individual's legally authorized representative is required and assent should be obtained from the participant. When participants who lack decision-making capacity have a legally authorized representative, written documentation of the appointment must be provided to the investigator at the time of consent, and a copy maintained by the investigator with the consent/assent documents. In research situations where there is the potential for direct benefit to the participant, the HRPP/ IRB may waive the requirement to obtain assent; however, permission from the legally authorized representative must be obtained unless the criteria are met to approve a waiver of informed consent. Even where the individuals are capable of consenting, the HRPP/ IRB may waive the consent requirements under the circumstances described in [Consent, Parental Permission, and Child Assent](#).

When reviewing research (i.e., pre-review, continuing review, protocol amendments, and reports of adverse events or unanticipated problems) involving cognitively impaired participants, the CIRB will include into its composition one or more individuals who are knowledgeable about, and experienced in working with, the cognitively impaired. When reviewing said research at the Expedited level, the reviewer(s) will be knowledgeable about, and experienced in working with, the cognitively impaired.

**When Following Department of Defense (DoD) Regulations:**

- If consent is to be obtained from the experimental participants' legal representative, the research must intend to benefit the individual participant.
- The determination that research is intended to be beneficial to the individual experimental participant must be made by the IRB.

**Vulnerable Participants - Pregnant Women, Human Fetuses and Neonates**

Research involving pregnant women, human fetuses and neonates may be approved at the [Exempt](#), [Expedited](#) or [CIRB](#) level. The Vulnerable Populations Checklist contains the worksheet for Research Involving Pregnant Women, Human Fetuses, Neonates, or Fetal Material, which must be completed by the reviewer(s) for projects being reviewed at the Expedited or CIRB level to ensure appropriate regulatory requirements are met prior to IRB approval.

When it is appropriate, any research project that includes women of childbearing potential as possible participants must include a statement that the particular treatment or procedure may involve risks to the participant (or to the embryo or fetus, if the participant is or may become

pregnant) as part of the informed consent process. Each participant will be advised to notify the investigator immediately should she become pregnant. The IRB should determine if the risk is great enough to exclude pregnant women from the research project or to study them separately.

When the IRB determines that a woman's participation would pose any risk to her fetus, should she become pregnant, the non-pregnant participants will be advised to avoid pregnancy during or following the research. When a woman's participation would pose any risk to her nursing infant, she will be advised to avoid nursing for a time during or following the research.

#### **When Following Department of Defense (DoD) Requirements:**

- Research involving pregnant women is subject to 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](#).

Additionally, when following DoD requirements:

- (a) Research involving pregnant women, prisoners, and children are subject to the DHHS Subparts B, C, and D, except where modified by DoDI 3216.02:
- (b) For purposes of applying Subpart B, the phrase "biomedical knowledge" is replaced with "generalizable knowledge."
- (c) The applicability of Subpart B is limited to research involving pregnant women as participants in research that is greater than minimal risk and includes interventions or invasive procedures involving the woman or the fetus as participants.
- Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g:
  - Research or experimentation may not be conducted, in the United States or in any other country, on a nonviable living human fetus ex utero or a living human fetus ex utero for whom viability has not been ascertained unless the research or experimentation:
    - May enhance the well-being or meet the health needs of the fetus or enhance the probability of its survival to viability; or
    - Will pose no added risk of suffering, injury, or death to the fetus and the purpose of the research or experimentation is the development of important biomedical knowledge which cannot be obtained by other means.
  - The risk standard must be the same for fetuses which are intended to be aborted and fetuses which are intended to be carried to term.
- For human participant research that would not otherwise be approved but presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates, DoD organizations must demonstrate to the senior designated official that the IRB has fulfilled its duties in accordance with Subpart B. Before human participant research activities may begin, the senior designated official must receive explicit written approval from the DoD Office for Human Research Protections.

### **When Following EPA Regulations:**

- Research involving intentional exposure of pregnant women to any substance is prohibited and not approved by the IRB.
- For research intended for submission to the EPA, research involving intentional exposure of pregnant women to any substance is prohibited and not approved by the IRB.
- The IRB must review observational research involving pregnant women and fetuses using [40 CFR 26](#) and [45 CFR 46 Subpart B](#).

### **Vulnerable Participants - Prisoners Involved in Research**

If a protocol involves the use of prisoners as participants, both the general IRB policies and procedures apply and the additional ones outlined in this policy. The Research Involving Prisoners Checklist (contained within the Vulnerable Populations Checklist) should be completed by the primary and secondary reviewers to document determinations required by the regulations and protocol specific findings justifying those determinations and retained in the protocol file.

The IRB may approve research involving prisoners only if these special provisions are met:

1. The IRB must consider any additional Federal, State, County, and local regulations when reviewing research involving prisoners.
2. When determining minimal risk, the IRB must consider physical or psychological harm normally encountered in the daily lives, or routine medical, dental or psychological examination of healthy persons.
3. The level of review must be CIRB (not Expedited or Exempt) for all research in which prisoners are the target population, the participant is a prisoner at the time of enrollment, or when a currently enrolled participant becomes incarcerated and research interventions and interactions would occur during the incarceration period or if identifiable private information will be obtained during the incarceration period.
4. The MSU IRB will include one or more individuals who are knowledgeable about, and have experience in working with, prisoners. The prisoner representative must have a close working knowledge, understanding and appreciation of prison conditions from the perspective of a prisoner. Suitable individuals could include present or former prisoners; prison chaplains, prison psychologists, prison social workers, or other prison service providers; persons who have conducted advocacy for the rights of prisoners; or any individuals who are qualified to represent the rights and welfare of prisoners by virtue of appropriate background and experience.

If a research project was not approved for prisoner participation and a participant becomes a prisoner after enrolling in a research study, the investigator is responsible for reporting the event in writing to the IRB within one business day of learning of the incarceration, as to whether the participant is to remain in the research study or not. All research interactions and interventions with, and obtaining identifiable private information for the individual(s) must cease until further approval is obtained from the CIRB. If neither research interactions or interventions nor obtaining identifiable private information will occur while the individual meets the regulatory definition of prisoner, IRB review and approval under this procedure and [§46 Subpart C](#) is not required.

If participants are members of another vulnerable population (such as children or pregnant women), protections under those relevant policies will apply in addition to the requirements of this policy.

#### Research Involving Prisoners Reviewed by the CIRB:

- When the CIRB reviews research involving prisoners, one or more individuals who are prisoners or prisoner representatives must be present at the meeting.
- A majority of the IRB (exclusive of prisoner members) have no association with the prison involved, apart from their membership on the IRB. At least one IRB member who is a prisoner or a prisoner representative with appropriate background and experience to serve in that capacity is present at the meeting.
- 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.
- The prisoner representative must review research-involving prisoners, focusing on the requirements in [Subpart C](#) or equivalent protections.
  - The prisoner representative must receive all review materials pertaining to the research (same as the primary reviewer).
- The prisoner representative must be present at a CIRB meeting when the research involving prisoners is reviewed. If the prisoner representative is not present, research involving prisoners cannot be reviewed or approved.
  - The prisoner representative may attend the meeting by phone, videoconference, or webinar, as long as the representative is able to participate in the meeting as if they were present in person at the meeting.
- The prisoner representative must present his/her review either orally or in writing at the CIRB meeting when the research involving prisoners is reviewed.

#### Participant Who Becomes a Prisoner:

If the participant becomes a prisoner while enrolled in a research study that was not reviewed according to [Subpart C](#):

- When [Subpart C](#) applies:
  - Confirm that the participant meets the definition of a prisoner.
  - Terminate enrollment or review of the research study under [Subpart C](#) if it is feasible for the participant to remain in the study.
    - The IRB Chair may determine that the prisoner participant may continue to participate until the CIRB 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 participant (including obtaining identifiable private information) cease until the CIRB can review this request to approve a change in the research protocol.
    - The CIRB, 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 well-being of the participant, now a prisoner, are 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 CIRB 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.

- 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:
  - Keep the participant enrolled in the study and review the research under [Subpart C](#).
    - If some of the requirements of [Subpart C](#) cannot be met, but it is in the best interest of the participant to remain in the study, keep the participant enrolled and inform OHRP of the decision along with the justification.
  - 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.
- When [Subpart C](#) does not apply and the IRB has written procedures for providing equivalent protections:
  - Confirm that the participant meets the definition of a prisoner.
  - Decide whether it is in the best interest of the participant to remain in the study or to terminate enrollment.
  - Also decide whether it is feasible for the participant to remain in the study.
  - If it is in the best interest of the participant to remain in the study, keep the participant in the study and review the research at the next meeting of the CIRB.

Participant who is Incarcerated Temporarily While Enrolled in a Study:

- If the temporary incarceration has no effect on the study, keep the participant enrolled.
- If the temporary incarceration has an effect on the study, handle according to the above guidance.

**Additional Requirements When Following Department of Defense (DoD) Regulations:**

Research involving prisoners are subject to DHHS Subparts [B](#), [C](#), and [D](#).

- For purposes of applying [Subpart B](#), the phrase “biomedical knowledge” shall be replaced with “generalizable knowledge.”
- When IRB reviews research involving prisoners, at least one prisoner representative must be present.
- Research involving a detainee as a human participant is prohibited.
- This prohibition does not apply to research involving investigational drugs and devices when the same products would be offered to U.S. military personnel in the same location for the same condition.
- Research involving prisoners of war is prohibited.
- The IRB is aware of the definition of “prisoner of war” for the DoD component granting the addendum.



In addition to activities permissible under Subpart C, two additional categories are permissible:

- Epidemiological research is permitted under the following conditions:
  - Where the sole purpose of the research is to describe the prevalence or incidence of a disease by identifying all cases, or study potential risk factor associations for a disease.
  - The research presents no more than minimal risk.
  - The research involves no more than inconvenience to the prisoner-participants.
  - Prisoners are not a particular focus of the research.
- Human participant research involving prisoners that would otherwise meet exemption criteria may be conducted, but must first be approved by an IRB.

DoD organizations conducting research involving prisoners must demonstrate to the senior designated official that the IRB has fulfilled its duties in accordance with Subpart C.

When a previously enrolled human participant becomes a prisoner, and the protocol has not been reviewed and approved by the IRB in accordance with Subpart C, the key investigator must promptly notify the IRB.

- For DoD-conducted research, the human protections director must notify the component office of human research protections.
- For DoD-supported research, the non-DoD organization must notify the DoD human research protection official and other federal agencies.

DoD organizations must demonstrate to the senior designated official that the IRB has fulfilled its duties in accordance with DHHS Subpart D, 45 CFR 46.407 and 21 CFR 50.54.

Research involving a detainee or a prisoner of war as a human participant is prohibited.

- This prohibition does not apply to activities covered by investigational new drug or investigational device provisions of FDA regulations, when the purpose is for diagnosis or treatment of a medical condition in a patient.
- Such treatment may be offered to detainees or prisoners of war with their informed consent when the medical products are subject to FDA regulations, and only when the same product may be available to DoD-affiliated personnel consistent with established medical practices.

The IRB is aware of the definition of “prisoner of war” for the DoD component granting the addendum.

If the research involves DoD-affiliated personnel, the key investigator must receive command or Component approval to execute the research.

Service members and all Reserve Component and National Guard members in a federal duty status are considered to be adults. If a Service member, Reserve Component or National Guard member in federal duty status, student at a Service Academy, or trainee is under 18 years of age, the IRB must carefully consider the HSR recruitment process and the necessity of including such member as a human participant.

Research involving large-scale genomic data from DoD-affiliated personal requires additional protections:

- The disclosure of DoD-affiliated personnel’s genomic data may pose a risk to national security; accordingly, written materials must describe administrative, technical, and physical safeguards commensurate with risk, including the secondary use or sharing of de-identified data or specimens.
- All research involving large-scale genomic data collected from DoD-affiliated personnel must have a certificate of confidentiality.
- Research involving large-scale genomic data collected from DoD-affiliated personnel is subject to DoD Component security review to ensure the adequacy of the proposed administrative, technical, and physical safeguards, including the secondary use or sharing of de-identified data or specimens.

**Vulnerable Participants - Students and Employees of MSU**

The following conditions must exist for research involving MSU students and/or employees to be approved by the HRPP:

1. Participation in the research must not bestow any competitive academic or occupational advantage over other MSU students or employees who do not participate, and the investigators must not impose any academic or occupational penalty on those participants who choose not to participate.
2. Participants who are MSU students and employees must not be systematically treated differently from participants that are not MSU students and/or employees.
3. Any student research pool offering extra credit to participating students must provide alternative opportunities to earn extra credit to students declining to participate in research.

The HRPP may make exceptions to any or all of the above conditions, given that the inclusion of these participants in the research provide direct benefit to the participant. The investigator should provide documentation supporting the exception request.

**Effects of Disasters on Human Research Protections Programs Guidance**

While events such as natural disasters are unlikely during the course of most research studies approved by the IRB, it may be helpful to know the process and expectations if this were to happen. The Office for Human Research Protections (OHRP) has issued guidance for this, which can be found here: <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/effects-of-disasters-on-human-research-protections-programs-guidance/index.html>.

**Section 3: Federally Funded Studies**

In addition to the procedures outlined in the relevant section(s) above, the following procedures apply when the study is funded by the Department of Defense (DoD); Department of Energy (DoE); Department of Justice (DoJ), National Institute of Justice and Bureau of Prisons (NIJ); Department of Education (DoEd); Environmental Protection Agency (EPA); and the Food and Drug Administration (FDA).

The following additional procedures coincide with the requirements listed in the bolded sections:

## Consent, Parental Permission, Child Assent and Waivers

### **DoD requirements:**

The following definition will also apply: Research involving a human being as an experimental subject. An activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Research involving a human being as an experimental subject is a subset of research involving human subjects. This definition relates only to the application of §980 of Reference (g); it does not affect the application of part 219 of Reference (c). This definition does not include activities that are not considered research involving human subjects, activities that meet the Exemption criteria at §219.101(b) of Reference (c), and research involving the collection or study of existing data, documents, records, or specimens from living individuals. ([DoD 3216.02](#), November 8, 2011).

- The IRB determines that the disclosure includes the provisions for research-related injury follows the requirements of the DoD component.
- If the research participant meets the definition of “experimental subject”, the waiver of the consent process is prohibited 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 the following are met:
  - The research is necessary to advance the development of a medical product for the Military Services.
  - The research may directly benefit the individual experimental subject.
  - The research is conducted in compliance with all other applicable laws and regulations.
- For a classified investigator, waivers of consent are prohibited.
- If the research participant does not meet the definition of “experimental subject”, the IRB is allowed to waive the consent process.

To comply with the addition of DoD requirements DODI 3216.02 (revised April 2020):

- Non-Exempt classified research must be conducted following the requirements of Instruction 3216.02.13.
- Written materials define “experimental subject” as an activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction. Research involving experimental subjects as defined in DODI 3216.02 is a subset of research involving human participants.
- Human participant research involving the testing of chemical or biological agents is prohibited, pursuant to Section 1520a of Title 50, United States Code (U.S.C.). Some exceptions for research for prophylactic, protective, or other peaceful purposes apply. Before any excepted testing of chemical or biological agents involving HSR can begin, explicit written approval must be obtained from the DoD Office for Human Research Protections (DOHRP).
- The following activities are not considered research involving human participants:
  - Public or internal information collections of facts or opinions, obtained initially or in follow-up requests, from individuals (including individuals in control groups) under treatment or clinical examination in connection with research on, or prophylaxis to prevent, a clinical disorder;
  - Direct treatment of that disorder; or

- The interpretation of biological analyses of body fluids, tissues, or other specimens; or the identification or classification of such specimens.

When following DoD requirements, the following must be reported to the DODHRPP within five days of completion of the report:

- (a) Reports of for-cause audits, reviews, or assessments conducted by or on behalf of the component office of human protections.
- (b) Reports of audits of DoD-conducted or DoD-supported human participant research by another federal or state agency, official governing body of a Native American or Alaskan native tribe, other official entity, or foreign government, within five business days of discovering that such audit reports exist.
- Allegations of serious or continuing noncompliance related to HSR that are substantiated by investigation, and subsequent actions taken based on the findings.
- Substantiated allegations related to classified HSR must be reported immediately (less than five days) to the DOHRP.

If the research involves DoD-affiliated personnel as participants, in addition to the basic and required consent disclosures, consent documents must include:

- If the research involves risks to their fitness for duty (e.g., health, availability to perform job, data breach), the informed consent document (ICD) must inform DoD-affiliated personnel about these risks and that they should seek command or Component guidance before participating.
- If applicable, a statement of potential risks for the revocation of clearance, credentials, or other privileged access or duty.
- A statement that the DoD or a DoD organization is funding the study.
- A statement that representatives of the DoD are authorized to review research records.

For greater than minimal risk research, consent documents must include the disclosure that participants may, for the duration of the study, be eligible for health care services for research-related injuries at a military treatment facility, and this eligibility for health care services extends beyond participants' participation in the study to such time after the study has ended.

Written materials must document how institutions will care for participants with research-related injuries, including injuries that are the direct result of activities performed by DoD-affiliated personnel in studies that are collaborative with a non-DoD institution.

In addition to recruiting participants in a fair and equitable manner, it is required for DoD studies that civilian researchers attempting to access military volunteers should seek collaboration with a military researcher familiar with service-specific requirements.

#### **DoED requirements:**

When complying with Family Educational Rights and Privacy Act ([FERPA](#)):

- Investigators indicate on the protocol whether educational records will be accessed.
- The reviewer will ensure that procedures and consents outlined are in compliance.
- Permission will be obtained from the schools where research is to be conducted.

When granting exceptions to parental/student consent to release student records for research: This responsibility may be delegated to the IRB or another individual or component of the institution (e.g. a FERPA committee):

- An educational agency or institution may disclose personally identifiable information from an education record of a study without consent if the disclosure is to organizations conducting studies for, or on behalf of, educational agencies or institutions to:
  - Develop, validate, or administer predictive tests.
  - Administer student aid programs.
  - Improve instruction.

A school district or postsecondary institution that uses this exception is required to enter into a written agreement with the organization or investigator conducting the research that specifies:

- The determination of the exception.
- The purpose, scope, and duration of the study.
- The information to be disclosed.
- That the information from educational records may only be used to meet the purposes of the study stated in the written agreement and must contain the current requirements in [34 CFR 99.31\(a\)\(6\)](#) on re-disclosure and destruction of information.
- That the study will be conducted in a manner that does not permit personal identification of parents and students by anyone other than representative of the organization with legitimate interests.
- That the organization is required to destroy or return all personally identifiable information when no longer needed for the purposes of the study.
- The time period during which the organization must either destroy or return the information.

Educational records may be released without consent under [FERPA](#) if all personally identifiable information has been removed including:

- Student's name and other direct personal identifiers, such as the student's social security number or student number.
- Indirect identifiers, such as the name of the student's parent or other family members; the student's or family's address, and personal characteristics or other information that would make the student's identity easily traceable; date and place of birth and mother's maiden name.
- Biometric records, including one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting.
- Other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.

**Department of Justice Requirements for National Institute of Justice-funded Research:**

- The confidentiality statement on the consent form must state that confidentiality can only be broken if the participant reports immediate harm to participants or others.
- Under a [privacy certificate](#), investigators and the research team do not have to report child abuse unless the participant signs another consent form to allow child abuse reporting.

- For research conducted within the Bureau of Prisons, required elements of disclosure include:
  - Identification of the investigators.
  - Anticipated uses of the results of the research.
  - A statement that participation is completely voluntary, and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable).
  - A statement regarding the confidentiality of the research information, and exceptions to any guarantees of confidentiality required by federal or state law. For example, a researcher may not guarantee confidentiality when the participant indicates intent to commit future criminal conduct or harm himself or herself or someone else, or, if the participant is an inmate, indicates intent to leave the facility without authorization.
  - A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility.

### Continuing Review of Approved Studies

#### **DoD requirements:**

Surveys performed on DoD personnel must be submitted, reviewed, and approved by the DoD after the research protocol is reviewed and approved by the HRPP/IRB. When a survey crosses DoD Components, additional review is required.

For any DoD-supported researcher, the following shall be promptly (no longer than within 30 days) reported to the DoD human research protection officer:

- Decreased benefit or increased risk to participants in greater than minimal risk research.
- Addition of vulnerable populations as participants.
- Addition of DoD-affiliated personnel as participants.
- When a previously enrolled human participant becomes pregnant, or when the researcher learns that a previously enrolled human participant is pregnant, and the protocol was not reviewed and approved by the IRB in accordance with Subpart B.
- When a previously enrolled human participant becomes incarcerated, or when the researcher learns that a previously enrolled human participant is incarcerated, and the protocol was not reviewed and approved by the IRB in accordance with Subpart C.
- A DoD-supported study's closure.
- When significant changes to the research protocol are approved by the HRPP.
- The results of the HRPP renewal/continuing review. Change of reviewing HRPP.
- When the organization is notified by any Federal department, agency, or national organization that any part of an HRPP is under investigation for cause involving a DoD-supported research protocol.

#### **FDA requirements:**

- The IRB must determine which clinical investigations require review more than annually.
- The IRB must determine which clinical investigations need verification from sources other than the clinical investigator that no material changes in the research have occurred since the previous IRB review. The IRB should consider:
  - The IRB's previous experience with that researcher or sponsor (e.g., compliance history, previous problems with the researcher obtaining informed consent, prior complaints from participants about the researcher).

- The projected rate of enrollment.
- Whether the study involves novel therapies.

## **Data Safety and Monitoring**

### **DoD requirements:**

If the IRB considers the appointment of a research monitor:

- Required for research involving greater than minimal risk, although the HRPP or IO 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 HRPP 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 investigators, interview human subjects, and consult with others outside of the study.
- Report observations and findings to the IRB, HRPP 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 HRPP can assess.

## **Financial Conflict of Interest for the Institution, Investigators and Research Team**

### **DoD requirements:**

- Initial and continuing research ethics education is required for all personnel who conduct, review, approve, oversee, support, or manage human subjects research.
- In addition to the training listed above, all investigators receiving funding from the DoD will be required to complete the DON-supported Extramural Performers, Initial Training available through the CITI Program.
- The DoD component may evaluate the educational policies to ensure that the personnel are qualified to perform the research, based on the complexity and risk of the research.
- Training will be documented through sign-in sheets for face-to-face training or a Certificate of Completion when accessing through the online CITI course. Training records will be maintained in an Institution-supported database.



## Noncompliance

### DoD requirements:

Determinations of serious or continuing noncompliance of DoD-supported research must promptly (no longer than 30 days) be reported to the DoD human research protection officer.

## Research Data Security

### DoE requirements:

HRPP Staff and/or IRB will complete the DoE checklist. This checklist will be maintained in the HRPP file for that study.

### DoJ requirements:

A copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document(s), data collection instruments, surveys, or other relevant research materials.

### Bureau of Prisons requirements:

- At least yearly, the PI must provide the Chief and the Office of Research and Evaluation with a report on the progress of the research.
- At least 12 working days before any report of findings is to be released, the PI must distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of the institution that provided data or assistance. The PI must include an abstract in the report of findings.
- In any publication of results, the PI must acknowledge the Bureau's participation in the research project,
- The PI must expressly disclaim approval or endorsement of the published material as an express of the policies or views of the Bureau,
- Prior to submitting for publication the results of a research project conducted under this subpart, the PI must provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, and the Bureau of Prisons.

## Requirements for IRB Approval of Non-Exempt Studies

### Department of Justice requirements when research is funded by the Bureau of Prisons:

- The selection of participants within any one organization must be equitable.
- Incentives may not be offered to help persuade inmate participants to participate. However, soft drinks and snacks to be consumed at the test setting may be offered.
- Reasonable accommodations, such as nominal monetary recompense for time and effort, may be offered to non-confined research participants who are both:
  - No longer in Bureau of Prisons custody, and
  - Participating in authorized research being conducted by Bureau employees or contractors.
- A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.
- Except as noted in the informed consent to the participant, the investigator must not provide research information that identifies a participant to any person without that participant's prior written consent to release the information. For example, research information identifiable to a particular individual cannot be admitted as evidence or used

for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertains.

- Except for computerized data, records maintained at an official Department of Justice site, and records that contain non-disclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system.
- If the investigator is conducting a study of special interest to the Office of Research and Evaluation (ORE), but the study is not a joint project involving ORE, the investigator may be asked to provide ORE with the computerized research data, not identifiable to individual participants, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.

#### **National Institute of Justice requirements:**

- All projects are required to have a [privacy certificate](#) approved by the NIJ Human Subjects Protection Officer.
- All investigators and the research team are required to sign employee confidentiality statements, which are maintained by the responsible investigator.

#### **DoD requirements:**

Non-exempt classified research must be conducted following the requirements of [3216.02.13](#).

When following the DoD requirements:

- Any suspension or termination of DoD-supported research must be promptly (no longer than within five days) reported to the DoD Office for Human Research Protections.

#### **Research involving U.S. Military Personnel (DoD Requirements):**

- DoD-affiliated personnel, military and civilian supervisors, officers, and others in the chain of command:
  - Are prohibited from influencing their subordinates to participate in research involving human participants.
  - Must not be present at any human participant recruitment sessions or during the consent process for DoD-affiliated personnel.
  - May participate in separate human participant research recruitment sessions.
  - For greater than minimal risk research involving recruitment of DoD-personnel, when it occurs in a group setting, the IRB must appoint an ombudsperson. The ombudsperson:
    - Must not have a conflict of interest with the research or be a part of the research team.
    - Must be present during the HSR recruitment, monitoring that the recruitment and informed consent explain that participation is voluntary and that the information provided about the research is consistent with the IRB-approved script and materials, including digitally provided materials.
    - Should be available to address DoD-affiliated personnel's concerns about participation.
- In conducting or supporting clinical research, the Secretary of Defense shall ensure that:
  - Women who are members of the Armed Forces are included as participants in each project of such research; and

- Members of minority groups who are members of the Armed Forces are included as participants of such research.
- The Secretary of Defense may waive these requirements regarding women and members of minority groups with respect to a project of clinical research if the Secretary determines that the inclusion, as participants in the project, of women and members of minority groups, respectively:
  - Is inappropriate with respect to the health of the participants,
  - Is inappropriate with respect to the purpose of the research, or
  - Is inappropriate under such other circumstances as the Secretary of Defense may designate.
- When research involves U.S. military personnel, limitations on dual compensation:
  - Prohibit an individual from receiving pay of compensation for research during duty hours.
  - U.S. military personnel may be compensated for research if the participant is involved in the research when not on duty.
  - 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.

**Research involving U.S. Military Personnel, limitation on dual compensation:**

- Prohibit an individual from receiving pay of compensation for research during duty hours.
- U.S. military personnel may be compensated for research if the participant is involved in the research when not on duty.
- 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 HRPP, according to local prevailing rates and the nature of research.

**DOE requirements:**

The HRPP reviews and approves protocols submitted by the investigators utilizing the DoE Checklist to verify compliance with the DoE requirements for the protection of personally identifiable information.

When following DOE requirements:

- The non-affiliated member must be a non-governmental member with the appropriate security clearances. This individual cannot be a current federal employee or contractor.
- Any IRB member can appeal a vote to approve research to the Institutional Official, Secretary of Energy, and Director of the Office of Science and Technology Policy, or the Director of National Intelligence, in that order.

## Scientific Merit or Scholarly Validity

### DoJ requirements:

The scientific merit or scholarly validity of proposed human subjects research will be evaluated as follows:

### Bureau of Prisons requirements:

The project must have an adequate research design and contribute to the advancement of knowledge about corrections. In conducting the scientific or scholarly review, the following will be confirmed:

- The research uses procedures consistent with sound research design, and
- The research design is sufficiently sound to yield the expected knowledge.

This review will not compare the value of the research to other research studies, nor will it serve as a peer review designed to maximize scientific quality.

## Suspensions and Terminations of Previously Approved Research

### DoD requirements:

Any suspension or termination of DoD-supported research must promptly (no longer than 30 days) report to the DoD human research protection officer.

## Unanticipated Problems Involving Risks to Participants or Others

### DoE requirements:

Investigators must promptly report the following to the HRPP:

- Any significant adverse events, unanticipated risks; and complaints about the research, with a description of any corrective actions taken or to be taken;
- Any suspension or termination of HRPP approval of research;
- Any significant noncompliance with HRPP procedures or other requirements;
- The PI must submit to the HRPP the completed Protocol Violation form as soon as possible, but always within 10 days. Serious problems must be reported verbally within (1) one business day, in addition to the submission of the written Protocol Violation.
- Any compromise of personally identifiable information must be reported immediately.
- The organization must periodically conduct self-assessments to ensure compliance with the HRPP procedures and other requirements.

### DoD requirements:

Any unanticipated problems involving risks to participants or others for any DoD-supported research must promptly (no longer than 30 days) be reported to the DoD human research protection officer.

## **Section 4: Glossary**

*Affiliated:* IRB membership status designating association with the university for the purposes of the IRB.

Note: A member (or alternate) is considered to be affiliated if he/she or a member of his/her immediate family is a current or past (within the last 2 years) employee (full or part-time); An adjunct, or visiting faculty member or instructor; paid or unpaid member of a university governing panel or board (not including the IRBs); volunteer working at the university (unrelated to IRB service); or university consultant or advisor (paid or unpaid). An emeritus faculty or retired staff member is also considered to be affiliated if

he/she has been retired or involved in paid or unpaid university activities (including research or service) within the last 2 years. Current undergraduate, graduate, and postdoctoral students are also considered to be affiliated, as described by HRPP policy.

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

*Anonymity/Anonymous-*When the researcher does not know who the participants are and has no way to link them to their responses.

*Benign Behavioral Intervention-* Brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Examples would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

*Child Assent-* In research studies involving children, assent (consent) of those children is required, in addition to Parental Permission. See the definition of Consent. Please consider the age and reading level of the children involved when developing the Assent Form.

*Children -* Persons who have not attained the legal age for consent to treatments or procedures involved in clinical investigations, under the applicable law of the jurisdiction in which the clinical investigation will be conducted. [§46.402\(a\)](#)

*CIRB –* Convened Institutional Review Board – occurs when the IRB meets to conduct business under its purview. Attendees could include all current IRB members, alternates, ex officio members, HRPP staff, ORED, and invited guests.

*Cognitive Impairment -* A psychiatric disorder (e.g., psychosis, neurosis, personality or behavior disorder), an organic impairment (e.g., dementia) or a developmental disorder (e.g., mental retardation) that affects cognitive or emotional function to the extent that capacity for judgment and reasoning is significantly diminished. Others, including individuals under the influence of or dependent upon drugs or alcohol, those suffering from degenerative diseases affecting the brain, terminally ill patients, and individuals with severely disabling physical handicaps, may also be compromised in their ability to make decisions in their best interest.

*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 in ways that are inconsistent with the understanding of the original disclosure without permission.” (In other words, the researcher knows who the participant is and may be able to link the participant to his/her responses, but agrees not to disclose them to protect the participant’s privacy.)

*Consent-*The informed consent process is the critical communication link between the prospective human subject and an investigator, and should be an active process of sharing information between the investigator and the prospective subject. Respect for persons requires that prospective research subjects be given the opportunity to choose what will or will not happen to them if they choose to participate in the research study, which necessitates these standards for informed consent.

*Continuing Noncompliance –* Ongoing instances of noncompliance associated with an individual investigator or project. The IRB may take into consideration the volume and complexity of an

investigator's activities or those associated with a particular study with regard to making the designation of continuing noncompliance.

*Convened Meeting* – A meeting where a quorum exists. A quorum is more than ½ of the voting membership of the IRB, where at least one member whose primary interests is in nonscientific areas, unaffiliated, or represents a general perspective is present and voting. This may also be referred to as a Full Board meeting or CIRB meeting.

*Deception* - Occurs when an investigator gives false information to subjects or intentionally misleads them about some key aspect of the research. (This is sometimes referred to as "active deception.") Examples of deception:

- The subject is given a "cover story" which falsely describes the purpose of the study, but provides a feasible account of the researcher's objective.
- The study includes a researcher's "confederate," an individual who poses as a participant, but whose behavior in the study is actually part of the researcher's experimental design.

*Exempt Review* – Review by the HRPP of research meeting the criteria for Exemption in accordance with [§46.104](#)

*Expedited Review* – A procedure to review research involving human participants by the IRB Chair or by one or more experienced reviewers designated by the IRB Chair from among members of the IRB.

*Family Educational Rights and Privacy Act of 1974 (FERPA)* - Protects the rights of students by controlling the creation, maintenance, and access of educational records. It guarantees students' access to their academic records while prohibiting unauthorized access by others.

*Financial Interest Related to the Research* - Any of the following interests in the sponsor, product or service being tested, or competitor of the sponsor held by the individual or the individual's immediate family:

- Ownership interest of any value including, but not limited to stocks and options exclusive of interests in publicly-traded, diversified mutual funds.
- Compensation of any amount including, but not limited to salary, honoraria, paid authorship, consultant fees, royalties, or other income.
- Proprietary interest of any value including, but not limited to, patents, trademarks, copyrights, and licensing agreements.
- Board or executive relationship, regardless of compensation.
- The occurrence of any reimbursed or sponsored travel (i.e., that which is paid on behalf of the individual and not reimbursed to the individual so the exact monetary value may not be readily available) related to the institutional responsibilities. This does not apply to travel that is reimbursed or sponsored by a Federal, State, or local government agency, an institution of higher education as defined at [20 U.S.C. 1001 \(a\)](#), an academic teaching hospital, or a research institute that is affiliated with an institution of higher education.

*Guardian* - An individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care, including participation in research. For purposes of subpart D of this part, a guardian also means an individual who is authorized to consent on behalf of a child to participate in research. [§46.402\(e\)](#)

*Human subject* - 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.

*Humanitarian Use Device (HUD)* - A device that is intended to benefit patients in the treatment and diagnosis of diseases or conditions that affect or is manifested in fewer than 4,000 individuals in the U.S. per year.

*Humanitarian Device Exemption (HDE)* - An application that is similar to a Premarket Approval application (PMA), but is exempt from the effectiveness requirements of a PMA. An approved HDE authorizes the marketing of a HUD.

*Immediate Family* - Spouse and dependent children.

*Incomplete disclosure* occurs when an investigator withholds information about the specific purpose, nature, or other aspect of the research. *Withholding information may or may not be considered deception*. Examples:

- *incomplete disclosure:*
  - The subject is informed about the purpose of the study or a certain procedure in general terms that are true, but not detailed enough to reveal the researcher's main or specific objective.
- *incomplete disclosure that is also deception:*
  - The study involves audiotaping or videotaping of subjects without their knowledge or prior consent.

*Interaction* - Includes communication or interpersonal contact between the investigator and participant.

*Intervention* - Includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the participant or the participant's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between the investigator and the participant.

*Institutional Conflict of Interest* - A situation in which the financial investments or holdings of MSU or the personal financial interests or holdings of institutional leaders (those with direct authority over the allocation of institutional resources) might affect or reasonably appear to affect the design, conduct, reporting, review or oversight of human subjects research.

*Institutional Official* - The Vice President for Research and Economic Development is the key Institutional leader authorized by the President to act on the Institution's behalf, specifically committing the Institution to compliance with all requirements of the Code of Federal Regulations, [45 CFR 46](#), and other applicable federal regulations (e.g., FDA [21 CFR 50](#) and [§56](#)).

*Investigational Device* - A medical device, which is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device.

*Investigator* - an individual performing various tasks related to the conduct of human subjects research activities, such as obtaining informed consent, intervening or interacting with participants, interpreting or analyzing identifiable private information or data for research purposes and communicating with the IRB. Any MSU affiliated individual (faculty, staff, or student (undergraduate or graduate) conducting research.

*IRB Member* – a voting member of the IRB.

*Key Personnel* – individuals who will be involved in the design, support, conduct, management or oversight of human subjects research.



*Legally Authorized Representative* - An individual, 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\(i\)](#) and [§50.3\(1\)](#)

*Limited IRB Review* – Under Exemption Category 2 (iii) and Category 3 (c), Limited IRB Review will be required to ensure that there are adequate provisions in place to protect the privacy of subjects and to maintain the confidentiality of data. At MSU, this will be conducted in a format similar to an Expedited review, where members of the IRB who have expertise in that area (ex: ITS), will review the protocol with regard to participant privacy and confidentiality of data.

*Major Donor*- As it relates to any gifts to the University, and as defined by the MSU Foundation, a major donor is a person or company that has given \$25,000 lifetime to the University.

*Noncompliance* - failure to comply with regulations (federal, state, local, institutional, program), deviation from the previously approved protocol, failure to fully disclose information relevant to the IRB review, or conducting human subjects research prior to IRB approval, whether intentional or unintentional.

*Non-Scientist*: An individual appointed to the IRB who (due to training, background, and/or occupation) is inclined to view research activities from the standpoint of someone outside the scientific or scholarly discipline of the IRB on which he/she serves.

*Nonsignificant Risk (NSR) Study* – A device study that does not meet the FDA criteria for a Significant Risk Device study (e.g., daily wear contact lenses, wound dressings). This categorization should not be confused with the term "minimal risk" as used by DHHS.

*Parent* - A child's biological or adoptive parent. [§46.402\(d\)](#)

*Parental Permission*- "the agreement of parent(s) or guardian to the participation of their child or ward in research". Parental Permission differs from consent, since the parent/guardian is not the intended participant of the research. Rather, in studies where children are the intended participants, the child provides his/her assent and also must have Parental Permission to be able to participate in the research study.

*Personal Identifying Information (PII)* - The state of Mississippi defines "personal information" specifically in Mississippi Code Annotated [§75-24-29](#) as an individual's first name or first initial and last name in combination with any one or more of the following data elements: social security number, driver's license number, or other information such as passwords. In research terms, it implies any data that could reasonably lead to discovering a personal identity.

*Principal Investigator (PI)* - Performs the same tasks as investigators but also has overall responsibility for the study.

*Prisoner* - any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.

*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 participant 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 participants. In order for obtaining private information to constitute human subjects research, it must be individually

identifiable (i.e., the identity of the participant is or may readily be ascertained by the investigator or associated with the information).

*Protected Health Information (PHI):* All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral is deemed "Protected Health Information" (PHI) under HIPAA federal law. Note: MSU is not considered a covered entity however the Longest Student Health Center would be.

*Regulations-* Usually refer to [45 CFR 46](#), which are the federal guidelines for the protection of human research subjects.

*Report of Noncompliance* – Report of noncompliance regarding human subjects research.

*Research* - A *systematic investigation*, including research development, testing, and evaluation, designed to *develop or contribute to generalizable knowledge*. Activities, which meet this definition, constitute research for the purposes of this policy, whether or not they are conducted or supported under a program, which is considered research for other purposes. For example, some demonstration and service programs may include research activities. [§46.102\(l\)](#)

*Serious Noncompliance* – Noncompliance which places participants or others at greater risk of harm than would have otherwise existed under the IRB-approved protocol, or the conduct of non-Exempt human subjects research without IRB approval.

*Significant Financial Interest* - A financial interest consisting of one or more of the following interests of the IRB member (and those of the IRB member's spouse and dependent children) that responsibly appears to be related to the IRB member's institutional responsibilities:

With regard to any publicly traded entity, a significant financial interest exists if the value of any remuneration received from the entity in the 12 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. (For purposes of this definition, remuneration includes 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 measures of fair market value).

With regard to any non-publicly traded entity, a significant financial interest exists if the value of any remuneration received from the entity in the 12 months preceding the disclosure, when aggregated, exceeds \$5,000 or when the IRB member (or the IRB member's spouse or dependent children) holds any equity interest (e.g. stock, stock option, or other ownership interest). Or Intellectual property rights and interest (e.g. patents, copyrights), upon receipt of income related to such rights and interests.

*Significant Risk (SR) Device* [§812.3\(m\)](#) - A device that presents a potential for serious risk to health, safety, or welfare of a participant and is:

- an implant or
- is used in supporting or sustaining human life or
- is of substantial importance in diagnosing, curing, mitigating or treating disease or otherwise prevents impairment of human health or
- otherwise presents a potential for serious risk to health, safety, or welfare of a participant.

*Site Permission-* When a research study will be taking place somewhere other than on MSU property, a permission letter is required from the appropriate authority for that location to show that they agree for the research study to be conducted there. In instances where studies will be working with schools, a letter of permission is required from both the Superintendent AND the Principal of each school involved.

*Student Participant Pool* – Students grouped together and identified as potential research participants, even when the exact nature of the research to be conducted has not yet been determined.

*Suspension of IRB Approval* – A temporary halt in IRB approval of some or all research activities.

*Termination of IRB Approval* – A permanent halt in IRB approval of all research activities.

*Unaffiliated Investigator (UI)* – A non-MSU affiliated individual.

*Ward* - A child who is placed in the legal custody of the State or other agency, institution, or entity, consistent with applicable Federal, State, or local law. [§46.409](#) and [§50.3\(q\)](#)



# **SMART IRB**

## **Master Common Reciprocal Institutional Review Board Authorization Agreement Standard Operating Procedures**

**Version Date: September 8,  
2016**

## Table of Contents

Introduction.....	4
Glossary of Terms.....	5
Responsibilities: PIs and/or Study Teams .....	8
Overall PI and Lead Study Team .....	8
Relying Site Study Teams.....	9
Responsibilities: Reviewing IRBs and Relying Institutions .....	10
Reviewing IRBs.....	10
Relying Institutions .....	11
Responsibilities: SMART IRB Points of Contact (POCs) .....	12
Establishing the Reviewing IRB .....	14
Establishing the Relying Institutions – Prior to IRB Approval .....	15
Adding New Relying Institutions – Post-IRB Approval .....	16
Coordination of IRB Review when a Single Central IRB is Not Identified .....	17
Initial Review: Submission and Review Process .....	18
Customization, Submission, and Review of Informed Consent Documents (ICD) .....	18
Continuing Review: Submission and Review Process .....	20
Protocol Amendment: Submission and Review Process .....	21
Record Keeping and Document Retention.....	22
Document Retention.....	23
Access to Locally Stored Records and Reliance-Related Documents .....	23
Supplemental Study Protocol Content.....	23
Federal Grant Congruency Review .....	25
HIPAA Privacy Rule .....	26
Waivers and Alterations of Authorization .....	26
HIPAA Authorization Language.....	26
Breaches of PHI.....	27
Other HIPAA Privacy Rule Requirements .....	27
Financial and Other Conflicts of Interest .....	28
Reportable Event Submission and Review Process .....	29
Noncompliance and Unanticipated Problems .....	29
Serious Adverse Events, Deviations, Subject Complaints, and Other Types of Reportable Events.....	29
Suspensions and Terminations of Reviewing IRB Approval .....	30

**Research Misconduct ..... 30**

**Other Reporting Requirements..... 30**

    Changes in FWA, IRB Registration, or Accreditation Status ..... 30

    Federal Audits and Legal Actions ..... 31

**Suspension or Restriction of Relying Site Investigator or Relying Site Study Team Member ..... 31**

**Withdrawal from Ceded Review ..... 31**

**Amending the Master Agreement..... 32**

**Standard Operating Procedure (SOP) Development, Adoption, Modification, and Maintenance 33**

**Ending Site Participation in Master ..... 34**

**Agreement or Specific Research..... 34**

    Scenario 1 ..... 34

    Scenario 2 ..... 34

    Scenario 3 ..... 35

**Appendix: Additional Multi-Site Research Management Roles and Responsibilities ..... 36**

## Introduction

The Standard Operating Procedures (SOPs) described in this document apply to all research studies—and to all participating investigators and administrators involved in the implementation and coordination of research studies—under the SMART IRB Agreement (henceforth SMART IRB), unless specific mandates or alternative requirements and processes for ceding IRB review and determining the Reviewing IRB apply (e.g., research conducted by clinical trial networks that have designated central IRBs or commercial, independent IRBs).

The SMART IRB SOPs are not intended to overlap with or replace existing institutional-level SOPs that have already been implemented internally at institutions participating in the SMART IRB Master Common Reciprocal Institutional Review Board Authorization Agreement (henceforth SMART IRB Agreement). Rather, these SOPs serve as a mechanism for highlighting the unique features associated with participating in the SMART IRB Agreement, and serve as guidelines for establishing reliant review of multi-site human research conducted using the SMART IRB Agreement.

The implementation of these SOPs helps assure that institutions using the SMART IRB Agreement follow the responsibilities documented within the SMART IRB Agreement, and provides a reference and guideline for internal stakeholders and external sponsors as to how multi-site research is undertaken using the SMART IRB Agreement. Furthermore, these SOPs provide an additional training source for investigators and administrators participating in the SMART IRB Agreement.



## Glossary of Terms

**Agreement:** SMART IRB Master Common Reciprocal Institutional Review Board Authorization Agreement.

**Ceded Review:** An instance of IRB review in which one or more Participating Institutions invoke this Agreement to transfer IRB review and oversight authority for an instance Research and rely on another Participating Institution’s IRB that accepts responsibility for IRB review and oversight of such Research.

**Confidential Information:** Any non-public, confidential and/or proprietary information, including but not limited to the scientific content of Research proposals and information provided by the Overall PI or Site Investigator(s) or other Research Personnel not generally known or available to the public. Information will not be deemed Confidential Information hereunder if such information: (a) is known to the receiving party prior to receipt from the disclosing party directly or indirectly from a source other than one having an obligation of confidentiality to the disclosing party; (b) becomes known (independently of disclosure by the disclosing party) to the receiving party directly or indirectly from a source other than one having an obligation of confidentiality to the disclosing party; (c) becomes publicly known or otherwise ceases to be secret or confidential, except through a breach of this Agreement by the receiving party; or (d) is independently developed by the receiving party.

**Data Use Agreement:** A written agreement meeting the requirements of 45 CFR 164.514(e)(4), pursuant to which a HIPAA Covered Entity may use or disclose a Limited Data Set for research purposes.

**DHHS:** U.S. Department of Health and Human Services.

**Exemption Determinations:** Determinations that Research is exempt from IRB review pursuant to Federal policy.

**FDA:** The United States Food and Drug Administration.

**Federal Policy:** The Federal Policy for the Protection of Human Subjects set forth in the DHHS regulations at 45 CFR Part 46, Subpart A and corresponding regulations of other federal departments and agencies adopting such Policy.

**FWA:** The Federalwide Assurance in which a research institution commits to DHHS that it will comply with the Federal Policy.

**HIPAA:** Collectively, the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and their implementing regulations.

**HIPAA Covered Entity:** A health care provider, health plan, or health care clearinghouse subject to HIPAA as further defined and provided in 45 CFR 160.103.

**HIPAA Privacy Rule:** The implementing regulations of HIPAA that address the privacy and rights of individuals with respect to PHI, found at 45 CFR Part 160 and Subparts A and E of Part 164.

**HRPP:** Human Research Protection Program.

**Human Subject (as Defined by DHHS):** 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) information that is both Private Information and Identifiable Information.

**Human Subject (as Defined by FDA):** An individual who is or becomes a subject in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient. A human subject includes an individual on whose specimen a medical device is used.

**Institutional Official or Signatory:** The person who has the authority on behalf of an institution to bind such institution to the terms and conditions of this Agreement.

**IRB(s):** Institutional Review Board(s).

**IRB Organization:** An independent IRB organization that provides IRB review services and has agreed to become the Reviewing IRB for another Participating Institution for an instance of Research under this Agreement.

**Joinder Agreement:** Such agreement in substantially the same form set forth at Exhibit B of the Agreement by which an institution represents and warrants that it meets all eligibility requirements for participation in the Agreement and agrees to be bound by the terms and conditions of this Agreement.

**Lead Study Team:** Generally, the Lead Study Team is the study team at the Reviewing IRB's institution. The Lead Study Team is designated by the Overall PI (see below) and, working in collaboration with the Reviewing IRB, ensures coordination of communication to and from all Relying Site Study Teams (see below), routing all IRB submissions to the Reviewing IRB and communicating IRB determinations to Site Investigators.

**Lead PI:** See Overall PI.

**Limited Data Set (LDS):** As defined in 45 CFR 164.514(e)(2), Protected Health Information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual: name; postal address information, other than town or city, State, and zip code; telephone numbers; fax numbers; electronic mail addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; vehicle identifiers and serial numbers; device identifiers and serial numbers; web Universal Resource Locators (URLs); internet Protocol (IP) address numbers; biometric identifiers, including finger and voice prints; and full face photographic images and any comparable images. An LDS may contain, for example: dates of birth dates of death; dates of service; town or city; state; or zip code or a combination of only those elements.

**Local Considerations:** Requirements of any applicable state or local laws, regulations, institutional policies, standards or other local factors, including local ancillary reviews, relevant to an instance of Research.

**Overall PI:** The lead multi-site principal investigator with ultimate responsibility for the conduct and integrity of Research (generally, the initiating principal investigator or funding principal investigator, as applicable).

**Participating Institution:** An institution (including an IRB organization) that meets the eligibility requirements set forth in the Agreement and agrees to accept the terms and conditions of the Agreement through the execution of a Joinder Agreement, thereby becoming a signatory party to this Agreement.

**Principal Investigators:** Together, the Overall PI and Site PI(s).

**PHI:** Protected Health Information as defined in 45 CFR 160.103.

**POC:** Points of Contact. At least one individual who will serve as the contact person responsible for

communicating on behalf of the institution with respect to matters concerning the initial and ongoing implementation of this Agreement. For example, the POC would be the person designated at each Participating Institution to make determinations regarding requests for his/her site to serve as the Reviewing IRB for Research or cede IRB review and are likely to be individuals within an IRB office or other component of the human research protection program.

**Relying Institution:** A Participating Institution that cedes IRB review to a Reviewing IRB for an instance of Research under the Agreement.

**Relying Site Study Team:** Relying Site investigators, including any local site personnel designated by the site investigator to carry out the applicable communication, coordination, and administrative procedures described within the Agreement and SOPs.

**Reportable Event:** Any potential unanticipated problems, noncompliance, or other information that must be reported to the Reviewing IRB in accordance with the Reviewing IRB's policies and procedures.

**Research:** Non-exempt human subject research within the meaning of the Federal Policy at 45 CFR or within the meaning of any other federal human subjects research regulations or policies; clinical investigations within the meaning of the FDA IRB regulations; and any other research, for which any Participating Institution(s) seek or are required to rely on a Reviewing IRB. As used in the Agreement, Research may reference a specific study or protocol in which there will be a reviewing and relying party operating pursuant to the terms of the SMART IRB Master Common Reciprocal Institutional Review Board Authorization Agreement, or collectively the studies subject to Ceded Review under the Agreement.

**Research Personnel:** Members of the research team (including Overall PI and Site Investigator(s)) engaged or involved in an instance of Research. These individuals may include, as applicable, physicians, research nurses, coordinators, data managers, lab technicians, postdoctoral fellows, students, volunteers and/or other personnel.

**Reviewing IRB:** The "IRB of record" (including an IRB Organization) to which authority for IRB review and oversight has been ceded by another Participating Institution for an instance of Research under the Agreement.

**Reviewing IRB Institution:** The Participating Institution whose IRB has become the Reviewing IRB for another Participating Institution for an instance of Research under this Agreement.

**Site Investigator(s):** An investigator(s) responsible for the conduct of the Research at his/her Participating Institution.

**SMART IRB Standard Operating Procedures (SOPs):** Standard Operating Procedures developed in support of the SMART IRB Master Common Reciprocal Institutional Review Board Authorization Agreement (aka SMART IRB SOPs).

**Terminating Institution:** A Participating Institution terminating participation in the Agreement.

## Responsibilities: PIs and/or Study Teams

### Overall PI and Lead Study Team

The Overall PI is responsible for identifying a Lead Study Team, and for providing the Lead Study Team contact information to the Site Investigators. The Overall PI and Lead Study Team (or their designees) are responsible for providing the information or performing the activities described below related to the reliance review process and once IRB review has been ceded:

- Work in collaboration with the Reviewing IRB and POC to determine and document specific roles and responsibilities for communicating and coordinating key information to Relying Institutions and the Reviewing IRB as described throughout these SOPs and summarized in the Appendix: Additional Multi-Site Research Management Roles and Responsibilities.
- Promptly responding to questions or requests for information from Site Investigators and/or study teams at Relying Institutions or the Relying IRB.
- Providing the Site Investigators with the IRB policies of the Reviewing Institution. This will include but is not limited to policies for reporting unanticipated problems, noncompliance, and subject complaints.
- Obtaining and collating information from Relying Site Study Teams and/or Relying Site Points of Contacts (depending on who is designated to provide that information at the Relying Institution) regarding local variations in study conduct, such as recruitment materials and process, consent process and language, and subject identification processes.
- Participating in conference calls regarding a study as requested.
- Providing participating Relying Site Study Teams with the IRB-approved versions of all study documents (e.g., consent and authorization forms, protocol, recruitment materials).
- Assisting Relying Site Study Teams and/or POCs at the Relying Institution(s) (depending on who is designated to provide that information) in ensuring consent documents follow the Reviewing IRB's template form and include applicable site-specific required language from each Relying Institution.
- When agreed upon in coordination with the Reviewing IRB, promptly reporting to the Site Investigator (or designee on the Relying Site Study Team) any unanticipated problems involving risks to subjects or others research-related subject injuries, or significant subject complaints that are related to or may affect subjects participating in the Research (i.e., the specific study or studies ceded to the Reviewing IRB) at the Relying Institution.
- Notifying Site Investigators of all Reviewing IRB determinations and communications, including those for initial review, continuing review, amendments, and reportable events.
- If a Relying Site Study Team does not provide the Lead Study Team (or designee) with the required information before the continuing review application is submitted to the Reviewing IRB, reporting the absence of this information as part of the continuing review and notifying affected Relying Site Study Team of lapse in approval for their site and any applicable corrective action plans.
- Providing access, upon request, to study records for audit by the Relying Institution, the Reviewing IRB, and other regulatory or monitoring entities.
- Following all requirements of the Relying Institution with regard to ceded review, such as ensuring administrative requirements for documenting ceded review have been met before study activation occurs at a Relying Institution.

## Relying Site Study Teams

The Relying Site Study Teams, which include Site Investigators, are responsible for providing the information or performing the activities described below related to the reliance review process and once IRB review has been ceded:

- Following all requirements of their home institution with regard to ceded review, such as ensuring other reviews or sign-offs required by the institution have been completed before a study is activated.
- Promptly responding to questions or requests for information from the Lead Study Team (or designee) as well as from the Reviewing IRB through the communication mechanism(s) established by these entities.
- Participating in conference calls regarding a study as requested by the Lead Study Team, Reviewing IRB, or home institution.
- Working with the Lead Study Team and the POC from their home institution, as applicable, to incorporate site-specific required language into the consent template to be used at their institution.
- Providing the sponsored programs office at their institution with documentation that IRB oversight for a study has been ceded to and approved by an IRB external to their home institution.
- Providing the POC from their home institution with information regarding local Site Investigator or other Relying Site Study Team personnel changes.
- Reporting to their home institution POC any changes in conflict of interest (COI) disclosures and resulting changes in COI management plans related to the Research (i.e., the specific study or studies ceded to the Reviewing IRB).
- Promptly reporting to the Lead Study Team (or designee) any applicable information for continuing review progress reports in accordance with the Reviewing IRB's policies and procedures for timing and content of such submissions.
- Reporting to the Lead Study Team (or designee) any changes (including funding changes and personnel changes), reportable events, and continuing review progress reports, for submission to the Reviewing IRB in accordance with the Reviewing IRB's policies and procedures for timing and content of such submissions.
- Promptly reporting to the Overall PI via the Lead Study Team (or designee) any unanticipated problems involving risks to subjects or others, subject injuries related to the research, or significant complaints that could impact the conduct of the Research (i.e., the specific study or studies ceded to the Reviewing IRB) in accordance with the Reviewing IRB's policies and procedures for timing and content of such submissions. Significant complaints are defined as those that cannot be resolved by the study team and a) suggest an increased or unexpected new risk or harm or b) change the risk/benefit ratio of the Research. Other complaints should be reported in accordance with the Reviewing IRB's policies and procedures.
- Promptly reporting to the Overall PI via the Lead Study Team (or designee) any potential noncompliance that occurs in relation to the Research (i.e., the specific study or studies ceded to the Reviewing IRB) in accordance with the Reviewing IRB's policies and procedures for timing of submission and content of such submissions.
- Providing, upon request, access to study records for audit by the local institution, the Reviewing IRB's institution, and other regulatory or monitoring entities.

## Responsibilities: Reviewing IRBs and Relying Institutions

This section of the SOPs provides an overview of the key responsibilities of Reviewing IRBs and Relying Institutions. The responsibilities of the POC, who plays a critical role in ensuring that many of these Reviewing IRB and Relying Institution responsibilities are met, are addressed in detail in the next section.

### Reviewing IRBs

The Reviewing IRB is responsible for reviewing and overseeing any studies ceded to it for the life of the study, unless the Institution ends its participation in the SMART IRB Agreement or a specific study as described in the “Ending Site Participation in the SMART IRB Agreement or Specific Studies” section below. In addition, the Reviewing IRB (or designee) is responsible for the following activities related to the initial reliance review process and subsequent management of the study:

- Working in collaboration with the POC and Lead Study Team (or designee) to determine and document specific roles and responsibilities for communicating key information to Relying Institutions and the Reviewing IRB as described throughout these SOPs and as summarized in the Appendix: Additional Multi-Site Research Management Roles and Responsibilities.
- Providing POCs and Relying Site Study Teams with template informed consent form(s), which indicate areas where the Relying Institutions must add information (e.g., local contacts)<sup>1</sup>.
- Sending written notification to the Overall PI and Lead Study Team of: (i) its decision to approve or disapprove any Research (i.e., the specific study or studies ceded to the Reviewing IRB), (ii) any modifications required to secure approval of the Research, and (iii) the date by which renewal of an approval is required.
- Upon reasonable request, providing to the Relying Institution with access to relevant records related to the IRB review.
- Promptly notifying the Overall PI and relevant POCs from a Relying Institution of its findings and actions with respect to any unanticipated problems involving risks to subjects or others or any research-related subject injuries or significant subject complaints that occurred at the Relying Institution—or that occurred at another Relying Institution if such events or actions relate to or may affect the conduct of the Research or the safety, rights, or welfare of subjects participating in the Research at the Relying Institution.
- In the event a continuing review is submitted after IRB approval for the study expires or the study expires before the Reviewing IRB can reapprove the study, notifying the POCs and Relying Site Study Teams from affected sites, in addition to the Overall PI and Lead Study Team, of the lapse in IRB approval and any applicable corrective action plans.
- Promptly notifying relevant POCs and Relying Site Study Teams, in addition to the Overall PI and Lead Study Team, of any finding of serious and or/continuing noncompliance that may affect the conduct of the Research or the safety, rights, or welfare of human subjects participating in the Research at the Relying Institution(s). If the finding of serious and/or continuing noncompliance has a study-wide impact, all Relying Institutions must be notified.
- Promptly notifying the Overall PI, Lead Study Team, relevant POCs, and relevant Relying Site Study Teams of any suspension or termination of IRB approval for that portion of the Research taking place at those Relying Institutions. If the suspension or termination is study-wide, all Relying

<sup>1</sup> Alternatively, a member of the Lead Study Team may assume responsibility for notifying Relying Site POCs and Study Team members as described in this section, if agreed upon by the POC for the Reviewing IRB.

Institutions must be notified.

- Unless an alternate reporting arrangement has been previously agreed upon between the Relying Institutions and Reviewing IRB, reporting to regulatory agencies and/or sponsors any findings of unanticipated problems involving risks to subjects or others, determinations of serious and/or continuing noncompliance, and/or any suspensions or terminations of IRB approval on behalf of all applicable institutions covered by this Agreement. The Reviewing IRB will also provide the involved Relying Institutions the opportunity to review and comment on the report before it is sent to federal authorities, such as OHRP, the FDA, or others.
- If the Reviewing IRB ends its participation in the SMART IRB Agreement or a specific study, informing all Relying Institutions of this change, as described in the “Ending Site Participation in the SMART IRB Agreement or Specific Studies” section below.

## Relying Institutions

Relying Institutions are responsible for the following activities related to the initial reliance review process and subsequent management of the study; these will generally occur through the Overall PI and Lead Study Team:

- Communicating local considerations to the Reviewing IRB, including requirements of applicable state or local laws, regulations, policies, and ancillary review processes as are relevant to the Research (i.e., the specific study or studies ceded to the Reviewing IRB). Generally, this will occur through the POC (see sections below).
- Providing information about local restrictions, stipulations, or requested substitutions to informed consent documents to the Reviewing IRB for its approval, including institution-specific language (such as the Relying Institution’s standard injury compensation language). Generally, this will occur through the POC (see sections below).
- Notifying the Reviewing IRB of the following:
  - Any unanticipated problems or findings of serious and/or continuing noncompliance that occurred on research that has *not* been ceded under this Agreement but that may have relevance to ceded Research, or
  - Any suspension or restriction of a Relying Site’s Study Team member(s) ability to conduct human subjects research.
- Disclosing any COI related to Research conducted under this Agreement and providing applicable management plans to the Reviewing IRB; this may occur through the Lead Study Team or the home institution POC.
- If the Reviewing IRB requests that the Relying Institution conduct an audit, reporting audit findings to the Reviewing IRB within a reasonable timeframe.
- Report to OHRP, federal funding agencies, and/or other federal oversight authorities and other applicable individuals any unanticipated problems involving risks to human subjects or others, serious and/or continuing noncompliance, and/or suspensions or terminations of IRB approval, if the event has occurred at the Relying Institution and the Relying Institution has not “unchecked the box” on its FWA and applies the federal regulations (and its subparts) to all human subject research, irrespective of funding source. For example, this reporting by a Relying Institution may be necessary if the event is specific to its institution, the research is not federally funded, and the Reviewing IRB has “unchecked the box” on its FWA.
- Notifying the Reviewing IRB(s) of communications regarding Research covered by this Agreement to/from the Relying Institution and FDA, OHRP, and/or other regulatory agencies (e.g., re. unanticipated problems or serious and/or continuing noncompliance), as applicable.
- Informing the Reviewing IRB if the Relying Institution ends its participation in the SMART IRB Agreement or a specific study, as described in the “Ending Site Participation in the SMART IRB Agreement or Specific Studies” section below.



## Responsibilities: SMART IRB Points of Contact (POCs)

This section of the SOPs provides an overview of the key responsibilities of SMART IRB POCs during the reliance review process and after IRB review is ceded.

Each Participating Institution in SMART IRB must designate a POC and an alternate POC. Generally, the POC is associated with the Participating Institution's IRB. However, some Participating Institutions will not have IRBs or will appoint an individual outside of the local IRB office to serve as a POC.

All Participating Institutions are responsible for designating an individual (a SMART IRB POC) to carry out the following activities; Participating Institutions may designate some of these activities to personnel other than the designated SMART IRB POC (e.g., Research Integrity Officers, legal counsels, Institutional Officials, or post-approval monitoring programs):

- Communicating to other SMART IRB POCs, the Lead Study Team, and to their Site Investigator the institution's decisions to serve as the Reviewing IRB, cede review to the proposed Reviewing IRB, or retain local IRB review of Research.
- Promptly reviewing reliance requests and any supporting materials to determine whether ceding IRB review or serving as the Reviewing IRB is appropriate, in accordance with that institution's policies and procedures.
- On a study-by-study basis, communicating with SMART IRB POCs at other institutions identified as potential study sites to identify a single Reviewing IRB and determine which institutions choose to rely on the identified Reviewing IRB.
- Consulting, as needed, with individuals and resources (e.g., other IRB staff, legal counsel) at the institution regarding ceding IRB review or accepting IRB oversight for Research under the SMART IRB Agreement.
- Addressing any questions from the Site PI and/or potential Relying Site Study Team regarding the SMART IRB Agreement reliance review process and status of the reliance request.
- Notifying Relying Institutions of any legal action related to Research that had been ceded to the institution's IRB under the SMART IRB Agreement.
- Notifying the Reviewing IRB regarding the outcome of any internal audit findings related to Research ceded under the SMART IRB Agreement that represent reportable information per the Reviewing IRB's policies and procedures (e.g. unanticipated problems, serious or continuing noncompliance, or other reportable information).
- As appropriate, notifying other SMART IRB POCs regarding the outcome of any other audit findings not addressed above and related to Research that had been ceded under the SMART IRB Agreement.
- Promptly communicating to SMART IRB administration, and to SMART IRB POCs at Participating Institutions with which the institution is engaged, any changes in the institution's designated SMART IRB POC(s).
- In regard to the institution's FWA, notifying POCs at other Participating Institutions of:
  - A suspension or restriction to the institution's FWA
  - A modification to the scope of research to which the FWA applies
  - Invalidation of the institution's FWA for any reason (e.g., termination or expiration)
  - Filing of a new or updated FWA (e.g., adding a new component to the FWA)
- Notifying SMART IRB Administration of changes in the components of the institution that are covered under the FWA.
- When the POC's institution serves as the Reviewing IRB Institution:
  - Working in collaboration with the Reviewing IRB and Lead Study Team to determine

and document specific roles and responsibilities for communicating key information to Relying Institutions and the Reviewing IRB as described throughout these SOPs and as summarized in the Appendix: Additional Multi-Site Research Management Roles and Responsibilities.

- In the event a continuing review is submitted after IRB approval for the study expires, or the study expires before the Reviewing IRB can reapprove the study, notifying POCs from all affected Relying Institutions (in addition to the Overall PI and Lead Study Team) of the lapse in IRB approval and any applicable corrective action plans.
- Verifying that any changes in Site PIs or Relying Site Study Team personnel have been signed-off on by the Relying Institution POC for submission to the Reviewing IRB.
- Communicating lapses in IRB approval to affected Relying Institutions as addressed in the “Continuing Review Submission and Review Process” section below.
- Communicating information related to reportable events to affected Relying Institutions as addressed in “Reportable Event Submission and Review Process” below.
- When a POC’s institution is a Relying Institution:
  - Communicating to the POC for the Reviewing IRB any questions or concerns about the Research and local considerations (e.g., State law and any outstanding institutional requirements that must be met), in coordination with the Relying Site Study Team.
  - Verifying, in coordination with the Reviewing IRB POC, that Site Investigator or Relying Site Study Team personnel meet the institutional requirements for the Relying Institution, including education, training, and qualifications to perform the Research and safeguard the rights and welfare of research subjects. This verification includes, but is not limited to, having any local institutionally required professional staff appointments, credentialing, insurance or other liability coverage, and training in human subjects protections, and background checks for their assigned role in the Research.
  - For any proposed changes in Site PI or Relying Site Study Team personnel, verifying, in coordination with the Reviewing IRB POC, that any institutional requirements for investigators and study team members are met, including education, training, and qualifications to perform the Research and safeguard the rights and welfare of research subjects. This verification includes, but is not limited to, having any local institutionally required professional staff appointments, credentialing, insurance or other liability coverage, training in human subjects protections, and background checks for their assigned role in the Research.
  - Notifying the Reviewing IRB’s POC regarding events that occur at the Relying Institution that may alter the Reviewing IRB’s decision to accept IRB oversight for the Relying Institution or the Relying Institution’s decision to cede review, such as suspension of research privileges of a Site Investigator at a Relying Institution. NOTE: This notification would be limited to events that might not otherwise be reported to the Reviewing IRB by the Lead Study Team (e.g., noncompliance concerns identified by the Relying Institution on a study not ceded to the Reviewing IRB).
  - Responding promptly to any requests for assistance or information from the Reviewing IRB’s POC (e.g., gathering information on behalf of the Reviewing IRB regarding reportable events occurring at the Relying Institution).

## Establishing the Reviewing IRB

This section describes the process for establishing a Reviewing IRB for any studies conducted under the SMART IRB Agreement. The process begins when a proposed human research study has been identified and an “Overall PI” has been established.

The default prioritization scheme used for identifying potential Reviewing IRBs will be as follows:

1. Reviewing IRB that has been pre-determined by study sponsor or grant or established by prior arrangement (e.g., network central IRB).
2. Overall PI’s Home Institution (HI) IRB. (NOTE: the HI is where the Overall PI is primarily employed or is affiliated.)
3. Another Participating Institution IRB, when Overall PI HI does not have an IRB or Reviewing IRB(s) is selected based on type of procedures to be performed, subject population, or other criteria; more than one Reviewing IRB may be appropriate if these will significantly vary among participating sites.

Each Participating Institution will determine whether the responsibility for submitting reliance request is assigned to the Overall PI, Lead Study Team, or the IRB POC. The Overall PI or designee submits a request and supporting documents via the mechanism established by the HI IRB and identifies a proposed Reviewing IRB, which may be the IRB at the HI or an external IRB. *If the Overall PI HI does not have an IRB*, the Overall PI will follow the institution’s policies for requesting the use of an external IRB.

The SMART IRB POC at the Overall PI’s HI reviews the request and supporting documents and determines, in consultation with other Participating Institutions as necessary, if the institution’s IRB will serve as the Reviewing IRB for the Overall PI and other sites. If the SMART IRB POC determines that the HI IRB agrees serve as the Reviewing IRB, the POC will notify the Overall PI of the decision, and proceed to the section below on “Establishing the Relying Institutions.”

If the HI has an IRB and declines to serve as the Reviewing IRB for all Participating Institutions, the HI SMART IRB POC will then determine whether the HI is willing to cede review to another IRB to serve as the Reviewing IRB for the Overall PI. If the HI is willing to cede review to another institution, the HI SMART IRB POC contacts the POC(s) for potential alternate Reviewing IRB(s) identified by the Overall PI. The Overall PI may participate in this process where necessary. Once the Reviewing IRB has been established, the SMART IRB POC (on behalf of the Reviewing IRB) will notify the Overall PI of the decision, and proceed to the section below on “Establishing the Relying Institutions.” If the HI is unwilling to cede review to another institution, the HI IRB proceeds to conduct a review of the study for its own study team. The other Site Investigators are referred to new potential Reviewing IRBs identified by the Overall PI or by the HI POC.

The Overall PI, SMART IRB POC, and representative(s) from the Reviewing IRB will establish and document the party who will assume responsibility for the reliance-related communication and administrative functions described within these SOPs for which flexibility exists (e.g., whether the Reviewing IRB will review waivers and alterations of authorization on behalf of Relying Institutions or allow the use of a HIPAA authorization separate from the consent document). A sample “Additional Multi-Site Research Management Roles and Responsibilities” matrix is attached to these SOPs.

NOTE: There may be situations where the Overall PI does not seek Ceded Review but a sub-group of POCs determine Ceded Review is appropriate for the Research. If the Overall PI and/or the POC for the Overall PI’s HI do not object, Participating Institutions may still participate in Ceded Review for the Research. In this case, a Site Investigator may make a request for Ceded Review to his/her HI IRB.

## Establishing the Relying Institutions – Prior to IRB Approval

Once the proposed Reviewing IRB has been established, the SMART IRB POC from the Reviewing IRB Institution contacts the SMART IRB POCs at the other known Participating Institutions engaged in the proposed research, providing these sites access to the available materials provided by the Overall PI. These potential Relying Institutions complete the following steps within 14 business days:

1. Review the materials provided by the Overall PI.
2. Render a determination about ceding IRB review to the proposed Reviewing IRB.

If a potential Relying Institution agrees to cede review to the proposed Reviewing IRB, the Relying Institution SMART IRB POC provides the following information to the Reviewing IRB POC, Overall PI, and local Site Investigator:

1. The decision to cede review.
2. Any outstanding concerns or requirements that must be addressed before the Reviewing IRB approves the Research for that Relying Institution.
3. Any local considerations related to the Research that the Reviewing IRB must consider.

NOTE: Once informed consent document (ICD) templates are available for site-specific customization, Relying Institutions will provide institution-specific language for a limited number of areas as described in the “Customization, Submission, and Review of Informed Consent Documents” section below.

If a potential Relying Institution declines to cede review to the proposed Reviewing IRB, the SMART IRB POC for the institution communicates this determination to the proposed Reviewing IRB POC, Overall PI, and local Site Investigator. If the institution still plans to conduct the research, the institution will do so by maintaining local IRB oversight, ceding to a different Participating Institution IRB or ceding to an IRB that is not part of the SMART IRB Agreement. On the rare occasion that more than one Reviewing IRB becomes involved in overseeing a multi-site study<sup>2</sup>, it is the Overall PI’s responsibility to ensure coordination among the reviewing IRBs.

---

<sup>2</sup> For example, it may be appropriate to identify more than one Reviewing IRB for a single study if a study involves both pediatric and adult populations and separate reviewing IRBs are established to oversee each population.

## Adding New Relying Institutions – Post-IRB Approval

This section describes the process for adding a new Relying Institution for Research already reviewed and approved by a Reviewing IRB under the SMART IRB Agreement.

This process begins when the Overall PI/Lead Study Team provides the new proposed Relying Institution Site Investigator and SMART IRB POC with available study materials. The POC completes the following:

1. Reviews the materials provided by the Overall PI (or designee).
2. Renders a determination about ceding IRB review to the proposed Reviewing IRB.

If the potential new Relying Institution agrees to cede review to the Reviewing IRB, the Relying Institution SMART IRB POC provides the following information to the Reviewing IRB POC, Overall PI, and local Site Investigator:

1. The decision to cede review.
2. Any outstanding concerns or requirements that must be addressed before the Reviewing IRB approves the Research for that Relying Institution.
3. Any local considerations related to the Research that the Reviewing IRB must consider.

The Overall PI (or designee) then completes and submits a protocol amendment to add the proposed new Relying Institution to the study in accordance with the SOP section on “Protocol Amendment Submission and Review Process.”

## Coordination of IRB Review when a Single Central IRB is Not Identified

Under some circumstances, more than one Reviewing IRB may be established for a particular study. In these cases, it is the responsibility of the Overall PI to coordinate and communicate to each Reviewing IRB the necessary information related to the conduct of the study across all institutions throughout the life of the Research, not just information related to the sites overseen by each Reviewing IRB. Such information must be communicated in accordance with each Reviewing IRB's applicable policies and procedures.

## Initial Review: Submission and Review Process

This section describes the IRB review process and responsibilities of the Reviewing IRB, Relying Institutions, Overall PI and Lead Study Team, Site Investigators and Relying Site Study Teams, and SMART IRB POCs.

Once the determination has been made regarding which institution will provide IRB oversight (i.e., act as the Reviewing IRB), as described in the “Identifying the Reviewing IRB” section above, the Lead Study Team submits an application for initial review to the designated Reviewing IRB following the processes and policies and using the forms established by the Reviewing IRB. The initial review application must contain sufficient information to allow the Reviewing IRB to identify a) all known institutions engaged in human subjects research that intend to cede review to the Reviewing IRB (Relying Institutions), b) the activities performed at each institution, and c) the Overall PI and Lead Study Team for the study.

The Reviewing IRB will review initial applications for new Research in accordance with the human subject protection requirements of each Relying Institution’s FWA, the federal regulations and ethical principles referenced therein, any other applicable federal human subjects research regulations or policies, and any local considerations communicated to the Reviewing IRB (e.g., state law). The processes and procedures for review will be in accord with the Reviewing IRB’s own policies and procedures. As part of its responsibilities for conducting the initial review, the Reviewing IRB must:

- Take into consideration the local considerations provided to it by the SMART IRB POCs from the Relying Institutions as part of their decision to cede review, including institution-specific information for any informed consent documents. This information will be provided to the Reviewing IRB as described in the section above on “Establishing the Relying Institutions.”
- Review and make any applicable determinations regarding requests for waivers or alterations of authorization under the HIPAA Privacy Rule unless alternative arrangements have been agreed upon per the SOP section below titled “HIPAA Privacy Rule”.

Unless an issue is discovered during the course of review that requires input from the Relying Institution, the Reviewing IRB generally will not provide any direct communication to the Relying Institution regarding the initial review of the application other than notifications about the Research review.

The Reviewing IRB will notify the Lead Study Team when it has approved the Research through its established processes. The Reviewing IRB may rely on the Lead Study Team to notify the Overall PI and Relying Site Study Teams of the IRB approval or notify the Relying Site Study Team directly.

If the Reviewing IRB disapproves the Research or disapproves a Relying Institution’s participation in the Research, the Reviewing IRB POC will inform the Overall PI and Lead Study Team. The Lead Study Team is responsible for notifying relevant institutions of the IRB’s determination to disapprove the study or the proposed Relying Institution’s participation in the Research. If the Research is disapproved by a Reviewing IRB, and the Overall PI chooses to seek approval from a different IRB rather than substantively revise the protocol materials to address the concerns of the IRB that disapproved the study, the study cannot be subsequently submitted to another Participating Institution for review without disclosing the nature of the previous Reviewing IRB’s disapproval.

## Customization, Submission, and Review of Informed Consent Documents (ICD)

This section describes how consent documents will be handled and certain language from Relying Institutions incorporated into them.

When informed consent documents (ICDs) are required for a study reviewed under the SMART IRB



Agreement, the ICD template(s) of the Reviewing IRB will be used for all Relying Institutions for that Research. If the Reviewing IRB uses a stamp to indicate approval of ICDs, the stamp of the Reviewing IRB will be used. However, Reviewing IRBs are not obligated to stamp approved ICDs, unless required by their own institutional policy or other regulatory requirement.

The Reviewing IRB will determine the content of ICDs except for sections for which Relying Institutions must provide their institution-specific language, as applicable. The institution-specific language in the ICD to be provided by Relying Institutions is generally limited to:

- Compensation for injury
  - Availability of treatment for injury
  - Payment or reimbursement of research costs incurred by subjects
- Local study team contact(s) for questions about the study

HIPAA waiver and authorization language is addressed separately in the “Waivers and Alterations of Authorization” section of these SOPs.

Relying Institutions will customize these sections of the ICD by one of two mechanisms, as determined through coordination between the SMART IRB POC and Relying Site Study Team:

1. The Relying Institution POC requests the local Relying Site Study Team incorporate the information into the appropriate section(s) of the ICD(s). Once this has been finalized, the Relying Institution POC provides the local language to the Reviewing IRB POC for reference. The Relying Site Study Team is responsible for forwarding the ICD(s) to the Lead Study Team for submission to the Reviewing IRB through the Reviewing IRB’s established processes.

OR

2. The Relying Institution POC takes responsibility for incorporating the information into the local ICD(s). Once finalized, the Relying Institution POC forwards the ICD(s) to the Lead Study Team for communication to the Reviewing IRB in accordance with the Reviewing IRB’s established processes.

The Reviewing IRB will ensure a copy of the approved ICD(s) is sent to the Relying Institution POC, Overall PI, Lead Study Team, and Site Investigators. The Reviewing IRB may rely on the Lead Study Team to distribute the IRB-approved ICD(s). If a Relying Site Study Team or Relying Institution requires changes to its local language after the Reviewing IRB has approved the ICD(s) for that site, an amendment must be submitted to and approved by the Reviewing IRB before revised ICDs can be used at that institution.

## Continuing Review: Submission and Review Process

This section describes the key components for continuing review and responsibilities of the Reviewing IRB, Relying Institutions, Lead Study Team, Relying Site Study Team, and SMART IRB POCs during this process.

The Lead Study Team will submit a continuing review progress report to the Reviewing IRB in accordance with the Reviewing IRB's policies and procedures (e.g., when the report is due and the mechanism through which it is submitted to the IRB). The Lead Study Team (or designee) is responsible for obtaining information from each Relying Site Study Team, regardless of whether the institution is under the purview of the Reviewing IRB, so that the Reviewing IRB can assess a comprehensive report regarding study progress, new information, and problems that have occurred. If a Relying Site Study Team does not provide the Lead Study Team with required information before the continuing review application is submitted to the Reviewing IRB, the Lead Study Team must report the absence of this information as part of the continuing review submission.

The Reviewing IRB is responsible for reviewing all relevant information for the Lead Study Team's and Relying Study Team's sites until the Research is closed. The Reviewing IRB will conduct continuing reviews in accordance with the human subject protection requirements of each Relying Institution's FWA, the federal regulations and ethical principles referenced therein, any other applicable federal human subjects research regulations or policies, and any local requirements communicated to the Reviewing IRB (e.g., state law). The processes and procedures for review will be in accord with the Reviewing IRB's own policies and procedures.

Unless a Reportable Event is discovered in the course of the continuing review, the Reviewing IRB generally will not provide any direct communication to the Relying Institution regarding the review. The Reviewing IRB will notify the Lead Study Team when it has reapproved the Research through its established processes. The Reviewing IRB may rely on the Lead Study Team to notify Relying Site Study Teams of the IRB reapproval (or disapproval) of the Research or notify the Relying Site Study Team directly. If Research is disapproved by a Reviewing IRB at continuing review, and the Overall PI chooses to seek approval from a different IRB rather than substantively revise the study materials to address the concerns of the IRB that disapproved the Research, the Research cannot be subsequently submitted to another Participating Institution for review without disclosing the nature of the previous IRB's disapproval.

In the event a continuing review is submitted after IRB approval for the study expires or the study expires before the Reviewing IRB can reapprove the study, the Reviewing IRB will notify all participating site SMART IRB POCs, Overall PI, Lead Study Team, and Relying Site Investigators of the expiration of IRB approval. The Reviewing IRB will notify the Lead Study Team and applicable Relying Institution POCs of any applicable corrective action plans required.

Relying Site Study Teams may be required by their home institutions to provide study updates to local officials (e.g., local IRB offices) and are responsible for meeting these requirements.

## Protocol Amendment: Submission and Review Process

This section describes the process for reviewing study amendments (i.e., changes to the study or supporting documents) and associated responsibilities of the Reviewing IRB, Relying Institution, Lead Study Team, Relying Site Study Team, and SMART IRB POCs during this process.

The Lead Study Team is responsible for submitting amendments (studywide or local amendments for Relying Sites) to the Reviewing IRB for review in accordance with the Reviewing IRB's policies and procedures (e.g., timing and mechanism of submission).

The Reviewing IRB will conduct reviews of changes in research in accordance with the human subject protection requirements of each Relying Institution's FWA(s), the federal regulations and ethical principles referenced therein, any other applicable federal human subjects research regulations or policies, and any local considerations communicated to the Reviewing IRB (e.g., state law). The processes and procedures for review will be in accord with the Reviewing IRB's own policies and procedures. A Relying Institution POC must authorize their Relying Site Study Team's submissions of the following types of changes to the Lead Study Team for consideration by the Reviewing IRB POC:

- Changes to a Site Investigator or other Relying Site Study Team personnel, in order to ensure these personnel meet the institutional requirements for the Relying Institution;
- Changes that appear to affect any state law or local considerations a Relying Institution noted as part of its agreement to cede review; or
- Changes that indicate a newly identified COI.

Relying Site Study Teams will report changes in COI to their local Relying Institution in accordance with the local procedures and policies for COI reporting and management already established at each site. Relying Institution POCs will coordinate with local COI administrators and the local Relying Site Study Team in order to communicate this information to the Reviewing IRB. Reporting new or updated COI information, as well as personnel changes, to local SMART IRB POCs will occur in accord with the Relying Institution's processes.

The Reviewing IRB will notify the Lead Study Team when it has approved an amendment/change in research through its established processes. The Reviewing IRB may rely on the Lead Study Team to notify applicable Relying Institutions of the IRB approval, where agreed upon in advance when determining and documenting specific roles and responsibilities for communicating and coordinating key information to Relying Institutions and the Reviewing IRB. In the case of local amendments (e.g., local recruitment materials, site-specific changes to consent documents) that do not affect all Relying Institutions, only the sites affected by the approved amendment must be notified of the IRB approval.

## Record Keeping and Document Retention

This section describes the process for maintaining and storing SMART IRB administrative records and the responsibilities of SMART IRB Administration, Reviewing IRBs, and Relying Institutions for the maintenance of these records, covering SMART IRB administrative records and study-specific IRB records related to reliance, but not the investigators' Research files.

SMART IRB Administrators, Reviewing IRBs, and Relying Institutions will maintain the following records in the locations specified in the table below:

<b>SMART IRB Records</b>		
<b>Record Type</b>	<b>Responsible Party</b>	<b>Storage Location</b>
Current SMART IRB policies and procedures including: SOPs, forms, templates, etc.	SMART IRB Administration	SMARTIRB.org
Current executed SMART IRB Reliance Agreements and Joinder Agreements, as well as any amendments	SMART IRB Administration and Participating Institutions	SMARTIRB.org and at Participating Institutions
Study-specific reliance requests including: identification of Reviewing IRB(s) and Relying Institutions, and Study Team information	Participating Institutions	Local storage at Participating Institutions
Minutes from IRB meetings at which Research ceded under the SMART IRB Agreement was reviewed; portions of the minutes that are relevant to a Relying Institution available upon request to designated officials of the Relying Institution.	Reviewing IRB	Local storage; available upon request
Records of any applicable COI management plans provided by the Relying Institution and received by the Reviewing Institution	Reviewing IRB and Relying Institution	Local storage
Records of events reported by Relying Institution and received by the Reviewing Institutions	Reviewing IRB and Relying Institution	Local storage; available on request
Study-specific review and approval notifications	Reviewing IRB and Relying Institutions	Reviewing IRB and Lead Study Team
Other general correspondence between the Relying Institution and the Reviewing IRB	Reviewing IRB and Relying Institution	Reviewing IRB and Lead Study Team; available upon request
Study-specific determinations related to ceding review to a Reviewing IRB (e.g., forms documenting decision to cede review; any outstanding concerns or requirements that must be addressed by the Reviewing IRB, and any institutional requirements related to the ceded study that the Reviewing IRB must take into consideration.)	Relying Institution and Reviewing Institution	Local storage

## Document Retention

The records described in the table above will be retained by the respective responsible parties for a minimum of seven years after the closure or termination of the study by the Reviewing IRB. Participating Institutions, including Lead Study Teams and Relying Site Study Teams, are advised to refer to their local institutional policies, as they may require a longer period of retention.

## Access to Locally Stored Records and Reliance-Related Documents

SMART IRB Administrators and Participating Institution personnel, including POCs, Study Team members, and Reviewing IRBs will have access, where relevant and appropriate, to records listed in the table above for all studies for which they serve either as a Reviewing IRB or as a Relying Institution.

All other reasonable requests for access to records not listed above, or records stored locally, will be granted upon request by the applicable SMART IRB Administrator, Reviewing IRB POC, or Relying Site POC, within a reasonable timeframe, and in accordance with the policies of the institution storing the records and applicable state and federal laws.

## Supplemental Study Protocol Content

This section describes the additional content (beyond that which is typically included in a human research protocol) that should be provided to the Reviewing IRB. This additional information addresses coordinating the conduct of the research across multiple sites and establishing roles and responsibilities that supplement the high-level information already included in these SOPs.

Recommendations for information that should be collected at key points during the reliant review process are outlined below.

When requests to cede IRB review are made the following should be identified:

- The Overall PI and Lead Study Team, which retains overall responsibility for the Research.
- Any applicable Coordinating Center, which is responsible for coordinating activities at all other sites, receiving and analyzing data, and developing and updating the study protocol as needed. The Coordinating Center may be the same as the Lead Study Team.

The following should be collected about potential Relying Institutions:

- All Institutions that will be involved in the conduct of the Research
- Types of activities that will occur at each site (e.g., subject recruitment, laboratory analyses, and/or data analyses)
- Nature of the site(s) at which various research activities will occur (e.g., hospital, academic medical center, research clinic, medical office).
- All personnel engaged in human subjects research at each known site, including names, institutional affiliations, role in the study (e.g., administering surveys, obtaining informed consent, reviewing medical records, data analysis), and where this person will conduct study activities.
- If the study involves sample banking, identification of all institutions at which samples will be stored, what samples will be stored at which site(s).
- Description of any differences among performance sites in study procedures, subject remuneration, or subject populations.

On a study-by-study basis, the following additional information may need to be provided to the Reviewing IRB using forms/format specific to the Reviewing IRB:

- Description of how potential subjects are identified and the recruitment methods used at each recruiting site.
- Description of how informed consent is obtained at each site and who conducts the consent and/or assent process, including any special processes for subjects, such as those who may be non-English speaking, illiterate, have impaired decision-making capacity, or who may be children.
- Description of data storage, including all sites at which data will be stored, what data will be stored at what site(s), data security measures employed, who will have access to identifiable data at a site, when data will be anonymized or destroyed, or if data will be transferred to a central site for storage.
- If the Research involves sample banking, additional information regarding how sample confidentiality will be protected, who will have access to identifiable samples, will whether an honest broker system will be used (and if so, who the honest broker is), when samples will be anonymized or destroyed, and what types of analyses may be conducted on the banked samples.

In addition to the information above, Lead Study Teams (or designee, such as a Coordinating Center) will need to establish processes to address the following issues:

- How they will ensure all Relying Site Study Teams have the most current version of the protocol, consent documents, and other supporting materials.
- How they will ensure that all Relying Site Study Teams use the same version of the protocol, including a description of the procedures that must be followed in order to amend the protocol.
- How they will communicate with, collect information from, and disseminate information to other sites, regarding:
  - Local ICD requirements
  - Study updates (e.g., recruitment holds for interim analyses, closure to enrollment) or other changes to the study
  - Continuing reviews
  - Local changes of protocol (e.g., personnel updates, COI updates)
  - Reportable events
  - Study closure
  - The plan for collection and management of data from all sites

## Federal Grant Congruency Review

This section describes how it will be ensured that any federal grant supporting research ceded to a Reviewing IRB is congruent with the proposed or approved (in cases where a grant is obtained after initial review has occurred) study, when required by federal regulations.

Current federal regulations (45 CFR 46.103(f)) require institutions with FWAs to certify for each application or proposal for non-exempt human subjects research conducted or supported by a Federal Department or Agency that it has been reviewed and approved by an IRB. Inherent in this certification is an assessment that the activities described in the grant are congruent with those described in the proposed or IRB-approved study.

The Lead Study Team is responsible for submitting any federal grant award or proposal that supports a proposed or approved study to the Reviewing IRB at the time of initial review or as an amendment (change of protocol) if the funds are awarded after initial IRB approval. If the federal grant is not held by a member of the Lead Study Team but by a Relying Site Study Team instead, the Relying Site Study Team must provide a copy of the federal grant to the Lead Study Team for submission to the Reviewing IRB. The Reviewing IRB is expected to review a copy of the entire proposal in order to understand the scope of a project.

The Reviewing IRB is responsible for comparing the grant to the proposed or approved research study (in cases where a grant is obtained after initial review has occurred) to ensure that activities included in the grant are congruent with those described in the study. The Reviewing IRB may request the Lead Study Team revise an IRB application to reconcile any discrepancy between the grant and the study (e.g., to add new procedures described in the grant that will be conducted), submit a new initial review application (e.g., when the grant appears to describe a new study), or provide clarification regarding the reason for the differences (e.g., when only part of the grant appears to support the IRB-approved application).

Upon request, the Reviewing IRB will provide documentation of grant-study congruency for the Relying Site Study Team at the Relying Institution that holds the grant. The Participating Institution that holds the grant is responsible for providing documentation of congruency for certification to its local sponsored programs office per local policies and procedures. Relying Institutions retain responsibility for making relevant certifications to a Federal Department or Agency for awards their Institution receives.



## HIPAA Privacy Rule

This section describes how determinations related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be handled under the SMART IRB Agreement.

Under the SMART IRB Agreement protected health information (PHI) will not be used or disclosed among collaborating institutions unless there is: (1) appropriate authorization to use and disclose such information for the purposes of research; (2) an appropriate waiver or alteration of such authorization has been granted by the Reviewing IRB in accordance with the HIPAA Privacy Rule, or; (3) the information constitutes a Limited Data Set and is shared pursuant to a Data Use Agreement as those terms are defined in HIPAA.

### Waivers and Alterations of Authorization

Reviewing IRBs are responsible for making determinations regarding waivers or alterations of authorization under the HIPAA Privacy Rule for all Covered Entities for which it serves as the Reviewing IRB, and will follow their institutional policies and procedures as well as federal regulations for the review and approval of waivers or alterations of authorization. Those Reviewing IRBs inexperienced with the interpretation and application of the HIPAA Privacy Rule are expected to ensure they have the adequate expertise to review and approve waivers or alterations of authorization and consult, as needed, with individuals with HIPAA Privacy Rule expertise, such as SMART IRB POCs at Relying Institutions that are Covered Entities, to adequately fulfill this function. Relying Institutions requesting approval of a waiver or alteration of authorization must provide the Reviewing IRB with specific local requirements and restrictions on use and disclosure of PHI that could prevent the IRB from approving the request; the Reviewing IRB will consider the specific requirements and restrictions during the review.

When considering waivers or alterations of authorization, Reviewing IRBs will not approve waivers for the release of directly identifiable data outside the Covered Entity without consulting with Relying Institution POCs to determine whether the policies of the Relying Institutions would allow such a disclosure.

In the event that the Reviewing IRB approves a waiver of authorization for use and disclosure of PHI, a Relying Institution may rely on the Reviewing IRB's determination to the extent that it comports with institutional requirements.

If the Relying Institution has a concern about a waiver, partial waiver, or alteration of authorization the Reviewing IRB has granted, then the Relying Institution should discuss alternative approaches with the Reviewing IRB. Until an alternative approach is agreed upon between the Reviewing IRB and the Relying Institution, the Relying Site Study Team cannot perform the activity covered by the waiver, partial waiver, or alteration of authorization.

In the event that a research subject revokes permission to use his or her PHI, the affected investigator will determine whether the revocation occurred due to circumstances that require reporting to the Reviewing IRB in accordance with the Reviewing IRB's policies and procedures.

### HIPAA Authorization Language

The language required under the HIPAA Privacy Rule to obtain authorization for the use and/or disclosure of PHI will be incorporated into informed consent documents (ICDs), unless the Reviewing

IRB agrees to the use of separate consent and HIPAA authorization forms. The Reviewing IRB will provide the Relying Institution with the proposed HIPAA authorization language, ensure that certain elements of authorization are sufficiently broad to cover the Relying Institutions (e.g., the sources of the PHI, who may use the PHI, and to whom the covered entity may disclose the PHI), and consider any institution-specific requirements for HIPAA authorization language that a Relying Institution wishes to be incorporated into combined consent/authorization documents. If a Relying Institution has institution-specific authorization language, they would be responsible for communicating this language to the Reviewing IRB. A Relying Institution can delegate this responsibility for communicating Institution-specific HIPAA authorization language to the Relying Site Study Team or Relying Institution POC.

## Breaches of PHI

Participating Institutions are responsible for investigating and reporting to appropriate authorities, including Privacy Officers at affected institutions, breaches of PHI in accordance with institutional policies.

In the event that a privacy breach is discovered, Relying Site Study Teams must promptly notify their local Privacy Officer. The local Privacy Officer must then ensure that the Lead Study Team and Reviewing IRB are notified of the breach, and should be involved in any subsequent investigation of the breach as well as any notifications individuals or offices required by local institutional policy (e.g., their local Institutional Official for the Protection of Human Subjects).

The Reviewing IRB may review the reported breach as a potential unanticipated problem in accordance with the Reviewing IRB's policies and procedures for unanticipated problems.

## Other HIPAA Privacy Rule Requirements

All Participating Institutions are responsible for their own compliance with HIPAA obligations, with the exception of the consideration of waivers and alterations of authorization as well as authorization review duties that the Reviewing IRB will perform as described above. These other obligations under HIPAA include accounting of disclosures made pursuant to a waiver of authorization and execution of data use agreements or business associate agreements.

## Financial and Other Conflicts of Interest

This section describes key components of the process for communicating and evaluating financial conflicts of interest (henceforth COIs) for Research under the SMART IRB Agreement, and responsibilities of the Reviewing IRB, Relying Institutions, Lead Study Team, Relying Site Study Teams, and POCs.

Relying Institutions are responsible for review and management of any COIs related to Research ceded to an external Reviewing IRB under the SMART IRB Agreement. Relying Institution POCs will take into consideration COIs and applicable management plans when determining whether Research will be ceded to the proposed Reviewing IRB or continue to be ceded to the Reviewing IRB (if the potential or new COI is identified after the study has been approved). If a study will be ceded to the proposed Reviewing IRB, the Relying Institution POC will coordinate with the appropriate COI administrator at his/her institution to ensure any COIs and applicable management plans are communicated to the Reviewing IRB. The Relying Institution POC may communicate this COI information directly to the POC for the Reviewing IRB or delegate this responsibility to the local Relying Site Study Team for submission to Lead Study Team, who will provide this information to the Reviewing IRB. If a Relying Institution's policies require IRB review of institutional COI, the Reviewing IRB will review such conflicts upon request.

Relying Site Study Teams must disclose any COI and applicable management plans to their SMART IRB POCs and the Lead Study Team at the time a reliance request is submitted and when the initial review application is submitted to the Reviewing IRB. Any new COIs identified for any Study Team member or updates to management plans must be reported to the Reviewing IRB. In these cases, Relying Site Study Teams provide information about new COIs or updated management plans to their local SMART IRB POC through the process established at his/her institution. The Relying Institution POC will coordinate with the appropriate COI administrator at his/her institution to determine whether any additional action is required by his/her institution regarding the new COI and/or updated management plan.

Relying Site Study Teams are also responsible for disclosing to the Lead Study Team any new COIs or updated management plans issued by the Relying Institution after the study is ceded. The Relying Site Study Teams must inform their SMART IRB POCs of these updates and obtain confirmation from their POCs that this new information does not affect the decision to cede IRB review and ensure no additional actions must be taken (e.g., potential removal of a study team member or restriction of some personnel's activities). The Lead Study Team is responsible for submitting information about new COIs or updated management plans to the Reviewing IRB in accordance with the Reviewing IRB's policies and procedures (e.g., timing and mechanism for submission).

The Reviewing IRB is responsible for the consideration of any COIs and applicable management plan(s) for Study Teams participating in Research that has been ceded to them under the SMART IRB Agreement. The Reviewing IRB will ensure that any management plan is incorporated into its deliberations and that any mandated disclosures to subjects are included in the approved informed consent documents, as the Reviewing IRB deems applicable. The Reviewing IRB may not modify any management plan or mandated disclosure to subjects without discussion and acceptance by the Relying Institution, and retains the authority to impose additional prohibitions or conflict management requirements that are more stringent or restrictive than those included in the Relying Institution's management plan. In the extraordinary circumstance that the Reviewing IRB is unable to implement or approve a Relying Institution's prohibitions or management plans, the Reviewing IRB will so inform the Relying Institution and withdraw the Ceded Review with respect to that Relying Institution.

If a proposed Reviewing IRB knows of any institutional COI involving its institution, that IRB should decline to serve as the Reviewing IRB, following the procedures in "Establishing the Reviewing IRB".

## Reportable Event Submission and Review Process

This section describes the key components of the process for review of reportable events after reliance decisions have been finalized and a study has been approved by the Reviewing IRB, as well as the responsibilities of the Reviewing IRB, Relying Institutions, Lead Study Team, Relying Site Study Teams, and POCs during this process.

All study teams under the purview of the Reviewing IRB will follow the Reviewing IRB’s policies and procedures for reportable events (e.g., what requires reporting, reporting timeframes, and mechanism for reporting). The Reviewing IRB will conduct reviews of reportable events in accordance with the SMART IRB Agreement and SOPs as well as its own policies and procedures. Relying Site Study Teams may be required by their local institutions to provide additional reports to local officials (e.g., local IRB offices) and are responsible for meeting these requirements.

### Noncompliance and Unanticipated Problems

Reports of potential or actual noncompliance and potential or actual unanticipated problems will be submitted to the Reviewing IRB by the Lead Study Team. These submissions will be reviewed by the Reviewing IRB in accordance with its own policies and procedures. Upon becoming aware of such a report, the Reviewing IRB will notify and work with any Relying Institution(s) involved in or affected by the report as follows:

- Reviewing IRB POCs will promptly inform any Relying Institution POCs not already aware of reports of noncompliance and unanticipated problems occurring at or involving that institution, even if the Reviewing IRB Institution’s information gathering regarding the report is ongoing.
- As needed, the Reviewing IRB Institution may request assistance from Relying Institution POCs in gathering information about the reported event.
- The Reviewing IRB POC will notify the Relying Institution POC(s) and Site PIs from the affected Relying Institutions, as well as, in some circumstances, those from unaffected Relying Institutions, of the Reviewing IRB’s determination regarding the reportable event.
- In the event that reporting to a regulatory agency(ies), sponsor, funding agency(ies), and/or other oversight authority(ies) is required under federal regulations or under the terms of a Relying Institution’s FWA, the Reviewing Institution will provide the Relying Institutions with opportunity to review and provide input on such reports (no fewer than 5 business days) before they are sent to the applicable entity(ies).
- If the Reviewing Institution agreed to cede the obligation to report to federal authorities to the Relying Institution, the Relying Institution will provide the Reviewing Institution with the opportunity to review and comment on the report (no fewer than 5 business days) before it is sent to the applicable entity(ies). The Reviewing Institution will promptly provide any comments on the report to the Relying Institution.

Relying Institutions remain responsible for ensuring that any additional actions regarding the reportable event are taken as required by that Institution’s policies and procedures.

### Serious Adverse Events, Deviations, Subject Complaints, and Other Types of Reportable Events

Reports of serious adverse events, deviations, significant subject complaints and other events specifically requiring reporting to the Reviewing IRB in accordance with Reviewing IRB policies and procedures will be submitted to and reviewed by the Reviewing IRB. If such a report is found to

constitute potential noncompliance or an unanticipated problem, the Reviewing IRB will notify and work with any Relying Institutions involved in or affected by the report as described in the section above on “Noncompliance and Unanticipated Problems.”

## Suspensions and Terminations of Reviewing IRB Approval

The Reviewing IRB will suspend or terminate the approval of studies in accordance its own policies and procedures. If the Research as a whole is suspended or terminated, the Reviewing IRB POC will promptly notify in writing all Relying Institution POCs, Overall PI, Lead Study Team, and Site Investigators of the suspension or termination. If a Relying Institution(s) is suspended or terminated, the Reviewing IRB POC will promptly notify the Relying Institution POC(s), Overall PI, Lead Study Team, and Site Investigators from affected Relying Institutions (and in some circumstances other sites) in writing of the decision to suspend or terminate the site(s). In the event of a suspension, the Reviewing IRB will determine whether it can continue to accept IRB oversight for the Relying Institutions or determine that it will end its oversight or participation in the specific Research, in accordance with the SOP sections below on “Ending Institution Participation in SMART IRB or Specific Research.”

## Research Misconduct

Both the Reviewing Institution and Relying Institutions are responsible for notifying each other regarding potential research misconduct.

Any individual at a Reviewing or Relying Institution who becomes aware of a potential instance of research misconduct must notify their local Research Integrity Officer (RIO) in accordance with local policies and procedures for handling cases of potential research misconduct. When the research involves a study ceded under SMART IRB, the local RIO will notify and confer with the RIOs at other affected institutions, including the Reviewing IRB’s institution.

If a Reviewing IRB discovers or receives information regarding potential or actual research misconduct, the Reviewing IRB will handle the report as a potential unanticipated problem with further notifications to Relying Institutions as outlined under that section of these SOPs.

## Other Reporting Requirements

This section describes other events that may occur that require reporting to the Reviewing IRB Institution and/or Relying Institutions.

## Changes in FWA, IRB Registration, or Accreditation Status

Reviewing IRB Institution and Relying Institutions are responsible for notifications regarding changes to FWA or accreditation status (also described in the Responsibilities section of this SOP):

- A Reviewing IRB Institution will promptly notify all Participating Institutions and SMART IRB Administration:
  - If its FWA is suspended or restricted, lapses, or changes in scope.
  - Of any loss or change in its accreditation status.
  - Of any expiration of or change to its IRB registration status.
- Relying Sites will promptly notify:
  - All Participating Institutions and SMART IRB Administration if their FWA is suspended or restricted or if its FWA lapses or changes in scope.

- SMART IRB Administration of any loss or change in its accreditation status.

Reviewing IRB Institutions and Relying Institutions are responsible for designating a point person for these types of communications, which may be the SMART IRB POC.

### **Federal Audits and Legal Actions**

The Reviewing IRB and Relying Institutions are responsible for notifying each other regarding audits findings related to studies ceded under the SMART IRB Agreement that represent reportable information per the Reviewing IRB's policies and procedures (e.g., unanticipated problems, serious or continuing noncompliance, or other reportable information) as well as legal actions related to any studies for which the Reviewing IRB provides IRB oversight. Participating Institutions will assist as appropriate the other(s) in investigating and responding to such issues. The Reviewing Institutions and Relying Institutions are responsible for designating a point person for these types of communications, which may be the SMART IRB POC.

### **Suspension or Restriction of Relying Site Investigator or Relying Site Study Team Member**

Relying Institution POCs are responsible for promptly notifying the Reviewing IRB of any suspension or restriction of Site PI or Relying Site Study Team member status to conduct research at the institution.

### **Withdrawal from Ceded Review**

If a Relying Institution determines that it must withdraw the Research from Ceded Review, it will notify the Reviewing IRB of this determination. Participating Institutions are responsible for designating a point person for these types of communications, which may be the SMART IRB POC.

When a change in acceptance of reliance occurs, the Reviewing IRB and Relying Institution(s) will work together to facilitate the transfer of IRB oversight with the goal of limiting the potential disruption to the Research and continuing human subjects protections. Until oversight is transferred, the Reviewing IRB will continue to assume oversight responsibility.

## Amending the SMART IRB Agreement

This section describes the key components of the process for amending the SMART IRB Agreement and the responsibilities of the individual(s) who carry out this process.

The SMART IRB Executive Committee (or designee) is responsible for determining whether an amendment to the reliance agreement is necessary. Suggestions for Agreement amendments may come to the Executive Committee from current Participating Institutions, prospective Participating Institutions, or from Executive Committee members themselves.

Once it is determined that an amendment is necessary, the Executive Committee (or designee) will designate an individual or group to draft or revise the Agreement.

During the drafting process, the individual(s) drafting the Agreement amendment will seek input from Participating Institutions as follows:

- Posting the proposed draft amendment language on the SMARTIRB.org website.
- Notifying all Participating Institutions of the change of the proposed amendment language and providing a 30-day comment period.
- Revising the draft language as appropriate based on any feedback received.
- Posting a revised draft of the amendment language on the SMARTIRB.org website.
- Notifying all Participating Institutions of any updates to the proposed amendment language and providing a 15-day comment period prior to finalizing the amendment.

If alternative proposals are received during the feedback process and determined to be preferable to the originally proposed amendment, the updated version will be communicated back to the appropriate individuals following the steps above.

If, after review and feedback is received from Participating Institutions, the Executive Committee (or designee) decides not to proceed with the amendment, it will be withdrawn. The Executive Committee (or designee) will notify all Participating Institutions of the withdrawal and why it was withdrawn, and no further action will be taken.

If the Executive Committee (or designee) decides to finalize the amendment, it will determine on a case-by-case basis whether the amendment can be finalized by simply notifying all Participating Institutions of the amendment when it represents a clarification or correction (e.g., refinement of a defined term), or whether the amendment is so significant as to require all Participating Institutions to re-execute the Joinder Agreement. If, after finalization, a Participating Institution is unable to accept the terms of the amended Agreement, the institution may terminate its participation in the SMART IRB Agreement as described in the SOP on “Discontinuing Site Participation in the SMART IRB Agreement.”



## Standard Operating Procedure (SOP) Development, Adoption, Modification, and Maintenance

This section describes the process to create and update SMART IRB SOPs and associated materials.

The Executive Committee (or designee) is responsible for determining whether new SOPs must be created or whether revisions to existing SOPs are necessary. Once a determination has been made that SMART IRB SOPs or associated materials (templates, forms, etc.) must be developed or revised, the Executive Committee (or designee) will designate an individual or group to draft or revise those document(s).

During the drafting process, the individual(s) drafting the new/revised SOPs and associated materials will seek input from the individuals or committees identified by the Executive Committee (or designee). Materials will be revised based on the review and feedback from these individuals/committees.

New or revised SOPs will be approved for finalization by the Executive Committee (or designee).

Once the necessary feedback and revisions have been incorporated into the draft SOPs and/or associated materials, SMART IRB Administrative personnel will finalize the documents by:

- Updating the “version date,” “approved by,” and “approval date” sections of the SMART IRB SOPs.
- Posting the updated SOP Manual and associated materials on the SMARTIRB.org website.
- Archiving the previous version of the materials.
- Notifying all affected Participating Institutions in writing of any material changes.

## Ending Site Participation in the SMART IRB Agreement or Specific Research

This section of the SOPs describes:

- The process by which a Participating Institution may terminate its participation in the SMART IRB Agreement altogether, or end its participation as a Reviewing IRB or Relying Institution for a specific Research ceded under the SMART IRB Agreement, and
- The responsibilities of the POC of the Terminating Institution, as well as those of any affected Reviewing IRB POCs and Relying Institution POCs during this process.

This section covers three scenarios:

- **Scenario 1:** Cases where a Participating Institution decides to terminate its participation in the SMART IRB Agreement altogether and the Institution does not have any current ceded Research and is not currently serving as a Reviewing IRB for any Research under the SMART IRB Agreement.
- **Scenario 2:** Cases where a Participating Institution decides to terminate its participation in the SMART IRB Agreement, and the Institution has current ceded Research under the SMART IRB Agreement for which they are the Reviewing IRB or are participating as a Relying Institution.
- **Scenario 3:** Cases where a Participating Institution needs to change the Reviewing IRB (either if they have ceded or are serving as that IRB) for specific Research currently under the SMART IRB Agreement, but does not want to terminate the SMART IRB Agreement (e.g., the Participating Institution wants to take back review of the Research or the Reviewing IRB must give up review).

### Scenario 1

A Participating Institution that does not have any current Research ceded and is not currently serving as a Reviewing IRB for any studies ceded under the SMART IRB Agreement terminate its participation under this Agreement upon 30 days prior written notice to SMART IRB administration and other Participating Institutions.

In the event of any planned discontinuation of an institution’s participation in the SMART IRB Agreement, the POC at the Terminating Institution will promptly notify SMART IRB administration. SMART IRB administration and the Terminating Institution POC will work together to update SMART IRB records and ensure that individuals affected by the termination are promptly notified of it. A Participating Institution may terminate its participation in the SMART IRB Agreement upon thirty (30) business days’ prior written notice to the other Participating Institutions involved in any ongoing Research under the Agreement.

### Scenario 2

A Participating Institution that has current Research under the Agreement for which they are the Reviewing IRB or are participating as a Relying Institution may terminate its participation under this Agreement upon thirty (30) business days’ prior written notice to the other Participating Institutions involved in any ongoing Research under the Agreement or sooner if other arrangements have been made for open and ongoing studies affected by the termination. Termination of participation in this Agreement by one Participating Institution will not end this Agreement with respect to the remaining Participating Institutions.

In the event of any planned discontinuation of an Institution's participation in the SMART IRB Agreement, the POC at the Terminating Institution will promptly notify SMART IRB administration.

For all studies for which the Terminating Institution participates as a Relying Institution, the discontinuing SMART IRB POC contacts the Overall PI of each study, requesting that the site be withdrawn from ceded review for the identified study. The Overall PI for each study will submit an amendment to the Reviewing IRB reflecting the change (see "Protocol Amendment Submission and Review Process").

If the Terminating Institution serves as the Reviewing IRB for any open studies, the discontinuing site SMART IRB POC contacts the POCs and Site Investigators for all Relying Institutions, and works in collaboration with SMART IRB administration, investigators, and the Relying Institution(s) POC(s) to identify a new Reviewing IRB for each study. A new Reviewing IRB will be established in accordance with the SMART IRB SOP on "Establishing Reviewing IRBs and Relying Institutions."

### Scenario 3

When a Relying Institution for a particular study seeks to change the Reviewing IRB on that study (i.e., the Relying Institution wants to stop ceding review to the current Reviewing IRB), the Relying Institution POC contacts the Overall PI of the affected Research requesting that the site be removed as a Relying Institution. The Overall PI for the study will remove the site by submitting an amendment to the Reviewing IRB in accordance with the SMART IRB SOP on "Protocol Amendment Submission and Review Process."

When a Reviewing IRB Institution on a particular study seeks to change the Reviewing IRB for that Research (i.e., the Reviewing IRB must give up the review), the Reviewing IRB Institution SMART IRB POC contacts the POCs and Site Investigators for all Relying Institutions, and works in collaboration with SMART IRB administration, investigators and the Relying Institution(s) POC(s) to identify a new Reviewing IRB. A new Reviewing IRB will be established in accordance with the SMART IRB SOP on "Establishing Reviewing IRBs and Relying Institutions."

Terminating an institution's status as Reviewing IRB for the particular study will not be finalized until arrangements have been made for establishing a new Reviewing IRB for all Relying Institutions that continue to participate in the Research.

## Appendix: Additional Multi-Site Research Management Roles and Responsibilities

This sample grid may be used to coordinate responsibilities for the administrative processes for which flexibility exists in the SMART IRB SOPs as to which party will be responsible. Use this or a similar mechanism to facilitate discussions between the Lead Study Team and Reviewing IRB and document determinations of responsibility.

Process	SOP Ref.	Overall PI	Lead Study Team	Relying Study Team	Relying POC	Reviewing POC	Other	Notes
Incorporating institution-specific required consent document language for a Relying Institution.	Customization, Submission, and Review of ICDs							
Submitting requests and supporting documents to identify the proposed Reviewing IRB on behalf of Overall PI.	Establishing the Reviewing IRB							
Communicating Reviewing IRB determinations to Relying Institutions, including approvals, renewals, amendments, and determinations of unanticipated problems, serious or continuing noncompliance, suspensions, or terminations	Responsibilities: PIs and/or Study Teams; Responsibilities: Institutions and IRBs							
Establishing procedures for an Overall PI and Reviewing IRB, to ensure all Relying Site Study Teams have and use the most current version of the protocol, consent documents, and other supporting materials	Study Protocol Content and Identification of Site Personnel and Activities							
Providing and communicating to all Relying Institutions any procedures that must be followed in order to amend the protocol	Study Protocol Content and Identification of Site Personnel and Activities							
Providing and communicating Reviewing IRB reporting requirements and associated policies and procedures for reportable new information	Study Protocol Content and Identification of Site Personnel and Activities							
When serving as a Reviewing IRB, receiving reports from Relying Institutions of potential unanticipated problems, noncompliance, or other information required to be reported by the Reviewing IRB's policies and procedures	Responsibilities: PIs and/or Study Teams; Responsibilities: Institutions and IRBs							
When serving as a Reviewing IRB, receiving reports from Relying Institutions of potential unanticipated problems, noncompliance, or other information required to be reported by the Reviewing IRB's policies and procedures	Responsibilities: PIs and/or Study Teams; Responsibilities: Institutions and IRBs							
When serving as a Relying Institution, sending COI information directly to the SMART IRB POC for the Reviewing IRB to consider	Financial and Other Conflicts of Interest							
When serving as a Reviewing IRB, receiving COI information from Relying Institutions	Financial and Other Conflicts of Interest							