## Table of Contents

### ADMINISTRATIVE

- SOP Portfolio Modifications .................................................................................................................. 5
- LISTSERV Responsibilities ..................................................................................................................... 9
- Mass Email Listerv Management ......................................................................................................... 13
- IRB Satisfaction Survey ......................................................................................................................... 17
- Training New IRB Staff ......................................................................................................................... 18
- IRB Department Travel ......................................................................................................................... 20
- Target Turn-Around Times in Business Days ....................................................................................... 23
- Inquiries & Complaints received about IRB submissions ..................................................................... 27
- Staff Continuing Education ................................................................................................................. 30

### COLLABORATIVE RESEARCH / CENTRAL IRBS

- Reliance Agreements for Ongoing Emory Studies ................................................................................. 31
- Obtaining Access to WIRB and NCI CIRB ........................................................................................... 37
- WIRB Study Processing ......................................................................................................................... 38
- NCI CIRB studies processing ................................................................................................................ 44
- Reviewing Notifications of UPs from External IRBs ........................................................................... 54
- Vetting NIH Single IRB Plans ............................................................................................................... 55
- XIRB Study Processing When Emory Relying on Another Institutions .................................................. 60
- Reportable new information submission Notification Process When Study is Subject to External IRB Review .................................................................................................................................................. 60
- Closing Out Multi-Site Studies ............................................................................................................. 63
- Processing A Reliance Modification (to Onboard a Participating Site) .................................................. 65
- Issuing HIPAA Waivers for XIRB Studies ............................................................................................. 68
- Reviewing Site-Specific Recruitment Materials and Brochures for XIRB Studies ................................ 69

### MEETING FACILITATION

- Meeting Facilitation Responsibilities ..................................................................................................... 70
- Drivers for IRB meetings ....................................................................................................................... 79
- Minutes Processing Procedures ............................................................................................................ 80
- Analyst Assistant Meeting Preparation ............................................................................................... 84
- Using the Roster Ultimata ..................................................................................................................... 86

### QA AND EDUCATION

- Acknowledgments & Noncompliance Determinations Made by Senior Team Q Staff ...................... 89
- IRB Noncompliance ............................................................................................................................. 91
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRB Team Q CAPA Follow Up</td>
<td>93</td>
</tr>
<tr>
<td>CMTE Q Meeting Facilitation</td>
<td>95</td>
</tr>
<tr>
<td>Communication of Report of Internal Study Subject Death</td>
<td>98</td>
</tr>
<tr>
<td>Review of Single Use, Expanded Access of Unapproved Drugs or Devices</td>
<td>100</td>
</tr>
<tr>
<td>External Webinars presented by Team Q</td>
<td>105</td>
</tr>
<tr>
<td>Process of Review of Expired Consents after Notification from OCR</td>
<td>107</td>
</tr>
<tr>
<td>Informed Consent Monitoring SOP</td>
<td>110</td>
</tr>
<tr>
<td>Internal QA/QI review of documents after IRB Review</td>
<td>112</td>
</tr>
<tr>
<td>Letters after FB with PIs, OHRP and FDA after SNC, CNC and UP determinations</td>
<td>114</td>
</tr>
<tr>
<td>Reportable new information submission Review Process</td>
<td>115</td>
</tr>
<tr>
<td>Education and Quality Assurance Team Mission and Process</td>
<td>123</td>
</tr>
<tr>
<td>IRB Record Review of Studies approved by the Emory IRB</td>
<td>125</td>
</tr>
<tr>
<td>Review of Safety Reports submitted by sponsors holding an IDE</td>
<td>128</td>
</tr>
<tr>
<td>Routing External UPs (FDA Regulated)</td>
<td>130</td>
</tr>
<tr>
<td><strong>STUDY MANAGEMENT</strong></td>
<td><strong>133</strong></td>
</tr>
<tr>
<td><strong>MODIFICATIONS</strong></td>
<td><strong>133</strong></td>
</tr>
<tr>
<td>Adding/Removing Study Personnel</td>
<td>133</td>
</tr>
<tr>
<td>Modification: Mod Applications IRB Processing from Preliminary Analysis through Approval</td>
<td>143</td>
</tr>
<tr>
<td>Modifications: Mods Indicating Increased Risk</td>
<td>148</td>
</tr>
<tr>
<td><strong>NEW STUDIES</strong></td>
<td><strong>150</strong></td>
</tr>
<tr>
<td>Pre-Review options and Ancillary Review Information</td>
<td>150</td>
</tr>
<tr>
<td>eIRB Processing of New Study Applications: Preliminary Analysis through Approval</td>
<td>154</td>
</tr>
<tr>
<td>Naming Conventions for eIRB Studies</td>
<td>158</td>
</tr>
<tr>
<td>RDRC Studies</td>
<td>159</td>
</tr>
<tr>
<td>Translation of Informed Consent Documents</td>
<td>161</td>
</tr>
<tr>
<td>Research Projects led by Non-Emory students</td>
<td>164</td>
</tr>
<tr>
<td>Training Verification</td>
<td>165</td>
</tr>
<tr>
<td>Electronic documentation of informed consent via “electronic signature” or “digital signature”)</td>
<td>168</td>
</tr>
<tr>
<td>Mobile Devices and Mobile Medical Apps Used in Research</td>
<td>173</td>
</tr>
<tr>
<td>Certificate of Confidentiality Process in non-federal studies</td>
<td>180</td>
</tr>
<tr>
<td>Data sharing certifications including genomic data sharing</td>
<td>186</td>
</tr>
<tr>
<td>COI: Handling Studies with Study Team Conflict of Interest</td>
<td>188</td>
</tr>
<tr>
<td>Institutional Conflict of Interest</td>
<td>195</td>
</tr>
<tr>
<td>Cost Option for Clinical Trial Agreements and ICFs</td>
<td>198</td>
</tr>
<tr>
<td>Sensitive Study Status</td>
<td>199</td>
</tr>
<tr>
<td>Imaging Studies</td>
<td>201</td>
</tr>
</tbody>
</table>
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to Handle GWAS Data Use Certification Requests</td>
<td>203</td>
</tr>
<tr>
<td>Humanitarian Device Exemption (HDE) Studies</td>
<td>204</td>
</tr>
<tr>
<td>ResearchMatch.org as a recruitment tool</td>
<td>208</td>
</tr>
<tr>
<td>Checking Biosafety Approval Status</td>
<td>209</td>
</tr>
<tr>
<td>Processing Studies that will use Deception or Incomplete Disclosure</td>
<td>210</td>
</tr>
<tr>
<td>Looking Up ‘In Case of Injury’ Option for Industry-funded Studies via ORA Reporting Export</td>
<td>213</td>
</tr>
<tr>
<td>St. Joseph and John’s Creek study site process</td>
<td>219</td>
</tr>
<tr>
<td>REMS study review</td>
<td>222</td>
</tr>
<tr>
<td>Prisoner Studies: Handling of New/Modification/Renewal Submissions when Prisoners are Subjects (Application of Subpart C)</td>
<td>224</td>
</tr>
<tr>
<td>Sponsor/Sponsor-Investigator at Emory Holding an IND/IDE: Review of Studies Involving Emory University</td>
<td>228</td>
</tr>
<tr>
<td>VA Studies with non-VA Sites – IRB Submission Requirements</td>
<td>235</td>
</tr>
<tr>
<td>Determinations and Reviews by IRB Staff</td>
<td>237</td>
</tr>
<tr>
<td>Categories of Research Reviewable by IRB Staff as IRB Designated Members</td>
<td>239</td>
</tr>
<tr>
<td>Study assignment by Director or designee</td>
<td>242</td>
</tr>
<tr>
<td><strong>DURING STUDY CONDUCTION</strong></td>
<td>244</td>
</tr>
<tr>
<td>Over-Enrollment Via Consent (No Research Activities including during Screening)</td>
<td>244</td>
</tr>
<tr>
<td>Transferring Study Participants Between Study Sites</td>
<td>246</td>
</tr>
<tr>
<td><strong>CONTINUING REVIEW</strong></td>
<td>248</td>
</tr>
<tr>
<td>Continuing Review: CR reassignment</td>
<td>248</td>
</tr>
<tr>
<td>Continuing Review Processing: Preliminary Analysis through approval</td>
<td>250</td>
</tr>
<tr>
<td>Continuing Review: Applying 30-day window</td>
<td>255</td>
</tr>
<tr>
<td>Continuing Review: REs/PDs/Noncompliance and Monitor Reports</td>
<td>256</td>
</tr>
<tr>
<td>Continuing Review: Processing study staff noncompliance with CITI and Clinical Research Training (formerly Key Concepts/Intro to CR) requirements</td>
<td>259</td>
</tr>
<tr>
<td><strong>CLOSE OUT</strong></td>
<td>261</td>
</tr>
<tr>
<td>Close-Out Processes</td>
<td>261</td>
</tr>
<tr>
<td>Informing Teams of Study Closure</td>
<td>264</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to describe the process of adding or modifying approved SOPs, Guidance, and Policies ('IRB documents') into the designated H drive area.

SCOPE OF SOP
The SOP applies to the SOPs, Guidance, and Policies affecting the Emory IRB.

RESPONSIBILITIES
- **IRB Designated Staff**: Add approved IRB documents to designated H drive area.
- **IRB Director**: Gives final approval of any new SOP in the designated H drive area.
- **IRB SOP Sub-committee**: Helps with the creation or modification of existing IRB documents; reviews and approves minor changes to SOPs and review new SOPs before IRB Director review.
- **Huron**: periodically, the eIRB system vendor (Huron) will send updates to improve the electronic system. These updates may include updates based on changes in the guidance or policies affecting human subjects' research. These changes will come in the form of updates to the electronic system and the Huron Toolkit.

PROCEDURE
*Note: The official SOP Portfolio is a pdf document that is uploaded to our website documents folder. There’s no link to it from our website itself in order to keep the document accessible only to the IRB staff. The direct link to the portfolio is: [http://www.irb.emory.edu/documents/SOP%20Portfolio.pdf](http://www.irb.emory.edu/documents/SOP%20Portfolio.pdf)*

After Huron updates
1. Periodically, Huron will update the electronic system and Toolkit. The Toolkit is the group of regulatory documents Huron created to be used with the electronic system. At Emory, we are only implementing some of the checklists and worksheets from the Toolkit.
2. When a Huron update affects our SOPs, P&Ps, checklist, and worksheets, we will update these documents in the next 30 business days, if required.

For SOP portfolio suggestions (staff)
1. To suggest changes to an SOP, copy the SOP from the SOP portfolio document in word.
2. Track changes and send them to IRB Associate Director to add to the agenda for the SOP subcommittee meeting for review. Save copy under H:\General\Admin IRB Documents\SOP Portfolio\SOP Portfolio Source Files\SOPs in process
3. The IRB subcommittee will review and approve (in case of minor changes) or review before sending to IRB Director (for major changes or new SOPs)
Instructions for IRB SOP sub-committee

1. The IRB SOP subcommittee will set up meetings at least every two months to review changes to the SOP portfolio. If there is no change to the SOPs that need to be implemented, the meeting can be canceled.

2. The subcommittee will review changes done after SOP review at the staff meeting, suggested changes by staff or new SOP additions.

3. The subcommittee can approve changes to existing SOPs considered in line with current practices, and administrative changes to the SOP portfolio. For major changes in procedures or new SOPs, the subcommittee will do an initial review and send revised and new SOPs to IRB Director for final approval.

Instructions for the SOP Portfolio manager

1. Make the approved changes to the Word document portfolio (H:\General\Admin IRB Documents\SOP Portfolio\SOP Portfolio Source Files\SOP Portfolio.docx)
   a. Copy and paste just the body text of the new/revised SOP into the main portfolio; copying the header and the log of changes often led to formatting issues.
   b. After changes, remember to update the table of contents so that the page numbers are accurate. This is done automatically by simply clicking on the table of contents, then click “Update Table” in the top tab, and select “update entire table”
   c. Finally, if applicable, put the separate new/revised SOP into the backup folder: H:\General\Admin IRB Documents\SOP Portfolio\Backup Files

2. Save the updated Word SOP Portfolio as a PDF within the same folder (overwrite the existing one)

3. Update the online SOP portfolio with the revised version:
   a. Log in to Cascade: https://cascade.emory.edu
   b. Select “RE Institutional Review Board – IRB” from the dropdown menu at the very top of the first window
   c. From the left-hand menu, navigate to Base Folder/documents/SOP Portfolio.pdf
   d. Go to the “Edit” tab
   e. Select the revised PDF version of the portfolio, then click Submit
f. Go to the “Publish” tab and click Submit (the Publish to Production and Publish to Staging should both be selected by default)

i.

4. After about a minute or so, check the online SOP link to make sure that the most recent version was successfully uploaded. You may need to press your browser’s refresh button to clear the cache (force it to “forget” the old version)

5. Email the IRB staff, letting them know about the changes. Direct the Pod leaders to review these changes at their next meeting and add to the next IRB staff meeting for in-dept review if needed.

See below an example of such email:

Subject: Changes to SOP Portfolio: November 1, 2018

Hi everyone,
Please, review the latest changes for the SOP portfolio, to keep up-to-date with new processes, as applicable. Remember to refresh your browser in case you do not see the changes.

Sr. RPAs: PLEASE SAVE THIS IN THE IMPORTANT NEWS TAB OF YOUR POD REPORT TO REVIEW DURING NEXT POD MEETING. FEEL FREE TO REVIEW ONLY THE SOPS AFFECTING YOUR TEAM.

See below for a summary of the current changes:

NEW SOP

- Data sharing certifications including genomic data sharing

Changes to SOPs

- WIRB Study Processing: updated location for email templates and added information for controlled substance studies
- NCI CIRB studies processing: added a section of how to process CIRB Modifications; added information for controlled substance studies

I have updated the portfolio online. You can find the portfolio at http://www.irb.emory.edu/documents/SOP%20Portfolio.pdf

Let me know if you have any questions,

Maria

PROCESS FLOW

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/7/2015</td>
<td>Added specific steps for updating the online SOP via Cascade</td>
</tr>
<tr>
<td>9/16/2016</td>
<td>Update folder where SOP drafts and ready SOPs should be saved</td>
</tr>
<tr>
<td>2/6/2017</td>
<td>Adding SOP subcommittee to process</td>
</tr>
<tr>
<td>1/18/2019</td>
<td>Aligning with the current process</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Added steps to update Emory regulatory documents when our IRB receives updates from Huron</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Change period for the review of toolkit changes and make changes to Emory regulatory documents</td>
</tr>
</tbody>
</table>
**NOTE:** Listserv responses MUST be given the same day or at the latest the next day, with no exceptions. If you can’t fully respond, at least email to say that you are working on it (or have passed it on to someone, see “Required Procedures for Handling Listserv” below). Listserv day starts at 4 pm the day before the assigned day. The shift ends at 3:59 pm on the assigned day. For example, for someone with a Wednesday assigned day, the shift will start at 4 pm on Tuesday and end at 3:59 pm on Wednesday.

### Required Procedures for Handling Listserv

| If you send a response to a listserv email | Not required but preferred practice: Bcc yourself on the response and then save the blind copy to your “Listserv Duties” folder to more easily keep track of what you have done and can let other IRB staff know what has been done if they have questions. Alternatively, save the sent email into your Listserv duties folder. |
| If you forward the email to another analyst | ALWAYS do so by clicking “Reply” and CC’ing the analyst. The reply should let the sender know you’ve received their email and are sending it to [analyst] to handle it. That way the sender knows who’s responsible for their inquiry. |
| If you don’t need to respond to the email b/c there is nothing to do | Bcc yourself on the email and indicate that there is nothing to respond to – save in your “Listserv Duties” folder. |
| If you cannot cover listserv due to illness or vacation | Communicate with another listserv staff member to ensure coverage (e.g. switch days for that week) and inform one of the Directors (or direct supervisor) |
| CITI Completion Reports | Just move to your “CITI Completion Reports” folder under inbox (best to set up a “Rule” so Outlook does this automatically) |
| If you handle listserv on a University Holiday | Complete tasks from your assigned day when you return to the office. |
| If Maria Wackerly is unavailable during your listserv day | Complete Maria’s tasks. |

### Types of Emails | How to respond/Action taken
<p>| Complaints from participants | Forward to Team Q (Maria Davila and Shara Karlebach); cc Director |</p>
<table>
<thead>
<tr>
<th>Compliance or UP-related</th>
<th>Send it to Team Q (Maria Davila and Shara Karlebach). If a specific study is mentioned, CC the owner of the study.</th>
</tr>
</thead>
</table>
| Contact IRB Staff Activity | Emails with this Subject line are generated when someone logs a comment in a study before the study is assigned to an analyst.  
If the comment is informational and not at all time-sensitive – someone will see it once it has been assigned – you don’t need to do anything about this type of email – Bcc yourself to indicate that no response was made and save to your “Listserv duties” folder.  
If the comment is a question or request for assistance that requires a response, you will need to 1) either send an email as a response, 2) refer the issue to someone else, or 3) respond via logged comment. Remember to Bcc yourself to keep track of what was done. |
| Corp_IRB_Options.xls from ORA-IT or OSP | The subject line is “Corp_IRB_Options – Records Found.” Note: Proposal ID is NOT the IRB file number. Listserv person is not expected to do anything with this email. |
| CTRC approvals (*) | Forward to the designated person (Maria Wackerly at MWACKER@emory.edu). The designated person will upload as a comment in eIRB. In addition, the designated person will upload DSMB plans, when submitted via listserv.  
The comment should include whether a study was approved, pended, or disapproved. Distinguish between DSMB plans and CTRC approval |
<p>| DSMC Plan approvals | Disregard any that are received |
| eIRB account requests | Direct to the IRB Website: <a href="http://www.irb.emory.edu/eirb/index.html">http://www.irb.emory.edu/eirb/index.html</a> |
| Emails containing identifiable health information, like the name of the study subject. | Delete the email from all folders (including the &quot;Trash&quot;) and send an email to all IRB staff (do NOT include the PHI) and request that they do the same (identify the email by sender or subject). |
| Fee/Cost Questions | Refer them to OCR’s memo on research fees located here: <a href="http://www.ocr.emory.edu/policies/index.html">http://www.ocr.emory.edu/policies/index.html</a> (pull-down ‘Research fees’). Otherwise, Sheila O’Neal, the finance supervisor for OCR, has offered to answer any questions about IRB fees or fee schedules. |
| FWA, IRB registration questions | First check the IRB website for the answer (or direct the questioner): <a href="http://www.irb.emory.edu/about/overview.html">http://www.irb.emory.edu/about/overview.html</a>. If still unclear, forward to IRB Director. |
| IRB authorization agreements, collaborating with other institutions | Forward to reliance listserv at <a href="mailto:irb-reliance@emory.edu">irb-reliance@emory.edu</a>. If the email is requesting input on a specific collaborative agreement, have the sender fill out a <a href="http://www.irb.emory.edu/about/overview.html">reliance request form</a> and email to the reliance listserv when completed. Emails updating studies for which Emory relies on another |</p>
<table>
<thead>
<tr>
<th>Institution (e.g. HTVN studies from Hutch): also forward to reliance listserv, copying Director.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership List Requests/Roster Requests</strong></td>
</tr>
<tr>
<td><strong>Need a copy of CITI completion report</strong></td>
</tr>
<tr>
<td><strong>NHSR Determination Requests/Triaging (</strong>)**</td>
</tr>
<tr>
<td><strong>Emails stating Costs option chosen for a particular study (</strong>)**</td>
</tr>
<tr>
<td><strong>CHOA In Case of Injury (ICOI) and Cost Options</strong></td>
</tr>
<tr>
<td><strong>PowerChart access inquiries from Emory Healthcare IT”Personnel Verifications” (</strong>)**</td>
</tr>
<tr>
<td><strong>Research Match emails</strong></td>
</tr>
<tr>
<td><strong>Removal from IRB listserv (&quot;blast&quot;) requests</strong></td>
</tr>
<tr>
<td><strong>Request for an in-person consultation</strong></td>
</tr>
<tr>
<td><strong>Study staff change questions</strong></td>
</tr>
<tr>
<td><strong>Study-related questions</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>WIRB questions, notifications, and forms</strong></td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td><strong>Emails from LITS about security reviews</strong></td>
</tr>
<tr>
<td><strong>Voicemails from IRB general number received via email</strong></td>
</tr>
<tr>
<td><strong>Sponsor not in the list in eIRB</strong></td>
</tr>
</tbody>
</table>

(*) If the designated person is out of the office, the listserver would be responsible for those tasks.

### LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/6/2014</td>
<td>Updated staff names to reflect new listserv assignments</td>
</tr>
<tr>
<td>5/7/2015</td>
<td>Updated several actions; removed Kevin as a contact</td>
</tr>
<tr>
<td>3/9/2016</td>
<td>Updated to reflect current processes</td>
</tr>
<tr>
<td>5/26/2016</td>
<td>Clarified how to handle holidays; other minor changes to update contacts and processes</td>
</tr>
<tr>
<td>9/16/2016</td>
<td>Updated the time the listserv shift starts and ends; clarified that the practice of emailing the listserv monitor back when answering emails can be replaced by saving the sent message under the Listserv Duties folder</td>
</tr>
<tr>
<td>10/5/2016</td>
<td>Updated contact people for IIAs and IIAs, as well as a contact person for emails in the listserv</td>
</tr>
<tr>
<td>11/8/2016</td>
<td>Added information about forwarding CTRC, Cost option, and CTRC to Adrianne</td>
</tr>
<tr>
<td>4/20/2017</td>
<td>Updates about NH/NHSRD process and other clarifications</td>
</tr>
<tr>
<td>7/14/2017</td>
<td>Minor changes. Instructions of who is responsible for NHSRD assignment when the designated person is out of the office</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Updated SOP replacing the designated person for some task and removing Mike Deryck and adding Hannah Allen. The added process if the designated person is out of the office</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Added CHOA ICOI email process; other minor changes</td>
</tr>
<tr>
<td>6/8/2018</td>
<td>Additional changes including updated to IAA information, and delete of outdated information</td>
</tr>
<tr>
<td>7/25/2018</td>
<td>Added more information about the LITS security review. Added the requirement of reviewing voicemails.</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to reflect changes after moving to the new system</td>
</tr>
</tbody>
</table>
SOP Title: Mass Email Listerv Management
SOP Category: Administrative
Established: 11/6/2015
Last Revision: 8/5/2016

PURPOSE
Provides steps to generate a list of recipients for a mass email from the IRB, formatting of the email, and management of the listserv online system.

SCOPE
Applies only to IRBResearch-L listserv, not for IRB-L listserv (associated with irb@emory.edu).

DEFINITIONS
• Blast: the email sent to all subscribers to the IRBResearch-L listserv.

PROCEDURES
Logging in for the first time
1. Go to http://listserv.cc.emory.edu/cgi-bin/wa?INDEX
2. If this is your first time – click on the blue text: get a new LISTSERV password.
Creating Email List

1. Run **rptSystem: All emails for mass mailing** and export results
   a. This pulls the emails of all eIRB accounts
   b. eIRB does not remove old/expired accounts; there will be redundancies but they are irrelevant to the Blast process
2. Remove all columns except Emails
3. Save as Text (Tab delimited) to the E-mail blasts folder on H
   a. General/QA Working Files/E-mail blasts/YEAR/MONTH
4. Go to the Emory Email List Service website
   a. [http://listserv.cc.emory.edu/](http://listserv.cc.emory.edu/)
5. From the top-right drop-down menu, select Subscriber Management
6. Select the Bulk Operations tab  
7. Select the Add/Do Not Remove option and choose the exported data as the Input File  
8. Import the file, checking for any error messages  
9. Open the Remove from listserv spreadsheet in the Email Blasts folder  
10. Remove all columns except emails and save as Text (Tab delimited) in /YEAR/MONTH folder  
11. Return to the listserv website and select the Remove/Do Not Add option and import the new Remove spreadsheet  
12. Open the Add to listserv spreadsheet in the Email Blasts folder  
13. Remove all columns except emails and save as Text (Tab delimited) in /YEAR/MONTH folder  
14. Return to the listserv website and select the Add/Do Not Remove option and import the new Add spreadsheet  

**Writing the Blast**  

1. Solicit topics from IRB staff  
2. Use a previous blast or the blast template as a guide  
3. Components:  
   a. Title: Emory IRB Update at Cambria 26, Date at Cambria 12  
   b. Table of Contents: Linking to individual sections; Title at Cambria 13 and Items at Calibri 11  
   c. Content: Titles linking back to TOC; Titles at Cambria 13, Body Text at Calibri 11  
   d. Contact us: Includes IRB email, phone number, website, and physical office; Title at Cambria 16, Body Text at Calibri 11  
   e. Unsubscribe instructions: Send unsubscribe email to listserv or request to IRB email; Calibri Italic 10  
4. TOC title link to sections  
   a. Highlight section title  
   b. Right-click and select Hyperlink...  
   c. Select Place in this Document  
   d. Select the appropriate Heading  
5. Content headings link back to the TOC  
   a. As above  
   b. Select the Things to Know heading  
   c. Repeat for each heading  
6. To create new headings  
   a. Go to the View Tab  
   b. Select Outline view  
   c. Add desired text  
   d. Set as Level 2  

**Unsubscribing instructions**  

1. Users can unsubscribe via two methods:
a. Send an email to listserv@listserv.cc.emory.edu and type UNSUBSCRIBE IRBRESEARCH-L in the body of the email, the subject should be left blank
   i. This automatically removes them from the list and generates an email to irb@emory.edu and to the listserv manager(s)
b. Send a request to irb@emory.edu. Please include the email address you wish to have removed

2. Add emails of individuals unsubscribing from listserv (via any method) to the master Remove from listserv spreadsheet
   a. If individuals still have eIRB accounts, their emails will be included in the original export file, even if they have unsubscribed

**Sending the Blast**

1. Paste the drafted blast into an email
2. Ensure HTML is enabled
3. Send the email to irbresearch-l@listserv.emory.edu

**Adding/Removing List Owners**

1. Login to the Emory Email List Service
2. From the List Management drop-down, select List Configuration then Manual List Configuration
3. Add/Remove the relevant email from an Owner line
4. Save

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/5/2016</td>
<td>Adding graphics to instruction plus instructions if logging in for the first time</td>
</tr>
</tbody>
</table>
SOP Title: IRB Satisfaction Survey
SOP Category: Administrative
Established: 8/31/2009
Last Revision: 2/11/2020

PURPOSE

The purpose of this SOP is to give IRB staff with the language to be used to log request to study teams for feedback.

SCOPE

This SOP applies to new studies, modifications, continuing reviews and reportable new information submissions for studies approved by the Emory IRB.

PROCEDURES

IRB Staff

1. Email Signatures: add the following blurb to your email signature.
   “Please click here to let us know how we’re doing!” where “here” has the following hyperlink: https://tinyurl.com/y2ph28bo

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/13/2015</td>
<td>Added Q language.</td>
</tr>
<tr>
<td>9/16/2016</td>
<td>Updated blurb to say “copying the link below and pasting it into your web browser” instead of “clicking on the link below”.</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Updated link. Removed a specific link for Team Q.</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Deleted the need to include the survey link in the approval letter of submissions as this is already included in the letter template</td>
</tr>
</tbody>
</table>
PURPOSE

Newly hired employees at the Emory IRB will be trained through a structured training program described in this SOP. This program will not only require the participation from the new hire but also current staff members of the IRB. All of the resources for this program can be found on the training program website (http://www.irb.emory.edu/staff_training/)

SCOPE

This SOP applies to all new staff that will be involved significantly in IRB issues. This SOP does NOT apply to Temporary Student Workers

RESPONSIBILITIES

- **IRB new hire training coordinator (“Coordinator”)** – IRB staff member who is coordinating the New Hire Training Program, commonly the new staff member supervisor
- **Go-To-Staff Member:** IRB staff member who is responsible for training the new hire on the designated day.
- **IRB Director:** Consult on questions or concerns that arise during the training and approve updates to the content of the training program as needed.

PROCEDURE

The hiring of the new employee will be announced to study staff as well as the start date of the new employee.

Pre-Hire Preparations

- Before the start date of the new employee, the Coordinator will ensure that the desk and the computer for the new employee are set. The supervisor of the new employee should contact ORA or contact the Associate Director in case this task was already completed.
- Before the start date of the new employee, the Coordinator will prepare the Go-To-Staff Training Sign-up Sheet and send out to the rest of the staff helping with the training so that they can sign-up for the specific days to train the new employee. Only staff leadership or Sr. RPAs should help with this task.

New Employee Training Program

- The training program will begin on the start date of the new employee. The training modules can be found on the training website. These will be completed according the new staff role and following the google document.
- The Analyst Assistant Module is reserved for only new employees that are being hired as Analyst Assistants. This module should be the last module completed during this training program.
- On the first day of training, the Coordinator will show the new employee where to find the checklists, omnibus forms, processing flowcharts, and all of the new hire documents on the H Drive (H:\General\Admin IRB Documents\New Hire Documents\Documents for New Hire).
- Each day of training, the Go-To-Staff Member will read through the designated module with the new employee and follow the directions within the module to complete all of the tasks required for that day.
- Each day during the training, the Coordinator will check on both the new employee and the designated Go-To-Staff Member for that day to make sure that the training is going as planned and to address any issues with the training program.
- Staff who volunteered for a certain day are responsible for finding substitutes if they have a foreseen absence; if they are unexpectedly absent, the Coordinator will ask for volunteers to substitute.
- The IRB Director should be contacted with any questions or concerns about the training process.
- The contents of the new staff training program will be updated as needed by the Director in collaboration with the Coordinator and Associate or Assistant Directors.

LOG OF SIGNIFICANT CHANGES

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<thead>
<tr>
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<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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</thead>
<tbody>
<tr>
<td>2/11/2020</td>
<td>Updating SOP to follow current practice</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to provide Emory's Travel policies and rules related to travel. This SOP provides additional information than what is provided under the current Emory Policy as applicable to IRB staff.

SCOPE
The review process and requirements for planning travel covered by the Emory IRB.

PROCEDURE
Booking travel: It is preferred that all travel be booked/reserved on an Emory issued a corporate credit card. If this is not possible, review the travel plan with TL or supervisor to determine whether expenses can be placed on an existing account. In the event that travel fees are incurred on a TL or supervisor’s card, the employee is responsible for complying with any policies referenced below, including submission of expense reports.

Travel Receipts
You are required to keep all receipts while traveling for proof of purchase. Keep the receipts until the report is approved for payment. Check the following document, so you are aware of Emory requirements involving keeping receipts during travel: https://www.finance.emory.edu/home/travel/receipt%20requirements%20effective%20d21413.pdf

Additional information can be found at http://policies.emory.edu/2.94

Air Transportation
Trips should be arranged through BCD travel. This is an external site, which requires a unique login and password. All air travel is billed directly to the SmartKey. Follow Emory IRB policies when booking flights, as there are restrictions. For details, read this policy: http://policies.emory.edu/2.95

Ground Transportation
For ground transportation needs, go to the Emory Finance webpage for information about renting a car during a trip. The Emory IRB will not compensate for rentals if the convention is adjacent to the hotel. Please contact your TL before you book or rent a car for business purposes.

If you choose to use your car for a trip done for business purposes, check the same page for current mileage reimbursement.

For additional information about ground transportation requirements, please go to http://policies.emory.edu/2.98

Lodging
If an employee uses a personal credit card for booking the hotel, a hold will be placed on the card that is generally equal to the amount of a day of stay. This hold is released once the final payment is made to the hotel.

In addition, the hotel will ask for a credit card upon check-in to cover incidentals. If you do not have a corporate card and providing a personal card is an issue, please make plans in advance to have a TL or supervisor provide their card information to the hotel shortly after check-in, or provide your personal credit card, which will be reimbursed after the trip is completed and the expense report is approved.

Please review the Emory policy about hotel bookings at http://policies.emory.edu/2.97

Meals

Personal meals are defined as meal expenses incurred when traveling on business and should only be considered for the days and hours of the actual business trip. Please note the following items from the Emory policy worth repeating:

- Only in rare circumstances should an individual traveler’s full day’s travel meals, taxes and tips exceed $100. Tips should be at or under 20%
- When multiple employees are involved, the highest-ranking employee of the hosting organization should incur the expense and submit it for reimbursement.
- When personal funds are used for individual meals, each separate expense and receipt must be listed individually on the expense report with the merchant name, date and proper receipt attached. No bundling or totaling of individual meals into one lump sum for the day or trip.

For more information, please read http://policies.emory.edu/2.100

Non-Reimbursable Expenses

Please see list of Non-Reimbursable or Payable Items under this policy: http://policies.emory.edu/2.104

Expense Reimbursement

Gather all related receipts, group them as personal or corporate card expenses, and tape them onto one 8-1/2 x 11 sheet:

- Label individual receipts as personal expense [pers] or corporate card [cc].
- Note type of expense on receipt (e.g., taxi, parking, shuttle, tolls, subway, etc.)
- Place asterisk [*] by alcohol expenses.
- Indicate meals as individuals or a group.
- If a group meal for 10 or fewer people list first and last names.
- If a group meal for more than 10 people indicate the number served.
• If a receipt is missing or lost, list the amount, type, date, and purpose of expense on one 8-1/2 x 11 sheet.

• Complete form located at http://ora.emory.edu/docs/orabo_travel_form.pdf

• Deliver documents to ORA Business Operations (ORABO) in 1599 Building, 4th floor, Northwest Corner.

LOG OF SIGNIFICANT CHANGES

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</table>
The turnaround times are listed in **business days**. Study team contributions listed below are considered the best-case scenario; the IRB cannot control additional delays on their part. Therefore, the overall “total days” are also a best-case scenario. The IRB staff should stay within our targets each time the study team responds to our requests for clarification or changes. Check WIRB/External IRB SOPs for TAT for those studies.

**Note 1:** Staff must log a comment to study team announcing their ownership of new study within 2 business days of being assigned the study (unless OOTO)

**Note 2:** The times below should be decreased if needed due to urgency – discuss with the Director or Associate or Assistant Director if not sure we should act on the request for urgent handling.

**Note 3:** Staff must respond to study team calls or log comments within two business days

### Performance Quotient Expectations

**New studies**

1. Biomed new study analysts:
   - 130-150 new studies per year, ~32-38 per quarter: No more than 5% PQ
2. Socio-behavioral new study analysts
   - 120-150 studies, ~30-38 per quarter: No more than 6% PQ
3. Hybrid new study analysts:
   - 130-150 studies, ~32-38 per quarter: between 5 and 6% PQ

**Modifications**

- 90-110 Modifications per quarter: less than 1% PQ

**Reportable new information submissions**

- 36 to 40 cases per quarter: no more than 5% PQ

Turnaround times and performance quotients are based on getting ~35 new studies per quarter, and ~100 Modifications per quarter, while reassigning all Continuing Reviews to an AA.

Variations from the above numbers due to understaffing or changes in submission volume will be considered when evaluating performance.

For AA’s processing Continuing Reviews, the targets are based on office requirements and alerting Associate or Assistant Director if other tasks need to be adjusted in order to accomplish this.
For reportable new information submissions, these numbers will not apply if team Q is assisting the office with other tasks, or has not a full team to work on cases.

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Initial Staff Screening</th>
<th>Omnibus Form Deadline and Pinging Schedule</th>
<th>F/up ltr out</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>FB New</td>
<td>Triage when logging comment, then 3-7 d of assignment depending on prioritization</td>
<td>Monday before the meeting (Friday for Tuesday meetings)</td>
<td>2 d of MTG</td>
<td>the aim is less than 1 calendar month or less</td>
</tr>
<tr>
<td>FB Mod</td>
<td>Triage upon receipt; 3-6 d depending on prioritization</td>
<td>Monday before the weekend (Friday for Tuesday meetings)</td>
<td>2 d of MTG</td>
<td>the aim is 3wks or less; PRIORITIZE based on relevance to subject safety</td>
</tr>
<tr>
<td>FB CR (once 45d or less pre-exp date)</td>
<td>Screen <strong>no later</strong> than 3 weeks from expiration (4 is better); <strong>earlier</strong> if Grady study; later if submitted less than 30 days before the expiration</td>
<td>Monday before the weekend (Friday for Tuesday meetings)</td>
<td>2 d of MTG but lower priority than New and Mod – UNLESS Grady, expiring, or study team needs for other reason</td>
<td>The ideal is IRB FB review at least 2 weeks prior to expiration, but 1 week if not possible</td>
</tr>
<tr>
<td>FB Post-Deferral Resubmission</td>
<td>3d – have Chair weigh in on adequacy of response before sending back to Full Board</td>
<td>Monday before the weekend (Friday for Tuesday meetings)</td>
<td>2 d of MTG</td>
<td>Send to the same panel if not urgent or submitted near that meeting; if urgent discuss with TL or Director as to whether we can send it to a different panel.</td>
</tr>
<tr>
<td>Post-Pending Response</td>
<td>2d of receipt</td>
<td></td>
<td>2 d of final approval</td>
<td>If the pending response is acceptable, aim for &lt;6d; otherwise, the aim is 2wks or less</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Initial Staff Screening</th>
<th>Pinging schedule</th>
<th>F/up ltr out</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple Expedited New</td>
<td>Triage when logging comment, then 3-7 d of assignment depending on prioritization</td>
<td></td>
<td>2 d of decision</td>
<td>the aim is 3 wks or less</td>
</tr>
<tr>
<td>Complex Expedited New</td>
<td>Triage when logging comment, then 3-7 d of assignment depending on prioritization</td>
<td></td>
<td>2 d of decision</td>
<td>the aim is 4 wks or less: <strong>USE PHONE OR EMAIL</strong> to resolve issues whenever possible to avoid delays (log notes in the study too)</td>
</tr>
<tr>
<td>Expedited Mod by Staff</td>
<td>Triage upon receipt; 3-5 d depending on prioritization</td>
<td>same day as approval</td>
<td>the aim is 1wk or less</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Expedited Mod by DR</td>
<td>Triage upon receipt; 3-6 d depending on prioritization</td>
<td>2 d of decision</td>
<td>the aim is 3wks or less</td>
<td></td>
</tr>
<tr>
<td>Expedited CR (once 45d or less pre-exp date)</td>
<td>Screen no later than 3 weeks from expiration (4 is better); earlier if Grady study; later if submitted less than 30 days before the expiration</td>
<td>2d of decision</td>
<td>The aim is IRB DR review no later than 1 week prior to expiration (more is better) when study team submits at least 30 days before the expiration</td>
<td></td>
</tr>
<tr>
<td>HSR Determination</td>
<td>Acknowledge immediately; 3d of assignment to screen. For each subsequent response, the IRB staff should reply within 2 days.</td>
<td>same day as determination</td>
<td>the aim is &lt; 1wk (*) – we do not wish to hold up projects that do not require any IRB oversight.</td>
<td></td>
</tr>
<tr>
<td>Exempt</td>
<td>Triage when logging comment, then 3-7 d of assignment depending on prioritization</td>
<td>2 d of decision</td>
<td>the aim is 3 wks or less</td>
<td></td>
</tr>
<tr>
<td>RE case: SNC or CNC</td>
<td>Triage within 1 to 2 days. Sent to CoRE within one week or sooner if having all required case information (**))</td>
<td>If applicable, the omnibus form should be added one week before the expiration</td>
<td>The aim is 4 weeks or less</td>
<td></td>
</tr>
<tr>
<td>RNI case: UP</td>
<td>Associate or Assistant Director will log a comment indicating this is a potential UP case. Send to CoRE within 1 to 2 days</td>
<td>If going to Q, one week before the meeting. If going to other committees, follow meeting deadlines.</td>
<td>If the case went to FB, one day after meeting if involves a safety issue that needs to be addressed with an Mod. If not, 1 to 2 days</td>
<td>The aim is for 4 weeks or less</td>
</tr>
<tr>
<td>RNI case: Not a UP, NC</td>
<td>Triage within 1 to 2 days. Sent to CoRE within one week or sooner if having all required case information, if applicable (**))</td>
<td>N/A</td>
<td>If expedited: 5 days if CoRE: 2 to 3 days</td>
<td>The aim is for 2 weeks or less</td>
</tr>
</tbody>
</table>

(*) There is often a lot of discussion with study teams so these determinations usually take longer to review, although we should aim to stay in our targets.
(**) Considering that there is some back and forth with the study team, it is acceptable to wait a week to send a case to CoRE. If the analyst has all the information, it is expected the case to be sent to CoRe sooner

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-28-2016</td>
<td>Complete revamp of targets and columns.</td>
</tr>
<tr>
<td>5/5/2017</td>
<td>Added timeline for comments from study teams</td>
</tr>
<tr>
<td>6/8/18</td>
<td>Revised/added quarterly volume associated with target Performance Quotients</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to explain the review process for inquiries or complaints from study teams about studies that were processed or are being processed by an IRB analyst.

SCOPE
The SOP applies to inquiries and complaints received by Associate or Assistant Directors, IRB Director, or other staff regarding items handled by an IRB analyst.

RESPONSIBILITIES
• IRB analyst (IA) – receives questions/complaints or addresses them when prompted by IRB Associate or Assistant Director or Director.
• IRB Associate or Assistant Director (ADs)- receives questions/complaints and checks with staff managing study to submit a final response for a team when applicable. The term TL is used in this SOP referring to ADs.
• IRB Director (ID)- receives questions/complaints and checks with Associate or Assistant Director and staff member before providing a final response to a team when applicable
• Team Q personnel- received questions/complaints and responds only if the response indicates the IA is following procedure. If not, it will forward questions to IA and TL.

PROCEDURE
Note: Often, the TL, Team Q personnel or ID receive calls, emails with questions or complaints about studies being reviewed by the IRB. Even if the complaint is unfounded, we are required to provide a response, and for that reason, the above-personnel will contact IA who owns the item, and/or their TL (or, if unavailable, another TL) for more information. There are some points to remember during this process:

• If there is enough information from the submission/emails to confirm that the IA has followed current procedure and turnaround times, the complaint recipient can respond directly to the study team, copying the IA and his/her TL
• In any response given to the study team, the IA and TL will be copied, to keep them in the loop about this question/complaint. Copying the TL is important so that the TL can help the IA with follow-up if any. The TL can also provide feedback to the IA if needed.
• The IRB leadership understands that mistakes will be made by IAs just because we are all human beings. Complaints will only lead to performance feedback if there is a pattern of making the same mistake multiple times (including not following turn-around-times) or there is a lack of responsiveness from the IA’s part with no justification (e.g. sick or vacation leave).

If question/complaint is received by IA directly
• The IA should review the email with the question/complaint in the next two business days. When responding to a question, the TL does not need to be included. If this is a complaint, the IA should copy their TL.
• If the study team is emailing/calling the IA about the same issue multiple times in a two-day period, and the review is following approved turn-around-times, the IA may reply to the study team, copying his/her TL, letting them know that the request/question was received and that we are working as fast as possible to resolve it.
  o If there are extenuating circumstances, the TL may offer to take ownership of the submission or other matter, for special handling and to avoid burdening the IA. This will be the exception in cases where there is a real need, and TL should remind the study team of this.
• If the study team is raising their voice, being unreasonable about their request, and despite using crucial conversation tactics, the study team is not cooperative, the IA will forward their question/concern to the TL to address.

If question/complaint is received by a Team Q personnel
• If there is enough information from the submission/emails to confirm that the IA has followed current procedure and turnaround times, the Team Q person can respond directly to the study team, copying the IA and his/her TL (if not self)
• If there is not enough information to show that the IA is following the procedure, the request will be forwarded to the IA and his/her TL.

If question/complaint is received by IRB Associate or Assistant Director
• If there is enough information from the submission/emails to confirm that the IA has followed current procedure and turnaround times, the question/complaint recipient can respond directly to the study team, copying the IA and his/her TL (if not self)
• If there is not enough information to show that the IA is following the procedure, the TL will copy the staff member in their response letting them know that the email was received and that the matter is being reviewed.
• The TL will contact the IA and their TL (if not self) to look into the matter.
  o If the issue was a lack of documentation, the IA will add to their record their communication with the team. The original TL (if available – otherwise the IA or their TL) will then answer, letting them know that the information was reviewed and that the procedure was followed, copying all parties.
  o If during the review of the question the IA’s TL and IA found that an error was made, the IA will work with the TL on resolving the issue, and the IA will email the study team letting them know about the correction of the human error.

If question/complaint is received by IRB Director
• If there is enough information from the submission/emails to confirm that the IA has followed current procedure and turnaround times, the ID can respond directly to the study team, copying the IA and his/her TL
• If there is not enough information to show that the IA is following the procedure, the request will be forwarded to the IA and his/her TL, and the ID will email the study team back letting them know that the email was received and that the information is being reviewed by the TL and IA.
  o If the issue was lack of documentation, the IA will add to their record their communication with the team. The original TL (if available – otherwise the IA or their TL) will then answer, letting them know that the information was reviewed and that the procedure was followed. Copy all parties.
If during the review of the question the IA’s TL and IA found that an error was made, the IA will work with the TL on resolving the issue and the IA will email the study team letting them know about the correction of the human error.

- The TL will provide an update to the ID when the matter is resolved if ID requests.

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</tbody>
</table>
SOP Title: Staff Continuing Education
SOP Category: Administrative
Established: 10/19/2019
Last Revision: 10/19/2019

PURPOSE
To explain the attendance expectations when a webinar or other IRB continuing education event is offered to the IRB staff.

SCOPE
The SOP applies to all the Emory IRB Staff.

RESPONSIBILITIES
• IRB analyst – responsible to attend the continuing education opportunity or justify their absence with their team leads
• IRB Team Lead- takes track of their supervisees attendance to continuing education opportunities

PROCEDURE
• When a new IRB continuing education opportunity is available, the staff will receive a communication via email or teams. The communication will let the staff know if the education event is mandatory or elective
• If the event is mandatory, the staff is required to attend via zoom (if working from home) or in person.
• If the staff member is unable to attend, the staff member needs to justify their absence with their team lead.
• In the case of a webinar, when the recording of the event is available, the staff member should reserve time to view the recording and email their team lead to confirm completion
• If there are no recordings available or the format of the presentation is not a video, the staff member is responsible for reviewing slides or publications available after the presentation. After this is completed, the staff member should email their team lead to confirm completion
• The team lead will reach out their supervisees if the staff member misses a continuing education opportunity and this absence was not explained in advance.

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COLLABORATIVE RESEARCH / CENTRAL IRBS

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<tr>
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<tbody>
<tr>
<td>SOP Category:</td>
<td>Collaborative Research / Central IRBs</td>
</tr>
<tr>
<td>Established:</td>
<td>9/20/2012</td>
</tr>
<tr>
<td>Last Revision:</td>
<td>1/18/2019</td>
</tr>
</tbody>
</table>

PURPOSE
Outline the process an analyst should use for establishing an IRB reliance agreement (IAA/IIA) for a single study where Emory has already approved a study and initiated study activities but submits an Modification or continuing review report which engages another non-Emory site. For new umbrella single-IRB reliance agreements for groups of studies now and going into the future (e.g. from a research network), please consult with the Director

For more information, please review the following guidance documents:

NOTES
• Before drafting a new IAA or IIA, it is a good idea to check the IAA/IIA tracking sheet on the H Drive under the External IRB Relationships folder>Reliance Agreement Tracking to ensure there isn’t one already (the request may have come in through the listserv or other methods previously).
• It’s important to ask your contact at the other institution whether the institution’s policies would consider the other institution “engaged” in the research and would consider the non-Emory study team members to be “agents” of the institution.
• It’s important to note that, where reliance on Emory is not required by the sponsor or by regulation, the other institution can conduct its own IRB review of the non-Emory study team members, and an IAA is not necessary.
• Emory has standing IAAs (or MOUs) with Georgia Tech, CHOA, Morehouse School of Medicine, St. Joseph’s, the Carter Center, UGA, and the American Cancer Society. See http://www.irb.emory.edu/forms/external-irbs/index.html for more information. Study-specific IAA’s are not required with these institutions unless there is a request to override the normal reliance direction for a given study.
• For reference only: Emory also has umbrella reliance agreements in place with the WIRB (Western IRB) and NCI CIRB, and with various institutions for the following research networks: NeuroNEXT, StrokeNet, UAB CIRB, Fast-As, and the HVN, HPTN, and CIITN (and possibly others since this SOP was updated). Separate SOP governs handling of studies under those IRB’s.

DEFINITIONS
• Reliance Agreement – Provides a mechanism for an institution or individual engaged in research to delegate the institutional review board (IRB) review to an independent IRB or an IRB of another institution. Often referred to as an IAA, IIA, or MOU.
• IIA – Individual or Institutional Investigator Agreement
• MOU – Memorandum of Understanding
RESPONSIBILITIES

• **IRB Analyst (RPA)** – Recognize when another institution may be collaborating in research (often discovered by having a non-Emory study site listed or else the addition of non-Emory study staff). Reviews Reliance Request Form provided by study teams and drafts memo and authorization to present to IRB Director.

• **Institutional Official/IRB Director** – Review all proposed reliance agreements and provide a signature (Director signs if not federally-funded or if I.O. is not available in a reasonable timeframe).

CONSIDERATIONS

Reliance agreements are governed by the Emory IRB P&Ps, *Emory IRB Relationships with Other Institutions; Reliance Arrangements for IRB Review*.

In general, Emory is open to **relying** on an external IRB when:

- Required by NIH or other funding agency, under the discretion of I.O.
- The other institution’s policies and procedures are comparable with Emory’s HRPP policies and procedures
- The bulk of the research activities take place in a geographic area other than that in which Emory University is located (though not international)
- If the study involves greater than minimal risk, it’s much preferred that the reviewing IRB is AAHRPP accredited. If not, consult with the Director.
- Emory typically chooses to retain review of a study and not rely on an external IRB when any clinical research *interventions* occur at an Emory site with Emory subjects.

In general, Emory is open to **reviewing** for another institution or individual investigator when:

- The other institution is **not** a separate site in a multisite *clinical* study (i.e. not when the other site is enrolling and performing the protocol interventions on their own patients/subjects)
- When the other institution’s or individual investigator’s activities are minimal risk
- When a local context is not expected to be a significant factor
- For an individual investigator, when they have no institutional affiliation and therefore no other possible IRB (note: Community Physicians may not conduct research at EHC facilities without Emory faculty collaborating and assuming responsibility for the study as PI)

PROCEDURE

• For any **AVAMC** studies: consult with IRB-VA liaison prior to proceeding

• If the request comes from a third party (i.e. not the Emory PI, e.g. other site’s IRB), first step is to verify with Emory PI that he/she is aware of the request and also desires the IAA. If applicable, this must be documented somewhere in the IAA records in case there are later questions about the appropriateness of the IAA.

• If there is a request to use another institution’s agreement template, the IRB Director must decide if we can accept the language in the agreement. Please check with her early in the process.

**Establishing a Reliance Agreement in Which Emory is REVIEWING**

Before anything can be signed, the following steps must be completed:

1. If not done already, the RPA will ask the study team to fill the **Reliance Request Form** to determine whether an IAA/IIA is appropriate or necessary.
2. Using the information provided on the worksheet, the RPA then drafts the Memo to IO and the IAA form (if other institution supplied an agreement to sign, consult with Director as to whether we wish to request use of our own template instead), and saves them on the H: drive in a new folder.

3. Log agreement on the Reliance Agreement Tracking sheet on the H Drive (H:\General\External IRB Relationships\Reliance Agreement Tracking).

4. Determine if the study team should make additional changes to the study submission. Additional changes could include adding the non-Emory study staff, new sites, editing consent form(s) to include other entities who can access study information, requesting a HIPAA waiver to access records from the external site.

5. REQUIRED: RPA presents the drafted memo and reliance agreement to the IRB Director for pre-approval/initials (and signature, if applicable), and then to IO for his/her signature (if not signed by Director).

6. Send the draft IAA, Reliance Request Form, and memo to QTL for delegation.

7. RPA updates Tracking Sheet with status and corresponds with the relying institution to obtain its signature (unless they already provided a signed agreement (not directly to the other institution’s I.O.). All parties involved should be CC’ed.

   Note: When Emory is the reviewing institution, our IO prefers the relying party to sign the agreement first.

8. Upon receipt of the partially signed agreement, RPA will:
   a. Update Tracking spreadsheet on the H Drive
   b. Note: If IO is not available, leave the packet with his administrative assistant.
   c. If IRB Director is not available to review the memo and IAA, have it double-checked by Team Q lead or other Associate or Assistant Director; if Director would have been signatory (i.e. non-federally-funded), IO can sign instead.
      a. After the final signature is obtained, scan the fully signed and executed document and add to the H: drive folder. Include PDF’s of any important correspondence.
      b. Send a copy of the fully executed agreement to the collaborating institution, and any other interested parties for their records.

9. Finally, update the Reliance Tracking Sheet and ensure that the H: Drive folder complies with the Document Management system outlined below and includes the following:
   a. Memo to IO/Director
   b. Fully executed reliance agreement
   c. Relevant email correspondence

10. The RPA should upload the executed agreement in eIRB as a logged comment in the study workspace along with the following text:

    Dear Study Team,

    A reliance agreement (IAA/IIA – choose one) has been executed for INSTITUTION/INVESTIGATOR to rely on Emory’s continued review and oversight of this protocol. [If not done already, explain what steps need to be taken in order to include the collaborators – Example, depending on what has already been done:] An Modification should be submitted to add INSTITUTION personnel engaged in research as study team members. If applicable, the Modification should also note INSTITUTION as a study site and include INSTITUTION in the HIPAA Authorization form as an entity with access to identifiable information.

    If you have any questions or concerns about the attached agreement, please let me know.
11. Do not add non-Emory personnel to the IRB submission until IRB oversight for the non-Emory personnel/sites is in place (either via IIA, IAA, or realization that an IAA or IIA is not needed), AND any other needed changes are made to the study in eIRB (unless required by relying site IRB, e.g. NIH).
   a. Do not send for an expedited review until agreement in place
   b. If FB review is required:
      i. hold from sending to meeting until agreement is in place; or
   c. Advise study team that the sites/personnel will be left off until we review and approve study, then they must be added on via Modification when agreement is ready.
      Note: ensure study is in Changes Requested by IRB while agreement is being worked up and executed. Site Administrator can submit changes for study team upon RPA’s request once executed.

**PROCESS FLOW**

Establishing a Reliance Agreement in Which Emory is RELYING
1. Complete steps 1-4 outlined above.
2. The RS will consult with IRB Director or AD as to whether an eIRB submission will be required for local purposes
   - Likely required if Emory will be doing any clinical procedures, but may be required for all studies in the future due to need to obtain COI disclosures, CTRC review even if no clinical procedures but is cancer related, etc.
   - If required, provide study team copy of template eIRB submission, using “Copy Study” activity on IRB protocol # 80101
3. Request a copy of the research protocol if we do not yet have it via eIRB submission; this will be used to verify the information presented in the worksheet, and to keep in our records.

4. Request a copy of reviewing IRB’s approval letter.
   - If reviewing IRB determined study is exempt, no IAA should be executed. Inform the Emory team that they must submit via eIRB for our own exemption determination. Skip remaining steps.

5. Present the drafted memo and reliance agreement to the IRB Director for pre-approval (and signature, if not federally funded). Provide protocol to Director upon request. Then leave with IO for his/her signature (if federally funded).

Note: If IO is not available, leave the packet with his administrative assistant with a sticky note indicating to contact you once signed. If IRB Director is not available to review the memo and IAA, have it double-checked by Team Q lead or other Associate or Assistant Director; if Director would have been signatory (i.e. non-federally-funded), IO can sign instead.

6. Send the partially executed agreement to the collaborating institution for its signature, either directly or via the Emory study team contact.
   - In the email, be sure to request that a copy of the signed and fully executed agreement be returned to us for our records.
   - Update Tracking spreadsheet
   - Follow-up on obtaining a copy of the executed agreement if it has not been sent within a week (SET OUTLOOK REMINDERS).

7. Finally, once duly signed agreement is returned, update the IAA & IIA Tracking sheet and ensure that the H: Drive folder complies with the Document Management system outlined below and includes the following:
   - Memo to IO/Director
   - Fully executed reliance agreement
   - Relevant email correspondence

Document Management
   - All files related to an IAA/IIA should be stored in a folder at H:\General\External IRB Relationships\Current IAAs (or Current IIAs, depending on the type of agreement)\ according to the type of agreement.
   - Memos to IO should be stored in the same folder as the IAA/IIA
   - File names follow a specific format
     o Emory Reviewing: EMORY IRB# EMORY PI_RELYING PARTY
     o Emory Relying: EMORY IRB# REVIEWING PARTY_EMORY PI
     o For IIAs: EMORY IRB# EMORY PI_INDIVIDUAL INVESTIGATOR SURNAME

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>3/11/2014</td>
<td>Reformatted and updated the procedures to reflect current practices</td>
</tr>
<tr>
<td>4/26/2016</td>
<td>Revised list of analysts who handle IAA’s and clarified that IRB director should review IO memos; removed name of IO’s admin assistant (since that changes with time).</td>
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<tr>
<td>9/16/2016</td>
<td>Updated to reflect new process and designated IAA/IIAs analysts.</td>
</tr>
<tr>
<td>Date</td>
<td>Update Details</td>
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<td>------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2/6/2017</td>
<td>Updated to reflect new division of duties between RPA and AAs</td>
</tr>
<tr>
<td>7/14/2017</td>
<td>Language clarification; update on process when IAA/IAA is not executed yet</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Added Hannah Allen (RS) to SOP, replacing Maria Davila</td>
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<tr>
<td>7/25/2018</td>
<td>Updated SOP to reflect current process</td>
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<tr>
<td>1/18/2018</td>
<td>Removing outdated step in process</td>
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SOP Title: Obtaining Access to WIRB and NCI CIRB
SOP Category: Collaborative Research / Central IRBs
Established: 11/8/2016
Last Revision: 2/11/2020

PURPOSE
The purpose of this SOP is to outline the steps necessary to provide IRB staff with access to accounts with WIRB and NCI CIRB.

SCOPE
The SOP applies to Emory IRB staff that will be processing studies that will be reviewed by WIRB and the NCI CIRB.

PROCEDURE
WIRB Studies: (see WIRB Study Processing SOP for more information)
• To gain access to the Emory WIRB Listserv: Request that the Listserv owner (Rebecca Rousselle) log into listserv.cc.emory.edu and add the IRB staff as a subscriber to the WIRB Listserv.
• To gain access to WIRB Connexus: The person requesting access navigates to the WIRB Connexus website and creates an account. This person should let the IRB Director or designee when this process is completed.
• Once the IRB staff has created an account, request that the IRB Director or designee email the WIRB Liaison to grant the IRB staff with view access to all current Emory studies.

NCI CIRB Studies: (see NCI CIRB SOP for more information)
• To gain access to the NCI CIRB IRB Manager: Request a new account from NCI CIRB IRB Manager – https://eapps-ctep.nci.nih.gov/iam/index.jsp.
• Request that the Director or designee email ncicirbcontact@emmes.com to update the roster to reflect the IRB staff as an Institutional Contact
• To gain access to CTSU Registered Member Website: The analyst must register with the CTEP-IAM registration system.

LOG OF SIGNIFICANT CHANGES

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<tr>
<th>DATE</th>
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<tbody>
<tr>
<td>11/1/2017</td>
<td>Update to WIRB contact information and minor clarifications</td>
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<td>2/11/2020</td>
<td>Updated to align with current process</td>
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SOP Title: WIRB Study Processing
SOP Category: Collaborative Research / Central IRBs
Established: 12/9/2014
Last Revision: 3/8/2020

PURPOSE
The purpose of this document is to outline the Emory IRB processing of WIRB studies.

SCOPE
The SOP applies to all new Phase I-IV drug or analogous device studies that are industry-designed, initiated, and sponsored (with a few exceptions listed on Form A) that are eligible for WIRB review.

DEFINITIONS
• Form A – the initial form submitted to the IRB as a notice that a Study Team has a study that they believe qualifies for WIRB.
• Institutional Sign-Off – The process step for which WIRB does not process a study until WIRB receives an email communication from Emory to verify local Emory requirements have been met.
• Institutional Hold – The process step for which WIRB holds the approval and consent form documents from the study team until WIRB receives an email communication from Emory to release the Institutional Hold.

PROCEDURE
WIRB Form A Processing
• A study team must complete the electronic Form A and attach it with the eIRB submission. Form A can be located here. When a WIRB submission is assigned to an analyst assistant (AA), the AA will verify that Form A indicated that the study was required to use WIRB as the IRB of record.
  o If Form A indicates the study should be submitted to the Emory IRB, let the person who assigned the study to you know so they can contact the study team.

WIRB eIRB processing:
• A study team can submit simultaneously to WIRB (via Connexus) and Emory IRB.
• Once the AA is assigned a WIRB study, the AA should do as follows:
  a. Log an intro comment according to our current turnaround time requirements (2 business days)
  b. Review the Pre-review and Ancillary Review SOP for information about completing these sections.
  c. Check that all study staff have appropriate CITI and Clinical Trials Training Certificates, by checking the CITI training tab and attachments if applicable. Check the Training Verification SOP for more information.
  d. Ensure that the In Case of Injury (ICOI) and Cost have been determined
     1. Follow our ICOI SOP to learn how to find this information. You can find the cost information as a logged comment in the study submission or by searching the Emory listserv email correspondence.
2. If ICOI and/or Cost are pending, the study team can submit to WIRB, if they wish. However, any discrepancies would require the study team to pay for future Modifications. Let the study know via a logged comment.
   a. The analyst is not required to verify the ICOI or Cost language in the ICF/HIPAA document during the sign off process. This process is done by WIRB.

- If any training is missing, send the study back to the study team using the “request changes” function. If not, keep the submission until the above-mentioned ancillary reviews are completed. Review our training verification SOP for more information.

- Once all local requirements have been verified:
  o Use the Institutional Sign-Off email template (found at H:\General\External IRB Relationships\Current Umbrella IAA\s and MOUs\WIRB\Email Templates) to email the study team, WIRB contact, and the WIRB LISTSERV. Copy and paste the template to a new email. Copy the WIRB liaison and any other designated WIRB personnel.
  o Upload a copy of the email as a comment to the study staff in the study history.

- Click on “confirm reliance”. You do not need to answer question 1 or 2 but say yes to question 3.

That concludes this part of the process. WIRB takes over review of the study but might seek some additional information from the study team and/or the IRB.

Emory Input during WIRB Review

- Once study is submitted to WIRB, WIRB analysts begin their review.
- WIRB Listserve gets cc’ed on communications between WIRB and the study team. Scan briefly to make sure there is not an issue that we can help with.
  o Issues that Emory IRB needs to weigh in on:
    ▪ Deviations from our WIRB/Emory consent/HIPAA template (denoted by WIRB as item 12 in WIRB tracking documents).
    ▪ Typically, Emory only really cares about deviations from ICI, Cost, Medical record, “How will my drug be provided,” and HIPAA language.
    • Ask the WIRB analyst for a tracked changed version of the consent.
    ▪ Contact Director or Associate Director to review the changes. If changes are minimal, include the exact text that is being changed within the body of the email, highlighting or striking-out to make it clear what the deviations are. Otherwise point to an attached track-changes copy and which pages contain the deviations
    ▪ No Institutional Sign-Off - look to see if we forgot to email it. Otherwise, are we still waiting on something to sign-off on the study?
    ▪ Ask Director for other issues.
  o Issues that the Analyst Assistants can approve without Director or TL approval:
    ▪ Changes in titles of ICF sections
    ▪ Correction of typos
    ▪ Inclusion of language related to Emory affiliated sites (e.g. Grady)
    ▪ Common terminology: reimburse vs, pay for; ill vs injured.

Checking the Status of WIRB Studies that have already been Submitted to WIRB:

- Contact WIRB study analyst (if known)
- Call Client Services at 800-562-4789
- Check the status electronically via connexus.wirb.com:
Login to WIRB site connexus.wirb.com
Select Workspace Sites
Sort columns by field you are looking for
Click study to view information.

Contact WIRB Liaison

Post WIRB Approval Processing:
Saving the Regulatory Email and Uploading Docs into eIRB
After the study is approved by WIRB, WIRB will send an email, titled “Regulatory Documents” to the WIRB LISTSERV containing the approval documents. The person handling the WIRB LISTSERV that day will:

- Open the email and save the attachments under the WIRB Study Document folder (H:\General\External IRB Relationships\WIRB\WIRB Study Documents\IRBXXXXX), only the ones with “initial review notice” in the attachment. Save the ones with the PI name next to the document. Only save the clean, approved version.
- Confirm that the Cost Option and ICI Option in the approved consent match the OSP and OCR determinations. Read every word of the Cost and Injury sections and compare to our template for the appropriate Option number determined for the study.
- Review the HIPAA language in the consent to ensure that it is the Emory HIPAA language, and that it includes all the required elements from our template. Also ensure that there are no remaining incomplete template placeholders left in the text.
  - Required sections: PHI that Will be Used/Disclosed; Purposes for Which Your PHI Will be Used/Disclosed; Use and Disclosure of Your Information That is Required by Law; Authorization to Use PHI is Required to Participate; People Who will Use/Disclose Your PHI; Expiration of Your Authorization; Revoking Your Authorization; Other Items You Should Know about Your Privacy.
  - If the study has an optional study, the following need to be added: brief description of sub study (fuller description should appear earlier in the form or replace “Study” with “Storage of (Data and/or Specimens) for Future Research; Authorization for This Use of PHI is Required to Participate in Optional Study, but Not in Main Study and Additional People Who Will Use/Disclose Your PHI for Optional Study.

- If they do not match, send the specific language deviations to the Emory IRB Director (or Associate or Assistant Director if she is absent) to see if we can accept the deviation. Copy the Emory analyst who owns the study (“owner analyst”)
  - If we can accept the deviation, WIRB listserv handler performs 5.1.c and
  - If we cannot accept the deviation, the Owner Analyst does the following steps:
    • Send “Need to revise WIRB consents...” email (found at H:\General\External IRB Relationships\WIRB\Email Templates) to the study team, CC’ing WIRB listserv and PI, instructing them to not consent anyone until they amend their consent forms to reflect the negotiated options.
    • Log Private Comment in eIRB with the approval documents (so study team cannot access them yet)
    • Log comment to Study Team in eIRB with text of the email in the eIRB shell, noting the same message has also been emailed.
    • Set a “Rule” in Outlook to move any future emails containing the Sponsor’s protocol number/ID in the Subject line to a special folder for this type of Modification notification so that you will see it immediately.
• Set a reminder to check in on the study team weekly to ensure they submit the Modification to WIRB. CC the PI, Study Coordinator(s), and WIRB listserv on all reminders. Log comments to Study Team in eIRB when reminders are sent.
• Upon second weekly reminder to submit Modification, CC IRB Director and Q Associate or Assistant Director.
• Once the Modification approval notification appears in that Outlook folder, review the revised ICF’s to ensure they are now correct, and go to step then proceed with the rest of this SOP.
• Remove the Outlook rule (leave the folder for future use)
• Upload the approved documents (“Certificate of Approval,” Consent Form/HIPAAAs, and Revocation) as a private logged comment into eIRB.

Sending Approved Consents to OCR/OTT for new studies
• The person who saved the approved consent forms should email the approved consents using the “Emailing W0000 Consent Form” email template (found at H:\General\External IRB Relationships\WIRB\Email Templates) to OCR and the WIRB LISTSERV
  o Add WIRB # to the subject line.
  o Upload approved consent forms (ICF/HIPAA, Rev. Letter).
  o In body of email, add in study title, WIRB #, and PI.
  o Sign email
  o Click send

• In addition, we should email OTT at OTT-ICG@emory.edu (copying the WIRB listserv) by using the “Emailing Consent and WIRB approval letter: EPEX # ADD” email template (found at H:\General\External IRB Relationships\WIRB\Email Templates) following these steps:
  o Upload approved consent forms (ICF/HIPAA, Rev. Letter)
  o Upload WIRB approval letter
  o In body of email, add EPEX Number.
  o Sign email
  o Click send

Removing Institutional Hold
• In eIRB, click on “Record sIRB Decision” and:
  o Click on “Approved” under question 1 (Determination).
  o Add the dates of approval as follows:
    ▪ Initial approval date of study: approval date in the WIRB approval letter
    ▪ Last day of study approval period: per WIRB approval letter
    ▪ Leave other fields empty
  o Under question 3, upload the letter from WIRB
  o Click on 2018 requirements if not FDA or DOJ regulated, or select Pre-2018
  o Under question 5 (Regulatory oversight), select as appropriate per protocol and contract. If the study is using a drug or device, select FDA. If HIPAA applies, click on OCR (Office of Civil Rights); if federally funded, select the funding agency (if listed, for example DoD) and HHS. Select others as applicable.
  o Under question 6, select as applicable
  o For Risk level: review the letter to see if the study was reviewed by Full Board and their risk level determination. In general, WIRB studies are considered greater than minimal risk.
  o On question 8, select as appropriate
On question 9, select clinical trial (if applicable) and collaborative.
- Under question 11, attach the consent documents received from WIRB
- Under question 12, say no (as we don’t need to send a letter).
- Under question 13, say yes.
- The study will be listed as “Active”. This completes this part of the process.

Beyond Initial Approval

Modifications
- WIRB Listserv gets cc’ed on all changes to research and on all approved regulatory documents. No need to save or upload approved Consent/HIPAA forms for already approved studies (however, you will have to check each regulatory document email to confirm this is not an initial approval).

PI Changes: depending of the study status (“Active” vs “External IRB”), the study team may submit a modification (that we can approve) or an “update study” function. We are advising teams to use the modification function if they have it but if not, the study should log a comment in the study history with a copy of the WIRB approval letter. If you verify this is correct, we can ask the team to click on “update study” and update the record. If they update the record without our intervention or previous review of the information, and there are any discrepancies, please let an IRB Director know for next steps.

Continuing Reviews
- WIRB Listserv gets cc’ed on expiration notices between WIRB and the study team. No need for IRB analyst to do anything.

Reportable new information submissions/ Unanticipated problems
- The WIRB SOP says that the PI should report local adverse events directly to WIRB if they meet the definition of Unanticipated Problem. WIRB will then communicate with our site as needed to resolve. WIRB sets the reporting timelines for the various types of reportable new information submissions, which are available on the WIRB website for PI reference. If Emory audit/inspection reveals compliance issues with our local site, then the “institution” must report those findings to WIRB per their reporting guidelines. IRB’s Team Q would be involved in those decisions.
- For REs and Unanticipated Problems that come to us from the PI, Sponsor, or WIRB, Emory IRB (Team Q) will not need to review or re-review, since we are not the IRB of record. However, Team Q should be notified of any WIRB determinations of Serious Non-Compliance and UPs. Refer to Team Q and Director if you are not sure what type of RNI it is.
- Save all emails related to REs and Unanticipated Problems under the WIRB Study Document folder (H:\General\External IRB Relationships\WIRB\WIRB Study Documents W00000XXX) after notifying the Q team.
- Update information in NC/UP folder at H:\General\QA Working Files\NC UP Complaints\NC UP tracking sheet.

WIRB Close-outs in SaaS system:
- WIRB close-outs are sent by email to the WIRB Listserv.
  - Save the correspondence and any attached documents in the specific WIRB Study Document folder (H:\General\External IRB Relationships\WIRB\WIRB Study Documents W00000XXX).
Navigate to the specific WIRB study workspace in eIRB and log a private comment with the WIRB email attached. Contact a Director to click on “close study” or “close site”.

Once the closeout is finalized, the owner of the study should email the close-out letter using the “Emailing W0000 Close-out” email template (found at H:\General\External IRB Relationships\WIRB\Email Templates) to OCR and the WIRB LISTSERV

- Add WIRB # to the subject line.
- Attach close-out letter
- In body of email, add in study title, WIRB #, and PI.
- Sign email and send

Helpful tips:

- When you forward emails, place the WIRB number in your subject line.
- CC the WIRB LISTSERV on ALL email correspondence

LOG OF SIGNIFICANT CHANGES

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<tr>
<td>4/30/2015</td>
<td>Updated close-out section to reflect use of electronic correspondence.</td>
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<tr>
<td>10/27/2016</td>
<td>Updated to reflect use of WIRB Smartform Template via eIRB.</td>
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<td>4/20/2017</td>
<td>Changes under “removing institutional hold” section, reflecting current process</td>
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<td>11/1/2017</td>
<td>Updates to reflect current process</td>
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<td>11/15/2017</td>
<td>Addition of process for Modifications after ICF discrepancy</td>
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<tr>
<td>1/31/2018</td>
<td>Updated box link to external IRB spreadsheet</td>
</tr>
<tr>
<td>2/21/2018</td>
<td>REMS reference added</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Added process to email OTT after WIRB approval</td>
</tr>
<tr>
<td>11/1/2018</td>
<td>Updated location for email templates; added information for controlled substance studies</td>
</tr>
<tr>
<td>4/11/2019</td>
<td>Adding the need of review HIPAA language during institutional hold process, and other clarifications.</td>
</tr>
<tr>
<td>6/27/2019</td>
<td>Adding process for PI changes</td>
</tr>
<tr>
<td>10/19/2019</td>
<td>Adding instructions of how to find ICOI and cost language</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Multiple changes to reflect the use of an electronic Form A and the fact that we are no longer issuing “shells” for study submission.</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Updating WIRB Close-out process in the new system. Updating Mod information for PI changes. Deleting redundant information and linking to other SOPs in the portfolio.</td>
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<tr>
<td>2/26/2020</td>
<td>updated process to change PI in the submission</td>
</tr>
<tr>
<td>3/8/2020</td>
<td>Changes in closeout process</td>
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PURPOSE
The purpose of this SOP is to outline the steps IRB staff uses to process studies reviewed by National Cancer Institute’s Central IRB (CIRB), and to facilitate maintenance of the Emory investigator roster and institutional information for CIRB.

SCOPE
The SOP applies to all studies reviewed by NCI’s CIRB with any Emory-affiliated study sites, including CHOA. The AVAMC may also use NCI CIRB but their process may differ.

RESPONSIBILITIES
• IRB Contact (IRB Analyst Assistant): responsible for providing access to NCI CIRB study area to study teams, as well document the study submission to CIRB in eIRB.
• Study Team – responsible to submit up to date and accurate information to Emory IRB.

List of the institutions on the CIRB roster affiliated with the Signatory Institution (Emory)-Code Names:

<table>
<thead>
<tr>
<th></th>
<th>Institution</th>
<th>Emory University</th>
<th>GA Code</th>
<th>CIRB Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emory University/Winship Cancer Institute</td>
<td>Emory University</td>
<td>GA005</td>
<td>CIRB Component</td>
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<tr>
<td>2</td>
<td>Grady Health System</td>
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<td>CIRB Affiliate</td>
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<td>GA011</td>
<td>CIRB Affiliate</td>
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<tr>
<td>4</td>
<td>Children’s Healthcare of Atlanta – Egleston</td>
<td></td>
<td>GA035</td>
<td>CIRB Affiliate</td>
</tr>
<tr>
<td>5</td>
<td>Emory University Hospital Midtown</td>
<td></td>
<td>GA013</td>
<td>CIRB Component</td>
</tr>
</tbody>
</table>

PROCEDURE

How can you or research teams obtain access to NCI CIRB Studies via IAM website:
- This is the first step to obtain access to the NCI CIRB IRB Manager. You are required to obtain this access in a different website (IAM) than the one you will use to access the studies (NCI IRB Manager).
- Click on this link [https://ctepcore.nci.nih.gov/iam/index.jsp](https://ctepcore.nci.nih.gov/iam/index.jsp) and click “Request New Account” in the bottom right hand corner.
- Let the IRB Director know after you create an account to gain access to the system. The Director will email ncicirbcontact@emmes.com to update the roster with the name of the IRB staff as an Emory Institutional Contact.
Steps to Provide Study Teams with Access to the NCI CIRB Participants Area

- NCI uses a platform called RUMS (Roster Update and Management System) to manage our roster of investigators, study staff, and administrative contacts.
  - Only people listed on Emory/CHOA’s roster may work on or be listed on studies at our sites (i.e. access the “Participants Area”)
- Anyone to be added to the Emory/CHOA roster must have an IAM account and a CTEP ID number. The study teams are responsible for doing that part.
- To add, revise, or remove personnel for the Emory/CHOA CIRB Roster, an Emory IRB staff person who has access to and is trained on RUMS (CTSU.org/public/default.aspx) must make the request in that system.
  - If a new IRB staff person needs to be given privileges in RUMS, the IRB Director may make that request to CIRB
- Study teams are encouraged to complete the webform at http://www.irb.emory.edu/forms/external-irbs/cirb.html to obtain an account to NCI CIRB’s IRBManager, IAM system. Alternatively, the study team can email the necessary information to WIRB listserv
- Once NCI CIRB processes the request, a separate email with login information will be sent to the new personnel’s email address.

Steps to Obtain Initial NCI and Local Emory Approvals

Study Team Identifies an eligible study

- Studies and related materials approved by NCI CIRB are made available to participants on the NCI CIRB website.

Beginning the local Emory review process
Once the study team submits the study via the eIRB smartform, the IRB Director (or delegate) will assign an owner (the IRB staff). The IRB staff goes to Step 2 below.

**Step 1: Study team begins the NCI CIRB approval process**
- Studies are opened by a Signatory Institution Principal Investigator by submitting the Study-Specific Worksheet to the CIRB for review via IRBManager.
- Note, the Study-Specific Worksheet must include any deviations from Emory/NCI CIRB’s Boilerplate Language (i.e. Radiation Safety Language for diagnostic tests).
- Our IRB staff is not involved in this process.

**Step 2: Emory IRB Processing of the NCI CIRB approval**
- NCI CIRB will email the PI an approval letter, along with the approved consent form
  - Note: the NCI CIRB may also email the Emory site approval document to IRB staff directly; **this should be ignored** unless for some reason the study team is unable to provide the approval documents.
- Study team should create a new submission ([see guidance](#)) and attach the following:
  - NCI IRB approved consent and assent if applicable
  - Site Information and HIPAA Authorization Form (addendum)
  - NCI CIRB approval letter for Emory site
  - NCI CIRB expiration date (via overall study approval) for the study in eIRB once available.

**Step 4: Processing Emory’s local acknowledgment**
Emory IRB staff will verify if:
- Review [the Pre-review and Ancillary Review SOP](#) for information about completing these sections.
- The study meets the criteria for a partial HIPAA waiver. This would apply if the study is looking at the medical record for the purposes of identifying eligible subjects before enrolling them.
  - You can find that information under the “Waiver Requests and Ancillary Considerations” section of the submission. Under subsection “HIPAA Applicability and Waivers Requested”, question 3, the study team should have selected this option: “Partial Waiver of HIPAA Authorization (to use or disclose PHI in order to identify and recruit potential research subjects, who will later provide HIPAA authorization”).
  - Send an email to any of the following staff designated reviewers: Rebecca Rousselle, Shara Karlebach, Maria Davila or Carol Corkran, to alert them they need to provide a partial HIPAA waiver approval. The reviewer must document their approval in the eIRB study History. The reviewer should let the staff know that this part was completed.
- All study personnel have the required training (CITI and Key Concepts/Intro to Clinical Research)
  - If study has VA as the only site: VA has their own training requirements. Their accounts should be associated with Emory to see the completion.
- All ancillary reviews have been completed
  - For IDS: check the protocol to verify if they are using IDS to stored the drug per Emory policy
    - If the study does not have a drug section, ask the study team to add.
  - Radiation: review the ancillary review space to verify this has been granted. If the consent form does not contain the radiation risks for diagnostic tests, the study team is required to add it to the [Site Information and HIPAA Authorization Form](#) (addendum), if the diagnostic tests are not part of the standard of care. To verify, look for the radiation safety review document. If there are any procedures done as part of the research, the radiation language should be added to the addendum.
Biosafety: review the ancillary review space to verify this has been granted. Check the questions in the last page of the submission for more information according to the Pre-review and Ancillary Review SOP.

Cost option: This information needs to be captured in the addendum form. You can find the cost information as a logged comment in the study submission or by searching the Emory listserv email correspondence. If you do not find this information, it means that the cost option has not been determined yet.

In Case of Injury (ICOI): we do not need to check as this information will be captured in the main consent. For your reference, this will always be option 1.

If study has VA as the only site (these studies are reviewed by our VA Liaison)
  - IDS, biosafety and Radiation safety: VA has their own pharmacy and it will not go through IDS. The VA Pharmacy does not give exemptions from the R&D process. The same can be said for other sub-committees. In case of questions, contact Jennifer Whelan at Jennifer.Whelan@va.gov

If study has both VA and Emory sites: Study team will have to submit one submission for the VA and one for Emory, so the ancillary review requirements are completed without confusion

- The study team will have a consent document and assent form if applicable (without expiration date, but with a version date) and a Site Information and HIPAA Authorization Form (addendum) with other important consent and HIPAA language. Ensure the following:
  - Verify that the documents provided match the approval letter from CIRB
    - If a consent/assent document does not match the approval letter, please inquire. In the case of an assent, if the assent is not referenced in the CIRB approval letter we will have to stamp it initially (do not require to restamp unless the document changes via an modification/site update-see below for that process)
  - The language in the addendum matches the required ancillary reviews.
  - Ensure that the HIPAA language in the authorization is not missing any elements
  - REMS process has been followed, per our SOP entitled: “REMS study review”. Also, make sure study completed Controlled Substance form per comment above if applies.

- If any changes are required, or if any training is missing, send the study back to the study team with requested changes, as you would with a normal study.
- When all the above is verified, you can move the submission to Active.

Moving a submission to Active

- In eIRB, click on “Record siRB Decision” and:
  - Click on “Approved” under question 1 (Determination).
  - Add the dates of approval as follows:
    - Initial approval date of study: date when we are issuing sign off letter
    - Last day of study approval period: per CIRB approval letter (found on the NCI CIRB approval or renewal letter for the overall study).
      - [Note, if the study team is unable to provide the overall study expiration date– check with IRB Director - you could set the expiration date to 1 year minus a day from the approval date].
  - Leave other fields empty
  - Under question 3, upload the letter from CIRB
  - Click on 2018 requirements if not FDA or DOJ regulated, or select Pre-2018
Under question 5 (Regulatory oversight), select as appropriate per protocol and contract. If the study is using a drug or device, select FDA. If HIPAA applies, click on OCR (Office of Civil Rights); if federally funded, select the funding agency (if listed, for example DoD) and HHS. Select others as applicable.

Under question 6, select as applicable.

For Risk level: review the letter to see if the study was reviewed by Full Board and their risk level determination. In general, WIRB studies are considered greater than minimal risk.

Under question 8, select as appropriate.

Under question 9, select clinical trial (if applicable) and collaborative.

Under question 11, attach the consent documents received from WIRB.

Under question 12, say yes (to stamp the documents and send the letter).

Under question 13, say yes.

Stamping of the Site Information and HIPAA Authorization Form (addendum): the addendum will need to be stamped initially with the acknowledgment date. The addendum does not need to be stamped after initial approval unless the HIPAA authorization changes. For more information, reference our website, NCI IRB Section, under “Consent...”. The consent does not need to be stamped at any time, but you need to verify that the consent the study team provided to you is the same version referenced in the CIRB approval letter. To stamp this document:

- Click on “Finalize Documents”. A new window will open. Click on the addendum or consent/HIPAA doc (as applicable), and then click Ok.
- Assent forms: if the study team provides an assent form, we do not need to stamp unless is not referenced in the CIRB approval letter.
- Revocation form: if not added at the end of the addendum, and provided as a separate form, we can stamp initially (do not need to re-stamp afterwards)
- Ensure that the addendum (and assent if applicable) is merged appropriately by opening them from the “Documents” tab. Check that the approval date is correct.

Issuing letter: Click on “prepare letter”. Select the letter named “External IRB Acknowledgment”. Generate the letter. Make changes to the draft letter and re-upload. Click on OK to close the window.

Click on “send letter”, click OK.

The study will be listed as “active”.

Responding to “CTSU Inquiry: Site Preference Setting Needed” emails
NCI needs to know which physical sites will be conducting research activities for studies becoming active at Emory (e.g. Winship, Emory University Hospital, Saint Joseph’s, etc.). The email will reference the NCI study number, not an eIRB number.

- Look up the eIRB shell in the Projects area of eIRB, under Fast Find (in case study is still in pre-submission), using a short part of the study protocol name (e.g. if the protocol is referenced as NRG-BA005, search for %BA005 in the “Project” field on the left of the screen).
- Look in the eIRB shell for the study to see what sites were selected in the Smartform
- Reply to the CTSU inquiry email with the code names for the sites selected.
  - If VA is a site, use code number GA002

Processing Continuing Review
• Study team must upload the NCI CIRB overall-study continuing review approval letter as a comment in the submission so the expiration date can be updated in eIRB

• No formal CR submission in eIRB is required.

• To modify the approval dates:
  o Click on “return to post review” and say yes to question 3
  o Click on “finalize documents”, and select the documents you are re-stamping if any
  o Click on “edit sIRB Decision”. Say “Approved” under question 1. Under dates (question 2), update the dates per the CIRB approval letter. Complete “effective date of study” and “last day of study approval” per the letter received.
  o Upload the letter the team logged as a comment under question 3
  o Click on pre-2018 under question 4 (if not selected already)
  o Skip questions 5 to 11.
  o Say yes to question 12 and click Ok.
  o The system will require to create a letter. Upload the same letter you received from the study team (approved CIRB letter).
  o Click on Send letter and the process will be completed.

• Remember: we do not need to re-stamp any document (NCI IRB Consent, Assent or our addendum)
  o If this is an old CIRB study, you may see a consent/HIPAA document in the submission instead of a CIRB consent plus addendum. If that is the case, the consent/HIPAA document will need to be stamped with the approval date shown in the NCI re-approval letter.

PROCESS FLOW

CIRB Modifications

NOTE: The study team may opt to submit a Modification/Update to separate the consent from the addendum. This will prevent the requirement of stamping consents in the future.

Modifications that require approval from NCI CIRB, that Emory does not need to review

• For studies with a CIRB consent and a stamped addendum: If the study team submits a modification with changes to the consent, we will need to ask them to “discard” the Modification unless the changes involve modifications to the addendum (including HIPAA language). The Emory IRB will not process Modifications or re-stamp documents after initial approval.
• Any translated documents not already approved by NCI CIRB. If the study team has questions, direct them to question 7 of the NCI Institution QA/QI
• Changes to locally produced advertisements/requirements. If the study team has questions, direct them to question 8 of the NCI Institution QA/QI

Modifications that require approval from NCI CIRB, and local context review by Emory IRB via eIRB

Note: Make sure you ask for tracked versions of the documents the study team wants us to review.

• Changes to the previously stamped addendum (assign to a designated reviewer). For example, if the HIPAA language changes.
  ▪ You need to email the designated reviewer to look at the changes and log a comment before clicking on “Accept Site Updates”. You can also ask for clarification if needed.
• Changes to PI (analyst to process): the IRB should request an approval letter/notice from CIRB approving the change before modifying the eIRB submission.
  ▪ Ask the study team if the study is still enrolling subjects as this change may require changes to the site addendum (PI Name).
• Changes to a consent/HIPAA authorization, for studies that still have that type of consent (vs. the separate consent and addendum) (analyst to process): As above, we need to confirm that the provided version has been approved by NCI IRB with a letter/notice of approval.

Modifications that do not require a Modification in eIRB, but do require re-stamping:
For studies with a combined consent/HIPAA document: Changes to the overall study that do not include a consent revision. Many times, a protocol update will require an update to the consent form just to update the version date to match the revised protocol. In this case, we must stamp those revised consent forms with the date you are processing it. They will need to submit a modification and we will be able to approve the changes that way. If not, they need to click on “update study” option and we will have to use the “return to post-review” to stamp the documents (see below for more information)

Processing CIRB Modifications

Depending on the study status (external vs active), the study team will have the option to submit a modification or an update to their study.

If the study team submitted a modification

• First, verify the changes being submitted. Under the modification space, check on:
  o View Modification
  o Review the initial submission to see what documents are being added or modified. Use the “history” and “compare” functions to see the differences in the documents.
• If all the above is correct, click on Accept Site Updates.
Then, click on Record sIRB Decision.

A new window will open. You do not need to make changes to dates or any other part of the form, but ensure the approval/expiration dates do not change from the last initial or CR approval by CIRB. Click on Approved, and in the last 2 questions state you need to send a letter and that you are ready to submit.
12. * Do you need to finalize documents or send a letter? *
   - Yes
   - No

13. * Are you ready to record the sIRB's decision? *
   - Yes
   - No

- Click on Finalize documents and select the addendum you are re-stamping.
- Click on Prepare letter. Modify the template as usual. For information about these technical steps in the system, use the “Staff Quick Reference document” document.

If the study team updated the study

If they do not have the option of submitting a modification, the study team should use the “update study” option. The study team may reach out to you if they do not see the “finalize update” option. You can use that opportunity to verify the document before clicking that for them. After that process is completed, and verifying that all looks in order, we will need to stamp the consents by clicking on the “return to post-review” button:

- Click on “return to post review” and say yes to question 3
- Click on “finalize documents”, and select the documents you are re-stamping if any
- Click on “edit sIRB Decision”. Say “Approved” under question 1. You do not need to make changes to dates or any other part of the form, but ensure the approval/expiration dates do not change from the last initial or CR approval by CIRB.
- Upload the letter the team logged as a comment under question 3
- Click on pre-2018 under question 4 (if not selected already)
- Skip questions 5 to 11.
- Say yes to question 12 and click Ok.
- The system will require to create a letter. Upload the same letter you received from the study team (approved CIRB letter).
- Click on Send letter and the process will be completed.

**Processing Reportable new information submissions**

In the event of a local unanticipated problem involving risks to subjects or others, or serious or continuing noncompliance, the PI is responsible for reporting to NCI CIRB, according to the NCI CIRB reporting requirements. If the information is considered a “serious compliance event” per the website guidance, please contact a Director for following steps.

**Processing Close-Outs**

Step 1: PI submits a Study Closure to NCI CIRB via IRBManager
Step 2: the study PI will log a comment into the submission with a letter from CIRB indicating the study has been closed. Contact a Director to click on “close study” or “close site”.

REFERENCE

- NCI CIRB SOPs: https://www.ncicirb.org/about-cirb/sops

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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</thead>
<tbody>
<tr>
<td>11/8/2016</td>
<td>Change formatting and added information under responsibilities</td>
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<td>2/6/2017</td>
<td>Changes to reflect current process</td>
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<tr>
<td>11/1/2017</td>
<td>Changes to reflect current process</td>
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<tr>
<td>2/21/2018</td>
<td>Added reference to REMS process and to ask teams to withdraw unnecessary Mods</td>
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<tr>
<td>11/1/2018</td>
<td>Added a section of how to process CIRB Modifications; added information for controlled substance studies</td>
</tr>
<tr>
<td>6/21/2019</td>
<td>Changes to consent stamping process</td>
</tr>
<tr>
<td>8/21/2019</td>
<td>Added additional steps for CIRB Mods for studies with a combined consent/HIPAA document</td>
</tr>
<tr>
<td>10/19/2019</td>
<td>Made clarifications to the whole SOP to reflect current practices</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Multiple changes to reflect that we are no longer issuing “shells” for study submission</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Updating Mod information for PI changes. Deleting redundant information and linking to other SOPs in the portfolio.</td>
</tr>
<tr>
<td>2/26/2020</td>
<td>Added more steps of how to update the expiration date after CIRB study renewal; updated process to review modifications via the modification or update study options.</td>
</tr>
<tr>
<td>3/8/2020</td>
<td>Clarified process for the use of assents and during the closeout of the study; other clarifications involving ancillary reviews and reportable new information reports.</td>
</tr>
<tr>
<td>4/14/2021</td>
<td>Minor changes to clarify the use of update vs modification of a study.</td>
</tr>
</tbody>
</table>
**SOP Title:** Reviewing Notifications of UPs from External IRBs  
**SOP Category:** Collaborative Research / Central IRBs  
**Established:** 12/09/15  
**Last Revision:** 2/11/2020

### PURPOSE
The purpose of this document is to detail how to process and review notifications of UPs that are received from external IRBs.

### RESPONSIBILITIES
- **IRB Analyst** – identifying and tracking the notification of UPs managed by external IRBs. Reporting selected notifications to the Office of Compliance or Risk Management, as needed.
- **Team Q** - reviewing the notifications of UPs managed by external IRBs and determining the applicability of the information to the local IRB in consultation with the IRB Director.

### PROCEDURE
**Unanticipated Problems**
1. External IRB will notify local contact (via listserv) of UP determinations. Alternatively, the study team may contact the Single IRB listserv.
2. IRB Analyst will forward the UP notification to Team Q.
3. Team Q, in consultation with the IRB Director, will review if the UP determination (coming from safety event) should be assessed for other studies using the same drug or device.
4. In consultation with Team Q, the IRB Analyst will forward the following notifications to the Office of Compliance and/or risk management as applicable:
   a. If the unanticipated problem indicates a major risk for other subjects e.g. A serious adverse event caused by negligence of the study team.
   b. The unanticipated problem was caused by an error in process that may reoccur without intervention e.g., laboratory process or pharmacy error
   c. If the UP involves a confidentiality breach if Emory is the responsible party for HIPAA waivers or consent.

**Egregious New Information (RNI)**
Egregious RNIs have to be reported to Emory offices (Office of Compliance, Risk Management Office, Emory IRB) in addition to the Reviewing IRB. The following are examples of egregious reportable events: wrong side surgery, wrong drug, wrong patient, fabrication or falsification of data, HIPAA privacy matters including potential confidentiality breaches. The study team may report these events

The report will be forward to the mentioned offices

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<tbody>
<tr>
<td>11/1/2017</td>
<td>Minor updates</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Adding information about process for Egregious RNIs</td>
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SOP Title: Vetting NIH Single IRB Plans
SOP Category: Collaborative Research / Central IRBs
Established: 5/15/2018
Last Revision: 2/11/2020

PURPOSE
This SOP outlines the process to review requests for Emory to serve as the Single IRB for federally-funded multi-site research at the grant application stage.

PROCEDURE

• As early as possible, the Emory investigator should submit a completed Single IRB Intake Form to the IRB Reliance Listserv (found at www.irb.emory.edu/forms/external-irbs/index.html at “What if I’m applying for NIH funding?”)
• Review the Single IRB Intake Form to determine whether Emory may serve as the single IRB or whether the study must be reviewed by an external IRB (another participating institution or a commercial IRB).
  o If Emory IRB is willing to be the IRB of record, notify the investigator they may proceed with the Single IRB Plan naming Emory IRB as the sIRB.
  o If Emory IRB is not willing to be the IRB of record, notify the investigator and provide two options:
    ▪ 1) The investigator can contact the IRBs of other participating sites to see if they are willing to serve as the reviewing IRB. Suggest to the investigator that the IRB will need to be AAHRPP accredited and have experience serving as the reviewing IRB for multi-site research. Instruct the investigator to confirm whether or not the IRB charges a fee to serve as the sIRB so the anticipated expense can be included with the budget.
    ▪ 2) The investigator can request a quote from WIRB or another commercial IRB and include that in the budget submitted with the grant. Refer the investigator to the information on our website including the quote request form.
• Once a single IRB is identified, the investigator may use the templates on the Emory IRB website to draft the Single IRB Plan.
• If Emory is not serving as the Single IRB, remind the investigator to use the Single IRB Quote Request Form found on the Emory IRB website to request a quote from WIRB and include in the budget submitted with the grant.
• Save the Single IRB Intake Form and any email correspondence on the H Drive at General>External IRB Relationships>NIH Grant Application Reliance Requests by opening a new folder and naming it as follows: Last Name, First Name – Title.
• Note: Once funding is secured, follow the Processing Reliance Agreements SOP (from reliance request to approval).

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<tr>
<td>8/31/2019</td>
<td>Removed “reliance specialist”</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to reflect current practice</td>
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</table>
TABLE OF CONTENTS

PURPOSE
The purpose of this SOP is to outline the steps the Reliance Protocol Analyst uses to process requests to rely on an external IRB (other than WIRB and NCI CIRB).

SCOPE
This SOP applies to any multi-site study where Emory is relying on an external IRB other than WIRB or NCI CIRB.

PROCEDURES
1. If IRB staff receives a reliance request via email, instruct the study team to complete the Reliance Request Form (found here).
2. Upon receipt of the Reliance Request Form, review the form to ensure all fields are completed.
   o If the request comes from a third party (i.e. any non-Emory or non-Emory affiliated personnel), forward the request to the Emory PI asking the PI to confirm he/she is aware of the reliance request and is planning to conduct the research. If so, send the Emory PI the New Reliance Request Form with instructions to complete and submit to the IRB-RELIANCE@LISTSERV.CC.EMORY.EDU.
3. Once the Reliance Request Form is determined to be complete, review the criteria below to confirm that the IRB is willing to pursue a reliance agreement. IN GENERAL, Emory will rely on an external IRB when:
   • Reliance is required by the NIH or other funding agency or sponsor, at the discretion of the Emory IO.
   AND
   • The other institution’s IRB is AAHRPP accredited OR has HRPP policies and procedures that are comparable to Emory’s HRPP policies and procedures, AND has robust policies and procedures for serving as the single IRB of record.
   • If unsure as to whether Emory will enter into a reliance for the specific project, consult IRB leadership for guidance. If Emory will not enter into a reliance for the project, inform the Emory PI and other relevant individuals that Emory is not willing to enter into a reliance agreement and instruct the Emory PI to submit to Emory.
4. If Emory is willing to rely on another IRB, ask the study team to submit a new study and email the XIRB Smartform Template Guidance when Emory relies on another institution.
5. Based on the information on the reliance request form, determine if the SMART IRB Master Agreement will be used to document reliance or if the reviewing institution prefers to use their own reliance agreement.
6. If using the SMART IRB agreement, complete the SMART IRB Agreement Checklist Emory Relying located in the SMART IRB folder H:\General\External IRB Relationships\SMART IRB or the form provided by the reviewing institution.
7. Create the reliance memo using the template located in the template folder H:\General\External IRB Relationships\Templates.
8. Route the reliance memo and IAA or Smart IRB Agreement Checklist for signature to the Emory IO if federally-funded and to the Emory IRB Director if not federally-funded.
9. Once the study team submits the XIRB study in eIRB, review the smart form and uploaded documents for consistency and completeness. Use the XIRB Study Checklist when reviewing the smart form H:\General\External IRB Relationships\Tools, Aids, Policy Guidance.
   a. Confirm that all required training has been completed and is up-to-date for all Emory study team members including CITI and GCP if applicable.
   b. Confirm that the latest approved protocol and grant documents are uploaded and can be opened without a password.
   c. Ensure that the EPEX number is entered if available. It should be available unless there are extenuating circumstances in which the funding is not yet available for the Emory PI to submit to OSP.
   d. If there are financial conflicts of interest noted, refer to the COI SOP.
   e. Review the ICF and HIPAA Authorization for the following:
      • Confirm the XIRB consent checklist is uploaded and the language inserted in the model consent form is consistent with what is noted in the Checklist.
      • If the Emory study team has not been provided an approved model consent form, they may use the appropriate Emory consent template in the Consent Toolkit (found here: http://www.irb.emory.edu/forms/consent_toolkit/index.html).
      • If the Reviewing IRB approved a waiver of consent, ensure this is noted in the IRB approval letter provided by the study team.
   f. Ensure that all departmental reviews, ancillary reviews, and OCR/OSP involvement have been completed, if applicable. Note that Office of Quality review must be completed before providing institutional signoff to the study team.
   g. If applicable, ensure that Margaret Huber in the Office of Compliance (mhuber@emory.edu) has completed a REMS (REMS mentioned in protocol) review of the study, or Controlled Substance form (box is marked in smart form). See new study checklist for more information.
   h. Review the language in the IAA or SMART IRB Checklist to determine if the reviewing IRB will serve as the Privacy Board and if they will issue partial HIPAA waivers. Ensure that documentation of any necessary HIPAA waivers is included if the Reviewing IRB will serve as the privacy board. If Emory will serve as the privacy board, follow the Issuing HIPAA Waivers for XIRB Studies SOP.
10. If changes to the smart form or uploaded documents are needed, click “Changes Requested by IRB Staff” and describe the changes that are needed. Complete the Local Context Review form provided by the reviewing IRB. If the form requests specific information regarding the study activities that will be conducted by Emory, forward the document to the Emory study team for completion of their portion of the form.
11. If a paper IAA or Smart IRB Checklist is being used, send the partially-executed IAA or checklist to the reviewing IRB for signature by the other institution’s IO, copying the Emory IRB reliance listserv. If reliance is being documented electronically, log into the electronic system being used and document Emory’s agreement to cede review.
12. If reliance is documented in an electronic system, save a pdf of the documentation generated by that electronic system and save in the smart form and study folder.

13. If a paper IAA or Smart IRB Checklist is being used, upon receipt of the fully executed agreement from the other institution, log a comment to the study team in eIRB attaching the fully-executed reliance agreement and Local Context Review form and save these documents in the study folder with the other reliance documents.

   a. *Logged Comment for Paper IAA*
      
      Dear Study Team,
      
      Attached, please find a fully-executed reliance agreement between Emory and [ ] for this study. This comment serves as confirmation that the Emory University IRB is relying on the ____ IRB review and oversight of the above-referenced study, pursuant to the attached agreement, effective [date of last signature]. Refer to the Cooperative Research page on the Emory IRB website for guidance on continuing reviews, Modifications and reportable new information submissions when Emory is relying on an external IRB.

   b. *Logged Comment for Electronic Documentation of Reliance*
      
      Dear Study Team,
      
      This comment serves as confirmation that the Emory University IRB is relying on the ____ IRB review and oversight of the above-referenced study, pursuant to the documentation made in the ____ electronic system on ____ [date]. Refer to the Cooperative Research page on the Emory IRB website for guidance on continuing reviews, Modifications and reportable new information submissions when Emory is relying on an external IRB.

14. Once the local context review process is complete and a fully executed reliance agreement is in place, log a comment and send an email to the study team including the PI and study coordinator providing them with “institutional signoff” so they can proceed with obtaining IRB approval from the Reviewing IRB. Instruct the study team to upload the approval letter once available from the reviewing IRB adding Emory as a site. Attach the completed local context review form(s) to the comment and email.

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>11/1/2018</td>
<td>Added information for controlled substance studies</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Removed Hannah Allen/Reliance Specialist</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to reflect current process</td>
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SOP Title: Reportable new information submission Notification Process When Study is Subject to External IRB Review

SOP Category: Collaborative Research / Central IRBs

Established: 1/23/2018

Last Revision: 2/24/2020

PURPOSE
This SOP will detail how to process and review notifications of UPs that are received from external IRBs.

RESPONSIBILITIES

- Reliance RPA – identifying and tracking the notification of UPs managed by external IRBs and reporting notifications to the appropriate institutional officials.
- Team Q – reviewing the notification of UPs managed by the external IRBs and determining the applicability of the information to the local IRB in consultation with the IRB Director.

TIMEFRAME

Once you receive notice of an RNI from an Emory researcher, you have 24 hours to review it and forward it to the appropriate Emory IOs as detailed below. Once you receive the RNI determination letter from the external IRB, you must complete the below procedure within 5 business days of the receipt.

PROCEDURE

- When negotiating a reliance agreement, the reliance RPA should negotiate a term into the Division of Responsibilities which requires the external IRB to notify Emory IRB when they receive a report or complaint against the Emory study team which involves wrong side surgery, wrong drug, wrong dose, UPs/deaths related to research, or falsification/fabrication of data.
- Any Emory researcher who reports a reportable new information submission to the external IRB must either 1) cc reliance RPA and Maria Davila at maria.davila@emory.edu on your email reporting the event to the external IRB or 2) if reporting via online platform, screenshot or save a copy of the online report and email to the reliance RPA and Maria.
  - Emory researchers must follow this procedure for every event that you would have been required to report to our IRB had we reviewed the research, and if the external IRB’s rules go beyond our requirements, you must follow this procedure for those additional events you are required to report to the external IRB.
- When the reliance RPA receives the reportable new information submission via email from the Emory researcher, the RPA will review the report to determine whether it falls into one of the following categories: wrong side surgery, wrong drug, wrong dose, UPs/deaths related to research, or falsification/fabrication of data.
- If it does fall into one of the above categories, the reliance RPA will create a file under on the H:\ drive in the QA Working Files\RE Notifications from External IRBs folder with study title and PI name, using the following format (1234 Jones) and save all necessary documentation in it.
- Forward the report to Compliance Manager Margaret Huber at mhuber@emory.edu, and Director of Claims Management Laura Deane at laura.deane@emoryhealthcare.org.
- The external IRB should send notice of its determination and the determination letter to the reliance RPA or other member of the team.
- The reliance RPA will add the determination to the NC UP spreadsheet located under the QA working files main folder. H:\General\QA Working Files\NC UP Complaints.
- The reliance RPA will create a folder on the H: drive in the QA Working Files\RE Notifications from External IRBs folder with study title and PI name, using the following format (1234 Jones) and put all necessary documentation in it OR, if the RNI already has a file, she will save the all documentation in the already-existing file.
- The reliance RPA will forward the UP notification to Team Q.
- Upon receiving the notification, Team Q will consult with the IRB Director and review if the UP determination should be assessed for other studies using the same drug, device, or study intervention.
- The reliance RPA will draft an email to the Emory PI with the IRB # and Study Nickname in the subject line stating the following:

  Dear Dr. __________:

  *We have received notification from [Reviewing IRB] that a reportable new information submission during the course of the above-referenced study constitutes a [type of determination]. Attached, please find the determination letter from [Reviewing IRB]. This determination will be reported to the sponsor and federal oversight agencies.*

  *It is imperative that you follow your CAPA Plan as written. If you find that there are any inaccuracies in this letter, please notify your point of contact at [Reviewing IRB].*

  *Please let me know if you have any other questions. Thank you for your cooperation.*

- CC the following individuals on the email:
  - Team Q Lead
  - IRB Director
  - Department head (Department Name)
  - Robert Nobles, PhD (Office of Research Administration)
  - Margaret Huber, RN (Office of Compliance)
  - If the study is funded....
    - For grants: Holly Sommers (Office of Sponsored Programs)
    - For Industry-sponsored: J. Cale Lennon III, PhD, MBA, CLP (Office of Technology Transfer).
  - Anne Adams, JD (Clinical Trials Audit and Compliance)
  - Stephanie DeRijke, RN, MSN (Clinical Trials Audit and Compliance)
  - If a COI exists, also copy Brenda Seiton, JD (Conflict of interest)
If Winship, also copy the following people:
  ▪ Bassel El-Rayes, MD
  ▪ Walter Curran, MD
  ▪ Sagar Lonial, MD
  ▪ Kim Nguyen

If related to the Investigational Drug Service, copy Susan Rogers, RPh (IDS)
If involving research at CHOA, copy Sarah Marie Huban, MA, BS (Children’s Healthcare of Atlanta IRB)
If involving research at Marcus, also copy:
  ▪ Ami Klin, PhD
  ▪ Lynn Perez MHSA

If involving research at Grady, also copy:
  ▪ Chadrick Anderson, MHA
  ▪ Shirley Marshall, MHA

If involving research at St. Josephs, copy Kristi McGinnis, CIM

• Once sent, save a copy of the determination letter and the email in the study folder under QA Working Files.

• Note: If you receive copies of external reports from agencies or notices of receipt of external reports from agencies, scan and/or save them under QA Working Files in the appropriate study folder. If the report produces any results, save the contents in the same manner and email to the IOs using the same process described above.

LOG OF SIGNIFICANT CHANGES

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<tr>
<th>DATE</th>
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<tbody>
<tr>
<td>11/1/2018</td>
<td>Added note about procedure when receiving copies of external reports from agencies</td>
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<tr>
<td>1/18/2019</td>
<td>Replacing Dr. Wynes with Dr. Sherer</td>
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<tr>
<td>8/31/2019</td>
<td>Removed “reliance specialist“. Replaced with “reliance RPA”</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Title change and minor term changes</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Updates personnel to notify</td>
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</table>
SOP Title: Closing Out Multi-Site Studies
SOP Category: Collaborative Research / Central IRBs
Established: 3/30/2018
Last Revision: 8/31/2019

PURPOSE
This SOP will detail how to close out studies that are multi-site 1) when Emory has ceded review to an external IRB and 2) when Emory is the IRB of record for external sites.

RESPONSIBILITIES
- Analyst – processing the close-out from the IRB side for studies where Emory is the IRB of record.
- Reliance RPA- processing the close-out from the IRB side for studies where Emory is relying on another IRB.
- Emory study team- collecting all necessary information and documents for the close-out and initiating the close-out. Being a liaison between the IRB and the other study teams.

PROCEDURE
Where Emory is the IRB of Record:
- Where only one site is closing down although the greater study is remaining open....
  - The Emory study team would submit an Modification in eIRB stating which site is closing, providing a study summary detailing why the site is closing as well as any other pertinent details and also giving assurance that no other study activities (whether enrollment, data collection, data analysis, study interventions, or investigator involvement) will be taking place either at the site or which engages the site.
  - Upon approval of the Modification, the Emory IRB analyst assigned to the study would send an Modification approval/close-out letter to the Emory study team, including in the letter a statement that the site has been closed out and that no other study activities are allowed to take place there.
  - The Emory study team would be responsible for providing the Modification approval/close-out letter to the relying site study team. The relying site study team would then be responsible for providing that letter to their institution’s IRB so that the institution could close out the study locally.
- Where the whole study needs to be closed out....
  - The Emory study team would follow the normal non-multi-site process for study close-out, processed by their Emory IRB analyst.
  - The Emory study team would be responsible for providing the close-out letter to all relying site study teams. The relying site study teams would then be responsible for providing the letter to their institutions’ IRB(s) so that the institutions could close out the study locally.

Where Emory is relying on an external IRB (both when Emory is closing as a site and when the whole study is closing):
• Emory’s study team would be responsible for providing any necessary information and documents to the lead study team to pursue the close-out process at the Reviewing IRB and/or would follow the Reviewing IRB’s close-out process.

• Upon receiving a close-out/Modification approval letter, the Emory study team would be responsible for submitting the letter to their RAS administrator, OCR contact, and any other ORA offices that need notification. The Emory study team would also need to email the letter to the reliance team.

• The reliance RPA would switch the state to “Closed” in the eIRB local submission.

• The reliance RPA would log a comment, attaching the letter, which states the following:

   **Dear Study Team:**
   [This study has been/Emory as a site has been] closed out by the external IRB. Please see the attached close-out letter. Please ensure that this letter has been provided to any ORA office that need notification. You are prohibited from continuing with any study activities at this time.

**LOG OF SIGNIFICANT CHANGES**

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<tr>
<td>8/31/2019</td>
<td>Replaced “reliance specialist” with “reliance RPA”</td>
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</table>
**PURPOSE**

This SOP outlines how the IRB Analyst/Reliance RPA should process an Modification to obtain IRB approval for participating sites to begin multi-site research post-Emory IRB approval of the main protocol, consent form, and other study documents.

**SCOPE**

This SOP applies to any study which has multiple sites engaged in human subjects’ research, where Emory is serving as IRB of record. It applies to new multi-site studies being handled by the IRB Reliance RPA as well as Emory studies which were previously approved as single-site studies but are now onboarding new sites, and Emory has agreed to be the IRB of record.

**ASSIGNMENT**

- For new multi-site studies, the main Emory study submission (approving the main protocol and model consent template) and any Emory Modifications making substantive changes to the study should be assigned to a designated Emory IRB Analyst. Any Modifications governed by this SOP, specifically on-boarding participating sites for a new study, should be assigned to the IRB Reliance RPA.
- For previously-approved Emory studies now onboarding new sites, the IRB Analyst assigned to the study should handle the reliance agreement and Modification.

**RELIANCE RPA/ANALYST RESPONSIBILITIES**

- Processing Modification and assigning for review
- Cross-checking the site-specific consent documents with institutional language provided in Local Context Worksheet
- Sending approval letter and any other approved documents to the Emory/Lead Study Team
- Setting up reliance agreement(s)
- Updating reliance tracking checklist and reliance agreement tracking spreadsheet during this process

**PROCEDURE**

1. Processing the Modification:
   a. Reliance RPA or Analyst checks that all questions have been answered and all documents uploaded as instructed in the Modification Request section of this SOP and processes the Modification as described in the SOP entitled Modification: *Mod Applications IRB Processing from Preliminary Analysis through Approval*.
   b. He/she opens Local Context Worksheet and checks that site-specific sections of Relying Site consent documents are correct and ensures that no changes have been made.
outside of the costs, in case of injury, HIPAA authorization, site name, and PI contact information.

c. If changes needed, he/she clicks “Changes Requested by IRB Staff” and informs the Emory/Lead Study Team of the requested changes in the text box.

d. When/if no changes needed, he/she clicks the “Assign Expedited Reviewer” tab and selects the appropriate designated reviewer from the dropdown menu (will be an IRB Staff Designated Reviewer).

e. Under Comments, he/she specifies that this is a Reliance Modification submitted to onboard a new site to the multi-site study and includes the Emory/Lead Study Team’s response to Question 2.0 of the Modification Request, stating also that the Relying IRB has confirmed that all site requirements have been completed and listing which new documents have been uploaded then presses ok.

f. The current state changes from “IRB Staff Review” to “Expedited Review.”

g. Once Review completed, Reliance RPA/Analyst opens the IRB reviews tab for the Mod application and clicks on “Review of” and accesses the Printer Version to view comments, determinations, and changes requested.

i. If changes requested:

   1. Click Draft Letter and choose Pending – Expedited template. Remember to include: PI’s post-nominal, letter date spelled out, requested changes in a bullet list (noted in the Reviewer’s notes in eIRB), and your name and title. Then click OK.

      a. If there was a numbered protocol Mod insert the highlighted text into the third line of the “RE” section: “IRB Modification (#) for IRB Study #xxx (Protocol Modification XX) (this is because Sponsors often get confused about the difference between our Mod numbering system and their protocol Mod numbering).

      b. Reset and resize the font of the CC: section at the bottom of the letter if needed

      c. Delete any language that doesn’t apply to the current Mod and remove rows that state “No Items to Display.”

   2. Once requested changes have been submitted, the state changes to “Expedited Review.”

      a. Review submitted materials to assess correctness. If any further changes needed, click “Request Changes by IRB Staff” and describe changes. If none, send Mod for contingency review by selecting Forward to Contingency Reviewer – EX” and the appropriate reviewer. Send reviewer an email about the review with a link to the Mod. Once contingencies approved, move to step ii.

ii. If no changes requested:

   1. Click Draft Letter and choose the Approved template. See i(1)(a), (b), and (c) for letter drafting.

   2. Select GENERATE OFFLINE DOCUMENT in main workspace BEFORE sending letter for signature and to PI. Click Obtain Signature and select your name in the pop-up window. Click OK. Click Send Letter to PI and click OK.
a. Please ensure that revised approved documents have been listed correctly.

3. *IF Mod included site-specific consent forms (if no site-specific consent forms, skip to next step):
   a. Go to main workspace and click Edit Consent Forms.
   b. Under Approved Consent Forms, remove tracked changes versions of the RELYING SITE-SPECIFIC consent documents and click OK.
   c. Click Consent Form Merge and only select the relying site-specific consent documents.
   d. Ensure that the approval date and expiration date are correct (and if not, put the correct dates). Click OK.

4. Log a comment to the study team that states the following:
   Dear Study Team:
   The Modification to onboard [list of relying sites] has now been approved. These sites are now permitted to begin research activities for this study. Please provide the approval letter to your contact for each Relying Site Study Team. [If consent forms: The stamped-approved informed consent documents for each Relying Site included are available under the Documents tab in the main workspace. It is your responsibility to provide each Relying Site with their site-specific consent document(s)]. The Relying Site Study Team is responsible for providing these documents to the appropriate offices at their institution. Please take a few moments to complete the Emory IRB Satisfaction Survey. We will use your responses to improve our service to the Emory research community. You can access the survey by copying the link below and pasting it into your web browser. We appreciate your feedback! https://tinyurl.com/y2ph28bo

5. Select Report to Committee Meeting> Report to Committee – Modifications Approved by Designated Reviewer > Select Meeting.
   a. The meeting should have a one-week lead time. Add to CMTE C if SHB study, and add to A or B if a Biomed study. It’s ok to add it to a “closed” meeting.

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<td>8/31/2019</td>
<td>Updated survey link. Replaced “reliance specialist” with “reliance RPA”</td>
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PURPOSE AND SCOPE
This SOP will outline how Emory IRB will issue HIPAA waivers to Emory study teams when Emory has ceded IRB review for a multi-site study. This SOP only applies when Emory has been designated as the Privacy Board for the Emory study team under the reliance agreement.

PROCEDURE

1. During the submission of the local context shell, the Emory study team should make sure to fill out the HIPAA sections of the SmartForm.
2. The Study Team should then request the type of waiver requested in a logged comment in eIRB.
3. The owner of the local context shell (reliance RPA or analyst) will assign the review of the waiver request to the IRB Director (or other authorized individual) via email. The IRB number should be included in the subject line of the email.
4. The authorized individual should review the waiver request within five (5) business days.
5. Once the authorized individual has made a decision, s/he should log a comment into eIRB that states the following:
   
   Dear Study Team,
   
   I have reviewed the request for a [type of HIPAA waiver] for this study and grant/deny the request based on the criteria in the regulation.
   
6. The analyst/reliance RPA will use the HIPAA Waiver Letter Template to draft a letter with the decision (IRB (H:)>General>External IRB Relationships>Templates>Letters>Letter Templates).
7. The analyst/reliance RPA should save the letter in the study’s External IRB Relationships folder on the H: Drive.
8. The analyst/reliance RPA should upload the letter into a logged comment in eIRB with the following text:
   
   “Please see attached letter granting (partial) HIPAA waiver.”

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<td>Updates to follow current process</td>
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<tr>
<td>8/31/2019</td>
<td>Replaced “reliance specialist” with “reliance RPA”</td>
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PURPOSE AND SCOPE
This SOP will outline how Emory IRB will do a local context review of any recruitment materials which have been approved by the Reviewing IRB when Emory has ceded IRB review for a multi-site study.

PROCEDURE

1. Upon submission of the local context shell to eIRB, the study team should log a comment with the recruitment material or brochure (which has been previously approved by the Reviewing IRB) as well a tracked-changes and clean version of the site-specific recruitment material or brochure (in which they have replaced the lead site’s contact information with contact information for Emory).

2. The owner of the local context shell (usually the reliance RPA) will assign the review of the recruitment material/brochure to a staff reviewer by emailing the staff reviewer. The IRB number should be included in the subject line of the email, and the tracked-changes site-specific recruitment material/brochure should be attached.

3. The staff reviewer should review the recruitment material/brochure within five (5) business days.

4. If the staff reviewer has requested changes, s/he should log a comment into eIRB that states the following:
   
   Dear Study Team,
   Please make the following changes to this recruitment material/brochure: [insert changes].

5. The Study Team should make the suggested changes and send the recruitment material/brochure back in a logged comment in eIRB.

6. Once the staff reviewer is satisfied with the recruitment material/brochure, s/he should log a comment into eIRB that states the following:
   
   Dear Study Team,
   I have reviewed the material(s) and have no concerns about the content. You have institutional signoff to have this material approved by the Reviewing IRB.

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MEETING FACILITATION

SOP Title: Meeting Facilitation Responsibilities  
SOP Category: Meeting Facilitation  
Established: 08/02/2013  
Last Revision: 4/20/2020  

SECTIONS
- Two Weeks Before the Meeting
- One Week (or more) Before the Meeting
- Pre-Meeting Pod Meeting (Monday on the Week of Meeting Day)
- Meeting Day
- Closing Activities after the Meeting
- Post-FB Meeting (as soon as feasible after the meeting, no later than the next day)

PURPOSE
This SOP provides an overview of the steps to be taken to effectively prepare for, facilitate, and perform tasks for a convened IRB Full Committee meeting. The responsibilities of facilitating a full board meeting will be shared by several members of the meeting team (Pod). The Pod will consist of a Sr. RPA, one or two RPAs and/or an AA.

NOTE: you will see the studies/CRs/MODS/RNIs assigned to your committee under “My Inbox”

RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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| AA    | sends invitation emails  
|       | keeps track of quorum  
|       | works with RPA and using RAS assigns reviews in eIRB  
|       | sends agenda email  
|       | sends email reminders to IRB staff  
|       | sets up for meeting  
|       | drives during meeting (completes omnibus forms as needed)  
|       | updates attendance in Roster Ultimata |
| RPA   | collaborates with AA on reviewer assignments  
|       | takes notes during meeting (can be in OneNote or a word document)  
|       | polishes minutes before sending to the AD or Director for review |
| Sr. RPA | leads the pre-meeting and post-meeting Pod meetings  
|         | takes backup notes during meeting  
|         | advises pod members as needed  
|         | sends email to pay community member |
| Directors | takes backup notes during meeting  
|           | reviews final version of minutes for QA/QI purposes |
PROCEDURE

Two Weeks Before the Meeting

• The AA sends an email to all regular and alternate members of the committee panel.
  o The invitation email template may be found under H:\General\CMTE\Meetings\1-Meeting Facilitation Prep Kit\Invitation and Agenda Email Templates\Invitation email text for all CMTEs\Invitation for Full Board NAMEMTG Meeting.
  o Lists of regular and alternate panel members are on the Roster Ultimata. As responses are received, the AA files the emails into a folder in their outlook and tracks attendance.
  o The AA will update the attendance by clicking on “Edit Meeting Attendance”. Alternatively, the members can update their attendance by clicking on “Confirm Attendance” or “Decline Attendance”.

• The AA creates a RAS and CMTE attendance document for the meeting. The template can be found under H:\General\CMTE\Meetings\1-Meeting Facilitation Prep Kit\RAS and CMTE Attendance. The AA records who will be in attendance, those who will not attend, but will do secondary reviews and those who will not attend or do reviews.

• The AA ensures that quorum will be met, with a minimum of 6 members in attendance in person or by conference-bridge for the duration of the meeting. This must include at least one physician-scientist and one unaffiliated non-scientist (community member). Important: As items are added to the agenda, note whether or not any of the members who constitute quorum are listed in the IRB applications and thus conflicted with that agenda item. If so, it may be necessary to have an additional member attend or call into the meeting during discussion and vote of that agenda item.

• The AA checks that members’ CITI certifications are up to date. This information can be found in the Roster Ultimata.

• The AA reviews the meeting agenda before the pre-FB meeting to assess what expertise will be required for new studies and other agenda items.
  o When mandatory expertise (oncology, pediatric or cardiology on a new study or modification) is not available, the AA notifies the Directors. With the help of the Director, the AA coordinates with other Pods to move the item to another agenda where that expertise will be present. The AA informs the IRB staff analyst-owner if the agenda item is transferred to another meeting agenda.
  o The AA and Directors may also inquire if a member expert from another panel will attend the meeting or call-in for the discussion of the specific agenda item(s) (in addition to his or her responsibilities to their primary panel that month.) If this is needed, it is recommended to first try members whose primary meeting is farthest from the meeting requiring assistance.
  o The AA consults with the Director for any issues involving the size of the agenda. If it appears that the agenda will be too light, the AA sends an email to IRB staff asking them to add agenda items. If the agenda is too full, a decision will be made to move items to a different meeting.
  o The AA also ensures that agenda items are listed under the correct agenda item type.
One Week (or more) Before the Meeting

• The AA closes the meeting agenda to additional items by going to the meeting space, and clicking on “edit meeting details”. Add “[CLOSED]” to the agenda name. Other informational iterations may be used such as “[CLOSED to Peds NS]”.

• The AA puts a message in MS Teams (using @General so everyone is notified) or emails the IRB staff, about the meeting closure and reminds IRB staff to upload an updated pre-review submission by close of business on Friday before the meeting week (that includes an updated NS checklist).

Analysts are responsible for making sure that any pending information is updated in the pre-review information the morning before the meeting. An email template can be found at H:\General\CMTE\1. Meetings\1-Meeting Facilitation Prep Kit\Invitation and Agenda Email Templates\Staff Reminder About Pre-review update.

• If there are still any quorum issues, the AA notifies the Director to resolve these issues. When assessing issues with the quorum, it is important to note whether or not any of the members who constitute quorum are listed in the IRB applications of the items on the agenda and thus conflicted. If so, it may be necessary to have an additional member attend or call into the meeting during discussion and vote of that agenda item to maintain quorum.

The Meeting or a category of review may be closed when:

• Total number of items on the agenda meets or exceeds 25
• A review category (New, Mods or CRs) reaches the limit for a good mix of study categories on the agenda
• The total number of reviews that can be effectively handled by members scheduled to attend has been reached

• The AA (with the assistance of the RPA if needed) fills in the RAS sheet. Save the RAS/Attendance sheet document under H:\General\CMTE\Meetings\Committee A or B\CMTE (Panel) \Review Assignments\(Year)

• The AA (with the assistance of the RPA if needed) assesses the number of members attending in the PS and NPS categories (only one A-NS and one UA-NS may attend each meeting). If the number exceeds the set limit (more than 5 for PS, more than 4 for NPS) the AA discusses the next steps with the IRB Director.

• The AA populates the member conflicts of interest (COI) for each item on the RAS, noting any member who is listed on the study team or who has a previously established conflict of interest made known to the IRB (such as marriage, supervisory relationship or financial conflicts). The AA assesses the impact of all conflicts of interest on quorum and the recommended order of the agenda, considering the availability of the member to attend the meeting. If there are any questions, the AA contacts a Director.

• The AA and RPA designate a time to meet and assign members to review agenda items on the RAS based on required expertise and review experience and/or ability. The AA and RPA ensure that a prisoner representative is available at the meeting in person or by conference if a prisoner study is on the agenda.
Assignment Considerations for RPAs/AAs:

- Try to limit reviews for members who are not VCs/CCs or community members to 4 or 5.
- Ensure that for new studies involving cancer drugs, children or cardiology, there is a specialist with that area of expertise present in person or by phone for the discussion of that item.
- Always have an MD as one of the reviewers on a study (the MD can be a secondary reviewer from another Committee, if necessary). Rarely, where a non-MD is a specialist in the field (e.g. Dr. Galt for radiation, Ms. Garrett for pediatric oncology studies), or where the study is low risk, then it is ok for the reviewer to be someone other than an MD.
- It is preferred that the specialist presents a study, but if a specialist is getting too loaded down with presentations, choose lower-risk, less complicated studies for presentation by a non-specialist (keep the specialist as a secondary reviewer). A genetics member should be assigned to studies with genetics if possible.
- Do not give a non-scientist a presentation for high risk, complicated cancer/cardiology/etc studies.
- Community members should generally be assigned to NEW studies for a thorough review of the consent form and for a layperson perspective, representative of the subject.

- The AA uses the completed RAS to assign the study reviews in the eIRB system. The AA logs a comment to the study team on each new study to provide a contact number should the Committee wish to contact the study team during the meeting. This is not required for Modifications or continuing review submissions.
- The following meeting processing steps take place in the meeting agenda space of eIRB. To assign reviewers to study submissions:
  - On the meeting space (not the agenda item space), click on “Assign Reviewer”
  - Click on the “Update” Field in each submission to assign reviewers. You can assign primary, secondary, tertiary, scientific (not used) and community reviewer. Choose the member and click OK to finish with the assignment.
  - After all the assignments are made, you could notify all assigned reviewers clicking yes to question 3. If you click no, you have the option to notify the members at a later time by clicking on “Notify Reviewers” in the main meeting space.
- The AA distributes the meeting agenda to members at least one week before the meeting date with copies to the Pod members and Director attending the meeting.
- Create Agenda for distribution:
  - To create the meeting agenda, go to “Prepare Agenda” in the main meeting space.
  - Select the agenda template and click “generate”. Review the draft agenda, and edit document removing empty information.
  - Upload the revised agenda (by clicking on the ellipsis and selecting “upload revisions’, if needed and then click OK.
- In the main study history, upload the following documents using the “Update Documents” button.
  - Reviewer presentation tools
  - Pertinent guidance or worksheet materials
  - Other information related to the upcoming meeting
Guidance on How IRB Makes Determinations of Serious or Continuing Noncompliance and UPs in case a UP is on the agenda

- The AA notifies the Chairperson and any affected members of an addition or change to the agenda that occurs after the agenda has been distributed to members.
- The AA emails individual reminders to Chairs or members of other panels who have been assigned a secondary or tertiary review for the meeting with a link to each study assigned. The email is to be titled “Secondary Reviewer Assignment for IRB Committee (Panel Letter/Number) on (Meeting Date)” and sent high priority.
- If the agenda includes VA agenda items, the Pod may consider adjusting the order of the agenda to accommodate the VA liaison.

Additions to a Closed Agenda or Closed Category may include:

- Team Q items and/or other emergencies where a patient is waiting for treatment, or items involving risks to current participants that necessitate immediate attention and the next available meeting is not a Q meeting.
- Requests for continuing review that are FDA-regulated and will expire before the next meeting as long as there is sufficient time for a proper review.

*Note: The meeting pod must be contacted before any addition to a closed agenda.*

**Pre-Meeting Pod Meeting (Monday on the Week of Meeting Day)**

- During the meeting, the Pod reviews any outstanding regulatory questions, current quorum, and member reviews already submitted for changes before the meeting.
- If a deferral is recommended, the Pod emails the assigned analyst-owner to see if a deferrable issue(s) can be resolved before the meeting with sufficient time to return and review the information. If the deferable issues cannot be resolved before the meeting, the Pod emails the IRB Director and Meeting Chair for approval. During this meeting, the Pod updates the RAS to document the reviewer’s recommendation (vote) on an agenda item (Approval, Pending Approval, Deferral, etc.).
- If a member has not completed his/her review, the AA sends reminder emails to those members during the meeting.
- The Pod checks the “Meeting Notes” folder against the RAS to ensure that all omnibus forms are uploaded and complete at `<H: General\CMTE\Meetings\Meetings\(Committee A or B or C\)\(Panel\)\Meeting Notes\(Year\)\(Month\)>`. If omnibus forms are missing, incomplete or contain unclear information, the Sr. RPA reminds the analyst owner to resolve the issues before the committee meeting. The Sr. RPA sends this email during the Pod meeting and copies the analyst owner’s supervisor.
- During the Pod meeting, the RPA creates a OneNote page for the meeting under the specific Committee section. Each member of the Pod creates a subpage to add their notes during the meeting. Alternatively, the notes can be saved in a word document.
- The Pod captures the pending administrative items for each new study in the RAS.
- The Pod reviews Mods to confirm they need to be reviewed by the committee and to review the current accrual to ascertain whether the committee needs to make a re-consent determination.
• The Pod reviews CRs for logged comments regarding missing DSMB and study progress reports so that the Pod will be prepared to mention these during the discussion of the CR.

• For unanticipated problems (UPs) cases: The case manager (Q team member) contacts the Pod team as soon as it is known that the UP case needs to be added to the agenda because the event represents an immediate safety concern. This occurs in cases where the next available meeting is not CMTE Q.
  o The case manager attends the meeting to assist with the notes for the case and emails them to the meeting Pod before the minute draft deadline.

Meeting Day
• For new studies, the RPA checks the study history for missing cost option information and checks the OSP ICOI Database Daily Spreadsheet for missing injury option information.
• The RPA updates the RAS as reviews come in or new information is obtained.
• The RPA finalizes the Pre-Meeting Huddle information.
• The AA completes meeting set-up responsibilities no later than 3:45 pm. (Analyst Assistant Meeting Preparation and Cleaning up SOP)

  FYI: The ORA Event Coordinator places drinks and snacks for the meeting in the conference room by 3:30 pm. In case of any issues, consult with Maria Wackerly.

  • The Pod team sets up their laptops for the meeting.
  • The assigned Driver (AA) for the meeting prepares to conduct driver responsibilities before, during and after the meeting (See Drivers for IRB Meetings SOP)
  • The RPA conducts the Pre-Meeting Huddle around 3:45 pm or when the Meeting Chair arrives.
  • Click on “meeting convened” under the meeting space to document the meeting is about to start. If this is not completed at this point, it can be completed after the meeting as long as it is completed on the same day. Do not close the meeting until the minutes have been approved by the IRB members, in case the meeting notes need to be revised.
  • The AA greets meeting guests. Confidentiality Agreements are required for any guest to an IRB meeting. The IRB recommends that guests schedule observations at least the day before the meeting for building security purposes and to be made aware of logistics and changes.
    o The AA ensures that confidentiality agreements are been signed before the meeting convenes.
      Guests arriving after the meeting has started may not enter and may reschedule their observation.
    o Member candidates attending a meeting as part of the appointment process should have already signed a member confidentiality form. The AA confirms a confidentiality form is on file or has the candidate complete the form at that time. (The person arranging the candidate’s visit should have already emailed the meeting Pod that the candidate is planning to observe the meeting.) The AA sends the candidate a courtesy reminder email or notification of any change of date, time or place.
  • The Pod makes sure doors are closed for privacy and confidentiality when the meeting convenes.
• The RPA announces the pending administrative issues before each agenda item when requested by the meeting Chair and reminds the Committee of those items before their vote should the Chair forget to ask for them.

• The Director, RPA and Sr. RPA take notes. Everyone should capture the following in their written notes:
  o Controverted issues during Committee discussion on an item and how they were resolved
  o Under “determinations and findings that require documentation” include:
    ▪ Comments on the submission whether positive or negative (e.g. the protocol was well-written. The consent form used too many medical terms). Refrain from taking notes of the description of the science of the study such as the description of why the study is being done, research activities, etc., as these are already documented in the submission.
    ▪ All pending issues discussed in the meeting and agreed upon by the Committee.
    ▪ All deferrable issues discussed in the meeting and agreed upon by the Committee.
    ▪ All determinations required by the Committee for the agenda item (e.g. IND or IDE exemption, determination on short-form request, sensitive study request, Subpart determinations or HIPAA waivers).
    ▪ Any instruction or comment to the study team that the Committee indicated should be placed in the letter to the study team.

Facts and statistics available in the submission should not be made part of the minutes unless related to pending, deferred, or unresolved controverted issues discussed during the meeting. An experienced Back-Up Note Taker, usually the IRB Director or her representative, may take free-form notes for the meeting indicating time meeting started, the agenda order, controverted issues, pertinent discussion, Committee instructions/comments to the study team, member recusals, returns and departures, the Committee determination(s), total vote (for, against, and abstain/names) and the time meeting ended.

• After meeting discussion, the RPA/Director at the meeting will display and ask the members to verify the information used to fill out the Full Board Information for each new study.

• The AA then documents the outcome of each agenda item by clicking on “Submit Committee Review”. You can save the notes and click “no” on question 10 (Are you ready to submit this review?). This step can also be completed during the post meeting meeting The notes must include:
  o Determination made
  o Risk Level
  o Pediatric risk levels if applicable
  o Dates (confirm, as dates are populated by the system)
  o Motion and Votes
    o Include all the recusals and other departures, and returns and permanent departures by individual members to and from the meeting.
**Closing Activities after the Meeting**

- The Pod team powers down, disconnects and plugs laptops into the laptop cart, disconnects, and stores other electronic devices in the containers provided, turns off the projector, retracts the large screen, returns the conference room furniture to the standard-setting when applicable, turns off the lights, and disconnects the conference bridge and returns it to its container. Alternatively, the Pod team may decide to use iPads instead, taking into consideration the additional time to set up the wi-fi connections for them.
  - The laptop cart, mice, laptop chargers, and large power strip must be returned to the IT offices on the 4th floor by staff closing the meeting. The laptop cart must be plugged into the source provided in the IT office so that the equipment may charge overnight.
  - The keys that open the laptop cart and the IT office must be left in the Lock Box on the 4th floor outside the IT office. The Lock Box requires an ID issued by IT and a unique passcode to access and return keys.
- The Pod returns sodas and water to the refrigerator in the pantry closet within the meeting room and places the chips on the designated IRB shelf with a note indicating: “IRB items remaining from IRB Meeting for ORA Events Coordinator Only”. The ORA Events Coordinator must retrieve these items the morning after the meeting to ensure a proper count for the IRB account.
- The Pod returns the candy to the locked Member File Cabinets in the IRB area.
- The Pod returns the IRB Keys (pantry closet and IRB member file cabinets) to the Lock-Box in the IRB Director’s office.
- The Pod ensures that the meeting area does not have any documents left behind. Any meeting-related documents are discarded in the “CONFIDENTIAL” bin outside the conference room. The Pod ensures all loaned portable meeting equipment is removed from the meeting room or properly secured.
- The AA plugs the phone in an office to ensure it is fully charged for the next use.

**Post- FB Meeting (as soon as feasible after the meeting, no later than the next day)**

- The Pod meets to review their notes from the meeting and fill out, as a group, the meeting determinations and other information captured during the meeting.
- The information should be added under each study reviewed, by clicking on “submit committee review” (for NS/MOD/CRs) or “submit RNI committee review” (for RNIs).
  - If there were no controverted issues or additional discussion for a study, please enter “None” on those boxes.
- **For new studies only:** From the Full Board Information document add all the language that corresponds to approved/pending sections. For example, if a PHW was approved, copy and paste the approval language to this section. You can find more information in the Non-exempt NS checklist template.
- Under question 10 (supporting documents) add all the worksheets that were approved during the meeting, plus the Full Board IRB Information Sheet that was completed (only for new studies)
- Click on yes under 11 to submit the review. You can revise this information again if needed, even after clicking yes.
• The AA sends an email or logs a comment in Teams letting the staff know that they can prepare letters.
• During the meeting, the AA updates the Attendance tab on the Roster Ultimata.
• The Sr. RPA notifies Julie Martin of the member(s) who should be compensated for attending the meeting. The email contains the following information:
  o Members name
  o Date of meeting
  o Panel’s name

Note: Follow the Minutes Processing SOP for timeframes and procedures to finalize the meeting minutes.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/14/2015</td>
<td>Overhauled to indicate current job requirements.</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Major changes to align with current process</td>
</tr>
<tr>
<td>4/11/2019</td>
<td>Adding need to plug phone after meeting</td>
</tr>
<tr>
<td>6/28/2019</td>
<td>Complete overhaul of process adding Pod meeting</td>
</tr>
<tr>
<td>7/16/2019</td>
<td>Updating to reflect current process</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Updated SOP for grammar, and to clarify responsibilities for team members</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated after new Huron eIRB</td>
</tr>
<tr>
<td>2/12/2020</td>
<td>Added that we will see NS/CRs/Mods and RNIs when assigned to our committees</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Clarification about what should be the eIRB location to assign reviewers to agenda items</td>
</tr>
<tr>
<td>3/8/2020</td>
<td>Reconciled that we are not using omnibus forms for studies submitted in the SaaS system (new eIRB) as this was replaced with an update to the pre-review submission (plus an updated NS checklist).</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Adding that the RPA/Director will ask the vicechair to take a moment to complete the Full Board information for each new study. This form should be uploaded in the study notes. Other minor changes.</td>
</tr>
<tr>
<td>4/20/2020</td>
<td>Additional clarifications to the process</td>
</tr>
</tbody>
</table>
SOP Title: Drivers for IRB meetings
SOP Category: Meeting Facilitation
Established: 5/14/2015
Last Revision: 8/31/2019

PURPOSE
The purpose of this document is to detail the responsibilities of the IRB meeting drivers in preparation for the full board meeting, and steps to follow during and after the meeting.

SCOPE
The SOP applies to the IRB staff serving as meeting drivers.

PROCEDURE
• The day of the meeting:
  o Arrives at the meeting room at approximately 3:30 pm to prepare his/her laptop:
  o Opens MS Word to make sure it is ready before the meeting.
  o Logs into eIRB to access the meeting’s agenda
  o Opens tab for each new study on agenda if desired
  o Opens the “Words to PI” file, located in the Meeting Facilitation Prep-Kit
  o Opens the omnibus forms for the studies
• During the meeting:
  o Responsible for Omnibus Forms for NEW studies only
  o First, display the item being presented. Display the History in case there are important notes (both the main study and Mod or CR being discussed.)
  o Omnibus forms: When the discussion begins for each new study, the meeting driver will fill out the section of the omnibus form “Findings by the Board”, including checkboxes and adding and protocol-specific comments. The driver will scroll down the form and document any determinations made by the panel during their discussion, including IND/IDE exemptions, device determinations, HIPAA waiver(s) granted, Subpart determinations, the motion, the vote and vote count, the risk level, and the approval period. The driver will follow the RPA and vice-chair instructions when filling out the forms.
  o When not completing the omnibus form, follow the members’ discussion and open documents and SmartForm sections being discussed, especially if you hear controverted issues.
  o Be prepared to navigate to secondary reviews when reviewers are not present if the VC does not mention them first.
  o After a vote on each new study (only): log a determination comment to Study Team in the Study History for each item on the agenda using language in the “Words to PI” file.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/14/2017</td>
<td>Updated to reflect new process in OneNote and limited driver responsibilities</td>
</tr>
<tr>
<td>6/8/2018</td>
<td>Changes to reflect current process</td>
</tr>
<tr>
<td>6/28/2019</td>
<td>Updates to driver functions</td>
</tr>
<tr>
<td>7/16/2019</td>
<td>Updates to reflect current process</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Replaced RPA with “meeting driver”</td>
</tr>
</tbody>
</table>
NOTES: Specific guidelines for review of Minutes are found in the “Minutes Keys”: H:\General\CMTE\1. Meetings\1-Meeting Facilitation Prep Kit\Minutes Related\Minutes Key

PURPOSE
The purpose of this document is to delineate the process of minute processing after a Full Board (FB) Meeting. The Minutes should meet the criteria outlined in 45 CFR 46.115(a)(2), 21 CDR 56.115(a)(2), and Emory IRB Policies and Procedures number 34.

SCOPE
The SOP applies to items reviewed at Full Board (FB) Meetings.

RESPONSIBILITIES
• Designated Pod Member (DPM)-will draft minutes after FB meeting.
• IRB Associate, Assistant or IRB Director (Directors)- will review minutes draft for final approval

DEADLINES
The first draft of minutes: Before the second Friday after the meeting.
Minutes distributed after Director review: When next month’s meeting invitation is sent

PROCEDURE
Before working on the Minutes
• After the Post-FB meeting, set Outlook event for the due date of the first draft, and invite the responsible Director
• After the Pod post-meeting meeting, the notes should have been reconciled. The RPA should look at the notes and make adjustments to the information in the meetings if needed, for grammar or syntax. Do not modify the information that was already sent to the study team in the approval, pending or deferral letters unless there was missing information.
• If the Pod missed information that should have been communicated to the study team, let the study analyst know and modify the submission meeting determination by clicking on “submit committee review”.

Preparing the Minutes
• Under the meeting’s space, click on “Prepare Minutes”
• A new window will open. On that window, click on the drop down menu under question 1. Review the minutes and make sure that all the pending notes, discussion and controverted issues were captured.
• Ensure that, for new studies, the language listed in the Full Board worksheet or other templates is used for all determinations.
• Ensure language complies with the minutes writing guidelines.
• Ensure that all issues are fully detailed in the minutes, instead of referencing separate reviewer comments. If the meeting was conducted via videoconference (Zoom), please indicate in the minutes.

• **Add the following under each submission to document attendance. Delete these instructions in red and non-applicable sections of the following information (for example, if no changes, just leave the section out):**

  - **Attendance, Quorum, and Conflicts of Interest**
    - ☐ N/A
    - ☐ The following member(s) stepped out of the room before the discussion and vote on this study: **Member Name**. Absent this member, the total number of voting members present was **Number**. After the vote on this protocol, **Member Name** returned to the meeting and the number of voting members present went to **Number**.
    - ☐ Before recusal, this member disclosed a conflict of interest with this study.
    - ☐ [If applicable] Committee member left the meeting permanently after the discussion and vote on this item. The number of voting members present went to **☐**
    - ☐ The following member(s) joined the meeting during the discussion of this study: **Member Name**. The number of voting members present went to **Number**.

• **For new studies, after “Motion”, add the following information for each, depending on the board decision:**
  - **For Pending studies:** The convened IRB determined that this study meets the criteria for approval of research per 45 CFR 46.111, with conditions. These conditions are detailed under “Recommended changes and reasons”.
  - **For Deferred studies:** The convened IRB determined has deferred approval of this study as it requires modifications to secure approval per 45 CFR 46.111. The specific reasons why this study was been deferred are detailed under “Recommended changes and reasons”.
  - **For Approved studies:** The convened IRB determined that this study meets the criteria for approval of research per 45 CFR 46.111.

• For RNIs, we will need to add all the information from the “RNI Full Board Document” in this same section.

• Save the draft, and email the responsible director to let them know that the minutes are ready for review. The director will find the revised minutes in the meeting space or under the history tab.

• If the Director has changes to the minutes, she will save a tracked change document to share with the RPA via email but will only save a clean copy in the system.

• After the director has reviewed and approved the draft minutes, the RPA will send draft minutes to AA for distribution with an attached draft during the next meeting invitation email. In the email, let members know that changes may be requested up to 7 business days from receipt of the email.

• If changes to the Draft Minutes are requested by the committee members, the AA will let the RPA know. The RPA shall make the revisions and upload a revised copy by clicking on “prepare minutes” and then selecting “upload revision” under question 2. The RPA will then send out the revised minutes to committee members for review again. Members should reply within 7 business days and then the minutes are deemed finalized.
Finalizing minutes

- After any requested edits made per member feedback, the draft minutes are considered finalized.
- The RPA changes the status of the meeting from “Meeting Convened” to “Meeting Complete” by clicking on “close meeting”.

Next Steps

- Edit Meeting Attendance
- Prepare Minutes
- Close Meeting
- Update Documents
- Update Other Agenda Items

- Click on “Approved Meeting Minutes” to finalize the minutes in the system

Next Steps

- Prepare Minutes
- Approve Meeting Minutes
- Update Documents

- Update the spreadsheet “Minutes Tracker Draft and Approved versions MD updates 2013 to Present” found under H:\General\CMTE\1. Meetings\Minutes
- The RPA should enter data related to the current set of minutes in the columns highlighted in yellow:
# LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/13/2015</td>
<td>Added purpose and Scope change of title and other updated to reflect current process. Combined with previous SOP entitled “Combining Omnibus Forms for Minutes”</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Revised to update this SOP with current process</td>
</tr>
<tr>
<td>6/28/2019</td>
<td>Changes in process after Pod meeting structure, not need to approve minutes anymore.</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updating to reflect current process after new eIRB system implementation</td>
</tr>
<tr>
<td>3/5/2020</td>
<td>Update of minutes process as we are no longer required to save a draft copy outside the system</td>
</tr>
<tr>
<td>3/8/2020</td>
<td>Additional clarifications to minutes process</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Adding approval/deferral/pending approval information to the minutes</td>
</tr>
</tbody>
</table>
SOP Title: Analyst Assistant Meeting Preparation
SOP Category: Meeting Facilitation
Established: 1/30/2017
Last Revision: 6/28/2019

PURPOSE
The purpose of this document is explaining the tasks analyst assistants (AAs) are responsible for when setting up for a full board meeting.

SCOPE
The SOP applies to the analyst assistants’ functions in preparation for a full board meeting.

RESPONSIBILITIES
• AA: to perform all activities assigned to them in preparation and closing for their assigned full board meeting.

PROCEDURE
PRIOR TO MEETING
• Set up recurrent meetings for laptop pick up, involving Enid Sullivan (or replacement). This could be done once every two years, as the recurrent calendar invite ends in 2 years.
• In order to set up the recurrent outlook meeting invitation, do the following:
  o Create a new Meeting and put following information:
    ▪ To: Enid Sullivan (or replacement)
    ▪ Subject: Laptop checkout – IRB
    ▪ Location: 5C
    ▪ Date of meeting and time frame (3:30pm to 6:30pm)
    ▪ Body: name, department, phone number, e-mail

DAY OF THE MEETING
• Setup start time is 3:30pm.
• Sometimes you are able to set up a little earlier, depending on the room availability.
• Name cards: check you Reviewer Assignment Sheet to make sure you have all the card needed for the meeting.
• Keys (located in RR office): required to access computer and pantry closets in 5C. Also, to pull name cards from the members cabinet.
  o Key box Code: 000
  o Key names: Laptop cabinet key, Pantry Key, laptops keys and member cabinet keys
  o The Pod will coordinate to make sure the keys are placed back on Rebecca’s office.
  o IT equipment/Laptop cart: set up laptops according to number of members/staff attending
  o Obtain the keys from the key Box on the 4th floor
  o Will Brown is the point of contact if you have any question regarding the IT equipment.

Note: Check with your Pod in case you need to set up computers for your Pod members and follow the meeting facilitation SOP for that process. In addition, don't forget to turn on the projector/release the
screen. Sometimes we help set up the driver computer. For now just make sure the computer is connected via the HDMI cord. We have connectors in case the HDMI cable is not working, so we may use those.

Setup the Phone:
Check with the previous AA who set up laptops the last time.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/12/2017</td>
<td>Deleting binder prep as it is no longer done</td>
</tr>
<tr>
<td>7/14/2017</td>
<td>Adding step before leaving meeting</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Changes made to align to current procedures</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Removed Mike Deryck</td>
</tr>
<tr>
<td>6/28/2019</td>
<td>Updates SOP to follow new Pod structure</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to explain how to manipulate the Roster Ultimata, track member attendance, how to add members, remove members, and archive the spreadsheet when changes are made.

SCOPE
The SOP applies to any staff who edit the Roster Ultimata.

RESPONSIBILITIES
- **Designated Pod Member (DPM):** track member attendance, keep CITI certification dates updated, add new members, remove old members, and archive spreadsheet when changes are made.
- **IRB Staff:** view the Roster Ultimata for guidance when assigning reviews or full board meeting items.

DEFINITIONS
**Attendance Record:** the attendance record is the percentage of meetings attended since the date of appointment. The appointment date is vital in interpreting this statistic.

PROCEDURE
RPAs who need view-only access can review all of the pages in the workbook by clicking the tabs at the bottom of the page. They can also search the workbook for a specific member by typing ctrl+f and using the dropdown menu next to “Within” to search the entire workbook.

A copy of the Roster Ultimata workbook should be saved as an archived version BEFORE making changes to the document. These changes include adding new members, removing members, changing members to a different committee permanently (temporary changes do not need to be archived).

1. **Archiving the workbook:**
   a. Click File, Save As, and select this file path: H:\General\CMTE\Members (and VCs)\Rosters\Archived
   b. Save the copy as “Roster DATE-DATE”. (Dates should be listed in MM-DD-YYYY format).
      i. The first DATE is the date of the last roster archival and the second DATE is today's date

To add new members:
Members must be added in at least three sheets of the document: the Attendance sheet and the All Members Sheet, and each committee the member is assigned.

1. First add the new member(s) to the attendance sheet.
   a. Insert a row for the new member alphabetically
b. Input the Member Name.

c. For the Attendance Record column, copy and paste the formula from the cell above your new row. Once the formula has been copied, select the text box at the top of the screen, in the tool bar, and change ONLY the parenthetical information after “DATE”. This should be located in two different places in the formula (the numerator and the denominator). Enter the appointment letter date to accurately calculate attendance for the new member since the appointment date. The date should be entered like this: (YYYY,MM,DD).

2. Navigate to the All Members sheet
   a. Insert a row where your new member(s) should be added
   b. Fill out all fields accordingly.
      i. Enter the committee where the new member will be serving in the appropriate column (for example “A1” in the A1 column).
      ii. If the new member serves as a backup on a committee, enter the committee with the “-A” suffix.
      iii. If the new member is a prisoner rep on a committee, enter the committee with the “-P” suffix.
      iv. Continue entering the rest of the information on the row, ensuring that all fields are filled out (this seems tedious, but helps inform the separate committee-specific spreadsheets with the appropriate information).
      v. Save the Document. Note that the committee-specific sheets are designed to pull information off the All Members sheet to display. There is no need to update those sheets specifically.

3. Navigate to each committee sheet the member is assigned
   a. Insert a row where your new member(s) should be added
   b. Fill out all fields accordingly.
      i. Continue entering the rest of the information on the row, ensuring that all fields are filled out.
   c. Save the Document.

To remove old members:
Members must be removed from at least three sheets of the document: the Attendance sheet and the All Members Sheet, and each committee the member is assigned to.

1. In the Attendance sheet, hover your cursor over the row number that you will remove and click. This should highlight the entire row.
2. Right click and select “Delete”. This should remove the entire row from the document.
3. Navigate to the All Members sheet, hover your cursor over the row number you will remove and click. This should highlight the entire row.
4. Right click and select “Delete”. This should remove the entire row from the document. Navigate to the relevant committee sheet, hover your cursor over the row number you will remove and click. This should highlight the entire row.

5. Right click and select “Delete”. This should remove the entire row from the document.

To track attendance:
Enter the committee meeting the board member attended in the appropriate row and column for each member. Note that this activity must be completed as soon after the meeting as possible to ensure that community members are paid correctly based on attendance.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/1/2018</td>
<td>Added a comment about what to do when the workbook asks if you want to save changes, despite no changes made</td>
</tr>
<tr>
<td>6/21/2019</td>
<td>Removed pivot tables from sheet. Added detail for how to manually update committee sheets.</td>
</tr>
<tr>
<td>6/27/2019</td>
<td>Updating after changes in meeting facilitation</td>
</tr>
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</table>
QA AND EDUCATION

<table>
<thead>
<tr>
<th>SOP Title:</th>
<th>Acknowledgments &amp; Noncompliance Determinations Made by Senior Team Q Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOP Category:</td>
<td>QA and Education</td>
</tr>
<tr>
<td>Established:</td>
<td>10/19/2011</td>
</tr>
<tr>
<td>Last Revision:</td>
<td>7/14/2017</td>
</tr>
</tbody>
</table>

PURPOSE
The purpose of this document is to specify in which circumstances a designated senior Team Q staff may acknowledge reportable new information submission submitted to the Emory IRB.

SCOPE OF SOP
The SOP applies to the reportable new information submissions submitted for studies reviewed by the Emory IRB.

RESPONSIBILITIES
- **Senior team Q staff**: Reviews and triages reportable new information submissions submitted to the Emory IRB. Under this SOP, the staff will also acknowledge certain type of events as explained below. “Senior” is defined as Associate or Assistant Director, or other Q staff designated by the Director as having sufficient experience and expertise to be considered “Senior.”
- **Non-senior team Q staff**: May administratively process acknowledgments on behalf of senior team Q staff, but would not make the determination themselves.

PROCEDURE
The designated serious Team Q staff is allowed to acknowledge the events as detailed in this SOP. The designated senior Team Q staff may, at his/her discretion, send any of these events to an IRB vice-chair even if noted in this SOP to get confirmation of appropriate review. The designated senior Team Q staff may acknowledge the following events:
- Study staff not added to IRB submission, as long as staff was proper research (CITI and, if applies, Emory Clinical Research training) and protocol training before starting study activities
- ICF/HIPAA documentation issues where:
  - The form used was expired but it was the correct version approved by the IRB
  - The subject signing the consent forgot to time and date. A note to file is required to clarify this matter.
  - The study team member forgot to time and date the signature. A note to file is required to clarify this matter.
  - Discrepancies in signature/date/time by subject or study team unless there is a pattern of noncompliance.
  - ICF missing fields in the consent form that do not involve options made by the subject or signature, e.g. initials in pages.
Lapses in approval for FDA trials where research activities did not take place during the lapse. Other studies do not need the submission of a RE.

Over-enrollment in a NMTMR study, when subjects have undergone study procedures (not only signing consent), as long as it is the first occurrence for a study, if HIPAA does not apply.

Any event caused by the subject’s (not the study team’s) lack of adherence to the protocol that, in the opinion of the principal investigator, does not affect the subject’s safety, rights and welfare or willingness to continue with study participation, and is not an unanticipated problem.

Adverse event (that is not an internal death) that is considered unanticipated by the principal investigator but for which the causal relationship to study participation is unknown, and no more information is or will be available. Such events will be acknowledged with directions to submit a new reportable new information submission if the cause of the event is determined as related at a later date.

Adverse event reported to the IRB per sponsor requirements, that the principal investigator considers anticipated or unrelated to study participation. For VA studies, this will need to be acknowledged by a VA reviewer.

Protocol deviation which the principal investigator considers not substantive and not affecting subjects’ rights, welfare, safety, or willingness to continue with study participation, and not affecting integrity of the research data, reported per sponsor requirements.

DSMB letter indicating that study can continue per the protocol without change, submitted per sponsor requirement only.

Protocol deviation that may minimally affect the integrity of research data, but does not affect subjects’ rights, welfare, or safety and which does not represent a pattern of noncompliance. Team Q staff should review prior reports and consult the vice-chairs when in doubt.

Examples of such deviations are:

- Visit occurred out of window.
- Test done for research (not for safety) purposes which was not drawn or was drawn out of window, which does not reflect a pattern of noncompliance.
- Missing data caused by subjects’ noncompliance with protocol (specifically, missed data when not completing surveys not used for diagnosis or treatment) or missing data due to programming errors that do not affect subjects’ safety.
- Surveys or survey items completed in error, when the surveys or survey items’ completion does not negatively affect subjects’ rights, welfare or safety. For example, the completion of a survey asking for information that may upset the study participant should be sent to a vice-chair reviewer.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/4/2016</td>
<td>Change in the procedure section</td>
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<tr>
<td>6/28/2016</td>
<td>Change in the procedure section</td>
</tr>
<tr>
<td>7/14/2017</td>
<td>Changes to procedure section</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this SOP is to describe the process of reviewing situations in which the IRB, either through the actions of the IRB Committee or its administrative office, may not have been in compliance with applicable regulations or its internal policies and procedures; this policy does not apply to instances of non-compliance by investigators or research team members. (NC). The Emory IRB Director, the Emory IO, and Emory Office of Compliance (OC) Director are tasked with making sure the Emory IRB complies with the IRB policies and procedures and applicable federal regulations.

SCOPE
The SOP applies to all actions and determinations taken by the Emory IRB Committee and/or its administrative office.

DEFINITIONS
- **Minor IRB NC**: NC with Emory IRB P&Ps or federal regulations that does not impact the rights, welfare, safety of subjects, or the integrity of the research data.
- **More than Minor IRB NC**: IRB NC, or identification of a repeated pattern of IRB NC, with Emory IRB P&Ps or federal regulations that could negatively impact the rights, welfare, safety of subjects, or the integrity of the research data.
- **Findings**: information or a fact that is discovered during the IRB internal QA/QI process.

RESPONSIBILITIES
- **OC Director** – reviews quarterly reports of IRB NC to identify potential patterns and immediate reporting needs.
- **IRB Director** - reviews More than Minor IRB NC issues to determine if they should be routed to the CoRe team.
- **IRB Q Team**: Compiles information to be sent to the CoRe Team.
- **CoRe Team**: reviews issues coming from ORC representative or IRB Director. If they find the issue to be More than Minor IRB NC, the event will be routed to the IO.
- **IRB Director and Associate or Assistant Directors** - manage spreadsheet to trend issues found during routine record reviews, or other issues identified by IRB staff, researchers or other members of the HRPP.
- **IO**: reviews More than Minor IRB noncompliance to assess reporting requirements and adequacy of CAPA plan.

PROCEDURE
1. IRB noncompliance issues may be identified during monthly routine internal review or during incident-based reviews by IRB staff, researcher or other members of the HRPP.
2. Director and ADs will go through the findings identified during the monthly QA/QI review in a later meeting. The IRB Director will review events identified outside the QA/QI review.
3. After Team Q has finished with the monthly internal QA/QI review, the Director and ADs will meet to review the findings and determine which findings are minor and which are potentially serious or continuing. A CAPA plan will be drawn up. The Director will do the same for events identified outside the QA/QI review.
4. The ADs will communicate the CAPA plan to the staff. The ADs will follow CAPA plans until completion. Some minor findings may not have a CAPA plan if already fixed or if it is considered unnecessary.
5. Minor IRB NC will be logged in a spreadsheet and
6. sent monthly to the OC Director or his/her designee. The information will be cumulative. If the OC Director/designee finds any concerning trends that might represent More than Minor IRB NC, he/she will email the IRB Director with his/her concerns.
7. Findings considered More than Minor will be sent by a member of Team Q to CoRe for review. Team Q will send a summary of the finding in question in the CoRe email.
8. If CoRe finds the information to be More than Minor IRB NC, it will be sent to the IO. If the CoRe finds the information to be Minor IRB NC, the determination will be logged in the spreadsheet.
9. The IO will review the information to assess reporting requirements and adequacy of CAPA plan.
10. If IO deems appropriate, the NC will be reported to OHRP.

**PROCESS FLOW**

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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</table>
PURPOSE
The purpose of this document is to describe how the IRB Team Q will follow up on the IRB-approved Corrective and Preventive Action (CAPA) plans presented during Committee Q meetings.

SCOPE
CAPA plans from studies reviewed during Committee Q meetings for possible serious and/or continuing non-compliance, and unanticipated problems resulting from study staff oversight or error.

DEFINITIONS
- **Corrective and Preventive Action Plan** – a plan developed by an investigator, with or without the assistance and guidance of the HRPP, following a root cause analysis into an instance of noncompliance or other problems in the conduct of human subjects research. The CAPA must include measures designed to correct the immediate problem and prevent its recurrence or the recurrence of a similar type of problem. CAPA plans are reviewed and may be modified by the IRB before being approved. Investigators are responsible for implementing CAPAs in a timely manner.
- **Committee Q** – Full Board Committee that reviews cases of possible serious non-compliance, unanticipated problems, and conflict of interest issues for ongoing studies. The COI committee prepares management plans for review by the IRB who has authority for final approval.
- **Team Q**: IRB staff team specializes in Education and QA efforts including non-compliance, unanticipated problems and protocol deviation review, analysis, data-gathering and presentation.
- **CoRe team**: A designated group of the IRB Chair, Director, and qualified IRB staff to investigate cases of alleged non-compliance and UPs. Their findings are documented as part of the IRB record. All cases of non-compliance, UPs, and suspensions and terminations will be investigated and followed by the CoRe team. Additional investigations by other units or individuals may proceed concurrently or in sequence with those of the CoRe team.

RESPONSIBILITIES
- **Committee Q** –reviews, request changes in, approve or disapprove CAPA plans, and follows-up reports at Committee Q meetings.
- **Team Q** – Team Q designated member will compile CAPA updates. The follow-up report will be presented at the Committee Q meeting every month. Every Team Q case manager will email the designated person CAPA updates. The Team Q designated member will add the information to the follow-up report for the next available Committee Q meeting.
- **Study Staff**: Responsible to complete CAPA plan in the time allowed by the Committee Q members. This period is normally 30 calendar days from the date of the meeting unless specified otherwise.

PROCEDURE
- After Committee Q reviews and approves the CAPA plan for a specific case, the CAPA will be added by answering yes to question 2 (is further action required) under “Submit RNI Committee Review”. The person adding the notes will assign the RNI Action to the appropriate party and will click ok. The RNI Action Plan will be included in the determination letter sent to the principal investigator
- After the meeting and the RNI will enter “Action Required” state.
• Every responsible party will follow up with the study team about the CAPA plan completion and the deadline.
• When the CAPA plan (RNI Action Plan) is completed, the responsible party will submit an Action Response in eIRB. The case manager will review the action response. The case manager will complete the Required Actions Reviewed activity and will mark the action completed as required or not.
• If the action is completed, the case manager will prepare and send an RNI Action Complete letter to move the RNI to “Review Complete” status.
• If the CAPA plan has not been completed in the allowed period, the case manager will notify the study team that non-completion by this deadline is deemed non-compliance and will request an explanation of the delay to be submitted along with a notice of completion. This new NC will be reviewed by CoRe. The CoRe team will be notified about the delay for any additional determination. The Team Q designated member will create a report of incomplete CAPAs for the Full Board after CoRe review if this is considered reportable to FB.

Extension for CAPA Plan

The study team may request a deadline extension. This extension may be reviewed and granted or denied at the CoRe team discretion.

REFERENCES

• IRB QA Plan 12.15. 08
• 45CFR 46.
• 21CFR 820.
• IRB policies and procedures

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>2/11/2020</td>
<td>Updates to align with new system</td>
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<tr>
<td>3/4/2020</td>
<td>Additional changes for clarification</td>
</tr>
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</table>
PURPOSE
Outline the necessary steps of facilitating a Committee Q meeting; before, during, and after the meeting.

SCOPE
Applies to Team Q and administrative staff who help conduct Committee Q meetings.

PROCEDURE

<table>
<thead>
<tr>
<th>Q RPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• creates a folder in H drive</td>
</tr>
<tr>
<td>• sends invitation emails</td>
</tr>
<tr>
<td>• keeps track of quorum using CMTE Q attendance Workbook</td>
</tr>
<tr>
<td>• <strong>preps for the meeting using CMTE Q Recap and Prep workbook</strong></td>
</tr>
<tr>
<td>• works with Sr. RPA and using RAS assigns reviews in eIRB</td>
</tr>
<tr>
<td>• sends agenda email</td>
</tr>
<tr>
<td>• sends email reminders to IRB staff</td>
</tr>
<tr>
<td>• sets up for meeting</td>
</tr>
<tr>
<td>• drives during the meeting (completes omnibus forms as needed)</td>
</tr>
<tr>
<td>• updates attendance in Roster Ultimata and emails Julie for Payment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q Sr. RPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• collaborates with RPA on reviewer assignments</td>
</tr>
<tr>
<td>• takes notes during the meeting (can be in OneNote or a word document)</td>
</tr>
<tr>
<td>• polishes minutes before sending to the AD or Director for review</td>
</tr>
<tr>
<td>• leads the pre-meeting and post-meeting Pod meetings</td>
</tr>
<tr>
<td>• takes backup notes during the meeting</td>
</tr>
<tr>
<td>• advises pod members as needed</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• takes backup notes during the meeting</td>
</tr>
<tr>
<td>• reviews final version of minutes for QA/QI purposes</td>
</tr>
</tbody>
</table>

**Before the Meeting**

1. The Q RPA creates a meeting folder in H:\IRB\General\QA Working Files\CMTE Q\YYYY. The folder title should be MM-DD-YYYY.
2. Create a meeting agenda and save it in the meeting folder. Individual items can be added as they are identified. A copy of the worksheets, plus any additional materials should be saved in PDF format under the “Meeting Materials” folder. The “RNI Full Board Document” should be saved under “FB Forms”. The meeting agenda is populated to the meeting space by clicking on prepare agenda, and then uploading the agenda under question 2 by clicking on the ellipsis and selecting “upload revision”.
3. Each meeting folder should include subfolders for PI letters, Fed Letters, Investigator slot spreadsheets, Meeting Notes, Meeting Materials, and FB forms. The Recap Spreadsheet is located under the YYYY folder.
4. The Q RPA uses the CMTE Q Recap and Prep Workbook to ensure documentation from prior meeting is complete, including CAPA and federal notifications.

5. During the first week of the month, the Q RPA sends an email invitation to all members to ensure quorum and get an accurate count of attendance. Each committee may have a maximum of five (5) physician scientists, a maximum of four (4) non-physician scientists and must have one (1) non-scientist and one (1) unaffiliated community member present (the non-scientist and unaffiliated scientist may be the same person). It is preferable to have a VA member present if VA cases are reviewed, but it is not required. Any identified conflicts of interest should be taken into account when ensuring quorum. To assign reviewers:
   5.1. Click on “Assign Reviewers” under the meeting space
   5.2. Click on “update” to each RNI and add the reviewers
   5.3. If there are other agenda items that need to be reviewed, assign a reviewer if applicable
   5.4. Say yes to question 3 to notify members of their assignments, if ready. If not ready, say no, and send when ready.

6. The agenda should be finalized and materials sent no later than the Friday before the meeting, if possible using the meeting space. The VA Compliance Officer and Director of Research/IRB Director at CHOA should receive an invitation to the meeting, and a copy of the VA/CHOA materials to be reviewed, if applicable. Guest arrivals should be noted on the agenda (for example, Dr. Jones and Ms. Smith will be present at 4:15 pm). The case manager of each study is responsible for inviting guests, providing directions, and noting arrivals on the agenda.

7. If any items are added or removed after the agenda and materials are sent, the members should be notified via email and through the system as soon as possible and provided any additional materials that are needed. New materials pertaining to a specific case may to all members. The case manager should notify the meeting facilitator when these changes have occurred.

8. If there will be call-ins to the meeting, the caller should be given the appropriate phone number. The meeting facilitator is responsible for setting up the teleconference equipment. The number for the Conference line is 404-727-1109 (access code 302014#).

Day of the Meeting

1. The administrative staff will set up drinks and snacks about 30 minutes before the meeting.
2. The Q RPA will place a sign near the elevator to indicate PIs attending the meeting to wait in room 5A.
3. The Q RPA will make all meeting materials available (as a viewer) to attending committee members on Emory Box.
4. The Q RPA will make available name cards and copy of the agenda for all committee members and staff at the meeting.
5. The Q RPA will ensure that laptops are set up for members and staff.
6. If necessary, Q RPA will set up the speakerphone.

After the Meeting

1. IRB staff should work together to clean up after meeting, including putting away IT equipment and locking the storage closet.
2. The laptop cart and other IRB equipment should be taken to the IT area for storage.
3. The day after the meeting, IRB staff will meet to recap the meeting and strategize plans for sending determination letters. Each case manager is responsible for creating his/her own letter and
ensuring it is sent to the PI. If specific follow up activities are required (site visit, Modification
required, etc.), the case manager is responsible for that follow up. CAPA plans will be reviewed.

4. Letters to federal oversight agencies should be drafted concurrently with the follow-up letters to the
PIs. Send draft letters (FDA/OHRP) to the IRB Director for review. Occasionally, the Institutional
Official will also be asked to review and comment. Letters should be sent to the feds within 1
month. If the matter is considered of great urgency, the letter should be sent earlier as possible.
The IRB co-Chair or vice-chair with medical expertise should sign any letters to the FDA; the IRB
Director may sign letters to OHRP. A copy of the email sent to FDA and OHRP should be kept in the
“Letter to Feds” folder under the meeting date folder.

5. Minutes should be completed and sent to the Associate or Assistant Director for review at least one
week prior to the next meeting. Follow the Minutes SOP for details about this process.

6. Every Team Q member will be responsible for follow-up with the study PI regarding CAPA
completion. The meeting facilitator should remind the Q team to add outstanding CAPA items to
the CAPA report worksheet in the meeting materials folder.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/13/2015</td>
<td>Update to follow current practices</td>
</tr>
<tr>
<td>3/4/2020</td>
<td>Changes in team members’ roles for CMTE Q</td>
</tr>
<tr>
<td>3/8/2020</td>
<td>Additional clarifications to process</td>
</tr>
<tr>
<td>3/13/2020</td>
<td>Updated responsibilities for members of the team</td>
</tr>
<tr>
<td>4/20/2020</td>
<td>Updated responsibilities for members of the team and included references to workbooks and Emory Box</td>
</tr>
</tbody>
</table>
PURPOSE
The death of a subject who is an Emory Healthcare (EHC) Patient or University Employee or Student while in a study raises major institutional concerns if the death is deemed unanticipated, related to study participation, and potentially increasing the risk for participant's or others. This SOP is intended to guide the IRB in communicating with EHC and University Officials.

SCOPE
Deaths considered unanticipated problems in Emory study participants

PROCEDURES
1. Assess whether we have enough information to notify others who need to know. In most cases, we will need more information or clarification; in such case, the IRB Director, Education & QA Lead, or Co-Chair should communicate directly with the PI, without cc’ing others who will want to know about it once we have all the relevant information. The reason for this is to avoid premature questions flooding in.
2. Recommend to the PI to let his clinical chair and any relevant research coordinators and study staff know about the event and any immediate implications for other study subjects.
3. Ask the PI whether he knows anything about whether the subject’s family is talking about bringing suit against Emory or has other serious concerns about the study’s relatedness to the death. This information should be included in the notification to Risk Management and OGC.
4. Once we have enough information to say whether the PI thinks it is related (probably, possibly, etc.) or not, and whether the PI thinks it is anticipated or unanticipated, and whether he thinks the protocol/ICF should be changed and subjects notified, the IRB Director or Education & QA Lead should do the following:
   a. Sent to CoRe for review.
   b. If CoRe considers the event to be a possible unanticipated problem, the following people should be alerted via email, (including the date when the full board will review the event):
      i. Robert Nobles, VP for Research Administration
      ii. Margaret Huber, OC
      iii. David Stephens, VP for Research
      iv. Jeffrey Lennox, Associate Dean for Clinical Research
      v. If Winship: Curran, Waller, El-Rayes, Rodger, and PI
      vi. Katie Lewis (OGC)
      vii. Cheryl Ritchie (Risk Management)
      viii. Anne Adams and Stephanie deRijke (CTAC)
      ix. Laura Deane (Office of Quality)
      x. William Bornstein (Office of Quality)
xi. Susan Rogers (IDS) – if it is a drug trial (Non-VA)

xii. IRB analyst owner of the study

xiii. Chair of IRB meeting that will be reviewing the possible UP

xiv. Anyone else it makes sense to alert (check with IRB Director first)

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
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<tr>
<td>1/18/2019</td>
<td>Updated Dr. Wynes with Dr. Sherer</td>
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<td>2/12/2020</td>
<td>Updated current IO</td>
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<tr>
<td>3/4/2020</td>
<td>Updated current OC contact</td>
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SOP Title: Review of Single Use, Expanded Access of Unapproved Drugs or Devices

SOP Category: QA and Education
Established: 7/27/12
Last Revision: 3/4/2020

BACKGROUND
The FDA allows the use of an unapproved medical drug or device both for research and under what is known as expanded access or compassionate uses. This allows for the use of drugs or devices for treatment purposes outside a research protocol.

PURPOSE
The purpose of this document is to describe the review process of a new study for the use of an unapproved (or not approved for a specific indication) drug or device for Compassionate or Emergency use, from submission to approval.

SCOPE
Compassionate/Emergency use of an unapproved drug or device in an Emory study participant or patient, done by an Emory affiliated physician. If the use is submitted from a doctor without an Emory affiliation, even if treating a patient in an Emory facility, it would be reviewed by WIRB or another external IRB. Expanded access uses at CHOA should be routed to the CHOA IRB.

DEFINITIONS
- **Sponsor:** A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator.
- **Sponsor-Investigator (S-I):** means an individual who both initiates and conducts an investigation, and under whose immediate direction the investigational drug is administered or dispensed. The term does not include any person other than an individual. The requirements applicable to a sponsor-investigator under this part include both those applicable to an investigator and a sponsor.

RESPONSIBILITIES
- **IRB Team member:** facilitates the submission of compassionate and emergency use request, verifying that the information provided is complete.
- **IRB Co-Chair:** reviews compassionate or emergency use requests before full-board review.
- **Investigator:** makes sure that the information submitted is complete and accurate, according to the information submitted to the FDA and/or the sponsor.
- **Sponsor:** submits an IND/IDE supplement to the FDA before use to obtain permission (for compassionate use only), and an IDE supplement after use as a follow-up report.

PROCEDURE

NOTE: Make sure to use our letter templates for IRB Chair concurrence, IRB acknowledgment of use or IRB approvals for these compassionate uses. The Team Q member should review the submitted information, and assist investigators when possible, directing them to the Emory policies and procedures, FDA guidance or to the Office of Compliance for the submission of the IND/IDE supplement (in case of an Emory Sponsor-Investigator).
**Emergency use of a device:** does not require IRB or FDA approval before its use but the study team needs to contact the FDA to inform them of the use. In addition, the study team should submit an application to the IRB for acknowledgment of this use. This will be reviewed at Full Board for acknowledgment. The application should contain information about all the protection measures used before use and the following:

- A description of the circumstances that required the use.
- IDE protocol with a description of the device and name of IDE holder.
- Copy of uninvolved physician’s assessment of use
- Copy of authorization from IDE holder if applicable
- Copy of consent document used for expanded access use (template use OK)

Before using the device, the physician should take as many of the following patient protection measures as possible, and provide the following information in the submission:

- Obtain a written independent assessment of the use of the device by an uninvolved physician
- Obtain documented informed consent from the patient or his/her Authorized Legal Representative
- Obtain documented authorization from the holder of the IDE for the Investigational Medical Device, if an IDE exists.
- Notify the Emory IRB by contacting the IRB Chair or his/her designee, and provide the Emory IRB with a written description of the circumstances necessitating the use of the device, along with copies of the uninvolved physician’s assessment, informed consent and the IDE’s holder’s authorization.
- Notify any other institutional officials who require notice under institutional policies.
- If the patient did not consent before the use of the device, the physician should document this matter as described under the Emory IRB P&P, entitled Waiver or Alteration of Informed Consent for Research.

After the Emergency use submission has been initially reviewed, the Team Q member will contact the study team in case of any required changes, while alerting the IRB Chair via email about the Emergency use. Once ready for review by the full board, the Team Q member will place the study in the next available meeting agenda, notifying the meeting facilitator and meeting Vice-chair. The Team Q member will assign the review of the Emergency Use to the meeting Vice-Chair and the IRB chair.

After the Emergency use is approved by the IRB FB, the IRB approval letter should be created and it should include the following:

- The patient should be followed-up for any unanticipated adverse device effects
- The treating physician should inform the IDE sponsor of the patient status after receiving the device, so they can comply with their IDE reporting obligations
- If an IDE does not exist, the treating physician should provide the FDA with a written summary of the conditions constituent the emergency, patient protection measures taken and patient results
- Evaluate the likelihood of similar use of the device occurring again at Emory, and if such future is likely, begin steps to obtain a new IDE or a modification to an existing IDE to cover the device’s future use and to obtain Emory IRB approval.
**Compassionate use of a device:** should be approved by the FDA before the use. The use will also need IRB approval or, alternatively, IRB chair concurrence of use. If the IRB chair determines that the use would benefit from expedited review, the use would be routed that way, even if IRB chair concurrence was requested.

If the study team is seeking IRB Chair concurrence, the following information is required:

- A description of the circumstances necessitating the use.
- IDE protocol with a description of the device and name of IDE holder.
- Copy of uninvolved physician’s assessment of use.
- Copy of authorization from IDE holder.
- Copy of consent document for expanded access use (using our current template)

The Team Q member will create a [folder](#) with the information received from the treatment team. To document the use in the system, the study team will create an RNI submission and will add all the documents required for the concurrence.

The Team Q member will contact the study team in case of any required changes, while alerting the IRB Chair about the Compassionate use. The IRB chair will confirm his/her concurrence with the use of the device via the submitted RNI. This concurrence will be sent to the study team. The physician should not use the drug or device unless and until FDA approval of the Compassionate Use and IRB concurrence (or Approval, in the case of a Compassionate Use for a group of patients) has been obtained. If the FDA approves the Compassionate Use and the IRB concurs, then the use may occur.

If the study team is submitting to the IRB instead of asking for IRB chair concurrence, or if the IRB chair decides the use should be reviewed via expedited review, the Team Q member will assign the study to the IRB clinical chair or vice-chair and process as normal.

After the approval of the device use, the IRB approval letter should include the following:

- The physician should develop a monitoring schedule for the patient and follow it in an effort to detect any possible problems arising from the use of the device.
- The physician should prepare a follow-up report on the use of the device, including a summary of patient outcome and a description of any problems encountered using the device. This report should be provided to the IRB within 5 days of the use, as well as to the sponsor.
- The Sponsor should provide the FDA with a copy of the follow-up report as an IDE supplement.
- If the compassionate use has not been approved by the FDA, the letter should state that the device cannot be used until FDA approval.

**Emergency use of unapproved drug:** This use does not need to be approved by the IRB although requires authorization by the FDA. Authorization of the emergency use may be given by an [FDA official by telephone](#), provided the physician explains how the expanded access use will meet the requirements and agrees to submit an expanded access application within 15 working days of FDA’s initial authorization of the expanded access use. The physician may choose to use [FDA Form 3926](#) for the expanded access application. The IRB will require a full submission within 5 working days of the use. This will be acknowledged by the Full Board. The submission should include:
• A copy of all information submitted to the FDA in connection with the Expanded Access use request.

• Informed consent form to be used or information demonstrating qualification for Emergency Use exception from informed consent. See the P&P entitled: Waiver or Alteration of Informed consent for Research, subsection entitled Emergency Medical Care Exception – Exception to the Requirement to Obtain Informed Consent for the Use of a FDA-Regulated Item in Emergency Medical Care Situations.

• Documentation of FDA approval for the Expanded Access Use request

**Compassionate use of unapproved drug:** this use will require FDA and IRB approvals (or IRB chair concurrence as explained later) before use. The physician may use [FDA Form 3926](https://www.fda.gov/ADA/Files/Forms/3926.pdf) for the FDA submission. A physician submitting an individual patient expanded access IND using Form FDA 3926 may select the appropriate box on that form to request authorization to obtain concurrence by the IRB chairperson or by a designated IRB member before the treatment use begins, in lieu of obtaining IRB review and approval. If the sponsor is submitting a Modification to an existing IND via Form FDA 1571, and because the form does not have a similar box, the information can be included in a separate request with the application.

If seeking IRB concurrence, the request should include the following:

• A copy of all information submitted to the FDA in connection with the Expanded Access use request

• Informed consent form to be used

If the FDA does not grant waiver of IRB approval or if the request was not made to the FDA via FDA Form 3926, the study team should submit an IRB application that would be routed to the Full Board per the regulations.

If the documentation received indicated the FDA has approved a waiver of IRB approval, the Team Q member will create a folder with the information received from the treatment team. To document the use in the system, the study team will create an RNI submission and will add all the documents required for the concurrence.

The Team Q member will contact the study team in case of any required changes while alerting the IRB Chair about the Compassionate use. The IRB chair will confirm his/her concurrence with the use of the drug via the approval of the RNI. This concurrence will be sent to the study team. The use can only start after the FDA approves the Compassionate Use and the IRB concurs.

If the study team is submitting to the IRB instead of asking IRB chair concurrence, or if the IRB chair decides the use should be reviewed via Full Board, the study will be routed as usual via a new study submission.

**REFERENCES**

FDA webpage: Expanded Access (Compassionate Use) at [https://www.fda.gov/NewsEvents/PublicHealthFocus/ExpandedAccessCompassionateUse/default.htm#Investigational_Drugs](https://www.fda.gov/NewsEvents/PublicHealthFocus/ExpandedAccessCompassionateUse/default.htm#Investigational_Drugs)

FDA Expanded Access for Medical Devices Guidance at: https://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/InvestigationalDeviceExemptionIDE/ucm051345.htm


LOG OF SIGNIFICANT CHANGES

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<td>Revamp of process per FDA changes; adding drugs to SOP</td>
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<tr>
<td>3/4/2020</td>
<td>Change in the process to align with the new system</td>
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PURPOSE
The purpose of this document is to explain the process Team Q members will follow to schedule an external webinar for our staff, ORA/OC staff or IRB members.

SCOPE
The SOP applies to external webinars presented by the Q team.

RESPONSIBILITIES
- **QA IRB analyst** – make sure to obtain sign in information for attendees and scan it to the designated folder in the H drive.
- **Q IRB Team Supervisor** - schedules the webinar and emails potential attendees.
- **IRB Director** - may schedule webinar and indicates if a webinar is required for the IRB Staff.

PROCEDURE
- The IRB Director or Q IRB Team Supervisor (per Director’s suggestion) will purchase an external webinar. The IRB Director will let Team Q members know if staff attendance/viewing is mandatory.
- The Q IRB Team Supervisor will schedule the webinar, finding a room suitable for the presentation. The room information will be emailed to the attendees. This list may include other IRB staff, IRB members, or staff from other divisions (at director’s request). The email should contain:
  - Link to adobe connect if the IRB staff is required to attend and the webinar takes place on a day other than Monday.
  - If the webinar offers credits and, if so, how to obtain those.
  - Copies of the PowerPoint for the presentation, if available.
- The registration information will be saved in a folder under the external webinar folder in the Emory IRB H drive. This can be found at H:\General\Education\External Webinars.
- In addition, the same room should be reserved from 15 to 30 minutes prior to webinar start time to allow for set up. This reservation will be sent only to Team Q members.
- On the day of the presentation, the QA IRB analyst will create a sign in page to capture all attendees. If the webinar is being broadcasted via adobe connect, the QA IRB analyst will do a “screen grab” to capture attendees via adobe connect.
- After the webinar if finalized:
  - The QA IRB analyst will scan the sign in page and save it under the external webinar folder that corresponds to the webinar. This can be found at H:\General\Education\External Webinars.
  - The Q IRB Team supervisor will send the power point presentation (if not sent earlier), and an attendance certificate/survey if applicable.
PROCESS FLOW

IRB Director/Team Q supervisor purchase webinar

Team Q supervisor purchases webinar and emails attendees

Team Q member creates sign in, and after webinar, scans completed form to H drive folder

Team Q supervisor emails attendees certificate of attendance and slides as applicable

LOG OF SIGNIFICANT CHANGES

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PURPOSE
The purpose of this document is to explain the process the IRB Team Q designee will follow after receiving an email from the Office for Clinical Research (OCR) about the use of an expired consent form.

SCOPE
The SOP applies to Emory studies that meet the NIH definition of Clinical Trial with or without EHC billable items and services, AND clinical research which doesn’t meet the definition of Clinical Trial, but does have EHC billables items and services. For these studies, a copy of the informed consent form (ICF) is placed on the electronic medical record by OCR.

DEFINITIONS
• Expired ICF: ICF that has an expiration date in the header of the document that precedes the date the subject signed the ICF. An expired ICF is not necessarily equivalent to an unapproved ICF version.
• ICF version: the number or date in the footer of the document. Any changes to the ICF’s content, approved by the Emory IRB, are reflected in a new ICF version date.

RESPONSIBILITIES
• IRB OCR representative – emails the IRB Team Q designee and the study team about the use of an expired ICF in a study approved by the Emory IRB. This person also will upload the ICF, and letter from IRB to the Emory electronic medical record (EeMR) if appropriate.
• IRB Team Q designee- reviews information, and emails OCR and study team as appropriate.

PROCEDURE
• When OCR receives an expired ICF via fax, email, or hardcopy, the OCR representative will email the study team to let them know that the consent may not be acceptable, copying the team Q designee and the IRB Director.
• The Team Q designee checks the ICF to see if the version of the ICF is that which is currently approved by the IRB.
• If the expired ICF is the current version:
  o Following the OCR email to the study team, the Team Q designee will reply-all stating this, and asking the study team to have the subjects sign an un-expired copy of the ICF.
  o The Team Q designee will also ask the study team to submit a reportable new information submission if any procedure took place before the subject reconsented.
  o In addition, the Team Q designee will email a letter to OCR stating that the expired ICF is the version currently approved by the IRB (See attachment 1).
  o OCR can then, at their discretion, upload the expired ICF into the medical record and the letter from the IRB.
• If the expired ICF is not the currently approved version:
  o The Team Q designee will reply-all stating the expired ICF is not the currently approved version, and will ask the study team to reconsent the subject(s) as soon as possible, and to send the signed correct ICF(s) to OCR to upload to the EeMR.
The Team Q designee will also ask the study team to submit a reportable new information submission if any procedure took place with the affected subject(s) before they were reconsented. The information will be sent to the CoRe team per the IRB’s current process if applicable.

If OCR receives the correct ICF forms, a letter will not be necessary.

**PROCESS FLOW**

**Process flow when the ICF version used is the same one approved by the Emory IRB**

1. OCR emails study team and Q designee
2. Q designee emails back with reconsenting instructions, ask study team to submit RE if procedures took place and sends letter for OCR
3. OCR will upload either expired ICF in eEMR with the IRB letter, or unexpired consent if reconsent was possible
4. If procedures took place before reconsent, the Q designee will send event to designated reviewer

**Process flow when the ICF version used is not the same one currently approved by the Emory IRB**

1. OCR emails study team and Q designee
2. Q designee emails back asking study team to reconsent and to indicate if procedures took place prior to reconsent
3. OCR will not upload ICF in eEMR and will wait to receive correct ICF version after reconsent
4. The Q case manager sends letter to OCR indicating the CoRe (FB) findings, final determination, and CAPA plan for the study, if OCR did not receive the subject reconsent form
5. If procedures took place, Q designee asks study team to submit a RE. The RE case manager sends event to CoRe.

**Attachment 1**

* Use IRB letterhead for this letter. Delete instructions in red.*
To whom this may concern,

On DATE we received an email from your office indicating an issue during with a subject’s informed consent process documentation (list the name of the subject; it should be one subject per letter for privacy requirements when uploading to the EeMR). Specifically, DETAILS OF EMAIL. During our review, we found the following:

The informed consent form (ICF) used to consent this subject has the same content as the currently IRB approved version of the ICF. We have instructed the study team to reconsent the subject for documentation purposes, and to submit a reportable new information submission if any research activities took place before the subject was reconsented.

You may use this letter for documentation purposes. Please let us know if you have any questions.

Sincerely,

NAME

TITLE

LOG OF SIGNIFICANT CHANGES

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PURPOSE
Representatives of the IRB (generally, members or staff) may conduct real-time informed consent observations as part of Emory’s human research protection program. This is a valuable measure for providing constructive feedback to investigators and ensuring the highest quality experience for prospective research subjects.

AUTHORITY & SCOPE
Federal regulations authorize an IRB to observe or have a third party observe the consent process and the research. The IRB staff will conduct informed consent monitoring in studies under the Emory IRB oversight.

PROCEDURES
- The IRB staff will give study teams advance notice of a proposed informed consent monitoring visit.
- The Emory IRB Informed Consent Monitoring Checklist should be used to capture relevant information for each session.
- The following procedure should be followed for consent observation:
  - In a private room or waiting area, the person obtaining informed consent should tell the prospective subject that a representative of the IRB is on site to observe the informed consent discussion. The IRB representative should then introduce him/herself to the prospective subject and ask for permission to observe the consent session. If the subject declines, the IRB representative will not observe that consent discussion.
  - The person obtaining informed consent will then conduct the informed consent discussion as usual, while the IRB representative observes silently, without taking notes or interjecting into the discussion.
  - The subject should be free to ask the IRB representative questions. If this happens, the IRB representative should answer them in a helpful manner.
  - At the conclusion of the discussion, the IRB representative will thank the subject and person obtaining informed consent and will leave the room. At that time, s/he should complete the checklist.
  - If the study team requests it, the IRB representative may may give immediate feedback on the discussion and mention any deficiencies in the process.
  - The IRB representative will send the PI a letter in follow up describing the deficiencies from the observation, if any, within three business days. Recommendations for improvements should be included in this letter. Study teams are encouraged to discuss the findings with the IRB representative or IRB Director.
  - If deficiencies in the consent process are noted, the IRB staff member may refer those findings to the IRB Compliance Review team, require additional education on the consent process, or provide on-site informed consent training for the study staff.
REFERENCES

- 45 CFR 46.109(e)
- 21 CFR 56.109(f)

LOG OF SIGNIFICANT CHANGES

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PURPOSE
The purpose of this document is to describe the process of auditing studies reviewed by the Emory IRB members and staff.

SCOPE
The SOP will apply to human subject research studies reviewed by the Emory IRB.

OBJECTIVES
• To ensure that the review categories are correct in more than 95% of the items reviewed
• To verify that the IRB staff is meeting the turnaround time targets in at least 90% of cases.
• To make sure the documents issues by the IRB are correct (including dates, information such as device risk determination, ICF/HIPAA, etc.)
• To verify that the Emory policies and procedures, and federal regulations are followed during study review, including studies under Department of Education, Department of Justice, Department of Defense, Department of Energy and the Environmental Protection Agency.

RESPONSIBILITIES
• IRB QA Team member – reviews determinations made by IRB staff and IRB members, and minutes that applied to the item, if applicable.
• IRB staff- The analyst will correct the documents, after confirmed findings from an audit which are corroborated by the IRB Associate or Assistant Director or IRB Director. Analyst also handles proper archiving of corrected documents.
• IRB Full-Board- reviews comments and approves corrected documents/minutes, if applicable.
• Designated reviewer- approves corrections of otherwise approved information, if applicable

PROCEDURE
Note: Studies reviewed at full board are audited by the minute reviewers. Effective on 8/29/2017, Team Q will only audited studies reviewed using the expedited review process.

Monthly, team Q will review a sample of new studies, Modifications and continuing reviews submitted to the IRB office during the past month. The review will include 3 items per staff member. The Team Q member will populate a dedicated excel document for this purpose. The findings will be reviewed by the Associate or Assistant Director and/or IRB director. Once the findings are verified, the IRB Associate or Assistant Director or Director will decide on the following steps. If necessary, the study team will be contacted for other follow up measures.

During the review, team Q will review the following documents:

• IRB Approval letters
• Electronic study history
• Informed consent and HIPAA forms.
• For CRs: submission of summary of events and other attached information
For Non-human subject research determinations: folder with information pertinent to review
Review of the correct use of review categories, subparts (for vulnerable populations), consent waivers, and applicable regulations.

The Team Q member will verify that the approval letters contain all the required information (e.g. device risk determination), and that the informed consent and HIPAA form have all the required elements.

**PROCESS FLOW**

1. IRB Team Q Member reviews 3 items per study analyst
2. After audit, the findings (if any) are shared with the Associate or Assistant Director and IRB Director
3. If findings are confirmed, the IRB director or Associate or Assistant Director will meet with the IRB staff to discuss study.
4. If necessary, the study team will be contacted to correct further.

**REFERENCES**

- IRB policies and procedures
- 45 CFR 46.101
- 45 CFR 46.102
- 10 CFR 745
- 34 CFR 98.3
- 28 CFR part 46
- 28 CFR part 512
- 40 CFR 26 Subparts C and D

**LOG OF SIGNIFICANT CHANGES**

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<td>5/13/2015</td>
<td>This SOP replaced Audit of Expedited, Exempt and Non-Human Subject Research Determinations and Internal QA/QI review of documents after IRB Full Board. Major overhauled to document the current review process</td>
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<tr>
<td>11/1/2017</td>
<td>Changes to the subject matter reviewed, as ADs are reviewing FB studies at the moment of auditing the FB minutes</td>
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• Letters to the PI and federal oversight agencies will be drafted by the case manager.
• Any letter to inform PIs about SNC, CNC or UP determinations should be reviewed by another member of Team Q for accuracy and readability before sending.
• Any letter to notify the FDA or OHRP about a SCN, CNC or UP determinations should be reviewed by the IRB Director before sending.
• For notifications to the FDA, the letter should be signed by the IRB chair (who is a MD or clinician). In the case of an absence of the IRB chair, a MD vice-chair may sign in the IRB chair behaves. For notifications to OHRP, the IRB Director should sign the letter. In case the IRB Director is absent, the IRB chair or the Institutional Official could sign the letter.
• Once the letter has been signed, the letter should be scanned as a PDF document and saved in H:\\irb_shared\\General\\QA Working Files\\CMTE Q\\YEAR\\DATEofMTG\\Letters to Feds
• The case manager should give the hardcopy of the letter to the meeting facilitation for archiving. The meeting facilitator will save the letter under the corresponding meeting section in the binder.
• The electronic copy of the letter to the PI should be emailed to the PI and Institutional officials, per our guidance document entitled: Everything you need to know when writing letters to PIs, FDA and OHRP after a FB determination of SNC, CNC or UP. A copy of this email should be kept under H:\\irb_shared\\General\\QA Working Files\\CMTE Q\\YEAR\\DATEofMTG\\Letters to PIs.
• For letters to FDA/OHRP, use guidance document entitled: Everything you need to know when writing letters to PIs, FDA and OHRP after a FB determination of SNC, CNC or UP. This guidance includes information of which Institutional Official should be copied in the letter and current email addresses for FDA and OHRP officials. When sending the email to the federal agencies:
  o Email the FDA/OHRP by themselves
  o Forward that sent email to the PI, copying the IOs
  o Save a copy of the email to the PI (that also contained the information of the email to the federal agencies) under H:\\irb_shared\\General\\QA Working Files\\CMTE Q\\YEAR\\DATEofMTG\\Letters to Feds
• If you receive an acknowledgment of receipt from OHRP or FDA, forward the email to the meeting facilitator and the study PI, if not copied before.

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PURPOSE
The purpose of this document is to describe the review process of reportable new information (RNIs) submitted to the Emory IRB office.

SCOPE OF SOP
This SOP scope is all RNIs submitted to the Emory IRB.

DEFINITIONS
- **IRB Team Q**: Specialized IRB staff who reviews reportable events, work on fact-finding with study team, and submit events to a designated reviewer, Compliance Review (CoRe) team and/or Committee Q as applicable.
- **Designated Reviewer**: A member who has been designated by the Chair to perform expedited reviews on a term basis, or as needed case by case, preferably in writing.
- **CoRe Team**: A designated group of the IRB Chair, Director, and qualified IRB staff that reviews reported events (including alleged non-compliance, potential UPs, potentially serious or continuing non-compliance), suspensions, and terminations. The CoRe team triages cases to determine whether they need a review at a convened meeting of the Emory IRB. The CoRe may engage the assistance of ad hoc consultants.
- **Committee Q**: A Full board meeting that primarily reviews potential serious and/or continuing noncompliance and unanticipated problem cases.
- **Non-reportable event**: An event that is not reportable to the IRB per the IRB Policies and Procedures.

PROCEDURE
**Screening of RNIs**
The Senior Q team member will screen the submission.
- If the case reported is potentially noncompliance, a reportable protocol deviation, or an unanticipated problem, it will be assigned to a Team Q member (see next section on CoRe Review).
- If the case is considered a minor protocol deviation, the Senior Q team member may send the RNI to a designated reviewer. In some cases, the RNI may be acknowledged by a designated member per SOP.
Other cases sent for Acknowledgment: If there is precedent for a case, via CoRe and/or FB, that indicates that the RNI is potentially noncompliance, but neither serious nor continuing, the Senior Q member may send the RNI for expedited review. The following specific precedents are already in place for sending to expedited review:

- Noncompliance involving the data collection from more charts than what was approved by the Emory IRB.
- Over-enrollment of subjects, in cases where the study is expected to enroll a large number of subjects as, for example, in a multi-site trial. If the study is considered of higher risk (for example a Phase I study) or the study has over-enroll with more than 25% of the approved number, the RNI should be sent instead to the CoRe Team.

To send to a designated reviewer

- Complete the pre-review and select “Additional review required” along with other applicable information.
- The review can then be assigned to the designated reviewer for processing
- Once the review is submitted, this completes the acknowledgement process. A letter is not required in these cases; however, it is a best practice to log a comment to the team informing them of our process for managing acknowledgements.

Events sent to the CoRe team

- If the case involves the VA, the following should be copied: Tony Laracuente, Jennifer Whelan, and Rodney Thompson
- If the case involves a privacy issue, the following should be copied: for CHOA, Meredith Capasse, Sarah Marie Huban and Privacy Advisor for CHOA (tomica.holmes@choa.org); for Grady, D’Andrea Morning (djmorning@gmh.edu); and for Emory, Margate Huber and Carol McMahon.
- Create a folder on the H drive in the QA Working Files\Non-Compliance or UP folder with study title and PI name, using the following format (IRB#RNI#PINAME plus initials of case manager).
  - When the case is under review, it should be located under the Pending folder.
  - If closed, the case should be moved to the Close folder. It should be located at H:\General\QA Working Files\NC UP Complaints\NonCompliance\Closed\IRB#RNI#PINAME removing the case manager initials.
- The Team Q member should contact the PI and study team for the input and clarification of data, and for a corrective and preventive action plan. Use current SOP Ed & QA Team Mission and Process.
- The information obtained is added to the worksheet. The form can be located at: H:\General\QA Working Files\Forms, templates and Guidance\Forms for RNI review
- The team Q member emails the worksheet information to the CoRe team. The information from the form should contain information from the title of the study to the CAPA plan. Other appropriate documents may be attached as well.
- The CoRe team as of March 1, 2014, is composed of Carlton Dampier, Maria Davila, Cliff Gunthel, Shara Karlebach, Rebecca Rousselle, Aryeh Stein, and Larry Tune.
- The CoRe team will “Reply All” via email with the recommendations. If anyone on the CoRe team
If the CoRe team determines that the RNI represents no noncompliance, not serious or continuing noncompliance or not an unanticipated problem, the RNI will be closed. The Omnibus form should be completed and non-applicable sections should be deleted.

- The RNI should be closed in eIRB by submitting the RNI pre-review with the appropriate determination. Once the pre-review is submitted, the case manager should still send a letter to the study team in the system.
- Some pre-review determinations will automatically move the RNI to “acknowledged” status, but a letter should still be written for cases closed by CoRe. You may have to navigate to find the RNI if it moves from your inbox as a result of the pre-review determination.
- If the RNI was reported outside eIRB, the letter should be created in word, signed, converted to PDF file, saved under study history and also emailed to the PI and study team. A copy of the letter sent to the PI should be saved in the RNI folder on the shared drive. Once the case is considered closed, the RNI folder should be archived in the closed folder.

If CoRe has determined that a safety report submitted in an RNI is not a UP, additional studies reporting the same safety event can be sent in an abbreviated form to the CoRe, with information about the study, to confirm that applies to this new study. The email should be saved in the folder on the shared drive in lieu of a worksheet. The RNI letter should also be saved in the same folder.

If the case is closed after a CoRe determination, the folder should contain the following:

- Letter to the PI: study number, PI last name, Letter to PI, date of issue (example 123 Smith Ltr to PI 11-5-12
- CoRe correspondence: CoRe determination on DATE
- Completed Omnibus form

Events sent to Committee Q

- If the CoRe assesses the RNI as potentially SNC or CNC, the RNI should be forwarded to committee Q for review. Upload a copy of the case worksheet as a private comment under the RNI history.
- If the CoRe assessed the information as a potential UP, the RNI should be sent to the next available full board meeting or CMTE Q if the RNI does not represent an immediate safety issue for subjects.
The following actions should be completed:

- Submit RNI Pre-Review and log the CoRe determination
  - Say yes to the last question to assign to the Q meeting
- The case manager is also required to inform Sarah Marie Huban and Meredith Capasse of any cases going to CMTE Q involving CHOA facilities via email.
- VA cases are required to be reviewed within 30 days. Notify VA RCO representative (Rodney Thompson) that a VA case is going to Q and invite him/her to the meeting.
- Saved the materials in the appropriate CMTE Q folder (do not include CoRe emails).
- Contact the PI to schedule the SNC/CNC/UP review for a Committee Q meeting. The PI must be invited (both by in-person and by phone). The PI may submit a response in writing or may be available to call in if they prefer. Schedule the case for an agenda based on the PI’s availability. If the PI cannot come to the meeting, consult with CoRe about moving the case to the next available meeting. In the case of UPs, the case should be reviewed at the next available meeting if it represents imminent harm to subjects, despite PI availability.

- If the board determines that an RNI constitutes an unanticipated problem or serious or continuing noncompliance, the following actions may be taken:
  - Suspension of the research:
  - Termination of the research.
  - Notification of current participants when such information might relate to participants’ willingness to continue to take part in the research.
  - Optional actions might include:
    - Modification of the protocol.
    - Modification of the information disclosed during the consent process.
    - Providing additional information to past participants.
    - Requiring current participants to re-consent to participation.
    - Modification of the continuing review schedule.
    - Monitoring of the research.
    - Monitoring of the consent process.
    - Referral to other organizational entities.

After the meeting

- Team Q will meet to review findings from the meeting and add the worksheet to the RNI Committee Review information under question 5. During this time, the CAPA plan will be added as well per SOP. Question 4 will be left empty. Question 6 should be marked as no unless the minutes are ready to be finalized.
- The PI should receive a determination letter within 2 business days. Follow available templates, and make sure institutional officials are copied if the issue was determined to represent an UP, SNC or CNC by the convened IRB. For external UPs, only the IO and OC representative should be copied.
- If applicable (after a UP, SNC or CNC determination), a letter to OHRP and FDA should be drafted and sent to the Director for review (refer to SOP). Specifically:
For studies funded with federal funds: report to OHRP
For studies using an FDA regulated product: report to FDA

- Once the FDA/OHRP letters have been reviewed by the Director, they can be emailed as a PDF to the study PI, federal oversight offices and university officials.
- The letters to OHRP and FDA should be logged in a comment under the RNI history, and saved in the study folder. These letters should also be saved under the CMTE meeting folder entitled “Letter to Feds.” The hardcopies should be given to the meeting facilitator for archiving.
- The RNI is closed in eIRB by sending the letter to the study PI. Once the case is considered closed, the RNI folder should be archived in the closed folder. If the case was considered serious noncompliance, continuing noncompliance or an unanticipated problem, the institutional officials should be copied. Follow available templates to determine who should be copied in this communication to the PI and/or federal oversight agencies.
- Save a copy of the sent email correspondence under the “PI letter” folder or “Letter to Feds” folder
- If the case is closed after a FB determination, the folder should contain the following:
  - Letter to the PI: study number, PI last name, Letter to PI, date of issue (example 123 Smith Ltr to PI 11-5-12)
  - CoRe correspondence: CoRe determination on DATE
  - Copy of worksheet
  - Copy of Letter to Feds: study number, PI last name, Letter to FDA or OHRP, date of issue (example 123 Smith Ltr to FDA 11-5-12)
- If the case has a CAPA pending item (RNI Action), the case should be moved from the “pending” folder to the “working on CAPA” folder. When the CAPA issue (RNI Action plan) is completed, the case can be moved to the “closed” folder.

For AVAMC Research:
- The medical center director must report the problem or event to the appropriate Office of Research Oversight research officer within five business days after receiving such notification.
- If the convened IRB or the IRB reviewer determines that the problem or event was serious, unanticipated, and related to the research, a simultaneous determination is required regarding the need for any action (e.g., suspension of activities; notification of participants) necessary to prevent an immediate hazard to participants in accordance with VA regulations.
  - All determinations of the IRB reviewer (regardless of outcome) must be reported to the IRB at its next convened meeting.
- If it was determined that the problem or event is serious, unanticipated, and related to the research, the convened IRB must determine and document whether a protocol or consent document modification is warranted.
- If the convened IRB determines that a protocol or consent document modification is warranted, the IRB must also determine and document:
  - Whether previously enrolled participants must be notified of the modification.
  - When such notification must take place and how such notification must be documented.
Cases involving an UP decision that affects multiple studies

- During the meeting, the board may make a UP determination. If the determination affects studies using the same drug or device, the board should make a note on the meeting minutes stating one or more of the following options:
  - Studies should review the information for the UP, and assess if an RNI or a MOD, is needed to add the new risk to their study documents.
    - The study team may disagree, and if so, they should explain why this UP does not affect their study
    - The RNI and MOD submission can be reviewed via the expedited process as a risk/benefit ratio analysis was done during the convened IRB meeting.
- After the meeting, the case manager will send an email to the IRB staff, letting them know that this UP may affect several studies, and that the RNI and MOD can be reviewed expedited, if applies. The email should contain the list of the studies.
- In addition, the case manager will log comments to each study, asking the study team to submit an RNI. If the original RNI had letters from the sponsor explaining the issue, they should be added to the comment. Here is an example for this comment:

  Dear study team,

  The IRB received the attached letter in a reportable new information submission involving a different IRB study using the same investigational agent than your study. The reportable new information was reviewed at an IRB convened meeting on DATE, and determined that the event of NAME OF EVENT, represents an unanticipated problem.

  The Board determined that this UP determination may affect your study. As such, you are may be required to submit a reportable new information. Please review the attached document, and submit a reportable new information with your assessment of this risk. If you do not agree with the submission of the reportable new information please let us know why this event does not apply to your study population. If you agree with the UP determination, you may also be required to submit an amendment to add the risk to the informed consent form. If this risk is already in your consent form, you may disregard.

  Your reportable new information and amendment will be reviewed via expedited process, as approved by the full board meeting on DATE. You have 10 business days to submit the RNI and AM or provide your assessment of why this event does not apply to your study. If your study is reviewed by an external IRB, please report to them directly.

  Let us know if you have any questions,

  The case manager is responsible to check that the RNIs and MODs have been submitted if required. The MODs will be processed by the study owner. If the study team does not take action in the allowed time, the case manager needs to escalate emailing the study team and the Senior Q member with the following information:

  Dear Dr. X,
On DATE, you were notified of an unanticipated problem determination that may affect your study. You were required to get back to us and indicate if this determination negatively impacts your study. Please, respond to this email with your assessment by close of business on DATE (Friday of this week). Failure to respond by this dateline represents noncompliance.

If you have any questions, please let us know,

NAME

- When the RNI is submitted, the information can be sent to a designated reviewer (DR) for expedited process. The DR should be a member of CMTE Q members who is a medical doctor. The message to the DR should include this information:
  - Determination was made during CMTE X on DATE
  - Assess if the UP determination also affects this study
  - Attach copy of the meeting materials and determination letter
  - Here is an example of the information for DRs:

    Dear Dr. X,

    This same event was reviewed by CMTE X on DATE for another study (IRB 123456). The event, NAME OF EVENT, was considered an UP. This same event is being reported for several studies. We need your help assessing if this event also applies for this study. If so, we will acknowledge this event as an UP for this study as well. Please submit an RNI to document the event. If you feel this event may affect this study differently and needs to be assessed again, let me know and I will send to the CoRe team.

    Looking forward to hearing from you,

    NAME of TEAM MEMBER

    PS: See attached documents from the Q meeting for your reference

- After the DR reviews the RNI, the RNI may be acknowledged or sent to CoRe for new review (if the DR does not think the UP determination affects this study). If the latter, the RNI will follow the CoRe review process as outlined before.
- If the RNI was confirmed as an Unanticipated Problem by the DR, the case manager will close the RNI with a letter to the study team.

REFERENCES

- IRB policies and procedures
- Emory SOP: Acknowledgments & Noncompliance Determinations Made by Senior Team Q Staff
- Emory SOP: Letters after FB with PIs, OHRP and FDA after SNC, CNC and UP determinations

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>11/19/2014</td>
<td>Addition of designated review process. Update of CoRe Information.</td>
</tr>
<tr>
<td>2/27/2015</td>
<td>Added step of “Emailing materials to all IRB members...”</td>
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<tr>
<td>4/30/2015</td>
<td>Added language to clarify sections, but not changes in process</td>
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<tr>
<td>6/3/2015</td>
<td>Added the information that is normally sent to the IRB members</td>
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<td>Date</td>
<td>Description</td>
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<tr>
<td>6/8/2015</td>
<td>Added actions than may be taken by FB after a SNC, CNC or UP determinations</td>
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<tr>
<td>2/8/2016</td>
<td>CAPA process reflected</td>
</tr>
<tr>
<td>10/18/2016</td>
<td>Revisions to CAPA plan</td>
</tr>
<tr>
<td>4/20/2017</td>
<td>Adding process of reviewing UP determinations affecting multiple studies</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Added process for when a safety event is called not an UP by CoRe, and there are multiple submissions with the same information for other studies</td>
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<tr>
<td>11/1/2018</td>
<td>Added information for CHOA privacy advisor</td>
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<tr>
<td>3/19/2018</td>
<td>Review of Process and changes through out</td>
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<tr>
<td>4/11/2019</td>
<td>Clarification to process</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to reflect new process after implementation of new eIRB system</td>
</tr>
<tr>
<td>2/13/2020</td>
<td>Updates SOP to align with current process</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Adding more information about the acknowledgment function</td>
</tr>
<tr>
<td>3/4/2020</td>
<td>Clarified additional steps in the system</td>
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MISSION

To support the Emory Research Community via Education/Outreach and effective quality assurance practice on behalf of the Emory IRB.

PROCESS

When a case is assigned to a member of the Education and QA team, the process will continue as follows:

If all attempts to obtain information for a case are unsuccessful, the E/QA team member will consult with IRB Director for next steps.

a) Communication strategies when obtaining information via email.
   (a) Always remember to remind the study team that you are a liaison between the IRB and the study staff and that you are gathering information needed by the IRB (or IRB members) so they can make a determination.
   (b) Have a friendly tone in your email, including words such as “collaborative” or “working together”, to reflect the cooperative mission of the E/QA team.
   (c) Help the study team with their corrective action plan, suggesting plans that worked for other teams.
(d) Do not jump to conclusions when asking questions. Remember to obtain complete information before sending the case to the CoRe team (if it is not something that could increase the risk for participants or others).
(e) If the information is not effectively obtained via email, call the PI/Study team and offer guidance and the opportunity for an in-person meeting.

b) Communication strategies when obtaining information via phone conversations.
   (a) Remember the tone of your voice and inflection when discussing problems with the study team. Remember to smile when talking.
   (b) Remember to include words that reflect the cooperative mission of the E/QA team as explained above.
   (c) Reassure the study team regarding their case. Explain the steps and, if needed, give them the definitions for Non-Compliance, Protocol Deviations and Unanticipated Problems.
   (d) If the conversation turns confrontational, avoid making any remarks or use of words that could sound challenging. Always remember to keep a friendly tone and explain why the questions are asked (you are a liaison for the IRB).
   (e) After the phone conversation has ended, promptly email the PI/Study team with a summary of the conversation, always offering additional help.
   (f) If the information is not effectively obtained, offer to have an in-person meeting.

c) Communication strategies when obtaining information in person
   (a) In meetings with PI/Study staff, remember that your body language is very important. Always shake the hand of your interviewee and look him/her in the eyes.
   (b) Do not cross your arms and always have a neutral expression on your face when asking questions.
   (c) If the answer is surprising, avoid making gestures that could make your interviewee feel uneasy or uncomfortable.
   (d) Make notes without being exclusively focused on note-taking. It is important to look at the interviewee eyes.
   (e) Finalize the meeting by thanking the interviewee for his/her time and giving him/her information to contact you if additional questions arise.
   (f) After the meeting, promptly email the study team with a summary of your conversations and next steps.

Remember that when dealing with difficult PIs or staff teams, you can always direct the call/email to the IRB Director for assistance.

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PURPOSE
The purpose of this document is to describe how the IRB Team Q conducts record reviews of studies approved at the Emory University IRB. The Emory IRB is committed to helping the research community maintain a high standard of compliance through education and guidance. Record Reviews will play an integral role in achieving this goal as it will allow the identification of problems offering opportunities for education.

SCOPE OF SOP
Record Reviews conducted in human subjects’ research overseen by the Emory University IRB.

DEFINITIONS
- Not-For-Cause Compliance reviews — Periodic compliance reviews are conducted using a systematic method to review IRB-approved research or IRB records and activities on a regular basis. The IRB will perform 10 routine record reviews per year.
- Directed Reviews — Assigned to Team Q from the IRB, ORA offices, or Emory affiliates to address a concern or previously identified potential for noncompliance.
- For-Cause Compliance Reviews: Designed to assess the Investigator’s compliance with federal regulations, state laws, and Emory IRB P&Ps. These reviews of IRB-approved research studies are in response to credible evidence of identified concerns or alleged noncompliance.

RESPONSIBILITIES
- Principal Investigator — After the IRB has notified the PI of the record review, the PI and study staff are responsible for providing all the required documentation as described in the notice. The PI is also responsible for responding to the record review findings within 5 calendar days of receiving the record review summary.
- IRB reviewers — The reviewers are responsible for giving a report of findings within 5 calendar days of the completion of the record review. The written report to the PI will include the IRB reviewers’ findings and a suggested corrective and preventive action (CAPA) plan, along with a reasonable deadline for completion (e.g. a month) The PI may adopt the CAPA as provided, or modify it to match his or her needs. The IRB reviewers will schedule reminders for follow up to ensure compliance.
- Reporting: After the report has been reviewed by the PI and the CAPA plan has been accepted, the IRB reviewer will send the report to the compliance review (CoRe) team. If the CoRe team makes a determination of possible serious or continuing non-compliance or an unanticipated problem increasing the risk for participants or others, the report will be reviewed at the full board meeting.

PROCEDURE
The process will start by communicating with the research staff and coordinator about the record review visit. The notice for the record review may vary according to review type. For Not-For-Cause compliance reviews, the study team will have two-week (10 business days) notice from the date of the initial communication to the date of the record review. For-cause compliance reviews will be conducted
within 2 business days of the IRB’s initial contact with the study team. The study team should respond within 24 hours to schedule the record review. Directed record reviews will be conducted according to study team needs or as mandated by the IRB.

1. The IRB will contact the study team to schedule the meeting. The study team has from 1 to 5 business days to respond to this request, depending on the record review type.

2. The IRB will conduct the record review on the scheduled date. The minimum documents needed for review are the study regulatory binder (for clinical research), protocol (all versions), informed consent and HIPAA consent forms (all versions), correspondence with the IRB, IRB submission records and individual study subject information. The IRB reviewers may give real-time feedback and answer questions about the information that is being reviewed. The IRB reviewer may also ask questions to the PI and study staff in case of doubts when performing the record review. The IRB reviewer may not communicate expected actions of the IRB.

3. The IRB reviewer will send the record review report within 5 business days of the record review’s completion. The PI will review the findings and CAPA, and determine if the findings are accurate and if he or she accepts CAPA as is, or if he or she would like to modify it.

4. The PI has 5 business days to respond to the reviewer findings.

5. The IRB and PI, and the study team if desired, will meet the following week to discuss the findings and next course of action including CAPA implementation and education opportunities.

6. The IRB reviewers will send the report and accepted CAPA plan to CoRe team for review, and later to the full board meeting if needed.

7. If findings required CoRe review, the study team should submit a RNI in 10 business days. If the study team do not comply with the request, the Team Q member will create the RNI for them and ask a super user for submission, documenting the communication with the study team about this requirement.

**PROCESS FLOW**

- IRB contacts study group to schedule the record review
- Depending on the record review type, the study team has between 1 and 5 days to respond
- Record review is performed on the scheduled date
- The PI and staff meet with IRB reviewers to discuss findings
- PI responds in the next 5 business days
- IRB record reviewer prepares the report and sends it to the PI
- After report review and CAPA plan acceptance, the report will be reviewed by CoRe team. Ask study team to submit a RE
- If CoRe team considered the findings to constitute possible SNC, CNC or UP, it will be reviewed by FB
- The PI will review the findings and CAPA, and determine if the findings are accurate and if he or she accepts CAPA as is, or if he or she would like to modify it.
- The PI has 5 business days to respond to the reviewer findings.
- The IRB and PI, and the study team if desired, will meet the following week to discuss the findings and next course of action including CAPA implementation and education opportunities.
- The IRB reviewers will send the report and accepted CAPA plan to CoRe team for review, and later to the full board meeting if needed.
- If findings required CoRe review, the study team should submit a RNI in 10 business days. If the study team do not comply with the request, the Team Q member will create the RNI for them and ask a super user for submission, documenting the communication with the study team about this requirement.
### APPLICABLE REFERENCES

- IRB QA Plan 12.15. 08
- 45CFR 46.
- IRB policies and procedures

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<td>8/5/2016</td>
<td>Adding RNI requirements if findings need CoRe review.</td>
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PURPOSE
The purpose of this document is to describe the process of reviewing progress reports received under 21 CFR 812.150 (b) (5).

SCOPE OF SOP
The SOP will apply to Emory human subject research working under an IDE.

DEFINITIONS
- **Investigational Device:** means a device, including a transitional device that is the object of an investigation. An investigational device is permitted by the FDA to be tested in humans but not yet determined to be safe and effective for a particular use in the general population and not yet licensed for marketing.
- **Investigational Device Exemption (IDE):** An IDE allows an Investigational Device to be used in a clinical study in order to collect the safety and effectiveness data required to support a Premarket Approval (PMA) application or a Premarket Notification submission to the Food and Drug Administration.
- **Sponsor:** A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator.

RESPONSIBILITIES
- **IRB QA Associate or Assistant Director** – reviews the progress report submitted by the sponsor or sponsor-investigator.
- **Sponsor or Sponsor-Investigator:** at regular intervals, and at least yearly, a sponsor shall submit progress reports to all reviewing IRB’s per 21 CFR 812.150 (b) (5).
- **IRB administrative assistant:** scans the progress reports, so they can be added to the study electronic record by the QA Associate or Assistant Director.

PROCEDURE
Once the IRB receives a progress report (different from the annual report that should be submitted at continuing review), the Team Q Lead will review the report to verify that it does not contain any new information that should be reported promptly to the board. If the progress report does not contain new information, the QA Associate or Assistant Director will forward it to the IRB administrative assistant who will scan it. The scanned progress reports will be saved under H:\General\Scanned Documents\IDE progress reports from Sponsors. Once scanned, the IRB administrative assistant will return the hard copies to the Team Q lead. The Team Q Lead will attach the scanned records to the study electronic history with a comment indicating that the report did not include any new information and requesting comments from the study staff about the report review. If the report includes new information that should be reviewed by the full board, the Team Q Lead will send the report to the CoRe per our SOP entitled Team Q NC-UP process SOP.
The report may be destroyed after scanning and archiving under the study history.

**PROCESS FLOW**

- IRB receives progress report from sponsor holding an IDE
- If progress report does not contain new information, the Team Q Lead will be forwarded it to Admin staff to be scanned. If the report contains new information, it will be routed to the CoRe team.
- Once scanned, the Team Q lead will attach the report to the study electronic record with a comment indicating that no new information was identified.

**REFERENCES**

- 21 CFR § 312
- 21 CFR § 812
- IRB policies and procedures

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PURPOSE
The purpose of this document is to describe how the IRB Team Q will route external unanticipated problems from studies considered FDA regulated.

SCOPE OF SOP
FDA regulated trials conducted in human subjects’ research overseen by the Emory University IRB.

DEFINITIONS
- **Investigational Device**: means a device, including a transitional device that is the object of an investigation. An investigational device is permitted by the FDA to be tested in humans but not yet determined to be safe and effective for a particular use in the general population and not yet licensed for marketing.
- **Investigational Drug or Investigational New Drug**: An Investigational Drug or Investigational New Drug means a new drug or biological drug that is used in a clinical investigations or a biological product that is used in vitro for diagnostic purposes.
- **Investigational Device Exemption (IDE)**: An IDE allows an Investigational Device to be used in a clinical study in order to collect the safety and effectiveness data required to support a Premarket Approval (PMA) application or a Premarket Notification submission to the Food and Drug Administration.
- **Investigational New Drug (IND) Application**: An application that must be submitted to the FDA before a drug can be studied in humans. This application includes results of previous experiments; how, where, and by whom the new studies will be conducted; the chemical structure of the compound; how it is thought to work in the body; any toxic effects found in animal studies; and how the compound is manufactured.
- **Sponsor**: A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator.
- **Sponsor-Investigator (S-I)**: means an individual who both initiates and conducts an investigation, and under whose immediate direction the investigational drug is administered or dispensed. The term does not include any person other than an individual. The requirements applicable to a sponsor-investigator under this part include both those applicable to an investigator and a sponsor.
- **Unanticipated Problem**: any unexpected problem related to the Research, including any unexpected adverse experience, whether serious or not, that affects the rights, safety or welfare of subject or others or that significantly impacts the integrity of the research data. OHRP considers unanticipated problems, in general, to include any incident, experience, or outcome that meets all of the following criteria:
  - Unexpected (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol.
and informed consent document; and (b) the characteristics of the subject population being studied;

- Related or possibly related to participation in the research (in this guidance document, possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); and
- Suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

**Unanticipated Adverse Device Effect (UADE):** any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects

**RESPONSIBILITIES**

- **IRB Team Q member:** reviews initial reported events and sends them to CoRe or FB if appropriate.
- **IRB analyst:** Makes sure study team reports events through a reportable new information submission (RE) form.

**PROCEDURE**

- If an external event is called an unanticipated problem by the sponsor (or S-I), then the event will be reported via RNI (and Mod if necessary).
  - If event does not merit changes via Mod (e.g. study is closed for enrollment without active subjects), Associate or Assistant Director will send event to DR.
  - If the sponsor has not requested changes in the study but the event may merit changes, (e.g. study is still enrolling or have active subjects) the event will be reviewed by CoRe. CoRe may acknowledge the event/no changes in study or may recommend FB to review the CoRe suggested changes to study.
  - If sponsor or S-I reports events as unexpected and related but does not call it a UP, the event will go through CoRe/FB as normal.
- If the event is reported only as a Modification, the IRB analyst will request the submission of a RNI as well.
- The IRB analyst will contact Team Q lead to notify about the Mod. Team Q only needs to know about Mod involving increased risk (e.g. changes to the ICF involving new adverse event).
- Team Q lead will assign the RNI to a Team Q member who will be in close communication with the IRB analyst.
- When the RE/Am goes to FB, the FB should make one of these two determinations:
  - The IRB acknowledges the UP determination, and determines that changes as submitted are appropriate.
  - The IRB acknowledges the S or S-I determination, but thinks additional changes are necessary.
- After the FB meeting, the IRB analyst will notify Team Q of the UP determination.
- The Team Q member will send FB determination letter to the PI, copying Kris West.

**PROCESS FLOW**
RE/Am is received. If only reported in Mod and risk may be increased, IRB analyst request RE

If S or S-I calls event a UP but does not ask for study changes
- No changes needed—send to DR
- Changes may be needed-send to CoRe/FB

IRB analyst (AM owner) will inform Team Q of FB action

If event goes to FB, FB may:
- Acknowledge UP determination and approve changes
- Acknowledges UP but require additional changes

UP letter done by Q, cc Kris West

AM letter done by IRB analyst

REFERENCES
- IRB QA Plan 12.15. 08
- 45 CFR 46.103
- IRB policies and procedures
- 21 CFR 812.3

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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STUDY MANAGEMENT
MODIFICATIONS

<table>
<thead>
<tr>
<th>SOP Title:</th>
<th>Adding/Removing Study Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOP Category:</td>
<td>Modifications</td>
</tr>
<tr>
<td>Established:</td>
<td>4/11/2014</td>
</tr>
<tr>
<td>Last Revision:</td>
<td>3/4/2020</td>
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PURPOSE
To explain the process of reviewing Modifications that include staff changes only.

SCOPE
The SOP applies to all approved, non-expired studies. If the personnel change includes an AVAMC study, alert Daniel Roysden (droysde@emory.edu) about the Modification.

PROCEDURE
1. Log into eIRB. You should be on the “My Inbox” tab. Click on the “Personnel Changes” tab. Review the “Date Modified” column to see the modifications you have to complete (per your assignment day).

   Remember: depending on your day, you are in charge of reviewing the modifications submitted from 4:00 pm the day before to 3:59 pm on the day of your shift. For example, if you are in charge of reviewing modifications submitted on Wednesday, start with the ones submitted from Tuesday at 4:00 pm to Wednesday at 3:59 pm. If you are in charge of the swift on Monday, you need to review all the submissions from Friday at 4:00 pm to Monday at 3:59 pm.

2. To open a modification, click on the link under the “Name” column
3. Once on the submission, you need to add yourself and the IRB coordinator. Click on “Assign Coordinator”

4. A new window will pop out. Click on your name and OK.
5. You will be back on the modification submission space. To view the submission, click on “View Modification/CR”

6. Notice that there are two sections in the submission. The summary and the actual submission. The summary will tell you what they are submitting and the people that they are adding or taking off the submission.
7. To verify what is being changed, you can click on Compare and then review the changes.

8. Review all the sections. If the following takes place, please click on “Assign Coordinator” and assign it to the main study owner of the study:
   - This Modification also contains changes to the study itself- “Other Part of the Study” was selected.
   - Addition of staff with a Financial interest
   - Adding someone as External Staff Member
   - PI Change
9. Click on Exit to come back to the modification page. Click on “View CITI training” and verify that the personnel being added have proper CITI training. Review the “Training verification” SOP for more information.

10. After training is verified, click on “submit pre-review. A new window will open. Scroll down to question 8.0 and click yes.
11. Click on “Assign Designated Reviewer”

12. Select yourself as a staff designated reviewer from the list. This action is only to move forward the submission as you will be completing the next steps.

13. Click on “Submit Designated Review”
14. Go to question 1, and click “Approved”

15. Scroll down to question 3 and select “expedited”.

16. Once you click on “expedited” a new question will open that ask you to select a category. Select the one that reads “minimal modification”
17. If you are asked to provide reasoning why a study needs to come back for expedited review, please say: “Not making changes to the submission, only modifying personnel”

18. Scroll down to question 9 and check the box, and then click on yes on question 10.

19. Click on “Prepare Letter”.

Post-Review

Entered IRB: 11/25/2019 7:28 AM
Last updated: 11/25/2019 8:31 AM

Next Steps

- View Modification/CR
- Printer Version
- Finalize Documents
- Prepare Letter
- Submit Designated Review
20. Click on Generate Letter after selecting the “Acknowledgment of Personnel Update” template. Open the letter, sign it with your name, and save it. Upload the revised version and click “OK”

21. Click on “Send Letter”

22. A new window will open. Review that the letter is the correct version you uploaded. Click on OK to send the letter to the study team, closing the submission.
23. The submission will be complete after this step.

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<table>
<thead>
<tr>
<th>DATE</th>
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<tbody>
<tr>
<td>5/13/2015</td>
<td>Added purpose and scope and update of the information</td>
</tr>
<tr>
<td>6/22/2016</td>
<td>Added guidance for incomplete requests</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Added information to respond to ineligible requests, replaced SOM contact name for volunteer verification and added VA information</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Overhaul of this SOP due to change of electronic system</td>
</tr>
<tr>
<td>2/26/2020</td>
<td>Added more detail about how to look for changes in the submission, and added graphics to identify MODS that should not be approved by the student workers</td>
</tr>
<tr>
<td>3/4/2020</td>
<td>Adding instructions in case the system ask for a justification of why a CR needs to take place again</td>
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</table>
PURPOSE
The purpose of this SOP is to outline the step by step procedures for processing a Modification from submission to approval.

SCOPE
This SOP applies to Modifications that need both expedited and full board reviews. If the modification is for staff change only, ignore as the dedicated staff members these modifications will take ownership of them. For combined mod/CR, the analyst should retain review and not assign to an analyst assistant. This SOP only applies to the modification process. Please see CR SOP for details on handling renewal submissions.

DEFINITION
- **Modification**: Any change to a current study that would require review from the IRB before implementation.
- **Ancillary Committee**: Refers to outside committees including Biosafety, Radiation Safety (RSC), CTRC etc., that would need to review a Modification based on any additional procedures being added that would trigger their departments review.

RESPONSIBILITIES
- **IRB Analyst**: Take the Modification through the entire process from submission to approval

PROCEDURES

**Analysis of Modification Application**

- Have the Mod Screening Guide accessible while analyzing the Mod application H:\General\Admin IRB Documents\Checklists, Forms, and Templates. For more information about pre-review and ancillary review information, review our SOP.
- If the Mod includes a 483 report after an FDA inspection to the study or sponsor, ask the study to remove this report and to submit via RE.
- If this Mod adds a drug under REMS or a drug considered a controlled substance;
  - Studies using controlled substances drugs should fill out the Investigator Checklist for the Use of Schedule I Controlled Substances and email to Margaret Huber at mhuber@emory.edu. Make sure you communicate with Margaret about next steps.
  - REMS process has been followed, per our SOP entitled: “REMS study review”. Please review REMS SOP and talk to a TL or IRB Director about following steps
If adding a new funding source, please reference Guidance to connect Grants and IRB Approved Protocols. If new DoD funding, see study checklist. The amendment screening guide includes additional considerations around new funding sources.

Verify that the proposed modifications have been made in the revised eIRB smartform and Mod application. For guidance on viewing changes please see “Staff Quick Reference document.”

If changes are needed, click the “Request Pre-Review Clarification” and inform the study team of the requested changes.

- The state of the Mod will change to “Clarification Requested (Pre-Review)”
- The study team will need to hit the “submit response” button to return the Mod back to the IRB to be processed. Sometimes the study team will make changes without submitting the study back. Be sure to occasionally review the “In Process” tab for logged comments to catch these Mods.

If no further changes are needed, determine the appropriate routing of the review (i.e expedited or full board). Please also complete the Pre-Review Note: Do not modify selections under “Regulatory oversight” and “Special determinations and waivers” sections unless the Modification impacts the applicable area. Reference the following SOPs to determine the appropriate route and reviewer of the Mod:

- Determinations and Reviews by IRB Staff: for minor administrative changes that can be approved by the analyst assigned to review the Mod
- Categories of research reviewable by IRB staff as IRB designated members: for selected Mod that could be reviewed by Associate or Assistant Directors or other Sr. RPAs.
- Modifications Indicating Increased Risk: for a Mod that may require Full Board review

For guidance on assigning for designated review, please see “IRB Staff Quick Reference”

Some considerations when assigning reviewers:

- For expedited studies: Assign expedited reviews to the reviewer whose specialty is most closely related to the study. For full board reviews assign to the committee who has a representative who has the needed specialty.
- For exempt studies: In situations where IRB staff can complete initial review for an exempt study, analysts can self-review Modification submissions. Modifications for studies that underwent limited IRB review initially (reviewed by a staff designated reviewer) must also be sent to a staff designated reviewer for a determination that the study’s exempt status has not changed.

- Under the Comments section, include a brief description of the proposed Mod when assigning the Mod for review. The description should allow a reviewer to quickly ascertain the contents of the Mod.
- Press “OK”
- The current state of the Mod should change from “Pre-Review” to “Non-Committee Review.”
- At this point you wait for the expedited reviewer to complete their review

After review is submitted the state will change to “Post-Review.” Go to the “Reviews” tab to find the reviewers determination.
• **If changes are requested**, select “Prepare Letter” and choose the template for “Modifications Required to Secure Approval”
  • Once your letter has been created, click “send letter” and wait for changes to be submitted back from team. Once you receive and screen the changes, assign back to reviewer per instruction below by following steps outlined in the [Staff Quick Reference document](#):
    ▪ When the answer is received, assign the study to the same reviewer again. The designated reviewer will see the submission under their reviewer inbox. Log a comment
    ▪ Ensure that the designated reviewer has selected the right approval/expiration dates, specially after a pending review. You can submit a review yourself to correct the issue, adding a comment of why you are resubmitting. If unsure, ask one of the TLs.

• **If you are ready to finalize approval**, first review the expiration date in the designated review space. Ensure that the expiration date is the overall study expiration date.
  • If the expiration date is incorrect, click of “submit designated review” and correct.
• After this check, click “Finalize Documents” on the study workplace. Select only the new or revised documents to change to PDF and watermark. Click OK. The Documents tab on the study workspace will include links to the final versions of the documents.
  • If no changes are requested, select “Prepare Letter” and choose the appropriate approval template from the drop-down selections.

**Tips for drafting letters:**

![Generate Letter](Generate Letter.png)

• Choose appropriate letter template and generate from the dropdown menu. Download the generated letter by selecting “Download Copy” and make the following edits:
  • Remember to include the PI’s post-nominal (degree – MD, PhD, MPH, etc.)
  • Delete the template letter language that does not apply to the current MOD and remove rows that state “No Items to Display.”
  • Edit the “ENTER NAME OF LETTER SIGNATORY” and “title’ fields to add your own name and title.
  • Save a copy of the letter on your desktop and “upload revision”

![Prepare Letter](Prepare Letter.png)

• Click “Send Letter”
• MOD/CR (see CR SOP for details on processing the CR portion of the submission). Reference the [Staff Quick Reference document](#) for details about handling this type of submission.
  a. Ensure that all documents were finalized appropriately by opening them from the “Documents” tab.
Full Committee Modifications:
• To start, log a private comment indicating why the modification requires Committee review.
• See Staff Quick Reference document for details on assigning for Committee review.
• Click on “Edit pre-review”, and add the following under question 6 (Notes):
  o The study is currently enrolling subjects (Y/N)
  o If this is a Sponsor-Investigator study:
    ▪ If this Mod is adding new sites (Y/N)
    ▪ If yes, the responsibility form should be included in the submission with an S-I consult approval (This is required before the Mod can be approved)
  o If this is a Risk Evaluation and Mitigation Strategy (REMS) (Y/N)
    ▪ If yes, has a REMS consult approval submitted? (This is required before the Mod can be approved)

Steps to Check the Full Board Committee’s Decisions Reviewer’s Review
Once the meeting pod has reconciled the meeting notes and omnibus forms and releases the agenda for letter writing via email, review the applicable forms to obtain committee decision.
• Follow steps outlined above and in the Staff Quick Reference document for further processing for either “modifications required” or approval.
• If modification is deferred, once team submits changes check that deferred issues have been addressed, schedule the Deferred modification to be reviewed by the same committee that conducted the initial review of the modification application (i.e. if CMTE B1 reviewed the modification in January meeting and deferred it, send to the next available meeting for CMTE B1).
• After the meeting, if the Deferred issues are approved, follow steps for processing approval.
• If a modification is pending approval, once the team submits the changes:
  o Email the study link to the designated reviewer
  o The designated reviewer can click on “Review Required Modifications” to document the changes made are adequate.
  o If the designated reviewer has any difficulties, you can complete the step above. Make sure you attach a confirmation that the reviewer agrees the changes as submitted are adequate (this could be an email communication).
  o Ensure that the designated reviewer has selected the right approval/expiration dates, specially after a pending review. You can submit a review yourself to correct the issue, adding a comment of why you are resubmitting. If unsure, ask one of the TLs.

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<tbody>
<tr>
<td>5/13/2015</td>
<td>Major overhaul of this SOP, with combination of previous SOPs involving Mod information.</td>
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<tr>
<td>8/11/2016</td>
<td>Clarify process for handling issue with consent merge following Mod processing</td>
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<tr>
<td>11/11/2016</td>
<td>Slightly revised suggested letter text for Modifications given approval after being pended by full board</td>
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<tr>
<td>4/20/2017</td>
<td>Deleted the step of setting expiration date under IIE (Post-expedited Mod review steps-APPROVED)</td>
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<tr>
<td>5/17/2018</td>
<td>Rearranged document for readability, added purpose, scope and definitions</td>
</tr>
<tr>
<td>11/1/2018</td>
<td>Added information about Controlled Substances</td>
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<tr>
<td>Date</td>
<td>Changes</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>1/18/19</td>
<td>Added clarification about exempt studies; aligned with Revised Common Rule</td>
</tr>
<tr>
<td>8/30/2019</td>
<td>Updated survey link</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Several changes to align with new eIRB system</td>
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<tr>
<td>2/12/2020</td>
<td>Added a link for the Modification screening guide</td>
</tr>
<tr>
<td>2/13/2020</td>
<td>Updated links in SOP</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Added link to pre-review/ancillary review SOP</td>
</tr>
<tr>
<td>2/26/2020</td>
<td>Updated formatting that clarified text</td>
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<td>3/8/2020</td>
<td>Added a step to check the expiration date in modifications approved by a designated review in case that, mistakenly the member added an expiration date</td>
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<tr>
<td>3/23/2020</td>
<td>Added that the study analyst needs to send an email to the designated reviewers after the study team respond to their required changes</td>
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<tr>
<td>4/14/2020</td>
<td>Adding additional steps after contingency review</td>
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<tr>
<td>4/20/2020</td>
<td>For DR contingency reviews, the RPA needs to assign the study back to the designated reviewer again to complete the process</td>
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PURPOSE
To explain the process of reviewing Modifications (Mod) that indicate an increase in risk, and to describe when a reportable new information (RNI) submission may be necessary.

SCOPE
The SOP applies to studies approved by the Emory IRB.

RESPONSIBILITIES
- IRB Analyst - will review the submission and assess if the Mod may need a RNI submission.
- IRB Team Q member – will assist analyst in determining if an Mod needs a concurrent RNI submission.

PROCEDURE
1. Determine if a RNI should be submitted along with the Modification:
   a. If this Mod information comes from an analysis of aggregated data by the sponsor (action letter, post-marketing data analysis, etc.) and if it appears to be unrelated to a specific adverse event, then no reportable new information submission is required.
      i. For example: the Mod states that, after reviewing data from all sites, they have discovered an increased frequency of event X, and they have decided to modify the protocol, ICF or IB. Such sponsor-prompted Mods do NOT require a concurrent RE. This is because the sponsor has done a review of these aggregated data and the IRB would have no additional information with which to do a better review, or call something an UP. The IRB’s task now is to review the proposed changes to protocol, IB and especially the ICF. This process can be completed by the Full Board, without the need of a reportable new information submission.

   b. If the Mod information includes a safety memo about an event involving an individual subject or subjects, a reportable new information submission may be required.
      i. For example, the Mod may state that X number of subjects experienced event X, detailing each clinical case in the report, and that is why the sponsor thinks the matter is unexpected, serious and will make changes to the protocol, ICF or IB. The study analyst should alert Team Q about the Mod. Team Q will verify if a RNI is required or not. If Team Q received a RNI that requires the submission of an Mod (if not already submitted), Team Q will log a comment into the study history to alert the study analyst.

2. Determine mode of review for Mod: When receiving a new risk via a Mod, check Onenote to verify if the information in the Mod was previously reviewed at FB and can go expedited in subsequent studies. The Onenote is called “One Note IRB Full Board Meeting Operations”, section “AM risk changes FB determined can be expedited for other studies (without RE).” If not, the new risk information should go to FB EXCEPT when it falls under 3(b) below.

*Note: If there are changes to the Investigator’s Brochure (IB) without ICF changes, then ask study team when changes to ICF are expected. If the study team said the changes to ICF are forthcoming, send to FB...
with a note explaining the study team has not provided ICF changes. Note in the omnibus form under “pending” section in Mod.

3. Handling of Modification with respect to Reportable new information submission (when required)

   a. If a reportable new information submission has been submitted and it has not already been reviewed by CoRe or Full committee (i.e., a determination of UP or not an UP has not been made), then analyst should contact the case manager for the reportable new information submission for more information. Case manager should also log a comment in Mod and communicate with study owner about RNI disposition.

   b. If the CoRe determines that the reportable new information submission is not a potential UP, and determines that there is no change to the overall risk/benefit ratio of the research study, then the Modification may go to expedited review.

   c. If the CoRe determines that the reportable new information submission is a potential UP that represents an immediate safety concern, then it must be reviewed at the next full board meeting. The IRB analyst should add the Modification to the same meeting’s agenda where the reportable new information submission will be reviewed, if possible. In general, Modifications and REs with new safety information should be reviewed in the next available meeting. Please, discuss this with the Q Team and meeting facilitators.

   d. If the CoRe determines that the reportable new information submission is a potential UP that does not represent an immediate safety concern, then it will be reviewed at the next Committee Q meeting. The Modification can also be reviewed at the Committee Q meeting if the only changes relate to the reportable new information submission and/or other changes do not need to be reviewed sooner (discuss with your Associate or Assistant Director or Director if not sure).

      i. Let the Team Q case manager and Q meeting facilitator know that the Modification will be reviewed at Committee Q so materials can be prepared. After the Team Q Meeting, the case manager will log a comment in the Modification history detailing if the Modification was approved as it is or if it has pending issues.

      ii. If the Modification was approved, the analyst should assign the review to him/herself for completion. This does not mean the analyst is making a determination; the Modification was approved at the Committee Q. The analyst is simply completing the review to move the Modification to the draft letter state.

      iii. If the Modification has pending issues, the Modification should be assigned to the Q chair (Dr. Stein) for review and final approval.

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<td>12/11/2015</td>
<td>Clarification of steps and updating to match current process</td>
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<td>2/27/17</td>
<td>Minor administrative edits</td>
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<tr>
<td>11/1/2017</td>
<td>Reformatting to improve readability and clarifications</td>
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NEW STUDIES

SOP Title: Pre-Review options and Ancillary Review Information
SOP Category: Study Management
Established: 2/24/2020
Last Revision: 3/5/2020

PURPOSE
To detail all the options to check during the pre-review of a new study submission. In addition, this SOP will cover the current ancillary review information.

SCOPE
The SOP applies to all studies reviewed by the Emory IRB.

RESPONSIBILITIES
- IRB analyst – reviews study documents to verify the selection of the correct options during pre-review and ancillary reviewer selection
- IRB directors - assist analyst if needed

PROCEDURE

Pre-review options
Review the protocol, consent form, and funding section to identify the correct options to select. If the study is sponsored by a subaward, review who is the primary awardee to make selections in this section. For example, if the study is funded by a subaward, if the subaward is funded with DoD funds, the study at Emory should be considered DOD funded. See below for more information about each option in the pre-review section:

1. Regulatory oversight: (check all that apply)
   - DOD (Department of Defense) – select as appropriate per funding
   - DOE (Department of Energy) – select as appropriate per funding
   - DOJ (Department of Justice) – select as appropriate per funding
   - ED (Department of Education) – select as appropriate per funding
   - EPA (Environmental Protection Agency) – select as appropriate per funding
   - FDA (Food and Drug Administration)- If the research is using a drug, device, biologic, dietary supplement or medical food, medical mobile app, or any other regulated investigational product even if previously FDA approved or if funded by the FDA (rare). If the use of the device is routine but not part of the research question, you may not need to select this box.
   - GDPR (General Data Protection Regulation)- select if this study has international sites under the GDPR mandate. See here a list of countries affected GDPR. If your study is affected, email Carol McMahon at OC to confirm steps moving forward (copy Rebecca and your team lead)
   - HHS (Department of Health and Human Services)- select as appropriate per funding. Generally, studies funded by NIH and other groups that may include a “National” in their title (not always, like CFAR). Use google if it is not clear.
   - ICH GCP (International Center for Harmonization of Good Clinical Practice)- Look for the term on the study protocol. If it says ICH-GCP, as adopted by FDA no additional action is required other
than checking this box. If they say ICH-GCP E6, loop IRB Director if not done already per NS worksheet.

- NSF (National Science Foundation) - select as appropriate per funding
- OCR (Office of Civil Rights)- if HIPAA applies or is requesting HIPAA waivers or any kind
- VA (Department of Veterans Affairs)- For VA studies only
- Other federal agencies- if not contemplated above, contact IRB Director
- Tribal law- if involving the study of a tribe

2. Special determinations and waivers-attach the following checklist to your pre-review per population or situation selected:
   - Broad consent: Institutionally, Emory is not allowing broad consent for any study. If a study requests the use of broad consent, please let them know this is not allowed. If the study team pushes back, contact a director.
   - Children: Subpart D checklist
   - Children who are wards of the state- Subpart D checklist
   - Cognitively impaired adults- HRP-417 - CHECKLIST - Cognitively Impaired Adults
   - Neonates of uncertain viability- Subpart B checklist
   - Nonsignificant risk device- Device checklist
   - Non-viable neonates-Subpart B checklist
   - Pregnant women- Subpart B checklist
   - Prisoners- Subpart C checklist
   - Students / Employees- no checklist required
   - Waiver of consent documentation- HIPAA attestation and waiver document
   - Waiver of consent for emergency research- HRP-419 - CHECKLIST - Waiver of Consent Process for Emergency Research (found in eIRB library)
   - Waiver of HIPAA authorization- HIPAA attestation and waiver document
   - Waiver/alteration of the consent process- HIPAA attestation and waiver document

3. Type of research: (check all that apply)
   - Biomedical/clinical- studies focused on medical test or procedures, or that involve medical chart review
   - Social/behavioral/educational- studies focused on humanities areas, public health, and psychology
   - Other- if does not fit any of the above

4. Additional study features: (check all that apply)
   - Clinical Trial- If it meets the NIH definition of a clinical trial (a research study in which one or more human participants are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes). Review the study team answer under question 1, section “For Clinical Research/Expanded Access Only) on the last page of the submission. If you do not agree with the answer, email Jennifer Prozonic for guidance.
   - Certificate of Confidentiality (CoC)- if the study is using a CoC. This applies to all human subjects’ research studies funded by the NIH or others if they were granted one. See here for more information.
• Collaborative- research conducted by more than one site when the procedures are divided by institutions.
• Deception- is a study involves deception, even if the deception involves incomplete disclosure
• Multi-Site Study- a study conducting the same procedures (following the same protocol) at different sites.

Ancillary Review Information
Every study should have a department reviewer at a minimum. Review the study protocol and study team members to determine what ancillary reviewers apply to the study. When picking a department reviewer, use the Emory Directory to find the PI’s affiliation.
• If you find that the PI is not a faculty member (SOM studies), he or she cannot fulfill the PI role.
• A nurse can be the PI if the study is under the School of Nursing (and minimal risk).
• Students at Rollins Public Health School can be PIs with a faculty advisor. To select a faculty reviewer:
  o In question 1, do not select an Organization; instead, select the faculty advisor in the “Person” field. Then select “Faculty Advisor Review” from the “Review Type” dropdown. Select “Yes” for “Is a response required?”. Feel free to send these instructions to the student so they can select their advisor.

You can search using part of the ancillary review name with a % sign before. When selecting the department, find the department under question number 1 (do not need to select a person, only the main organization), select the type of review under question 2 and select if the review is required or not. All ancillary reviews are required before the study can be approved except for the Office of Quality.

See below for the ancillary reviewers to pick per study (not includes department reviewers):
• Conflict of Interest- if a study team member has disclosed a financial interest or said yes to question 3 under “Waiver Requests and Ancillary Considerations” (last page of the IRB submission).
• Controlled Substance Consult- if the study said yes to question 7 under the “Ancillary Review Information” section (last page of the IRB submission) or by identifying the use of a controlled substance in the protocol or consent.
• CTRC (Human Cancer Studies)- if study team said yes to question 1 under the “Ancillary Review Information” section (last page of the IRB submission)
• EHSO Biosafety- if study team said yes to either of the options under question 2 under the “Ancillary Review Information” section (last page of the IRB submission)
• EHSO Radiation Safety- if study team said yes to question 3 or 4 under the “Ancillary Review Information” section (last page of the IRB submission)
• Office of Quality- if the uploaded CRKP form (uploaded on question 4, under the “For Clinical/Expanded Access only” section) indicates that either EML, Nursing, or Radiology is involved. Office of Quality review applies to a clinical trials conducted at Emory Healthcare.
• REMS Consult- if the study said yes to question 8 under the “Ancillary Review Information” section (last page of the IRB submission), or by searching the term “REMS” on the study protocol or consent
• S-1 Advisory (for Sponsor-Investigators)- if the study is under the oversight of an Emory Sponsor Investigator
• Veterans Affairs Medical Center, Atlanta- for all studies conducted at the Atlanta VA or under VA

Note: if the study answered “yes” to questions 5 (human embryonic stem cells) or 6 (human fetal tissue) under the “Ancillary Reviewers” section (last page of the IRB submission), please contact an IRB director.
for additional steps. Review the “Sensitive Study Status” SOP if yes to question 5 under the “For Clinical Research/Expanded Access Only” section. If the study said yes to question 3 (expanded access) under the same section, contact a member of the Q team (may need to be reassigned).

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
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<tbody>
<tr>
<td>3/5/2020</td>
<td>Clarification on OoQ Ancillary review</td>
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</table>
IRB Staff Initial Analysis/Screening

1. Once assigned as the IRB coordinator, it will appear in the “Pre-Review” state under your inbox. For more information about pre-review and ancillary review information, review our SOP.

2. The Director who assign the study to you did a high-level review of the study and assigned ancillary reviews, included the department. You are required to verify that the selections are correct when reviewing the protocol and study smartform.

3. Open the appropriate checklist (non-exempt, exempt, retrospective/secondary).

4. While in the main study workspace, click the “View Study” button. Screen the study per whichever checklist you chose.
   a. This form is not purely a checklist; you are expected to write notes to yourself for posterity and notes that can be easily transformed into suggested revisions for the study team.

5. Once done screening, click the “Submit Pre-Review” button in the main study workspace. Look at the Huron IRB Staff Quick Reference (page 17) for additional information on how to complete this process.
   a. For any study that requires HIPAA authorization and/or waivers, you MUST check the box for OCR (Office of Civil Rights) in question 1.
   b. Check applicable boxes in question 2 and fill out any applicable determination/waiver/population worksheets.
   c. Check one or more boxes in question 3 to best characterize the study.
   d. Check any boxes that apply in question 4.
   e. Enter the missing materials in question 5.
   f. Enter any other notes, including requested changes to the submission, in question 6.
   g. Upload the new study checklist in question 6.
   h. Check “No” in question 7 unless the study is ready to be reviewed as submitted, with no revisions.
   i. Click OK.

If study need revisions after your initial review

6. Click “Request Pre-Review Clarifications” button to send back to study team for revisions. Look at the Huron IRB Staff Quick Reference (page 15) for additional information on how to complete this process.
   a. You are required to remind study teams of their changes to the submission, at least at a weekly basis. If they are not responding to your comments or emails, contact a Director to withdraw the study.

2. Once re-submitted, screen the submission for the changes you requested. If the study team made the revisions to your satisfaction, click “Submit Pre-Review” again.

3. Make any necessary changes to the responses in questions 1-7 and change the response to question 8 to “Yes.” This will change the state to “Pre-Review Completed.”

Ancillary Reviewers
1. Click the “Manage Ancillary Reviews” button and click the “Add” button to add any appropriate reviewing bodies. Select the group (not person) under question 1, select the group again under question 2 and click on yes if a response is required.

2. Review this page (under Submit a study in eIRB) on our website or the checklist for more information about ancillary reviews.

Finish Pre-Review

1. If going the full board route, complete your Pre-Review and include notes that would be helpful to have during the meeting, such as why the study might require FB review (if not readily apparent), special determinations, subparts, potential IRB member conflicts, etc. Fill out the last page of the non-exempt checklist for this purpose.

2. Assign the study to a Designated Reviewer or full board meeting agenda.

Designated Reviewer route:

1. Select a reviewer in question 1 according to our current SOP on who can review what.

2. In question 2, enter notes to the reviewer such as— but not limited to—exempt/expedited categories, subparts, recruitment methods, verbal/online vs. signed consent, HIPAA waivers, funding source, and whether the study has the appropriate permissions/ethics approvals in place.

3. In question 3, upload any pertinent checklists:
   a. Emory Subpart B Checklist
   b. Emory Subpart C Checklist
   c. Emory Subpart D Checklist
   d. Emory Checklist- Cognitively Impaired Subjects
   e. Make sure other appropriate checklists (HIPAA, IND exemption, Device Checklist, REMS, Controlled substance, Dietary supplements, Mobile medical Apps, etc.) are in the record as filled by the study team. These checklists are located on our website under “Study Submission Guidance”

4. Click OK. This will change the state to “Non-Committee Review.”

5. Once the reviewer submits their review, the state will change to “Post-Review.”

6. If DR requests revisions:
   a. Click “Prepare Letter” in the main study workspace.
   b. Choose the appropriate template and click “Generate.”
   c. Under “Draft letter,” click the link to download the letter template and make revisions.
   d. You will need to save a local copy of the letter, make the revisions within that letter, and upload the revised copy to the study using the “Upload Revisions” option in the activity details.
   e. Once revisions are complete, click “Send Letter.”
   f. After the PI/proxy submits the changes, the study will appear in the “Modifications Submitted” state.
   g. Click the “Compare” button in the left-hand top corner of the main study workspace to examine the changes to the submission made by the study team. Look at the Huron IRB Staff Quick Reference (page 16) for additional information on how to complete this process.
   h. In the Basic Study Information section, question 8, click the “History” link under “Document History.”
   i. On that pop-up page, check the boxes for the documents you want to compare, and then click the “Compare” button; this will produce a “track changes” copy of the new protocol.
Screen the document for the revisions you requested as well as any other revisions the study team may have made. Once done, click “Exit.”

7. To confirm that the changes the team provided were adequately addressing the issues the reviewer brought up, go to the main study workspace, click the “Review Required Modifications” button.
   a. Confirm whether the study requires continuing review and make sure that it is reflected in question 1 on the pop-up page.
   b. Enter the approval date (and expiration date if applicable) in question 2.0.
   c. Enter any relevant notes in question 3 and upload any documentation in question 4.
   d. If the study team revised the study satisfactorily, email the study link to the designated reviewer.
   e. The designated reviewer can click on “Review Required Modifications” to document the changes made are adequate.
   f. If the designated reviewer has any difficulties, you can complete step e above. Make sure you attach a confirmation that the reviewer agrees the changes as submitted are adequate (this could be an email communication).

Full Committee Review route:
1. Look at the Huron IRB Staff Quick Reference (page 23) for additional information on how to complete this process. Click the “Assign to Meeting” activity and assign the study to the next available, appropriate meeting; this will change the state to “Committee Review.”
2. Click on “Edit Preview” to include an updated NS checklist and update the board before the meeting. This should happen the Friday before the meeting.
3. Keep in mind the membership of the committee.
4. Try not to assign studies where PI/Co-Is are members of that committee but try to assign studies to committees where the specialty of the study is represented in the membership.
5. Reviewers will be assigned to the study by the meeting pod.
6. After the study is reviewed:
   a. Study was approved as is: prepare letter as detailed in the next section.
   b. Pending or Deferred:
      i. Click on prepare letter and select the appropriate pending letter. All pending/deferred items should populate in the letter. Reconcile the letter with the notes in the “reviews” tab to confirm all the information is in the letter. Send the letter to the team.
      ii. When the study team submit the changes
         1. If pending:
            a. After reviewing the changes to ensure completeness, email the chair of the FB meeting with a link to the study. The vice-chair can click on “Review Required Modifications” to document the changes made are adequate.
            b. If the vice-chair has any difficulties, you can complete the step above. Make sure you attach a confirmation that the reviewer agrees the changes as submitted are adequate (this could be an email communication).
            c.
            d. After the above is completed, send the approval letter (follow the next section).
2. If deferred:
   a. After reviewing the changes to ensure completeness, click on “submit pre-review”. Document any changes to your review, if pertinent. Assign to the same committee who review the study.

Preparing approval letter
1. Look at the Huron IRB Staff Quick Reference (page 25) for additional information on how to complete this process. After all the changes has been confirmed go to the main study workspace, click “Finalize Documents.” Make sure you do not skip this part, as this is step will allowed the approved documents to populate in the letter.
2. On the pop-up page, select the documents you wish to finalize, and click “OK.”
3. Click “Prepare Letter.”
4. Under “Draft letter,” click the link to download the letter template and make revisions.
5. You will need to save a local copy of the letter, make the revisions within that letter, and upload the revised copy to the study using the “Upload Revisions” option in the activity details.
6. Once revisions are complete, click
7. Click “Send Letter.”
8. Study will now appear in “Approved” state.

LOG OF SIGNIFICANT CHANGES

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<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>10/18/2016</td>
<td>Under “After Review”, Step 6, change “obtain signature” with “Send Correspondence letter”</td>
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<tr>
<td>6/8/2018</td>
<td>Removed need for VA liaison to have VC sign letters to investigators in eIRB; merged with SOP “Process of New Approved or Pending Studies or Continuing Reviews”</td>
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<tr>
<td>11/1/2018</td>
<td>Added information about when is OK to send a study to an expedited reviewer or to full board when finding expired research training; added information about REMS and controlled substances</td>
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<tr>
<td>1/18/2019</td>
<td>Editorial changes and addition of common rule information; added OoQ clarification language.</td>
</tr>
<tr>
<td>6/28/2019</td>
<td>Clarifying that Pod team makes meeting assignments</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Updated customer service link</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Several changes to align with new eIRB system</td>
</tr>
<tr>
<td>2/13/2020</td>
<td>Updated broken links</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Added link to Pre-review and Ancillary Review SOP</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Adding additional steps after contingency review</td>
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PURPOSE
The purpose of this document is to describe the naming conventions used to signify special study designations in the short title the study.

DEFINITIONS / NOMENCLATURES
- Emory Sponsor Investigator study – [SI]
- External IRB shell – [XIRB]
- NCI Central IRB – [CIRB]
- Department of Defense – [DoD]
- Veteran Affairs – [VA]
- Western IRB – [WIRB]
- REMS- [REMS]
- Chart Review- [Chart Review]

PROCEDURE
When reviewing a study that meets one or more of the special study considerations listed above, edit the study short title to add in the appropriate bracketed designation before the official study short title. If more than one designation applies, list multiple designations in alphabetic order.

When adding the nomenclature to the study title, log a comment to the study team explaining that the IRB added that information for future study tracking.

LOG OF SIGNIFICANT CHANGES

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<td>2/21/2018</td>
<td>Added REMS as a nomenclature to use</td>
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<tr>
<td>6/21/2019</td>
<td>Removing non-used options</td>
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<tr>
<td>2/11/2020</td>
<td>Add/remove options</td>
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PURPOSE
The purpose of this document is to describe the procedures for the coordination between the Institutional Review Board (IRB) and the Emory Radioactive Drug Research Committee (RDRC) on protocols involving the use of radioactive drugs for research projects designed to obtain basic information regarding metabolism (e.g., kinetics, distribution, and localization) or human physiology, pathophysiology, or biochemistry.

BACKGROUND
The Radioactive Drug Research Committee (RDRC) program under 21 CFR 361.1 permits certain basic research using radioactive drugs in humans without an IND. The RDRC is the body charged with classifying all radioactive drugs as either new drugs requiring an Investigational New Drug Application (IND) for investigational use (21 CFR 312), or as generally recognized as safe and effective when administered under the conditions specified in the RDRC regulations. Key requirements include that 1) number of subjects should not exceed 30, 2) only adults with legal capacity be enrolled, 3) all females of childbearing potential either confirm they are not pregnant on the basis of a pregnancy test or state in writing they are not pregnant, and 4) the investigator shall immediately report to the RDRC all adverse effects associated with the use of the radioactive drug.

RESPONSIBILITIES
- **RDRC**- Review and approve the use of research-related administration of radioactive material to subjects. RDRC is also tasked with reviewing all adverse effects associated with the use of the radioactive drug in research and immediately reporting to the FDA all adverse reactions probably attributed to the use of the radioactive drug in research.
- **IRB** – Ensure human research protocols involving the research-related administration of radioactive material to subjects have prior RDRC approval and that the study protocol include the required reporting to RDRC. In addition, alert RDRC and study team of need for IND if study team requests increase in enrollment to over 30 subjects obtaining the radioactive agent.

PROCEDURE
1. When a study is submitted that involves a radioactive tracer not approved by the FDA for the indication described in the study, the IRB analyst will review whether the study has an IND or RDRC approval for the use of the tracer.
   a. If the study does have an IND, than the study falls outside the scope of this SOP.
2. For studies that meet the qualification for RDRC IND exemption, the IRB analyst will ensure that:
   a. RDRC approval has been granted before the IRB grants final approval.
   b. The authorized investigators in the RDRC approval letter are listed as study staff, including the “Authorized User”
   c. The radioactive tracer is listed in the drug section of the eIRB Smartform
d. The protocol and DSMP include that the investigator shall immediately report to the RDRC all “adverse effects” associated with the use of the radioactive drug in the research study.

e. The protocol and consent note that only adults (18 and older) with legal capacity will be enrolled.

f. The protocol and consent note that all females of childbearing potential confirm they are not pregnant.

3. Once all of the above requirements have been verified, the IRB analyst should assign the study to an IRB Committee meeting – these studies do not qualify for expedited review under F(1) due to the possibility of allergic reaction.

4. After the initial IRB approval, IRB analyst should note whether future modifications that substantially change the protocol may require additional review by the RDRC or, alternatively, an IND application. Analyst should consult with RDRC if needed.

LOG OF SIGNIFICANT CHANGES

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**PURPOSE**
To instruct analysts about acceptable methods of translation of written informed consent documents into languages other than English.

**SCOPE**
Applies to all non-exempt studies that plan to target non-English speakers for enrollment, regardless of whether the study involves international sites. This does not apply to studies requesting to use a “short form” to enroll occasional non-English speakers. The Emory IRB will only review the research activities that Emory agents are engaged in. If consent documents fall outside of the scope of Emory IRB review, there is no need for us to review translations. However, if Emory is the primary awardee of a grant, translated documents will likely be required for IRB review, regardless of whether Emory is otherwise involved in the human subjects’ research activities.

**INTRODUCTION**
In order to ensure the quality of translation of consent documents into foreign languages, the Emory IRB requires some level of documentation that the translation is accurate.

**Recommendations for study teams:**
- In most cases, it’s best for the team to first seek approval of an English version of the informed consent document before beginning translation to prevent having to revise both the English and translated documents based on IRB change requests. The translations would then be submitted via Modification. The English version of the informed consent document should be stamped after initial approval.
- A local Ethics Committee or IRB may require changes to translated informed consent documents that are submitted for their approval. For this reason, it may be advantageous for study teams to wait to submit their translated documents to the Emory IRB until after the local approval is in place.

  - **Note:** Emory may collaborate on studies led by an international site where the informed consent document was first created in a foreign language. In that case, the translation policy still applies, but the translation would be into English.

There are two acceptable methods for documenting the quality of the translation

**Methods of Documenting Translation Quality:**

- **Certified Translator:** The team can hire a certified translator to translate the English version of the form into the foreign language. As proof of translation by a certified translator, the study team may submit:
  - Current, valid certification of translator’s credentials along with an invoice or memo stating the specific document that was translated.
- Other: Consult with your Associate or Assistant Director or the Director any other form of documentation that mentions the specific document that was translated and attests to the translation quality

In addition to the documentation for translation services, the IRB must receive the translated forms.

- **Translation by a non-certified translator:** This is a two-step process. To start, anyone, including members of the study team, may translate the English version of the informed consent document into the foreign language. For the back-translation, the study team must find someone else to perform a translation into English from the already-translated foreign language document. The IRB reviewer will compare both English documents to confirm that the back-translation retains the same message as the original English version. All versions, appropriately labeled, should be submitted to the IRB.

**PROCEDURE**

1. An analyst receives a new study or an Modification that indicates intent to enroll participants that do not speak English (should be evidenced by selecting “Non-English Speakers” as a Study Population type), along with translated versions of consent documents.
2. The analyst reviews the new study or Modification to see if documentation of one of the appropriate translation methods has already been provided.
3. If documentation hasn’t been provided, the analyst should log a comment to notify the study team that they should begin the process of documenting translation through one of the above-listed methods and that translated copies will not be approved until that is complete, though the rest of the study may be approved. The analyst should continue triage of the new study or Modification.
4. The analyst assigns new study or Modification to a designated reviewer or to a full board agenda. The analyst makes a note in the study history as to the current status of translated documents.
   a. **If adequate documentation has not been provided:** The study or Modification can be approved without documentation of translation, but the study team will not be able to enroll any subjects using the translated consent form until they provide documentation of one of the above-listed methods of translation. The IRB analyst should not stamp the foreign language consent forms until a reviewer is able to review the documentation of translation. The IRB analyst should notify the team in the approval letter that the foreign language consent forms are not approved for use, and furthermore, that the team cannot enroll any subjects using translated consent documents. Also, the analyst should notify the team that an Modification will be required to submit documentation of translation.
5. Once the new study or Modification has been approved, the analyst lists all of the consent documents in the approval letter. The analyst should stamp all approved versions of the informed consent documents, including the English version even if it’s not going to be presented to subjects.
Note: Sometimes the formatting and language of translated versions of documents look strange after eIRB applies the stamp. Most often, teams are able to open the documents and see the correct formatting and language with the stamped approval date.

Modifications revising approved, translated ICFs

1. Modifications that are only making administrative changes (such as contact information) can be approved without further translation quality documentation as long as the change can be verified in the revised document.

2. Minor Modifications that can be sent to a staff designated reviewer can receive pending approval with only a tracked changes version of the English consent form. The Modification would be ready for contingency review with a translation of the revised English form and documentation of the translation quality through one of the two approved methods.

3. Modifications that may change the risk/benefit ratio of the study and would require designated review by a vice chair or full board review may require two Modifications to update the study and the translated ICF. One Modification would include the protocol or other study changes and incorporation of those changes into the English version of the consent document. After approval of those changes, the study team would follow up with translation of the revised English ICF and documentation of translation quality through one of the approved methods.

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
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<tr>
<td>2/1/2019</td>
<td>It was clarified that the English version of the consent form should be stamped when approved.</td>
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</table>
SOP Title: Research Projects led by Non-Emory students

SOP Category: Study Management
Established: 8/28/2013
Last Revision: 9/16/2016

PURPOSE
To determine when a student is engaged in research when the student is from a different school and is also a staff person at Emory and/or Emory is not engaged in research but a student is requesting access to Emory protected health information (PHI).

PROCEDURE:
1. Determine if Emory is engaged in research:
   b. Consider questions such as: is the research project is related to the student’s job at Emory? Will the results be used in the context of their job? Are the procedures a part of their job?
   c. Are they acting in any other way as an agent of Emory for the purposes of the research project? (OHRP considers an agent to be an individual who (1) acts on behalf of the institution; (2) exercises institutional authority or responsibility; or (3) performs institutionally designated activities)
   d. Are there other Emory collaborators acting as agents of Emory?

2. Other issues to consider:
   a. Is the student obtaining IRB review from his or her academic institution?
   b. If not engaged in research, is the student requesting access to Emory PHI? If so, alert Anne Adams.
   c. If the student’s name will be listed on the publication, will Emory be listed as their affiliated institution?
   d. If Emory is engaged, can the student be listed as PI, or must it be a faculty member?
      i. If an IAA is in place where the student’s academic institution relies on Emory IRB review, refer to our normal P&Ps for student research to determine if the student can be PI, if the student is also affiliated with Emory.
      ii. If the student’s academic institution will review the study, then an Emory person should be PI for the Emory IRB submission
   e. If Emory is not engaged, then the student researcher does not need to submit to the Emory IRB, but should obtain permission to conduct research at Emory from the appropriate departmental authority

REFERENCE
Guidance on Engagement of Institutions in Human Subjects Research
http://www.hhs.gov/ohrp/policy/engage08.html

LOG OF SIGNIFICANT CHANGES:

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<tr>
<td>9/16/2016</td>
<td>Added clarification to align with current process</td>
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</table>
PURPOSE
The purpose of this document is to guide IRB personnel in the use of the applicable websites to verify that required research training is complete. This SOP will cover verification of CITI certification, Clinical Research Training for investigators (now the CITI Good Clinical Practice [GCP] course, formerly Key Concepts training), Clinical Research Coordinator training in CITI or Introduction to Clinical Research 2-day course completion. Specifically, the SOP will provide guidance on accessing the CITI to confirm research staff course completion from logging into the system to obtaining the information. In addition, it will clarify the required Modules per Emory University IRB office. For Clinical Research Training and Clinical Research Coordinator training, it will outline steps for obtaining proof of completion.

SCOPE
It applies to new clinical trials and Modifications to add personnel to clinical trials, which are submitted on or after 7/16/2012 for all Emory PI’s, Co-I’s, or Sub-I’s, and coordinators on Clinical Trials.

DEFINITIONS
• CITI – or the Collaborative Institutional Training Initiative. It is valid for three years.
• CITI Good Clinical Practice and ICF (GCP), as part of the Training for investigators (formerly Key Concepts in Clinical Research for Investigators Course) - A mandatory CITI GCP course to be completed by any investigator (PI, Co-I, or Sub-I) on a federally funded or FDA-regulated clinical trial. Course completion is valid for three years for federally funded studies and recertification is via the CITI biomedical refresher course.
• CITI Clinical Research Coordinator course (formerly Introduction to Clinical Research): A mandatory CITI or class-based course to be completed by research coordinators or other staff assisting the study PI (including residents and fellows). Course completion is valid for three years.

RESPONSIBILITIES
• IRB analyst: responsible for checking that the research team staff has received the required training for new submissions, Modifications (adding new staff) and continuing reviews (CITI and all training for people added within the last approval period).

PROCEDURE
Procedures for Emory/CHOA or VA CITI
Using the View CITI Training screen
You will find this option under each submission. Click on it and a new window will open with this information. If the information does not populate, as the study team for the certificate for each person who does not show or shows as incomplete/not done.

Study teams should provide additional clinical trials training via a certificate if this does not populate under CITI.

For Viewing Emory’s Required Modules

- For Emory/CHOA: Login to www.citiprogram.org using your own personal login. If you are a new employee, please contact the IRB staffer in charge of CITI so they can request institutional access for you to Emory and CHOA CITI’s. Make sure you have a CITI account that is associated with Emory and CHOA.
  - For VA CITI: Checked with VA liaison or staff designated person for access to this information.
- Scroll down until reaching “Institutional Administrator’s Menu” and click on “Emory University”
- Under “Active Courses Being Used”, select the type of course you desire.
- A new page will open indicating the “Required” and “Optional” modules for Emory University.

Clinical Research Training for Investigators (formerly Key Concepts and Introduction to Research):

On all new studies and Modifications (adding new staff) submitted on or after 7/16/2012, check if this study is NIH-sponsored or if this is a FDA regulated Clinical Trial. For information about what constitutes an FDA-regulated trial, check our website at http://www.irb.emory.edu/forms/faqs.html. In general, an FDA trial will be using a drug, device, biologic, vitamins (or other dietary supplement), medical food. If in doubt, check with a member of the staff leadership. If the answer is yes:

- Identify the PI, Emory co-investigators, and Emory sub-investigators and Emory personnel listed in the “Coordinators” category.
  - For more information, please check this website from the Office for Clinical Research: http://www.ocr.emory.edu/training/index.html
- Ensure that there is proof of completion of the appropriate course for each of the above personnel. It should be uploaded in question 4 under Local Documents. Alternatively, the information could be part if the CITI training record.
- If any proof of completion is missing, please ask the study team to provide or to contact Bridget Strong for assistance.
  - If the PI has not completed the course, the study may not be given final approval until they have completed it.
  - If a Co-I, Sub-I, or Coordinator has not completed the appropriate course, then the study may receive full approval if that person is removed temporarily from the list of study personnel. That person may later be added back on, via Modification, once they have completed the course.
- Be sure to confirm dates on any certificate provided by the team.
- If the team requires assistance with this process, please have them contact the Office of Clinical Research.
- The IRB will accept CITI GCP or CITI Clinical Coordinators training certificates from research staff who took the training after June 1, 2016. For people who did not take GCP after June 1, 2016, or never
took Key concepts training/certification has expired, they may provide an older GCP training certificate.

- If the study is NIH funded, the study team needs GCP training (GCP course in CITI, not only the modules in the Biomedical Course) every three years
- If the study is not NIH funded, the GCP training does not expire.

**Steps to follow if CITI and/or Key Concepts/Introduction to Research are not up to date:**

1. If study team members do not have up-to-date CITI or Key Concepts:
   1. Study team can opt to remove the offending study team members temporarily, instead of waiting on them. The member can later be added back via an amendment or through the study staff change tool. Reference our Continuing Review: Processing study staff noncompliance with CITI and Clinical Research Training (formerly Key Concepts/Intro to CR) SOP for handling noncompliance.
   1. Do not send to expedited reviewer until all CITIs are up to date OR the offending member has been removed from the study.
   2. You can send to full board. The lack of training is a pending issue, if the study team decides not to temporarily remove the offending member. This DOES NOT apply to the PI or CO-I whose specialty is required to conduct the study. Their CITIs have to be current before the study can move forward.

Reference our Continuing Review: Processing study staff noncompliance with CITI and Clinical Research Training (formerly Key Concepts/Intro to CR) SOP for handling noncompliance.

**REFERENCES**

- Emory Required Training for Investigators, Clinical Research Nurses, and Coordinators [Chart](#).
- CITI Program modules: [www.citiprogram.org](http://www.citiprogram.org)
- Mandatory Training Requirements for Clinical Research Residents and Fellows.
- Mandatory Training Requirements for Clinical Research Coordinators and Nurses
- Mandatory Training Requirements for Investigators Conducting Clinical Research.

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/16/2016</td>
<td>Updated to reflect changes in policy and IRB procedure</td>
</tr>
<tr>
<td>10/18/2016</td>
<td>Clarification about certificates accepted by the IRB as proof of training</td>
</tr>
<tr>
<td>2/6/2017</td>
<td>Removing the GCP expiration.</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Clarifying that GCP training is also required in federally funded CTs</td>
</tr>
<tr>
<td>11/1/2018</td>
<td>Added new forms to check for CITI certificates using links to automated reports; clarified that, if not NIH funded, GCP does not expire for FDA studies</td>
</tr>
<tr>
<td>10/19/2019</td>
<td>Deleted links from SOP as they will be saved in a different location</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to align with new system</td>
</tr>
</tbody>
</table>
PURPOSE

The purpose of this document is to explain the current available options Emory researchers have to use electronic informed consent documentation (eICD). This SOP is not applicable for cases where the IRB can waive written signature/documentation of consent (e.g. online survey studies) or for studies done at the VA or CHOA.

Note: HIPAA authorization may be obtained via electronic signature as well, when in compliance with the below SOP and federal guidance. LITS will not review requests of eICF if the study does not involve IIHI, PHI or sensitive information but the IRB will need to verify that the app or software capturing the signature complies with the requirements in Part 11.

SCOPE

The SOP applies to all studies submitted to the Emory IRB and when the Emory IRB provides local context information to external IRBs.

RESPONSIBILITIES

- IRB analyst – responsible for letting the study team know about the current available options for the use of eICD, making sure the use aligns with previously approved parameters given to us by LITS
- LITS representative - reviews proposals to implement eICD outside the current approved options
- QA/QI Associate or Assistant Director- facilitates the discussion with LITS representatives and investigators

FEDERAL GUIDANCE (OHRP and FDA)


PROCEDURE

- Review our guidance document (When is a LITS security review needed?) to review the current software approved at Emory to create eICD.
- Electronic documentation of consent is not permitted by CHOA or the AVAMC (though they do allow online consent with waiver of signature when regulatory criteria are met).
- The protocol and/or smartform should include a plan for providing copies of the signed consent to participants. (HHS and FDA regulations require that the person signing the informed consent be given a copy of the written informed consent form (45 CFR 46.117(a) and 21 CFR 50.27(a)), unless the requirement for documentation of informed consent has been waived under 45 CFR 46.117(c) and 21 CFR 56.109(c)).
Although FDA regulations do not require that the subject’s copy include a signature, FDA recommends that a copy of the signed informed consent form that includes the date when the eIC was signed be provided to the subject.

The copy provided to the subject can be paper or electronic (i.e. be provided on an electronic storage device, not via email unless encrypted). If the copy provided includes one or more hyperlinks to information on the Internet, the hyperlinks should be maintained and information should be accessible until study completion (if a paper version is provided, it should contain the necessary content from any hyperlinks).

- The protocol and/or smartform must include a plan for verifying the identity of the subjects that will be electronically signing the Informed Consent, for FDA-regulated investigations.
  - FDA regulations do not specify any particular method for verifying the identity of an individual and accepts many different methods. For example, verifying someone’s identity can be done by using information from some form of official identification, such as a birth certificate, government-issued passport, or a driver’s license. In addition, use of security questions to confirm an individual’s identity can also be considered.

- If using Redcap to obtain electronic signature for informed consent:
  - Note: The investigator should submit to the IRB copies of all forms (electronic and paper forms) and informational materials, including any videos and Web-based presentations, which the subject will receive and view during the eIC process.
  - The study team should submit an MS Word version of the informed consent language that will be signed electronically by subjects.
  - Once IRB-approved, the study team should not send the consent form to subjects via email, unless encrypted. If not using encrypted email they should explain in the submission that the form will be sent via a link to an email previously provided by the study subject or LAR.
  - The signature area could be drafted the same as the ICF/HIPAA template or could allow for documentation of signature of the person obtaining consent at a later time. Here is an example:

<table>
<thead>
<tr>
<th>Name of Person Conducting IC discussion</th>
<th>Date when IC discussion took place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Person Conducting IC discussion</td>
<td>Date when IC was signed by person obtaining consent</td>
</tr>
</tbody>
</table>

- It is important that the Redcap system captures the signature of the subject in a way that it can be electronically audited. The ideal format is as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Name of Patient</td>
<td></td>
</tr>
<tr>
<td>* must provide value</td>
<td></td>
</tr>
<tr>
<td>2) Name of Legally Authorized Representative with authority for research decisions</td>
<td></td>
</tr>
<tr>
<td>* must provide value</td>
<td></td>
</tr>
<tr>
<td>3) Relationship to Patient</td>
<td></td>
</tr>
<tr>
<td>* must provide value</td>
<td></td>
</tr>
</tbody>
</table>
The study team should later submit, via Modification, a final electronic form to the IRB to show that the eICF version contains the same information as the mock-up approved by the Emory IRB, including document approval and version date. The study team cannot enroll anyone with the electronic method until this Modification is approved.

The study analyst should include in the approval letter the following:

- The IRB approved use of electronic informed consent via Redcap is contingent upon the submission of an Modification showing the final version of the electronic informed consent as it will be seen by subjects
- Do not use the eICF until this Modification is approved by the IRB
- Per Emory’s sensitive information policy/HIPAA (as applicable), do not send the copies of the informed consent to subjects via email. You may send a link to the system containing the eICF for the subject’s review. The Modification can be sent for expedited review.

If not using Redcap
- If the study team is not using an approved eConsent method, they should ask for a LITS security review of the app/software they want to use for eConsent.
- Study team should go to this link: https://emory.service-now.com/sp?id=kb_article&sys_id=e5c2c8d8f5c6f1c055c77bd8604896c2 to place a ticket for this review.
- The form has the information to provide under “more information”
- The study team should be advised that this process may take time, and to work with LITS and let the IRB know if their eICF platform was approved.
- If the study is funded, let OSP know (at osp@emory.edu) that the study will be reviewed by LITS for a security review as this may affect contract negotiations or require additional actions such a Business Associate Agreement.
- For more information about the LITS security review report, and how to address its findings, see the SOP entitled: “Mobile Devices and Mobile Medical Apps Used In Research”, under “LITS report Review”.

See below an example of an acceptable electronic ICF:
INFORMED CONSENT FORM

INSTRUCTIONS

Please review the enclosed information carefully. There are two sections below.
1. The first section is a summary of the study.
2. The second section is the detailed informed consent form for the study.
3. Please complete ALL the fields at the bottom of the form.
4. You will need to re-size this form if you are using a smartphone so that you can see everything.
5. You will need to click on the green + sign at the very bottom of the form. This is where you will sign using your finger on your phone or tablet. If you are using a computer, you will use your mouse to sign.
6. Once you have completed all the required fields and added your signature, please click on the "submit" button to finish.
7. If you have any trouble completing this form, please call the person who explained the consent to you.

Thank you!
Your Research Team

SUMMARY

A stroke is caused when blood vessels in the brain become blocked. These blocked arteries are caused by blood clots. The only medication approved to treat this is called tissue plasminogen activator or TPA. This medicine tries to break up the clot. It also must be given within 4.5 hours from the time when the stroke happened. Unfortunately, when the blood clot is in the large blood vessels in the brain this medication doesn’t always work.

When these types of blockages occur, a procedure called a “thrombectomy” may be performed. This procedure is when a specially trained doctor uses a catheter to remove the clot and restore blood flow to the brain. Currently, this procedure is only done when the stroke onset was within 8 hours.

The purpose of this study is to determine if regular medical care plus “thrombectomy” is beneficial after the normal time window. To be eligible, stroke onset must be within the last 6-24 hours. The brain images on CT scans will also be used to make sure there is possible brain tissue to save.

Other important information:
• This is completely voluntary
• Patients are randomly assigned to 1 of 2 groups. This is like a flip of a coin.
  • Group 1 is medical management alone or
  • Group 2 is medical management plus thrombectomy

• If assigned to Group 2, you will get an angiogram and then the trevo device will be used to try to remove the blood clot
• The risks are outlined in the full consent below
• The study team will follow your care throughout your hospital stay
• At 30 days and 90 days you will have a follow-up visit

Before making your decision:
• Please carefully read this form or have it read to you
• Please listen to the study doctor or study staff explain the study to you
• Please ask questions about anything that is not clear
LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/20/2017</td>
<td>Updated process when not using Redcap</td>
</tr>
<tr>
<td>4/20/2017</td>
<td>Updated broken links</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Remove need for study team to send email to Derek or Maria</td>
</tr>
<tr>
<td>7/25/2018</td>
<td>Added that we should let OSP know if the study is under a security review when the study is funded</td>
</tr>
<tr>
<td>4/11/2019</td>
<td>Adding example of eICF and clarifying when this request need to be sent to LITS</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Clarified that email can be used if it is encrypted. Other minor clarifications.</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this SOP is to inform analysts, in a step-by-step fashion, how to identify and process studies that are using mobile devices and apps, including the use of mobile medical devices and apps.

SCOPE
The SOP is intended to cover two types of research studies:

- Studies that use mobile devices for communication/data collection with subjects (e.g. smartphones, tablets) regardless of what specific applications are used on those devices. Main issue is data security/privacy.
- Studies that are testing or using applications (‘apps’) on mobile platforms that meet the definition of “medical device” per FDA. Main issue is whether FDA regulations apply, and if so, which ones. Data security is also a possible issue.

DEFINITIONS
- FDA Enforcement Discretion: The FDA does not intend to enforce the requirement of the FD&C Act.
- Medical Device: An instrument being used for the diagnosis of a disease or other conditions, or the cure, mitigation, treatment, or prevention of disease, or is intended to affect the structure or any function of the body of man.
- Mobile App (Application): Software application that can (but not inherently is) run on a mobile platform. It can also include web-based software applications executed on a server.
- Mobile Medical App: Any mobile app that meets the definition of a device, in section 201(h) of the Federal Food, Drug, and Cosmetic Act; and is intended to:
  - Be used as an accessory to a regulated medical device; or
  - To transform a mobile platform into a regulated medical device.
- Mobile Platform: Commercial, “off-the-shelf”, computing platforms which are handheld in nature [e.g. smartphones, tablets, portable computer devices].
- Regulated Medical Device: Any device that meets the definition of a medical device as defined in section 201(h) of the FD&C Act, and that has been cleared or approved by the FDA review of a premarket submission or is otherwise classified by the FDA.

NOTE: The 21st Century Cures Act (12/13/2016) amended the definition of “device” in the Food, Drug and Cosmetic Act to exclude certain software functions, including some described in this guidance document. FDA is assessing how to revise this guidance to represent their current thinking on this topic. For additional information, refer to https://www.fda.gov/MedicalDevices/DigitalHealth/default.htm.

WHAT SHOULD YOU DO WITH THE INFORMATION GATHERED PER THIS SOP?
The following procedures involve gathering information from the study team that may not have already been part of the submission.

- If this is an investigator-initiated, local study, the information may be added to the protocol document (and consent form, as needed).
If this is a multisite study and Emory is not the lead site, the information may be provided in a second document, and/or throughout the eIRB smartform and consent form.

If the use involves the collection of individually identifiable health information (IIHI)

For studies taking place at CHOA, please log in to CHOA intranet (Careforce) and access this link for information on how to submit for security review. Please refer all questions to BISRA@choa.org.

For studies taking place at Grady: email the device and data use information to the Grady privacy officer, D’Andrea Morning, at djmorning@GMH.EDU for her review and approval. Upload the email in the study history for our records.

If the study is funded, let OSP know (at osp@emory.edu) that the study will be reviewed by LITS for a security review as this may affect contract negotiations or require additional actions such a Business Associate Agreement.

PROCEDURE FOR MOBILE MEDICAL APPS USED IN RESEARCH STUDIES

1. Review our information chart, to make sure the app/software needs to go to LITS for review
2. Determine whether a study involves mobile medical devices / apps
   a. Review the protocol and Smartform for mention of mobile platforms / apps
   b. Review if the proposed use involves the collection or storing of IIHI
      • If not, the medical device/app does not need to be vetted by LITS.
      • If yes, the study analyst should ask the study team to put an IT ticket through this link: https://emory.service-now.com/sp?id=kb_article&sys_id=e5c2cd88f5cdf1c055c77bd8604896c2 The form has the information to provide under “more information”
   c. Determine whether the mobile platform+app is a medical device per FDA definition (aka intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease; see References and Definitions above)
      • If not, the mobile device/app does not need to be included in the device section of the Smartform. Skip to section 2 to review ownership of the mobile device.
   d. For mobile medical devices/apps:
      • Check to see that the device is listed in the protocol and consent form:
         o If the protocol is sponsor generated, a separate addendum in the Research Design of the Smartform may be acceptable.
      • Check to see that the device is listed in the Device Section of the Smartform.
      • Review whether the device is likely to be a considered a non-significant risk device, significant risk device, or does it fall under the category of devices for which the FDA will practice enforcement discretion.
         o For studies with enforcement discretion (see FDA guidance)
            a. The study team should select the following options when filling out the device section of the Smartform:
               i. “This is not an FDA approved use of the device” should be selected under Q2.0
               ii. Holder of the IDE number should be “N/A” under Q4.
               iii. Q5 should be “Non-significant Risk” device, with “Mobile Medical app” included in the text box for justification of risk classification.
               iv. Q6 should be selected as “Yes” for reusable device.
v. For Q8, if there is not device manual, PI should provide clarification for why there is not a device manual.

3. Once screening procedures are complete, send to FB or expedited reviewer, as applicable.
   • Mobile medical apps under enforcement discretion will need a device risk determination. The risk determination will be made by the expedited reviewer.
   • For studies with mobile medical devices, except if they fall under FDA enforcement discretion, the study will have to go for a FB device determination unless:
     i. the device is already FDA approved per indication OR
     ii. The device is IDE exempt
4. PROCEED TO “COMMON PROCEDURES” SECTION BELOW.

PROCEDURE FOR USE OF MOBILE PLATFORMS IN A RESEARCH STUDY (NOT MOBILE MEDICAL APP)
1. Review our information chart, to make sure the app/software needs to go to LITS for review
2. Determine ownership/possession of the mobile device/app (whether a medical device or not):
   a. Review if the proposed use involves the collection or storing of IIHI
      i. If not, the mobile platform does not need to be vetted by LITS.
      • If yes, the study analyst should ask the study team to put an IT ticket through this link: https://emory.service-now.com/sp?id=kb_article&sys_id=e5c2cd88f5cdf1c055c77bd8604896c2. The form has the information to provide under “more information”
   b. Confirm with the study team whether the mobile device will be given to the subject or if the subject will be using their own mobile device.
      i. If the subjects will be using their own mobile device, have study teams confirm the following: (the following should be addressed in the protocol and in the consent)
         • Will an app need to be downloaded onto their own mobile device?
         • Will the information on the app be encrypted?
         • Will the study team be able to monitor the activity of the mobile device? If so, how will this be done?
         • What are the security measures being taken to ensure the confidentiality of their information?
         • How will the app be removed from their device?
            o The removal of an app from a subject’s device should be included and detailed in the “exit” procedures associated with a subject’s completion of the study.
      ii. If the subjects will be provided the mobile device, have study teams confirm the following: (the following should be addressed in the protocol and in the consent):
         • Cost questions
            o Is the subject responsible for paying for the device (the device itself)?
            o Who will be paying for the fees (e.g.: data, phone and texting fees)?
If the device is being “overused” (beyond what was assumed to be needed for the purposes of the study) who pays for the additional fees

- Misuse and accidents
  - What will the study team do if the mobile device is lost or stolen? Are subjects liable for damages?
  - Is there a security measure put in place to deactivate or wipe the mobile device remotely? If so, what is it? Under what circumstances will this occur?
  - What will be done if the mobile device is misused (e.g. visiting illicit sites, using the device for personal reasons such as texting or calling friends).
  - If the mobile device is used for personal unauthorized reasons, who will be responsible for the ensuing fees? What are the consequences?

- Access:
  - Will the study team be able to monitor the activity of the mobile device? If so, how will this be done?

2. PROCEED TO “COMMON PROCEDURES” SECTION BELOW.

COMMON PROCEDURES FOR ALL OF THE ABOVE

5. Determine security of data and PHI:
   - Will the study team be gathering identifiable data (i.e. location) from the device? If so, why and how will it be used?
   - The study team must provide details of how information gather via the mobile device will be stored and how it will be protected
   - The study team should establish a system or schedule of contacting subjects via the device (if this is part of the study), so as to avoid calling in the presence of third parties or in situations where it is dangerous to answer (e.g. while driving).

EXAMPLE OF FEEDBACK FROM FDA RE: DOSE-CALCULATION APP

Rebecca Rousselle,
Thank you for your inquiry into the mobile medical apps email inbox. You inquired about drug dose calculators: “The type of app I’m curious about would perform a standard calculation, which previously was available in commonly-used spreadsheets or textbook guidelines, but is now put into an app. The calculation may be complex, but only involves numbers plugged in by the physician (the app doesn’t do any data collection/imaging itself). The result would be used to determine the dose of some kind of drug. If the app had a significant error, the patient could be adversely affected, depending on the kind of drug for which the app is designed to calculate.”

Based on the limited information you provided, FDA believes that simple drug dose calculators falls under enforcement discretion. The FDA intends to exercise enforcement discretion (meaning that FDA
does not intend to enforce requirements under the FD&C Act) for apps that are simple drug dose calculators that can be performed without the software tool.

Section V B5 of the mobile medical apps guidance states the following:

Mobile apps that perform simple calculations routinely used in clinical practice

These are apps that are intended to provide a convenient way for clinicians to perform various simple medical calculations taught in medical schools2 and are routinely used in clinical practice. These apps are generally tailored for clinical use, but retain functionality that is similar to simple general purpose tools such as paper charts, spreadsheets, timers or generic mathematical calculators. Examples of such general purpose tools include medical calculators for:

- Body Mass Index (BMI)
- Total Body Water / Urea Volume of Distribution
- Mean arterial pressure
- Glasgow Coma Scale score
- APGAR score
- NIH Stroke Scale
- Delivery date estimator

Based on the limited information on the websites of the six sample calculators that you provided, all the apps would be placed under enforcement discretion for falling within functionalities outlined in FDA’s MMA guidance referenced in Section VB5 above.

You also posed the question: “if the risk of the drug to be dosed would affect the FDA’s position on this type of app.”

If a drug dosing calculator provides automatic dosing or is intended for drugs that have a narrow therapeutic window, the drug dosing calculator may require regulatory oversight.

This response is not a classification decision and does not constitute FDA clearance or approval for commercial distribution.


LITS report review

After the LITS review occurred, the LITS security will send a report to the study team and the IRB. The LITS report will be emailed to our listserv. The listserver will upload the report to the study submission as a comment to study staff.

The report will contain information about the findings. See the following chart to ask for additional information from the team:
Risk level definitions, mitigation timelines, and risk acceptance criteria

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
<th>Mitigation Timeline</th>
<th>Risk Acceptance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical</strong></td>
<td>The Security Review has determined that the current level of risk associated with the finding is <strong>critical (severe)</strong> in its current state.</td>
<td>The risk must be fully remediated or mitigated to an acceptable level within 30 days if system is live. If the system is not yet live, the risk must be fully remediated or mitigated to an acceptable level before the system goes live or is connected to a production Emory network.</td>
<td>Critical risks can only be accepted by VP/Dean level leadership with the consent of Emory’s Chief Information Security Officer.</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>The Security Review has determined that the current level of risk associated with the finding is <strong>high (substantial)</strong> in its current state.</td>
<td>The risk must be fully remediated or mitigated to an acceptable level within 60 days if the system is live. If the system is not yet live, the risk must be fully remediated or mitigated to an acceptable level before the system goes live or is connected to a production Emory network.</td>
<td>High risks can be accepted by Director/Chair level leadership. VP/Dean level leadership must be informed that the risk is being accepted by the study team department Director/Chair.</td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>The Security Review has determined that the current level of risk associated with the finding is <strong>medium (moderate)</strong> in its current state.</td>
<td>The risk must be fully remediated or mitigated to an acceptable level within 90 days.</td>
<td>Medium risks may be accepted by study team department Director/Chair level leadership.</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>The Security Review has determined that the current level of risk associated with the finding is <strong>low (tolerable)</strong> in its current state.</td>
<td>Risk remediation is recommended, but not required at present.</td>
<td>Low risks do not need to be explicitly accepted.</td>
</tr>
</tbody>
</table>

If a finding was deemed more than low, we should expect a letter from the study team department Director/Chair (or VP/Dean as applicable) to allow the use of a device/software.

**References**

- Emory IRB P&Ps: Chapter 65- INVESTIGATIONAL MEDICAL DEVICES
• FDA Guidance on Mobile Medical Applications at
  https://www.fda.gov/downloads/MedicalDevices/.../UCM263366.pdf

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>4/20/2017</td>
<td>Updated broken links</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Added information about Grady Privacy officer</td>
</tr>
<tr>
<td>2/7/2018</td>
<td>Clarifying that mobile medical apps under enforcement discretion do not have to go to FB for risk determination.</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Removed need to email Derek or Maria; added information from CHOA IT person and the link to our information chart</td>
</tr>
<tr>
<td>7/25/2018</td>
<td>Added that we should let OSP/OTT (add email OTT) know if the study is under a security review when the study is funded. Added information about LITS security review report.</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Updated contact for CHOA for security reviews</td>
</tr>
</tbody>
</table>
SOP Title: Certificate of Confidentiality Process in non-federal studies
SOP Category: Study Management
Established: 6/26/2012
Last Revision: 1/18/2019

PURPOSE
NIH grants Certificates of Confidentiality (CoCs) for all federally funded studies and for studies that will collect sensitive information from participants. The CoC protects the research record from forced disclosure, such as subpoena.

For federally funded studies that automatically receive a CoC, please ensure that the template CoC language is in the ICF and process as usual. The remainder of this SOP applies only to non-federally funded studies obtaining sensitive information from subjects.

- Per NIH, sensitive information includes (but is not limited to) information relating to sexual attitudes, preferences, or practices; information relating to the use of alcohol, drugs, or other addictive products; information pertaining to illegal conduct; information that, if released, might be damaging to an individual's financial standing, employability, or reputation within the community or might lead to social stigmatization or discrimination; information pertaining to an individual's psychological well-being or mental health; and genetic information or tissue samples.

Please note: our Institutional Official (I.O.), who needs to sign off on these applications, may push back even if the study seems to meet NIH’s guidance on what qualifies for a CoC. We do not want study subjects to get an inflated or false sense of security from the CoC language. The CoC only covers information in the research study records, and research results placed BY THE STUDY into the medical record. If there is documentation elsewhere of the subject’s stigmatizing condition (e.g. HIV diagnosis at a non-Emory clinic, or mention of illicit drug use already in their EHC or other medical record from self-report at a past physical exam), the CoC will NOT protect that. We would prefer only to sign off on CoC’s that protect information that may not appear anywhere else in a subject’s records. The IRB Director can help you determine whether the I.O. is likely to push back, as well as how to make sure the memo contains the information the I.O. will be looking for.

SCOPE
The SOP applies to all non-federally funded human subject research where the research activities are likely to solicit information considered to be sensitive per the NIH definition above. See here for information about CoCs: http://irb.emory.edu/forms/coc.html

RESPONSIBILITIES
- IRB Study Analyst – Owner of the study to which the CoC applies or will apply; can also acknowledge own Modifications that simply upload approved CoCs; delays stamping of consent forms until CoC is in place, if applicable
- Institutional Official (I.O.) – signs CoC applications before they are sent to NIH
- IRB Director – Reviews CoC cover memos before they are sent to I.O.
- IRB Reviewer (contingency or expedited) – May require CoC for new studies, or ongoing studies when more sensitive information starts being collected or identifiers are introduced; Determines if subjects can be enrolled prior to CoC being in place

PROCEDURE
Processing studies that will have a CoC (new studies or Modifications)

Note: if this is a new multi-site study for which a CoC already exists (due to other sites already enrolling with a CoC in place), please skip to the CoC Assurance section.

Charted Procedure:

New Study/ Mod received by analyst. CoC document uploaded in DSMP?

Yes.

Continue Processing the study/AM until approval, (note in the letter that enrollment cannot begin until CoC is in place) then process CoC application per chart 2 below.

No.

Give the team two options:

Move toward approval w/o CoC to enroll earlier.
- Team submits 2 ICF versions (1 with CoC language and 1 without)
  *it will be up to a reviewer/FB to determine if this is appropriate for the study

Final outcome: approved.
- Write approval letter and state that consent form version (insert version with CoC language) may not be used until an Amendment is submitted with the approved CoC.
- Stamp consents w/o CoC language for immediate use and process CoC application per chart 2 below.

Wait for CoC before enrolling.
- Keep CoC language in ICF and move forward with review.
- Write approval letter and state that enrollment cannot begin until CoC in place. Do not stamp consents.
- After approval, continue processing CoC application per chart 2 below.

Final outcome: team needs CoC before enrolling.
- The team can remove the ICF without CoC language and send changes back.
- Continue processing. Write approval letter and state that enrollment cannot begin until CoC in place. Do not stamp consents.
- After approval, continue processing CoC application per chart 2 below.

AM with CoC in DSMP section is submitted
- Analyst processes the memo as per chart 2 instructions but can administratively approve the Mod and stamp the CoC language ICF
  *be sure to remove the non-CoC language ICF from the documents tab!
Written Procedure:
1. If consent form states that there is a CoC for the study, and/or if approved CoC is uploaded in DSMP section:

   a. Is the consent form language consistent with the presence - or absence - of CoC in SmartForm DSMP section? (Both has the required language describing the CoC, and also does NOT have the language about records being disclosed subject to subpoena [since CoC prevents disclosure based on subpoena])

      i. If yes, proceed with screening as normal with no further consideration to the CoC.

      ii. If there is a CoC uploaded in DSMP section or elsewhere but no CoC language in consent form, request that the study team insert our required CoC language into the consent form.

      iii. If consent has CoC language, but no evidence of a CoC in DSMP section or elsewhere:

          1. Have study team confirm that they have or will be applying for a CoC;

             a. If study team will not be applying for a CoC: request that study team remove the erroneous CoC language, and process the study as a regular non-CoC study. (Note: IRB reviewer(s) may still request CoC in their review, if they feel it is necessarily in order to minimize risk, and this would be a pending issue.)

             b. If study team does have an NIH-approved CoC that they neglected to attach, ask them to upload now and process as per (1)(a)(i) above.

             c. If study team does not yet have approved CoC but will be applying for one, there are two choices, depending on whether the study team wants to enroll subjects prior to obtaining a CoC:

                i. If the study team agrees to not enroll any subjects until a CoC is granted, then they will submit only the CoC-version of the consent form.

                OR

                ii. If the study team requests enrollment of subjects prior to the approval of the CoC:

                   1. The study team should request IRB approval of two versions of the consent form(s) – one with the CoC language, and one without any reference to CoC (to be used until the CoC is approved by the NIH; because NIH advises against using language like “we plan to obtain a CoC”)


2. For full board studies, put a note in the omnibus form “Pending Issues” section asking IRB to determine if study team can start enrolling prior to CoC being approved despite potential exposure of sensitive data to subpoena; if members feel CoC is necessary for study, then the no-CoC version should be removed from the smartform and not stamped.

3. For expedited studies, include note to reviewer asking them to make the determination listed above (and email to follow up if they neglect to do so)

2. Post-approval processing instructions (for study that has CoC language in consent but does not yet have approved CoC):
   a. Lack of approved CoC from NIH is not a pending issue, but any consent form(s) that have the CoC language in them must NOT BE STAMPED until the CoC is approved by the NIH.
   b. In approval letter (whether full board or expedited) state that the consent form version [insert version with CoC language] may not be used until an Modification is submitted with the approved CoC
   c. Once Modification is submitted to upload the approved CoC, **IRB Study Analyst** may “approve” (really just acknowledge) the Modification.
   d. Once Modification is approved with NIH-approved CoC (to be placed in DSMP section of Smartform), use “Edit Consent Forms” to remove any stamped non-CoC versions of the ICF (if applicable), and then stamp the CoC version of the ICF.

**Handling CoC applications**

*Note: if this is a new multi-site study for which a CoC already exists (due to other sites already enrolling with a CoC in place), please skip to the CoC Assurance section.*

Chart 2
1. Study team forwards application to IRB analyst. (*Note, the assurance page of the application **must** be on the study team’s department letterhead, and be signed by the PI prior to coming to us for institutional official signature).
   a. The study team may have trouble figuring out how to create an electronic copy of the overall CoC application for us to review. They should consult with the NIH or their own IT resources since we are unable to access the NIH’s system to assist.

2. Print out copy of the PDF of the signed CoC application, along with the most recently approved informed consent form and corresponding approval letter (e.g. if the CoC was planned from the start of study, this will be the initial approval letter and the initially approved consent document; if the CoC was requested after the initial approval of the study and consent modified through an Modification, print out the Modification approval letter and approved, Modended consent form).

3. Update the CoC Tracker file Under H:\IRB\General\Certs of Confidentiality
4. Draft memo for IO to sign using “Template MEMO to IO RNI COC” in the same folder, and save the draft memo in a folder for the COC study. **If the study does not already have a folder, create one.

5. Provide the memo, consents, and application to the Director for review. After Director approves the memo, place sticky tabs on the packet pages to indicate where the I.O. must sign and where the CoC language is printed in the ICF. Hand-deliver the entire packet to Dr. Sherer assistant.

6. Receive IO signed packet from Dr. Sherer assistant.

7. Scan the packet and save the electronic file in the appropriate study folder at H:\IRB\General\Certs of Confidentiality.

8. Notify the PI/study team that the packet is completed and Email the signed packet to the PI and study team. The hard copy of the packet should be made available for pick up, if requested by the study team.

9. Attach the scanned file to a logged comment to study team in eIRB.

10. Once the study team has received the approved CoC, update the CoC Tracker file and ensure that a copy of the CoC approval letter is uploaded in the study history.

There is guidance for researchers available on the web. Please direct researchers there if they have questions, [http://www.irb.emory.edu/forms/coc.html](http://www.irb.emory.edu/forms/coc.html).

**Handling CoC Site Assurances**

Assurance documents are signed when Emory will invoke a CoC already in place in a multisite study, where Emory is not the main study site. The process for CoC assurances is basically the same as the above procedure. The only difference is that since the CoC is already in place, the team will submit a statement of assurance (on their departmental letterhead) rather than an application. There is template language available in the CoC Kiosk if the study team needs it. In the assurance process, the “packet” will include the cover memo, assurance document, approved informed consent form, and approval letter. The folder name to be saved on the H drive should be titled “CoC Assurance XXXXX PI name”.

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<tr>
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<tbody>
<tr>
<td>5/13/2015</td>
<td>Clarification of process</td>
</tr>
<tr>
<td>12/23/2015</td>
<td>Revamping of SOP following current NIH requirements.</td>
</tr>
<tr>
<td>3/1/2016</td>
<td>Language addition to reflect use of IRB subcommittee use, use of department letterhead and</td>
</tr>
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<td></td>
<td>signature of PI for requests, as well as other language clarifications without content changes.</td>
</tr>
<tr>
<td>11/22/2016</td>
<td>Updated name of template Memo to IO</td>
</tr>
<tr>
<td>5/5/2017</td>
<td>Addition of section: handling CoC assurances; other minor clarifications</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Added charts, clarified SOP for new NIH CoC policy from 10/1/2017, other minor clarifications.</td>
</tr>
<tr>
<td>1/18/2019</td>
<td>Updated Dr. Wynes with Dr. Sherer</td>
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</table>
**PURPOSE**
The purpose of this document is to explain the steps to follow if reviewing a study under a data sharing requirement, including genomic data sharing.

**DEFINITIONS**
- Genomic data sharing repository (e.g. dbGap): public repository for individual-level phenotype, exposure, genotype, and sequence data, and the associations between them. dbGaP assigns stable, unique identifiers to studies and subsets of information from those studies, including documents, individual phenotypic variables, tables of trait data, sets of genotype data, computed phenotype-genotype associations and groups of study subjects who have given similar consents for use of their data.
- Institutional Certifications: Institutions are responsible for assuring, through an Institutional Certification, that plans for the submission of large-scale human genomic data to the NIH meet the expectations of the Genomic Data Sharing Policy (examples of research within the scope of the GDS Policy can be found in the Supplemental Information to the Policy). An Institutional Certification must accompany the submission of all large-scale human data to the NIH Database of Genotypes and Phenotypes (dbGaP). The Institutional Certification (for sharing human data), should also be provided to the funding NIH Institute or Center prior to award, along with any other Just in Time information (for extramural researchers) or at the time of scientific review (for intramural researchers).
- **Provisional Institutional Certification**: to be used in a situation such as for a prospective study where the IRB has not completed its review of the protocol and therefore the institution cannot attest to all of the elements of the formal Institutional Certification

**RESPONSIBILITIES**
- IRB analyst – reviews checklist submitted by study team and verified if consent has required information to allow data sharing
- IRB Director- reviews information

We have a guidance for investigators in our website at [http://www.irb.emory.edu/forms/Data_Sharing.html](http://www.irb.emory.edu/forms/Data_Sharing.html)
Study teams should fill these forms as appropriate:
- Institutional Certification Request form for Emory submitting data
- Institutional Certification Request form for Emory not submitting data

**PROCEDURE**
- If this is a urgent, very tight-turnaround request, strongly recommend to OSP analyst that OSP instead sign the “Provisional Institutional Certification” – state that IRB believes this is an appropriate use of the Provisional version. This form can be found under the NIH Institutional Certifications page.
- Request comes into IRB from OSP and/or Study team
- Refer study team to IRB form to fill out and await it
The IRB analyst reviews as follows:
  o Does the Consent Describe Sharing? Y/N
    ▪ If sharing is described if it is optional? Y/N or N/A
  o Genetic or Genomic Research Described? Y/N
  o If Genetic or Genomic Research Described is it optional? Y/N or N/A
  o Data Use Specifications:
    o Appropriate for DbGaP submission (if applies): Y/N
    o Unrestricted or restricted areas: Y/N
    o Controlled access: Y/N
  o If study in question was approved by the IRB before January 23, 2015, ICF will only need to make reference to sharing data or samples, but not as explicit as above
  o If the study wants to access a database or repository approved after January 23, 2015, a waiver of consent will not be valid for this purpose.

After this process was completed, forward the information the study team sent and what was reviewed to the IRB Director or designee.

The IRB Director or designee will determine if this information is consistent with the approved study and protocol, and forward letter to IRB chair for signature
  o If the IRB Director or designee finds that the study did not allow for this use, she will communicate with study team

After the Chair signs the letter, the IRB Director will forward to IRB analyst to communicate with study team and to log a comment in eIRB with the letter.

REFERENCES
  • NIH webpage: Institutional Certifications.
  • dbGAP submission process: chart
  • NIH Guidance: Expectations for Non-NIH-funded Submission Requests
  • NIH Institutes and Centers Genomic Program Administrators
  • Provisional Institutional Certification form

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PURPOSE
The purpose of this document is to detail the steps necessary for the IRB to review all studies that have an investigator conflict of interest.

SCOPE
The SOP applies to all human subject research where the COI Office / Investigator has identified that the investigator has a conflict of interest.

RESPONSIBILITIES
- **COI Office** - charged with reviewing and identifying potential conflicts of interest and creating COI management plans as needed.
- **IRB Study Analyst** - processing studies in which investigator(s) have disclosed COI in accordance with this SOP; verifying adoption of management plan in studies; escalating when study teams do not comply with management plan within required timeframe.
- **COI Program Specialist** - COI staff person responsible for coordinating certain communication between the COI Office, the IRB CoRe Team, and the IRB.
- **IRB Director or delegate** - Responsible for notifying investigators via email of their IRB-approved management plans and deadlines thereof; also for following up if investigators do not comply by deadline, by requiring submission of Reportable new information submission and further action if needed.
- **IRB CoRe** - IRB subcommittee responsible for reviewing and approving (with additions as needed) COI management plans that affect human subjects research.
- **IRB Full Committee** - responsible for re-reviewing management plan when the investigator objects to any additional requirements recommended by IRB CoRe.

TARGET TURNAROUND TIMES

**Time 0 (Zero)** = When COI Office receives notification from conflicted party that they have accepted the COI management plan, or when the timeframe for objection has elapsed

**Targets**

When plan is approved by CoRe “as is”:
- 14 calendar days (two weeks) from Time 0 to when IRB CoRe determination letter uploaded in eIRB and emailed to IRB analyst and Director
- 2 business days for Director to send plan to conflicted party and PI
- 10 calendar days for study team to make necessary changes in eIRB, before referred to Team Q

When CoRe requires changes:
- 14 days from Time 0 to when IRB determination letter is uploaded into eIRB and emailed to IRB analyst and Director
• 2 business days for Director to send required changes to conflicted party via email
• 5 business days to allow conflicted party to object (must be stated in email to PI)
• 10 additional calendar days for final CoRe determination letter to be prepared by COI Program Specialist, sent to IRB analyst and Director, and Director to send to conflicted party and PI

**PROCEDURE**

*NOTE: The changes to P&Ps that allow for the CoRe review described below went into effect at the P&P subcommittee meeting on March 17, 2015*

**POV of IRB Study Analyst**

1) Disclosure via New study/Modification in eIRB (for disclosures that come initially from COI office, please see (3) below)
   a. If the Smartform or logged comment indicates a COI:
      i. Ask study team if they have disclosed to the COI office (unless this has clearly been done, based on content of comments), and if so, what the status of COI review is. If this takes place outside of eIRB, document the exchange in the History.
      ii. Contact COI Program Specialist, copying IRB Director, informing them of disclosure and study number and what is known of COI review status. Await feedback as you continue processing the submission as follows...
      iii. Depending on the nature of the study:
          1. For Full Board study/AM, the item can be assigned to an agenda, as long as COI remains a pending issue until there is confirmation of COI Committee review or finding of no conflict; and until a management plan (if applicable) is accepted by the investigator and the plan is approved (with additions if needed) by IRB CoRe. **Include this requirement in the Agenda Item Notes and in a logged comment in the History.**
          2. For expedited items, do not send to reviewer until COI review is complete, and if applicable, a management plan is accepted by the investigator and the plan is approved (with additions if needed) by IRB CoRe.
      iv. Upon receipt of an IRB CoRe-approved management plan from the COI Program Specialist (as an email and/or logged comment), the IRB Study Analyst should review the management plan against the eIRB record to ensure that the study team has made the required changes if any (e.g. revising the protocol, Smartform (e.g. recruitment or consent sections, and including updating the COI section, if necessary), consent form(s), etc). Log comment in History stating that you have verified this.
      v. After confirming that the revisions have been completed, the IRB Study Analyst should send the item for the appropriate further review (may be full board initial review, contingency review if COI was a pending issue, or expedited initial review). Indicate in Agenda Item Notes (if sending for initial full board review) that COI management plan has been reviewed and implemented by the IRB CoRe.

2) Continuing Review
a. If Investigator COI box is checked, look at main study workspace Smartform to see if this is being disclosed for the first time. If already disclosed, there is no need to take further action regarding COI (unless you do not see evidence that there ever was COI review or a management plan, in which case contact the COIPS and IRB Director).

b. If the disclosure is new, ask study team if they have submitted to the COI office (unless this has clearly been done). If far in advance of expiration, send back to study team to get their response; otherwise can obtain response via call/email/logged comment as needed, but document the exchange in study History.

c. Contact COI Program Specialist, copying IRB Director, informing them of disclosure and study number and what is known of COI review status. Log a comment in the History stating that you have done this. Note, eIRB currently does not send notification to the COI office if selected during the CR process.

d. Process the CR as usual; this is not a pending issue (though an Modification may need to be submitted once a management plan is approved, per section (3) below). Alternatively, if the conflict was incorrectly identified, you may need to deselect the option for the study team.

3) COI Management Plans for Ongoing Studies In Absence of eIRB Disclosure
Sometimes a COI will develop in an ongoing study, and the study team does not initially submit an Modification with that information in eIRB. Therefore you may hear about it first from the COI Office or Program Specialist, as follows:

a. COI Program Specialist will send an email and log a private comment to the analyst informing them that the study team has been given 10 business days to submit an Modification to implement the COI management plan and check the “COI” box in the eIRB Smartform.

b. IRB Study Analyst should set calendar reminder for 10 business days to double-check that study team complies with updating the study to implement COI management plan and check the COI box.

C. If no Modification is submitted within the timeframe, log a comment to the study team reminding them. Also email the IRB Director Team Q for escalation, and log a comment in the History stating that you have done this.

d. Hand off responsibility for monitoring management plan completion to the Team Q and IRB Director.

POV of COI Program Specialist
1) Notification of Investigator or Study COI is sent to you by IRB Analyst, due to disclosure in eIRB:

a. Reply to analyst to acknowledge receipt, and estimated turnaround for next steps (if not able to complete remaining steps immediately)
   i. If COI Committee has already determined a management plan, follow step 2 below and inform the IRB Analyst of current IRB approval status (e.g. whether IRB CoRe has reviewed and approved yet).
   ii. If COI management plan has not been determined by the COI Committee, ensure they are aware of the disclosure, and CC the IRB Analyst.
   iii. If COI Committee determined there was no conflict or plan needed, inform the IRB Analyst that eIRB form should be edited to remove disclosure.

b. Follow steps below once COI Committee review is complete (Step 2 when COI is present; Step 3 when COI Office review finds no COI exists)
2) **COI Exists, Management Plan is finalized by COI Committee and Dept/Sherer Review Period has Elapsed**
   a. Save Management Plan on IRB shared drive (\General\COI\COI Mgmt Plans, under the appropriate folder).
   b. **If study already is present in eIRB:**
      i. Email the management plan and study link to non-clinical IRB CoRe with the following information using the “CoRE COI determination needed” email template (H:\General\COI\COI Omnibus Forms and Determination Letter Templates):
         1. If an investigator’s COI involves multiple studies, you may include the multiple management plans in one email – see template – summarizing them separately if there are differences in the plans. The result is still multiple omnibus forms however.
      ii. Set reminder to follow up with CoRE to ensure votes received in timely manner.
      iii. After a determination is made by IRB CoRe (with at least 3 agreements, including a Vice Chair), update the COI Omnibus form and save on H:Drive (H:\General\COI\COI Mgmt Plans) after creating a folder. Also save PDF of all CoRe email responses/votes.
         a. If multiple studies were involved in the above CoRe email, you may use one folder to hold all documents for those studies. Include the eIRB numbers and PI names in the name of the folder.
      iv. Create Determination Letter – one per management plan (even if CoRe reviewed multiple plans at once);
         1. If the Management Plan is accepted as is:
            a. Use the Accepted As Is COI Mgmt Plan Determination Letter, found at “H:\General\COI\COI Omnibus Forms and Determination Letter Templates” to craft a final determination letter. Save in case folder on shared drive.
         2. If there are changes to the Management Plan (e.g. adding additional requirement):
            a. Use the Not Accepted COI Mgmt Plan Determination Letter, found at “H:\General\COI\COI Omnibus Forms and Determination Letter Templates” to craft a final determination letter. Save in case folder on shared drive.
         3. Forward to IRB Director for final approval of language and authorization for digital signature, then create PDF of signed letter and save on H: drive folder.
      v. Update COI Office records and tracking spreadsheet accordingly
      vi. Email approved management plan and the signed PDF’d letter to IRB Director, copying IRB analyst.
         1. Include links to each study involved and who is analyst (on each, if more than one study); otherwise not clear
         2. If study already approved and ongoing, include in the email a deadline of 10 business days to implement, and reminder to the IRB Analyst to check in 10 business days. “Analyst(s): Please set Outlook reminder to
verify that changes are made within 10 business days; if not, escalate to Team Q and Director.”

3. If study is not yet finally approved, indicate to IRB Analyst that the COI management plan implementation must be a pending issue.

vii. Upload approved management plan and letter into eIRB submission’s History as Private IRB Comment (not visible to study team); also paste in text of above email.

viii. Log Comment to Study Team (visible to study team) stating simply that a Conflict of Interest Management Plan has been approved by the IRB and the IRB Director will be emailing shortly with the formal letter and further instructions.

    c. If study not yet present in eIRB

        i. Record case on COI tracking spreadsheet and await inquiry from IRB staff once study is submitted.

3) COI Office finds No COI Exists

    a. No required action

**Escalation Procedure when Study Team Does Not Comply with Mgt Plan Within Timeframe**

1) For Mod or CR, if required changes not submitted w/in 10 bus days, alert Team Q and IRBD and require study team to submit RE

**POV of IRB Director:**

- As member of CoRe, submit opinions re: COI management plans on a timely basis (14 calendar day total turnaround for CoRe determination)

- When COI Program Specialist sends IRB CoRe determination letters, email those directly, within 2 business days, to conflicted party and PI stating that the IRB has accepted the management plan (as-is or with required changes), and that either (a) the requirements of the plan have already been met in the IRB submission and no further action is needed, or (b) the required changes must be submitted in eIRB (1) before the IRB can issue final approval, or (2) via Modification within 10 calendar days, and if the Modification is not submitted within that timeframe a Reportable new information submission may be required. “Please let me know if you have any questions or concerns and thank you for your work to manage this conflict.”

    - Copy IRBA and COI Program Specialist
    - Update COI tracking spreadsheet when email sent

For flow chart on next page:

**IRBA: IRB Analyst**

**IRBD: IRB Director**

**COIPS: COI Program Specialist**
## COI Disclosure (New study, Mod, or CR)

| If IRBA aware first via eIRB, IRBA notifies appropriate parties per SOP | If COIPS receives inquiry from IRBA, COIPS checks status at COI Office; responds with status to IRBA |

## COI Management Plan Required and Finalized by COI Office

("No COI" determinations handled differently, see written SOP (in progress))

| IRBA continues processing CR through review (not pending); may send Full Board Mod or New study to meeting with COI as pending issue (add to Agenda Item Note and History); but must delay sending expedited Mod or New study for review until COI mgt plan approved and adopted | COIPS sends plan through IRB CoRE per SOP using templates; sets reminder to ensure votes received in timely manner; saves determination form once vote complete; once approved update COI Office records; email approved plan and Letter to PI to IRBD, copying IRBA; upload approved mgt plan and letter in eIRB History as PRIVATE comment with deadline if applicable; log comment to Study Team saying a mgt plan has been approved by IRB and IRBD will be emailing shortly. |

## COI Management Plan Approved by IRB

| IRBA receives IRB-approved management plan from COIPS (email or History comment), then reviews IRB submission to see if any requirements are outstanding; notes findings in History; holds final review of Mod or New study until all changes are made. For Mod or CR: IRBA reminds study team in 10 business days; if not complete email IRBD for escalation with note to History. | COIPS updates COI tracking sheet to reflect CoRE approval and deadline; IRBD emails investigators with plan. If Mod/CR, also include deadline; IRBA and IRBD each set reminders to follow up with study team in 10 bus days; for Mod or CR, if required changes not submitted w/in 10 bus days, alert Team Q and require study team to submit RE. |
## LOG OF SIGNIFICANT CHANGES

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<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>5/7/2015</td>
<td>Replaced the SOP titled “Conflict of Interest Management Plan Process” with all new procedures</td>
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<tr>
<td>8/17/2015</td>
<td>Added to IRB COI Liaison Analyst’s responsibility to keep IRB analyst informed of plan status.</td>
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<tr>
<td>5/18/2016</td>
<td>Updating the number and composition of CoRE needed for acceptance. Also updated responsibilities between IRB and COI.</td>
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<tr>
<td>12/20/2016</td>
<td>Major overhaul of entire SOP. Removal of IRB COI Liaison role.</td>
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BACKGROUND
This SOP outlines the Emory IRB’s responsibilities pursuant to the Emory Institutional Financial Interests Involving Human Subjects Research (Policy 7.24, http://policies.emory.edu/7.24)

DEFINITIONS
- **Institutional Financial Conflict of Interest involving Human Subject Research**: exists when the University Institutional Conflict of Interest Review Committee determines that a Significant Institutional Financial Interest held by Emory University or an Institutional Leader can significantly and directly affect or reasonably appear to affect the institutional processes for the design, conduct, reporting, review, or oversight of human subject research.
- **Licensed Intellectual Property in Human Subject Research**: When Emory licenses its intellectual property (IP), the University may receive equity in a company as a result of a licensing agreement for Emory IP; receive royalties or other fees as compensation for the use of that IP; and/or may receive equity or other financial interest as part of a co-investment in a licensee or related company.
- **Gifts**: In compliance with the Emory Gift Acceptance Policies & Procedures, Emory Policy 3.7, any gifts to Emory must be unconditional, in furtherance of Emory’s charitable mission, and non-reciprocal. Per the procedures identified in Emory Policy 3.7, any gifts of equity in individual companies will be sold as soon as it can be practically and legally accomplished. These procedures will be used for any gifts of equity in companies that utilize Emory Intellectual Property to produce a drug, device, diagnostic, etc. that is involved in Human Subject Research at Emory.
- **Significant Financial Interests of Institutional Leaders**: Pursuant to this policy, Institutional Leaders shall recuse themselves from any business decision, allocation of University resources or personnel, approval process, or oversight review process involving a company with which they have a Significant Institutional Financial Interest that is related to Human Subject Research at Emory. If recusal is not possible in order to carry out their University obligations, they must divest the Institutional Financial Interest. Any exception must be reviewed by the Provost and the Vice President for Research Administration, who may request an advisory opinion from the University Institutional Conflict of Interest Review Committee. For example, a Department Chair should not review or approve an IRB protocol for Human Subject Research when she has a Significant Institutional Financial Interest in the sponsor or provider of test material in the protocol. Emory may receive gifts from corporate donors that may also sponsor research involving human subjects. When a gift meets the Institutional Financial Interest threshold, the gift must be reviewed pursuant to the procedure in Policy 7.24, Section III, E.

ROLES AND RESPONSIBILITIES
- **Investigator**: To the best of their knowledge, Investigators shall identify the use of Emory Intellectual Property in Human Subject Research on the IRB application. Those protocols shall be forwarded to the Vice President for Research Administration or his designee for assessment and review.
• **Office of Technology Transfer:** shall compile a list that includes: (i) all entities in which the University holds an equity interest as part of a licensing arrangement; and (ii) a list of technologies sorted by licensee where Emory has received more than $100,000 in royalties annually. These lists shall be updated every six months or as requested by the COI Review Office. Using this list of entities, the COI Review Office will search the IRB databases to determine whether an identified entity is the financial supporter for the study. The COI Review Office shall refer any identified IRB protocols and licensing information to the Vice President for Research Administration. The Vice President for Research Administration, or designee, shall follow the procedures for assessment and review.

• **The Office of the Vice President for Health Affairs Development (for Gifts to Emory):** shall provide to the IRB Department a list of corporate donors that give more than $500,000 in cash per annum to a Department or Center. On a reasonable basis, the IRB will review the list of donors against a list of active protocols. If a listed Donor is the sponsor or financial supporter of Human Subject Research, the IRB will refer the research and gift proposal for review by the Vice President for Research Administration, or his designee. The Vice President for Research Administration, or designee, shall follow the procedures for assessment and review.

• **University Conflict of Interest Review Committee:** When an Investigator submits an explanation of Compelling Circumstances the VPRA may send the protocol to an ad hoc independent organization, including an external IRB independent of Emory, or may form an ad hoc committee that includes one member from outside Emory. These experts will formulate a recommendation as to whether an Institutional Financial Conflict of Interest exists and how it could be managed. In reviewing the research, the Significant Institutional Financial Interest, and the explanation of Compelling Circumstances, the Committee will use the Criteria for Evaluating an Institutional Financial Conflict of Interest in Policy 7.24, Section III, E.3.b.1. The Committee may determine that the Significant Institutional Financial Interest is too great and the research should not occur at Emory, unless divestiture is possible prior to the commencement of the study.

• **Vice President of Research Administration (VPRA):** Receives notification when Institutional Conflict of Interest is revealed in the context of a human subjects research protocol. The VPRA shall make an initial assessment of whether a Significant Institutional Financial Interest related to the research exists, then require either disclosure in publications/consent/presentations, or ask investigator for compelling circumstances why the research should proceed at Emory.

• **IRB Director:** Ensures that IRB-COI Liaison follows up as required when alerted of ICOI disclosure

• **IRB-COI Liaison:** Communicates with COI Office re: any institutional COI issues disclosed to either IRB or to COI Office

• **IRB Analyst:** Alerts IRB-COI Liaison and IRB Director if any studies come to Analyst where Institutional COI is checked.

**PROCEDURE**

**Procedures For When Human Subjects Research Involves Emory Licensed Intellectual Property, or is Funded by Entities Who Provided Large Gifts to Emory**

1. The IRB is alerted to the presence of Institutional COI by either
   a. the investigator (in the eIRB application)
      i. IRB Analyst must alert the IRB-COI Liaison and the IRB Director
ii. The above individuals will inquire with the Emory COI office and the VPRA to see what stage Emory’s review of the potential ICOI is in.

iii. If/when the VPRA has determined that there is a significant financial institutional COI, and he or the ad hoc Committee has agreed that the research may still be conducted at Emory (i.e. the conflict can be adequately managed), he will share the management plan with the IRB, which may include things like disclosure in the informed consent form, and/or referring the study to an external IRB for review.

1. If external IRB will review and study not yet approved at Emory, communicate to study that outside IRB submission is required, and refer to Team Theta for any additional assistance needed.

2. If study will remain at Emory IRB (rare), transfer ownership of study to IRB-COI Liaison.

b. Or the VPRA
   i. Will then skip to step (a) (ii) above

2. The IRB of record (either Emory IRB or external IRB such as WIRB) must review the Institutional Conflict of Interest management plan and determine if any additional elements are needed.

NOTE: The IRB shall review the management plan as part of its initial review of a new protocol. If an ICOI arises after initial IRB approval has been granted, the IRB will review the management plan following notice by the UCOIRC

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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1. OCR pre-award staff identifies the COST OPTION for a clinical study, checks it on a worksheet, signs it, scans it, and emails it to OSP/Contracts listserv AND IRB listserv. This PDF or word document has the IRB File # on it.

2. IRB Listserv attendant will forward this email to the designated person who will look up the study, and upload the document as an attachment with a comment like: “CTA Cost Option is #___ per attached.”

3. The study IRB analyst checks the selected Cost Option against the draft ICF.

4. IRB Analyst posts a comment in the History and/or Agenda Item Notes about the Cost Option being verified and correct in the ICF (or not yet verified, etc.)

FOR PEDS/CHOA STUDIES

1. As above, the CHOA IRB Manager or the RAS pre-award specialist will email the IRB listserv with a PDF or word document containing a study cost option

2. After the information is posted under the study history, the study analyst checks the selected Cost Option against the draft ICF.

3. IRB Analyst posts a comment in the History and/or Agenda Item Notes about the Cost Option being verified and correct in the ICF (or not yet verified, etc.)

4. Contact the following people for additional questions:
   a. Sarah Marie Huban (CHOA IRB Manager) for COG studies
   b. Xiayang “Chloe” Xie “Shay” (RAS pediatrics) for other Pediatric studies

Note: the Monday report to the IRB listserv is about the In Case of Injury option, not the Cost Option.

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
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<tr>
<td>2/6/2017</td>
<td>Addition of CHOA process</td>
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PURPOSE
The purpose of this document is to outline the procedure to process sensitive study requests/determinations.

SCOPE
The SOP applies to clinical research studies in which the study team seeks to keep the subject’s consent/HIPAA and other sensitive information from being uploaded into EeMR due to the stigmatizing nature of the information.

BACKGROUND
In order to ensure that EHC physicians are aware of a patient’s participation in a clinical trial, and how that participation might affect their symptoms or treatment options, the Emory Office of Quality requires that study information be placed in any EHC medical record that a study participant may have. OCR takes the “Clinical Research Key Points” summary and the consent/HIPAA form from eIRB and/or the study team and uploads them into the ERMS research management system. If a subject has an EeMR Record, or gets one created when they come seeking medical treatment at EHC, then those documents are automatically transferred into the subject’s EHC EeMR. For studies with stigmatizing information that would not already be part of their EHC medical record, the study team can request Sensitive Study Status from the IRB, and complete the “Clinical Research Key Points for Sensitive Study” document to keep certain study-related information out of the EeMR. In either case, the consent form must accurately reflect what study information will be placed in the EHC EeMR.

PROCEDURE

• New Studies/Modifications
  1. Study team should request “Sensitive Study Status” by selecting yes to Q5.0 under the For Clinical Research/Expanded Access Only of the Smartform.
  2. IRB Analyst should review the consent form to make sure that the appropriate template language regarding the exclusion of the consent form and study information from the medical record is included.
  3. IRB Analyst should send the study for appropriate review (FB or expedited). (if declined by expedited reviewer and study team disagrees with outcome, request should be referred to FB).
  4. IRB Analyst should include the reviewer’s determination of sensitive study status in the approval letter, if granted (if declined, and study team agrees with outcome, then consent should be reverted to non-sensitive template language).
  5. For studies with sensitive study status, the IRB Analyst should forward the approval letter to OCR@emory.edu.

• Misc.
For approved studies that are found to contain Sensitive Study Status language in the consent, but have not been granted sensitive study status (i.e. IRB review overlooked this discrepancy):

1. Consult with the IRB Director and/or OCR to check to see if the consents are actually being uploaded to ERMS
2. If consents are being uploaded, have study team submit an modification and RE to correct the discrepancy.
3. If they are not being uploaded, then have study team submit an amendment to use simple language re: no study information will be placed in any EHC medical record you might have, instead of the sensitive study template language.

**LOG OF SIGNIFICANT CHANGES**

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<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tr>
<td>2/11/2020</td>
<td>Update to align with new system</td>
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SOP Title: Imaging Studies
SOP Category: Study Management
Established: 3/10/2014
Last Revision: 6/8/2018

PURPOSE
The purpose of this SOP is to detail to IRB Analysts what are the required elements for processing imaging studies.

SCOPE
This SOP applies to any study that utilizes any of the below referenced imaging modalities as a research intervention.

DEFINITIONS:

- Emory University Radiation Safety Committee (RSC): The RSC reviews Research that involves the use of radioactive isotopes, x-rays or other radioactive materials. Requirements for when RSC review of a Research protocol is necessary can be found at the following website: http://www.ehso.emory.edu/documents/guideline-for-rsc-review-of-human-research-studies.pdf
- Radioactive tracer: A radioactive molecule that can be sent through the body's circulatory or urinary system, with its progress followed by a radiation-sensitive machine.
- Radioactive contrast: a solution or colloid containing radioactive material used for visualizing soft tissue structures. Such contrast media indicate their positions or distribution in the body by their gamma ray emissions.

PROCEDURES:
Below are two categories of modal related to imaging studies. For additional assistance please see guidance on referring to Radiation Safety.

fMRI/MRI scans
- Determine if the study could be expeditable vs Full Board.
  o In general, determine if fMRI or MRI being used does not utilize any radioactive tracers (some MRI's use these). If they do, please make sure the study team registers with RSC and the study is assigned to a full board meeting.
  o fMRI/MRI studies may be expedited if no contrast is being used and the overall study is minimal risk and all other procedures fit into the expedited categories. The designated reviewer must be a medical doctor.
- If the study is using a radioactive tracer or contrast, make sure that the risks section of the consent, contains the following information:
  o A warning that the subject should not participate if they have any type of metallic object implanted in their body. The MRI may cause these objects to move or heat up.
  o The loudness of the machine (subjects are usually given earplugs)
The machine requires the subject to be in an enclosed space for a prolonged duration of time. If the subject is claustrophobic they may wish to opt out of the study. *(language may be altered for open MRI)*

- The incidental findings language from our Modular Consent Language document (posted on IRB website) **must be included verbatim** in every study that utilizes an fMRI or MRI for research purposes only, in either the risk section or its own section called “Incidental Findings”

**Please note**

- A clinical trial with research scans added that are not done as standard of care may need to add incidental findings language to the consent form.
- Often times these studies are done through the Psychology department. The Psychology department is not part of the covered entity and may not need a HIPAA Authorization form. However, if the study staff includes investigators (doctors) that are part of a covered entity, and the study involves billing and treatment, then HIPAA may apply.
- Many of the fMRI and MRI studies will come from Dr. Gregory Berns laboratory called the Facility for Education and Research in Neuroscience (FERN). Although the following fMRI/MRI directions were specifically designed for studies submitted by the Berns lab they are applicable to all studies using fMRI’s and MRI’s as a research intervention.

**Other Scans**

For studies utilizing scans such as MUGA, Bone Scan, PET, PET/CT, Myocardial Perfusion, VQ Scan, Thyroid, or exposure to radiation of any kind, please make sure the study team lists “radiation” in the “Biomedical Research” section, to trigger Radiation Safety Committee review, and the study is assigned to a full board meeting.

**LOG OF SIGNIFICANT CHANGES**

<table>
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<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tr>
<td>11/6/2014</td>
<td>Expanded the scope from just fMRI and MRI to cover all studies where imaging is done for research</td>
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<tr>
<td>2/18/2015</td>
<td>Adding information about other imaging that may require referral to RSC and review by FB</td>
</tr>
<tr>
<td>4/27/15</td>
<td>Adding note about the potential for HIPAA requirement based on study staff.</td>
</tr>
<tr>
<td>12/10/2015</td>
<td>Administrative changes made for clarity and note about clinical trials with research scans.</td>
</tr>
<tr>
<td>6/8/2018</td>
<td>Minor clarifications</td>
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SUMMARY

Genome-Wide Association Studies (GWAS) and “large-scale genomic analyses” are increasingly common. Investigators at Emory may wish to participate in GWAS via NIH-supported repositories by submitting genetic samples/data and/or requesting the use of it. As part of the process for submitting genetic samples/data, the investigators need to have a Data Use Certification signed by an appropriate Emory official. Per the latest NIH genomic data sharing policy effective January 25, 2015, additional steps are needed for NIH-funded studies including large scale genomic analyses. The IRB has a role in certifying/approving data sharing plans at the time of grant submission for these types of studies, as well as when the data is ready to be submitted to a public repository.

If requests come to the IRB either from OSP or the investigators to certify/sign-off on data sharing plans or data sharing activities, the IRB must have the following:

1. The letter or form that we are being asked to sign, pre-filled with information about the study and the data sharing restrictions as proposed by the investigator
2. The grant application including the data sharing plan portion
3. Indication of whether the samples from which the data was gathered were collected prior to, or after, January 25, 2015 (or both)
4. Copies of all informed consent forms used to collect the samples from which the data was gathered.

The Emory IRB office handles these requests and arranges for signature by the IRB Director after verification that all criteria are met. In her absence, a Co-Chair, Vice Chair, or an Associate or Assistant Director may sign after verifying in the protocol record that all criteria are met.

IRB Staff: if you have questions about GWAS or genomic data sharing issues, please check with IRB Director.

REFERENCES

- Learn more in the NIH GWAS Points to consider at: http://gds.nih.gov/pdf/PTC_for_IRBs_and_Institutions.pdf
- You may also obtain more information at http://gds.nih.gov/

LOG OF SIGNIFICANT CHANGES

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<td>9/16/2016</td>
<td>Updated with information about 1/25/15 policy change</td>
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**PURPOSE**
The purpose of this document is to describe the IRB process for reviewing studies under a Humanitarian Device Exemption.

**SCOPE OF SOP**
The SOP will apply to Emory human subject research working under a HDE.

**DEFINITIONS**
- **Investigational Medical Device**: means a device, including a transitional device that is the object of an investigation. An investigational device is permitted by the FDA to be tested in humans but not yet determined to be safe and effective for a particular use in the general population and not yet licensed for marketing.
- **Humanitarian Use Device (HUD)**: medical device intended to benefit patients in the treatment or diagnosis of a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year – 21 CFR 814.3(n). To obtain approval for an HUD, a humanitarian device exemption (HDE) application is submitted to the FDA.
- **Humanitarian Device Exemptions (HDE)**: allows use of an HUD; the HDE application is similar in both form and content to a premarket approval (PMA) application, but is exempt from the effectiveness requirements of a PMA. An HDE application is not required to contain the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. The application, however, must contain sufficient information for FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment. Additionally, the applicant must demonstrate that no comparable devices are available to treat or diagnose the disease or condition, and that they could not otherwise bring the device to market.
- **Sponsor**: A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator.

**RESPONSIBILITIES**
- **IRB analyst**: initially screens application before sending it to IRB Full Board or the IRB Chair.
- **IRB Chair or Co-Chair**: reviews the progress reports submitted by the sponsor or sponsor-investigator. The Chair or Co-Chair must be a clinician.

**PROCEDURE**

**Initial Review Submission**
Note: The Emory IRB cannot the IRB of record for community physicians who want to use a HUD for non-research purposes. We can only serve as the IRB of record for Emory physicians using HUDs at Grady or Emory. If the HUD is being used at St. Joseph’s Hospital, CHOA, etc., their IRB will review the HUD submission.

- Non-research HUD
  - The study team should provide the following documents with the submission (forward this checklist to the treating physician for their information):
    - A copy of the HDE approval order
    - A description of the device
    - The product labeling
    - An ICF is not required if used under the FDA-approved use, but the study team should submit an information sheet for the patient. The information sheet should describe a general definition of the FDA’s HDE program, a brief description of the device and related procedures, risk/benefit ratio, and physician contact information if the patient experiences a device-related adverse event. If the HDE holder has developed a patient information packet, this packet always should be distributed to patients prior to receiving their HUDs. Labeling for the HUD may also be made available to the patient to provide further information regarding the device’s HUD status and possible risks/benefits packet for the patient. See here for the Emory IRB template.
    - A summary of how the physician proposes to use the device, including a description of any screening procedures, the HUD procedure, and any patient monitoring with follow-up visits, tests, or procedures. Refer here for a protocol outline.
    - The IRB reviewer also may request that the physician submit documentation that he/she is qualified through training and expertise to use the HUD.
      - The staff should confirm the approval status of the HUD. The information can be found at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfHDE/HDEInformation.cfm.
      - Letter template information can be found at H:\General\QA Working Files\Forms, templates and Guidance\Letter templates & guidelines.

- Research HUD
  - Even though HUD’s are “approved” devices, the sponsor may still want to gather data from the uses of the device in order to support a premarket approval. If this is the case, then the PI should provide a research protocol and research informed consent and HIPAA Authorization. This information should be reviewed and approved by the IRB, and all regular IRB P&Ps should apply.

Note: Off-label use of an HUD for research purposes requires an IDE. And unless it is an emergency, before an HUD is used off-label treatment, the FDA recommends that the HDE holder obtain FDA approval of the use following the compassionate use policy for unapproved devices. IRB approval is also required per our policies and procedures.

Continuing Review Submission
- Non-research HUD
  - When a continuing review application is submitted to the Emory IRB, the IRB analyst will screen the information.
As a part of Continuing Review, the IRB reviewer may request the HDE holder to provide safety information on the HUD provided to the FDA in periodic reports required under 21 CFR Section 814.126(b)(1).

It is mandatory for the PI to provide a detailed list of each use of the HUD within the previous approval period. Summaries should include a brief description of the patient’s condition (with no identifiers), how the device was used, whether or not an information sheet was provided to the patient, and the patient’s outcome.

The analyst will route the continuing review, as permitted by the FDA regulations, to the clinician IRB Co-Chair for expedited review. The chair will make the decision if the HDE should be reviewed at Full Board instead of expedited review for any reason.

The IRB analyst and reviewer should compare the uses made of the device to the approved scope of the HDE/indication.

If there is a case where the PI appears to have used the device off-label, without informing the IRB in advance or within 5 days of the use, the analyst in charge of the continuing review should alert the Q team of possible non-compliance (NC).

Reportable new information submission for NC/UPS and Emergency/Compassionate Use

- Research or non-research HUD
  - The study team should follow Emory IRB’s usual reporting P&P for reporting protocol deviations, noncompliance, and unanticipated problems.
  - If the protocol deviation involves an emergency use or compassionate use in a single patient:
    - If the device user is or can be added to the HUD submission, study team should submit an RNI to report this matter. Team Q will send the event to FB using the appropriate emergency use omnibus form.
    - If the device user is not and cannot be on the HUD submission (per the PI choice), the device user must submit a new eIRB application of their own. Please make Team Q aware so they may follow up and take ownership of that submission.
    - A study team can add the new device user to an approved study to avoid a new submission.

Note: The Emory IRB will not review HUD compassionate/emergency use request for community doctors. If the original HUD PI wants to add this community physician to the submission, this may be allowed. Please contact the IRB Director for more information about this process.

Close-Outs

- If the treating physician has use the device in new patients since the last CR approval (to the close-out), he/she should include a detailed list of each use of the HUD within this period. Summaries should include a brief description of the patient’s condition (with no identifiers), how the device was used, and the patient’s outcome. The close out should be reviewed by a medical vice-chair.
- If the close-out is submitted and the treating physician has not used the device in new patients since the last CR, the close-out can be processed by an analyst.

REFERENCES

- 21 CFR Part 812 (investigational devices)
21 CFR Part 814 (premarket approval of medical devices)
• 21 CFR Part 860 (device classification procedures);
• 21 CFR Parts 862 –892 (device type classifications)
• IRB policies and procedures

LOG OF SIGNIFICANT CHANGES

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<td>Replaced “should” with “must” to state Chair/Co-Chair must be a clinician; added HUD definition</td>
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<td>5/14/2015</td>
<td>Added New Study and Reportable new information submission sections.</td>
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<tr>
<td>6/29/2015</td>
<td>Added close out section and information for template letter.</td>
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<tr>
<td>9/16/2016</td>
<td>Added links to current tools and clarified Emory IRB position on reviewing HUDs for community</td>
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<td>physicians.</td>
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SOP Title: ResearchMatch.org as a recruitment tool
SOP Category: Study Management
Established: 7/28/2014
Last Revision: 5/14/2015

PURPOSE
The purpose of this document is to detail the steps necessary to add ResearchMatch.org as a recruitment tool.

SCOPE
The SOP applies to all studies that want to add ResearchMatch.org (RM) as a recruitment tool.

PROCEDURE
- Emory researcher includes RM template language ([ResearchMatch IRB Protocol Template Language](#)) in the research protocol or, more likely, as an addendum (separate document) to the protocol, uploaded in the “Research Design” section next to the protocol. Alternatively, it can be uploaded as a stand-alone document, along with #2 below, to the “Recruitment and Payment” section of the IRB application form in the question where flyers are uploaded.
- Study team adds the use of RM as a recruitment document in the “Recruitment and Payment” section of the eIRB and adds the RM template language as a stand-alone document (usually the same text as the main recruitment flyer, but with all research contact information removed).
- Emory IRB reviews and approves the submission in eIRB
- Study team follows the ResearchMatch Registration Instructions to register in RM. A copy of IRB’s approval of the overall study, as well as the text for the recruitment ad, is required. When RM use is being added via Modification, registration with RM should be done after the Modification is approved by the IRB.
- Emory IRB ResearchMatch Liaison receives email from RM.org, alerting them that there is a study pending approval. Emory IRB RM Liaison logs into RM system (IRBEmoryRM/IRB2010RM), confirms study has IRB approval to use RM as recruitment tool with correct ad content, and sets study expiration date in RM.org.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
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<th>DATE</th>
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<tbody>
<tr>
<td>10/22/2015</td>
<td>Addition of links for template language and instructions. Modification of Process flow</td>
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</table>
SOP Title: Checking Biosafety Approval Status
SOP Category: Study Management
Established: 5/2/2012
Last Revision: 5/11/2016

PURPOSE
The purpose of this document is to describe the procedures to check the status of Biosafety Approval.

SCOPE
The SOP applies to all studies that may require Biosafety approval (ex. all recombinant DNA use in humans directly (i.e vaccine) or indirectly (autologous cells sent off for treatment with lentiviral vector and then infused back to patient)).

RESPONSIBILITIES
- **Biosafety Analyst** – review and update the Emory Bio_Chem Protocol Box. In addition, Biosafety analysts may log a comment in eIRB regarding the status of the Biosafety review.
- **IRB Analyst** – ensure that all studies needing Biosafety review have obtained the necessary approval.
- **IRB Superuser** – may be required to provide Biosafety approval in eIRB
- **Study team** – select Biosafety review as a necessary review in the eIRB Smartform and apply for the necessary approval.

PROCEDURE
Once the study team has selected Biosafety as a necessary ancillary review, the IRB analyst should wait for confirmation of the completion of the Biosafety review by either:
1) Waiting for a Biosafety analyst to log an approval comment into the study OR
2) Review the Biosafety Emory Box File (Bio_Chem Protocols)
   a. Note, only select IRB individuals may have access to this Emory Box file. If you do not have access, you can ask either an Associate or Assistant Director/ Biosafety analyst to provide you access.

If you find that one of your studies has been approved by Biosafety, you can ask a superuser to do the approval in eIRB; likewise if you find out it’s not actually required for a study, a superuser can remove the requirement in eIRB.

LOG OF SIGNIFICANT CHANGES

<table>
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<tbody>
<tr>
<td>5/11/16</td>
<td>Updating SOP to reflect Biosafety Committee use of Emory Box</td>
</tr>
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</table>
SOP Title: Processing Studies that will use Deception or Incomplete Disclosure
SOP Category: Study Management
Established: 5/17/2018
Last Revision: 5/17/2018

PURPOSE
The purpose of this document is to outline special considerations when processing studies that will utilize deception or incomplete disclosure. The IRB will determine when certain restrictions apply, and consider the extent to which the deception in a given study interferes with the subject's ability to give informed consent. The IRB will need to 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.

SCOPE
The SOP applies to any study that will utilize deception or incomplete disclosure.

RESPONSIBILITIES
• IRB analyst – Review studies to determine whether deception or incomplete disclosure is included in the research plan.
• IRB Associate or Assistant Director and/or Director- Serve a resource for analysts in cases where appropriate process of review in unclear.

DEFINITIONS
Deception-occurs when an investigator gives false information to subjects or intentionally misleads them about some key aspect of the research. Examples include:
• 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.
• Participants complete a quiz and are falsely told that they did poorly, regardless of their performance.
• Participants who don’t know they are in a research study are observed to see how they behave when they find valuables (e.g., wallet, laptop) unattended in a public location.
• The study includes a researcher's "confederate," an individual who poses as a participant, but whose behavior in the study is actually part of the researcher's experimental design.

Incomplete disclosure -occurs when an investigator withholds information about the specific purpose, nature, or other aspect of the research. Withholding information may or may not be considered deception. Examples include:
• Participants are asked to take a quiz for research, but they are not told the research question involves how background noise affects their ability to concentrate.
• Participants are told they are completing a survey to evaluate customer service when the true purpose of the study is to correlate psychological responses with patient care satisfaction.

Incomplete disclosure that is also deception. An example:
• The study involves audiotaping or videotaping of subjects without their knowledge or prior consent.

PROCEDURE
Considerations when triaging studies:
In keeping with federal regulations and ethical codes established by the Belmont Report and the American Psychological Association, the IRB will consider the following criteria when reviewing research involving the use of deception or incomplete disclosure:

- The study must not involve any more than minimal risk to the subjects.
- 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).
- Prospective subjects must not be deceived about any physical or psychological risks, discomforts, or unpleasant emotional experiences of the study.
- 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. This is sometimes known as “authorized deception” because it provides participants with an opportunity to decide whether or not to participate, knowing that they aren’t receiving complete information. 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.
- In addition, the research must meet the criteria for a waiver of one or more elements of informed consent.
- Whenever appropriate, researchers should debrief participants. The debriefing should occur 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.

Please note: Research involving incomplete disclosure but no deception may be reviewed as Exempt. Research employing deception may not be reviewed as Exempt under the Pre-2018 Common Rule. Under the Post-2018 Common Rule, such research may be reviewed as Exempt if it otherwise meets the Exemption criteria and the deception is authorized (see § 46.104(d)(3)(iii)).

Research that involves incomplete disclosure, or that involves mild deception where the topic is not sensitive and the participants are not vulnerable, may be reviewed as Expedited with the discretion of the designated reviewer. Research that involves deception where the topic may be sensitive and/or the participants may be vulnerable should be referred to full board for review, in parallel with consultation with the Committee C Chair in case she determines that the study may receive expedited review. The IRB Analyst should also consult with the Associate or Assistant Director or IRB Director to determine whether Full Board review is appropriate.

**PROCESS FLOW**
Determine whether study involves deception and/or incomplete disclosure

If Incomplete Disclosure?

If study meets the criteria for Exempt review, may be an option. If Exempt categories do not apply, may go Expedited.

If Incomplete Disclosure, Mild Deception, or both?

If mild deception & topic is not sensitive or participants are not vulnerable, analyst should consult with the Committee C Chair or Director.

If possible, expedite. If not expeditable, assign to CMTE C for review.

Significant Deception?

Analyst should consult with the Committee C Chair or Director.

Not Expeditable?

Assign to CMTE C for review.

*Adapted from University of North Dakota IRB’s ‘Guidance on the Use of Deception or Incomplete Disclosure in Research”

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BACKGROUND

The IRB must ensure that the “In Case of Injury” language in the informed consent form(s) is accurate, and for industry-funded studies, the correct language depends on how the contract is negotiated with the Sponsor. The Office of Technology Transfer handles industry contract negotiations, and they allow Sponsors to choose from one of three template options for coverage of research-related injuries (known as Options 1, 2, and 3 – see Emory ICF template for the language). The OTT staff register the negotiated Option in a database, to which IRB staff have access via an Excel report that we can export at any time. This Contracts database export report allows the IRB analyst to learn who among the OTT contracts staff are working on a particular contract, to see what In Case of Injury option was selected (if any), and to check on the status of a research contract when the option isn’t yet registered.

NOTE: the database does not include federal grants; for those, the IRB assumes the In Case of Injury option is “1” (likewise for unfunded or internally-funded studies).

IF ANALYST DOES NOT HAVE ACCESS TO THE BELOW REPORT:

1. New Staff Training coordinator or IRB Associate or Assistant Director or Director must write to ora-it@emory.edu and request access to “Contract

PROCEDURE

1. Click on https://oraws2.emory.edu/shared_web/secured_apps/

2. You will be asked to enter your Emory credentials, unless you were previously logged in with Shibboleth:

3. Once logged in, navigate to “IT Resources” tab:
4. Click on “ORA Reporting Export” tab:

5. Click on “OSP Contract Tracking Data Peoplesoft/COMPASS merged data”:

6. File will download automatically to the location all your downloads go to, most likely the Download folder.

7. To find Injury Option number:
   - Go to “View” tab of MS Excel Ribbon and select “Freeze Panes” and then “Freeze Top Row”
   - Find the row for the study you are looking for (via EPEX number, study title, etc – EPEX number is easiest)
   - Scan over to the columns titled “Subcontract Option 1”, “Subcontract Option...
2”, and “Subcontract Option 3.”

- If option has been determined, one of those cells will say “Yes” and the other two will say “No.” If all say “No” (the default), then go back to the Status column to see if it says something other than “Completed” – if so, that is why the Option is not yet available. You may be able to see what is going on with the contract more specifically via the Notes column.

8. Communicate the Option Number to the study team for purpose of writing or revising consent form(s).

9. If you are unable to find the information, you should check the Master Clinical Trial Agreements page of the OCR website at http://www.ocr.emory.edu/ocr%20submission/Master%20Trial%20Agreements.html. If you still haven’t found an option, you will be required to review our listserv to make sure the information was not already sent via email. If you cannot find it the same day, you are required to put a tickler to receive the email in your inbox. The email will look something like this:

From: IRB Departmental List <IRB-L@LISTSERV.CC.EMORY.EDU> On Behalf Of ORAIT_NO_REPLY@EMORY.EDU
Sent: Saturday, October 27, 2018 5:00 Mod
To: IRB-L@LISTSERV.CC.EMORY.EDU
Subject: Corp IRB Options - 4 Record(s) Found

2018-10-27 05:00:05--Started Processing--

2018-10-27 05:00:05--Successfully Found and inserted 4 records into Corp_IRB_Options.xls file

<table>
<thead>
<tr>
<th>Proposal_ID</th>
<th>Title</th>
<th>Investigator</th>
<th>Subcontract Option 1</th>
<th>Subcontract Option 2</th>
<th>Subcontract Option 2 Dollars</th>
<th>Subcontract Option 3</th>
<th>Date Option Update</th>
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<tbody>
<tr>
<td>0000049150</td>
<td>CA204-192: Phase 2 Study of Lenalidomide/Dexam... in Pts. w/R</td>
<td>Kaufman, Jonathan Lyle</td>
<td>YES</td>
<td>NO</td>
<td>-</td>
<td>NO</td>
<td>Oct 26 2018 02:39:45:000PM</td>
</tr>
<tr>
<td>0000049164</td>
<td>ADXS-503-101: Phase 1/2 Study of ADXS-503 w/ Pembrolizumab Pt</td>
<td>Ramalingam, Surish Sakkarai</td>
<td>NO</td>
<td>YES</td>
<td>-</td>
<td>NO</td>
<td>Oct 26 2018 11:44:10:000AM</td>
</tr>
</tbody>
</table>
10. To create a rule for a specific EPEX number, to make sure you get this information real time:
   - Create new folder under listserv folder
   - Click on listserv folder, then click “rules” then click “Create new rule”
   - Click “Advanced Options”

   - Select “with specific words in the body”
• Click on “specific words” in box below the large list of selections
• Enter the EPEX number, click Add, then click OK
• Click Next
• Select “move it to the _______ folder”

• Click Next
• Select “run this rule now on messages already in “listserv folder”
## LOG OF SIGNIFICANT CHANGES

<table>
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<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>11/1/2018</td>
<td>Change graphic in step 5. Added information about expectation if the ICOI is not in the report when run</td>
</tr>
<tr>
<td>1/18/2019</td>
<td>Added step of checking Master Clinical Trial Agreement page.</td>
</tr>
<tr>
<td>4/11/2019</td>
<td>Adding instructions of how to set up a rule in outlook for specific EPEX numbers</td>
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</tbody>
</table>
PURPOSE
The purpose of this document is detailing the steps for handling a study submission including or adding John’s Creek and/or St. Joseph (SJHC) as a study site in order to ensure compliance with institutional requirements and ethical and religious directives (ERDs). Per an MOU (created when EHC, St. Joseph’s, and Johns Creek became partially owned by a Joint Operating Company [JOC]), Emory IRB is the IRB of record for any studies involving Emory or Emory Healthcare personnel, that have St. Joseph’s or Johns Creek as study sites. EHC has set up an Emory Clinic (TEC) location in leased space on the St. Joseph’s campus; research studies might take place there, or at the actual hospitals, or both. St. Joseph’s does not have an IRB or Research Oversight Committee anymore. Rebecca Heitkam will review protocols and consents to verify compliance with ERDs.

SCOPE
The SOP applies to all new studies and Modifications including St. Joseph and/ or John’s Creek as a study site (other than chart reviews and clinical trials/research conducted at other Emory sites (e.g. EUH) but isolated diagnostic services performed at ESJH for research purposes due to patient convenience or equipment availability).

DEFINITIONS
- ERDs - Ethical and Religious Directives for Catholic Health Care Services
- SJHC - St. Joseph Healthcare

PROCEDURE
IRB Analyst:
1) Review the eIRB submission overall for mention of St. Joseph and/ or John’s Creek as a location where study activities will take place.
   a. Confirm that Emory St. Joseph/Emory Johns Creek is selected as a study site in the Smartform
   b. Leased space (i.e. TEC) should be reflected using the “other” site selection as well (See appendix 1 for an example)
      i. Confirm with study team whether activities will take place in leased space or not.
   c. Advise the team (when requesting changes) that they will need at least one physician on the study team is credentialed to practice at SJHC (or Johns Creek, as applicable).
2) Determine if SJHC local context (ERD’s and credentialing) review is required. If not, the rest of this SOP does not apply
   a. Chart reviews do not require ERDs review.
   b. Clinical trials/research conducted at other Emory sites (e.g. EUH) but isolated diagnostic services performed at ESJH for research purposes due to patient convenience or equipment availability do not require ERDs review, though the informed consent should include information about where study procedures will or may take place.
      c. All other studies taking place at SJHC, TEC at SJHC or Emory Johns Creek require ERD review
3) Email the Rebecca Heitkam (rebecca.heitkam@emoryhealthcare.org) a copy of the study protocol and consent forms. (See appendix 2 for an example)
a. For an expedited study, email when the study is assigned to you
b. For a full board study, email once the study is assigned to a committee. Include the meeting date and a reminder that there still may be changes required by the IRB.

4) Confirm that the study used the proper consent form template if St. Joseph/Johns Creek are engaged.
   a. Studies taking place only at the St. Joseph’s leased space (TEC) do not need a St. Joseph’s template, as St. Joseph’s is not considered to be “engaged” in that scenario. Note: ERD review is still required.
   b. Ensure that the correct terminology for “birth control” is used, per our template, and that no specific birth control methods other than abstinence are listed (e.g. no mention of birth control pills, condoms, etc).

5) If SJHC local context approval is not in place (per logged comment from study team) prior to IRB approval of the study or Modification, process IRB approval as usual but add caveat to approval letter stating “Note: No research-related activities may begin at the [St. Joseph’s/Johns Creek] site(s) until the site ERD approval is received from Rebecca Heitkam or her designee. Any changes required by the site must be submitted to the Emory IRB via an (other) Modification.

6) Once ERDs approval is received, the analyst will log the information as a comment to study team.

PROCESS FLOW

Appendix 1

Study Sites
- A site is where recruitment will occur
- A site is where the research will take place
- A site is data collection will take place
- A site is where data analysis will take place
• A site is where data will be stored

1.0  *Indicate all locations where the Emory Investigator will conduct this study:

- Emory Children’s Center
- Emory Clinic
- Emory St. Joseph’s Hospital
- Emory University Hospital Clinical Research Network
- Winship Cancer Institute
- Other - In Atlanta metropolitan area

2.0  If "Other - ", list all other locations where the Emory Investigator will conduct the study:

<table>
<thead>
<tr>
<th>Name of the Site</th>
<th>IRB of record for this site</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEC at St. Joseph</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 2

For expedited studies:

Hello Ms. Heitkam,

IRB0000XXX, a new study/Modification, has listed St. Joseph/John’s Creek as a study site. Please advise the study team when your approval is granted, replying all to this email.

For Full Board Studies:

Hello Ms. Heitkam,

IRB0000XXX has listed St. Joseph/John’s Creek as a study site. The study is currently assigned to a committee meeting on X/X/201X. Please note that the committee may request changes to the study. Please advise the study team when your approval is granted, replying all to this email.

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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<tbody>
<tr>
<td>10/7/2015</td>
<td>Update to purpose and procedures to align with current MOU</td>
</tr>
<tr>
<td>11/12/2015</td>
<td>Update to indicate that chart reviews and trials where only isolated diagnostic services performed at ESIH for research purposes due to patient convenience or equipment availability no longer need ROC/ERDs review.</td>
</tr>
<tr>
<td>03/08/2016</td>
<td>Minor changes to clarify that The Emory Clinic in the leased space at SJHC still requires ROC review.</td>
</tr>
<tr>
<td>11/15/2017</td>
<td>Revised to reflect that Kris McGinnis is no longer at Saint Joseph’s and there is no longer an ROC.</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Clarification on process as Rebecca H needs to be emailed with protocol and ICF information</td>
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</table>
PURPOSE
The purpose of this document is to explain the process an IRB analyst will follow when reviewing a study under Approved Risk Evaluation and Mitigation Strategies (REMS) requirements.

SCOPE
The SOP applies to studies either reviewed by the Emory IRB or at Emory reviewed by an external IRB under REMS requirements.

RESPONSIBILITIES
• IRB analyst – reviews protocol to identify if drug or biologic is under REMS program & confirms ODP review
• IRB Associate or Assistant Director or Director- initial review of protocol to identify if drug or biologic is under REMS program & flags study as one under REMS
• Office of Compliance Designated Person (ODP)- confirms that protocol/ICF is in compliance with REMS requirements

PROCEDURE FOR NEW STUDIES REVIEWED BY THE ECOMY IRB
1. Study will be assigned by IRB Director/designee, indicating that the study is under REMS requirements. It is possible that an analyst will receive a study that was not flagged; in those cases, the analyst should verify with a TL or IRB Director
2. The analyst will contact the ODP and direct the study team to fill out the REMS Investigator Checklist.
3. The ODP will verify that the study protocol and informed consent include all the requirements for that drug under REMS. That information can be found at this [FDA website](https://www.fda.gov)
4. When the information is complete, the ODP will log a comment under the study history indicating that the REMS requirements are met in the submitted protocol and informed consent
5. The IRB analyst may send the study to full board (FB), before this process is completed. If the ODP review has not been completed before the IRB meeting, the analyst should complete omnibus form accordingly.
6. When forwarding the study for FB review, the analyst will add to the agenda items notes that the study is under REMS requirements.
7. After the study is approved, the approval letter should include the following language:
   “This study utilizes a drug(s) under FDA required REMS. You must ensure your study remains compliant with current requirements as listed in the “REMS Document” and the protocol/informed consent document”

PROCEDURE FOR STUDIES REVIEWED BY AN EXTERNAL IRB
• Follow same steps from 1 to 4 as above.
• The study will not be given an institutional signoff until the REMS requirements are verified.
PROCEDURE FOR MODIFICATIONS REVIEWED BY THE EMORY IRB

1. If the Mod adds a new drug under REMS requirements, follow steps as detailed before, letting the ODP know, and making sure the ODP has reviewed the checklist. The Mod may be placed on FB agenda prior to completion, making sure the omnibus form reflect that this process is still pending.

LOG OF SIGNIFICANT CHANGES

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<tbody>
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<td>2/21/2018</td>
<td>Added process for Mods</td>
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<tr>
<td>4/11/2019</td>
<td>Clarified that REMS process applies to research at Emory or reviewed by our IRB</td>
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</table>
PURPOSE
The purpose of this document is to describe the review process of new study submissions, continuing reviews, and Modifications by the IRB analyst and prisoner representatives when research involves Prisoners.

SCOPE
This applies to all IRB staff.

DEFINITION
Prisoner: an 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. Individuals are prisoners if they are in any kind of penal institution, such as a prison, jail, or juvenile offender facility, and their ability to leave the institution is restricted. Prisoners may be convicted felons, or may be untried persons who are detained pending judicial action, for example, arraignment or trial (45 CFR46.303).

Important Notes
• One member of the Emory IRB shall be a Prisoner or a Prisoner Representative. A Prisoner Representative is defined as an IRB member who has appropriate background and experience that includes a close working knowledge, understanding and appreciation of prison conditions from the Prisoner’s perspective.
• The fact that the Emory IRB meets the compositional requirements for the review of a Research protocol involving Prisoners will be documented in the meeting minutes at which the Research protocol is reviewed.
• When a prisoner representative completes a review, please contact Regina Drake so she can process payments.

PROCEDURE
RESEARCH PROTOCOLS THAT INITIALLY PLAN TO INCLUDE PRISONERS AS HUMAN SUBJECTS:
Note: If a study intends to enroll both prisoners and non-prisoners, and is federally funded (thus requires OHRP certification for involvement of prisoners), study team may be advised to consider omitting Prisoners as a study population at initial submission, and add them via Modification after initial IRB approval is in place, depending on how urgently they wish to begin. This would enable them to begin enrolling non-prisoners immediately.

Exempt studies:
Not Applicable - Research involving prisoners cannot be reviewed as exempt, except for research aimed at involving a broader subject population that only incidentally includes prisoners.

**Expedited new studies:**
- IRB analyst should complete the top portion of the Subpart C Worksheet, and highlight the portion to be completed by the prisoner representative. Upload this document in the “Research Design” section of the eIRB Smart Form.
- IRB analyst should first send the study to a primary designated reviewer via eIRB. Please alert the primary designated reviewer that the application will then be reviewed by the prisoner representative.
- Once the primary designated reviewer has completed his/her review, and any requested changes have been made by the study team, IRB analyst should contact IRB Super user to change the state of the study to allow for the review to be assigned to the prisoner representative.
- The IRB analyst should work with the prisoner representative to complete the eIRB review and Subpart C Worksheet, as needed.
- IRB analyst should upload the completed Subpart C Worksheet in the “Research Design” section of the Smart form so it becomes part of the permanent record.
- **IRB analyst documents Subpart C category in the approval letter.** Final approval letter should not be issued for federally funded Subpart C studies until we have received confirmation from OHRP about the certification of the Subpart C findings.
- If the study is federally funded, IRB analyst must draft a letter certifying the Subpart C Category findings to OHRP
  - The letter should be drafted for the IRB Director to review (may be reviewed by Associate or Assistant Director in Director’s absence).
  - The OHRP letter will require verification of the Grant number – may be requested from study team if not in eIRB.
  - A sample OHRP letter can be found at H:\General\Subpart C OHRP Cert

**Expedited new studies not involving interactions with prisoners (i.e. involve only existing data or record reviews):**
Per OHRP, AARHPP, and Emory IRB P&Ps, review by the prisoner representative is not required for minimal risk studies that do not involve interactions with prisoners.

**Full Board new studies**
- For a new study, the prisoner representative must be present, either in-person or by speakerphone, at any meeting of the Emory IRB for FULL Board review of new research protocols involving Prisoners and Modifications adding Prisoners. Inform the meeting Pod that a prisoner representative is needed for the meeting.
- If a continuing review, IRB analyst must document participation of the prisoner representative in the review, but the prisoner representative does not have to be present for the full board review of the application.
- If an Modification alter risks/benefits/involvement of Prisoner subjects, the information should be reviewed at full board. If an Modification is not altering the above, then the information can be reviewed expedited.
• For new studies, or Modifications adding Prisoners as subject population for first time (see following section for more details on the latter case):
  o IRB analyst should pre-fill the Subpart C Omnibus form to be filled out at the meeting.
  o After the meeting, IRB analyst should save the Subpart C Omnibus form in the Research Design section of the Smart form.
  o IRB analyst needs to document Subpart C category in the approval letter. Final approval should not be granted for federally funded Subpart C studies until we have received confirmation from OHRP about the certification of the Subpart C findings.
  o If the study is federally funded, IRB analyst must draft a prisoner certification letter to OHRP
  o The letter should be drafted for the IRB Director to review (may be reviewed by Associate or Assistant Director in Director’s absence).
  o The OHRP letter will require verification of the Grant number – may be requested from study team if not in eIRB.
  o A sample OHRP letter can be found at H:\General\Subpart C OHRP Cert

Continuing Reviews:
Continuing reviews for studies that required a prisoner representative review must also be reviewed by a prisoner representative. For full board studies, representative must attend or call in for the review of the renewal. Expedited renewals may use the reviewer assignment procedure listed under “Expedited new studies” above.

Modifications:
  o Any Modifications that are changes to the research require prisoner representative review, if such review was required initially.
  o Any Modifications that are purely administrative and would not be considered changes to the research requiring IRB review, per OHRP, may be reviewed without a prisoner representative’s input.

IF A PARTICIPANT BECOMES A PRISONER WHILE ENROLLED IN A RESEARCH STUDY THAT HAS NOT BEEN REVIEWED ACCORDING TO SUBPART C
• The study team must immediately notify the IRB (via Modification or other communication) that a participant has become a prisoner, the IRB shall confirm that the participant meets the definition of a “Prisoner.”
• The IRB shall ensure that either:
  o The PI terminates enrollment of the subject OR
  o If it is feasible for the participant to remain in the study, cease any research activities until the IRB reviews the research under Subpart C (following the steps outlined above) or not if it meets the “Non-DHHS” criteria per the P&Ps.

• Review the Modification and make one of the following findings:
  o The study is neither DHHS-funded nor considered VA Research, and the “Non-DHHS” criteria below are met, OR
  o The research meets the criteria set forth in Subpart C of the Common Rule. The PI must provide written documentation if he/she feels there are special circumstances that justify why research
activities should continue while the IRB reviews the research under Subpart C. The special circumstance should be reviewed by a Vice-Chair.

Non-DHHS Criteria:
- The research is NOT conducted or funded by DHHS or Veterans Administration (VA).
- The subject was not incarcerated at the time of enrollment, and subsequent incarceration was unexpected.
- The incarceration does not put the rights and wellbeing of the subject in jeopardy with respect to the study.
- The prisoner representative has been consulted.
- The terms of the subject’s confinement do not inhibit the ethical conduct of the research.
- There are no other significant issues preventing the research from continuing as approved.
- This approval is limited to the individual subject and does not allow recruitment of prisoners.
- One of the following is true:
  - The subject will be at increased risk of harm if withdrawn from the research
  - The research presents no more than Minimal Risk and no more than inconvenience to the subjects

For DHHS-Regulated Research:
The research shall be reviewed per Subpart C
- If some requirements of Subpart C cannot be met:
  - If it is in the best interests of the subject to remain in the study, the subject shall remain enrolled and the IRB shall inform OHRP of the decision along with the justification.
  - Otherwise, the IRB shall advise the PI to remove the participant from the study and to keep the participant on the study intervention under an alternate mechanism as necessary.

- When considering whether to terminate enrollment, the IRB/PI should consider the risks associated with termination of the subject in the study.
  - If the participant cannot be terminated for health or safety reasons, the IRB should advise the PI to keep the subject enrolled in the study and it shall review the research under Subpart C.
  - If some requirements of Subpart C can’t be met, but it’s in the best interest of subject to remain in the study, the subject shall remain enrolled and IRB shall inform OHRP of the decision along with the justification.
  - The IRB shall advise the PI to remove the participant from the study and to keep the participant on the study intervention under an alternate mechanism as necessary.
  - If a participant is incarcerated temporarily while enrolled in a study, and if that incarceration has no effect on the study, the participant shall remain enrolled.
  - If the temporary incarceration has an effect on the study, the IRB shall handle the case according to the case set forth above.
  - Note: An adolescent (e.g., age 14) detained in a juvenile detention facility is a prisoner therefore; the IRB would need to comply with Subpart C and Subpart D – Children.

LOG OF SIGNIFICANT CHANGES

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<th>DATE</th>
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<tr>
<td>10/19/2019</td>
<td>Adding additional detail after the P&amp;P changes, dated 9/13/2019</td>
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PURPOSE
The purpose of this document is to describe the review process of submissions by the IRB analyst and Office of Compliance designated person (ODP), when the study involves an Emory Sponsor or an Emory Sponsor-Investigator (S-I) holding an IDE for a significant risk device or IND.

SCOPE
FDA regulated studies, involving an Emory faculty member holding an IDE for a significant risk device or an IND.

DEFINITIONS
- **Investigational New Drug (IND) Application**: a request for authorization from the Food and Drug Administration (FDA) to administer an investigational drug or biological product to humans which must be secured prior to administration of any new drug, biological product that is not the subject of an approved New Drug Application, or Biologics/Product License Application. An IND may be required for a clinical investigation using a marketed drug for a use other than the indications in the approved labeling. [21 CFR § 312.3].
- **Investigational Device Exemption (IDE)**: An IDE allows an Investigational Device to be used in a clinical study in order to collect the safety and effectiveness data required to support a Premarket Approval (PMA) application or a Premarket Notification submission to the FDA. Investigational use also includes clinical evaluation of certain modifications or new intended uses of legally marketed devices. All clinical evaluations of investigational devices, unless exempt, must have an approved IDE (either abbreviated or issued by the FDA) before the study is initiated. [21 CFR § 812.3].
- **Sponsor**: A person who takes responsibility for and initiates a clinical investigation. The sponsor may be an individual or pharmaceutical company, governmental agency, academic institution, private organization, or other organization. The sponsor does not actually conduct the investigation unless the sponsor is a sponsor-investigator. [21 CFR § 312.3, 812.3].
- **Sponsor-Investigator**: an individual who both initiates and conducts an investigation, and under whose immediate direction the investigational drug is administered or dispensed. The term does not include any person other than an individual. The requirements applicable to a sponsor-investigator under this part include both those applicable to an investigator and a sponsor. [21 CFR § 312.3, 812.3].
- **Annual or Progress Report Submission**: A report submitted to the FDA by the IND or significant risk IDE holder within 60 days of the anniversary date that the IND went into effect or at regular intervals and at least yearly for an IDE for a significant risk device. The report contains the study progress information, general investigational plan for the following year, and other applicable information. [21 CFR § 312.33, 812.150].
RESPONSIBILITIES

- **IRB analyst** – verifies that the information in eIRB, including the protocol and DSMP, is complete, requests the S-I or Sponsor to contact the ODP and informs ODP accordingly.
- **ODP designated person**: responsible for providing Sponsor/Sponsor-Investigator training and reviewing IND and IDE information on the Emory S-I Responsibility Checklist, ensuring that it reflects the information submitted under the IND or IDE application to the FDA.
- **Emory investigator holding IND or significant risk IDE**: makes sure that the information submitted in eIRB and on the Emory IND or IDE Responsibility Checklist is complete and accurate, according to the study protocol submitted to the FDA.

PROCEDURE FOR NEW STUDIES

- The IRB analyst will update the ancillary review option adding “S-I advisory”.
- The IRB analyst will notify the Sponsor/S-I to contact the ODP for training. The analyst will ask Sponsor/S-I to provide additional information about the study IND/IDE (e.g. IND/IDE submission date, if IND/IDE is required, FDA correspondence, etc.) and to fill out the Emory S-I IND or IDE Responsibility Checklist.
- A study cannot be placed on a FB agenda until we receive a FDA “study may proceed” letter or the date of IND/IDE submission is more than 30 days
  - If the team pushes back, the analyst will contact the Associate Director for additional steps
- If the study team received an IND or IDE letter stating that it is pending some contingencies before proceeding, the IRB analyst will ask the team for the information received from the FDA (via email, for example) and the changes to the protocol and consent forms sent to the FDA to address said contingencies. The study cannot be placed until we receive documentation that 30 or more days have passed since the submission of the IND or IDE information to the FDA. The FDA correspondence should be uploaded under the drug section, question 4 (protocol/ICF changes should be uploaded in their respective section in eIRB).
- When the study is ready for Full Board (FB), the IRB analyst will add the study to the next available meeting agenda, informing FB if the S-I Advisory sign-off is complete or pending review
- The ODP will upload the Emory IND or IDE Responsibility Checklist when submitting the S-I Advisory sign-off.
  - Click on “Submit Ancillary Review” and upload the checklist under question 4.
  - The information will be updated under the “review” tab.

For studies with an Emory investigator as Sponsor that include non-Emory sites, the Emory sponsor will complete the appropriate multi-site Responsibility Checklist.

If the non-Emory sites include international sites, the Emory sponsor must provide the IRB with assurance that they are aware of international regulations and have appropriate processes in place. For interventional clinical studies, specifically studies with investigational drugs or devices, the IRB should stipulate that the sponsor will need a CRO or legal counsel review prior to initiating the study at the international site. Moreover, clinical studies require international site IRB/EC review. The IRB analyst should contact Kris West in OC before sending the study to full board, as a CRO and/or consult with the general counsel may be necessary. The IRB analyst will work with the ODP to obtain the required documentation.
PROCEDURE FOR CONTINUING REVIEWS

At continuing review, the IRB analyst will request that the Emory Sponsor/S-I complete the Emory Sponsor Responsibility Checklist Continuing Review Update and forward to the ODP. In addition, the IRB analyst will ask the team to fill out the “S-I addendum checklist”.

The ODP will review the Emory Sponsor Responsibility Checklist Continuing Review Update to confirm that processes are in place so that processes are in place to meet Sponsor/S-I responsibilities. If processes are not in place, the ODP will work with the Sponsor/S-I and make the IRB analyst aware of any significant concerns, including DSMB report. Once the Emory Sponsor Responsibility Checklist Continuing Review Update is complete and the ODP has confirmed that the processes are in place to meet Sponsor responsibilities, the ODP will notify the IRB analyst via email and will attach the completed Responsibility Checklist under question 4 under the “manage ancillary review” activity. If the study is in data analysis only, the Sponsor-Investigator Responsibilities Checklist is not required.

At continuing review, the IRB analyst will ensure that the IND or IDE annual or progress report submission to FDA is included in the continuing review application. If the annual report submission is not included in the application, the IRB analyst will determine from the ODP the anniversary date that the IND or IDE went into effect. If the date will occur in the future, the IRB analyst will create an Outlook reminder to follow up with the study team to submit the annual report at the next continuing review. If the anniversary date has already passed, the IRB analyst will request a copy of the annual report submission. If the annual report submission is not provided, the IRB analyst will notify the ODP and the Team Q lead. The continuing review can still be assigned to a Full Board committee meeting without the IND or IDE annual report; however, this might be deemed a pending issue by the committee.

When the continuing review is ready for Full Board review, the IRB analyst will add it to a meeting agenda and include the following information in the omnibus meeting materials: 1) S-I has/has not completed the Emory Sponsor-Investigator Responsibility Checklist Continuing Review update if required; 2) ODP has/has not confirmed that processes are place to meet Sponsor responsibilities, and 3) the status of the IND/IDE annual report submission.

PROCESS FLOW FOR CONTINUING REVIEW
PROCEDURE FOR AMENDMENT TO ADD NON-EMORY STUDY SITES, CHANGE SPONSOR OR INVESTIGATOR, AND/OR MODIFY THE PROTOCOL

Note for any change to the protocol/IB/IC: if there are any delays in the submission of these documents (check cover letter or dates on the documents), please check with Team Q as the study team may require the submission of a reportable event.

- CHANGE SPONSOR

The IRB analyst will request that the Emory Sponsor/S-I holding an IND or significant risk IDE complete the Emory Sponsor-Investigator Responsibility Checklist (if changing Sponsor) and forward to the ODP.

The ODP will review to confirm that processes are in place so that Sponsor responsibilities are met and appropriate regulatory actions have been taken. If processes are not in place, the ODP will work with the S-I and make the IRB analyst aware of any significant concerns. Once the Emory Sponsor-Investigator Responsibility Checklist is complete and it is evident that S-I responsibilities are being met, the ODP will notify the IRB analyst via email and will edit the amendment in eIRB to include the completed form(s) under question 4, under the “manage ancillary review” activity. The ODP will also log a comment in the amendment study history regarding the completed form(s) before IRB review. The IRB analyst will also confirm that the Sponsor submitted an IND amendment or IDE supplement to the FDA to change sponsor. The study analyst will verify that the FDA amendment/supplement was submitted and that the protocol and ICF have been changed accordingly.

- CHANGE OF PRINCIPAL INVESTIGATOR

If the study changes the study PI, without changing the Emory Sponsor, the Emory Sponsor is required to not only change the eIRB record, but also to submit an IND amendment or IDE supplement to the FDA. The study analyst will verify that the FDA amendment/supplement was submitted and that the protocol and ICF have been changed accordingly.
• **CHANGES THAT MODIFY THE PROTOCOL**

If the Emory Sponsor/S-I holding an IND or significant risk IDE is making modifications to the protocol required to be submitted to FDA as defined by 21 CFR 312.30 / 812.35, the Emory Sponsor/S-I holding an IND or significant risk IDE will need to either (1) include documentation that they have submitted the change to the FDA or (2) add a date for when they will submit to the FDA. If the FDA submission date is a future date, the study team is also responsible for logging a comment in the study, confirming that they have notified the FDA of the change; this will not be a pending issue for the review and approval of an amendment.

- **Studies where the Emory Sponsor/S-I holds an IND**
  - Substantial modifications to the protocol must be approved by the FDA and IRB. Substantial modifications include any change in a Phase 1 protocol that significantly affects the safety of subjects or any change in a Phase 2 or 3 protocol that significantly affects the safety of subjects, the scope of the investigation, or the scientific quality of the study. Examples of changes requiring an amendment under this paragraph include:
    - (i) Any increase in drug dosage or duration of exposure of individual subjects to the drug beyond that in the current protocol, or any significant increase in the number of subjects under study.
    - (ii) Any significant change in the design of a protocol (such as the addition or dropping of a control group).
    - (iii) The addition of a new test or procedure that is intended to improve monitoring for, or reduce the risk of, a side effect or adverse event; or the dropping of a test intended to monitor safety.

- **Studies where the Emory Sponsor/S-I holds a significant risk IDE**
  - A sponsor must obtain (FDA and IRB) approval... prior to implementing a change to an investigational plan, unless the change does not affect:
    - (i) The validity of the data or information resulting from the completion of the approved protocol, or the relationship of likely patient risk to benefit relied upon to approve the protocol;
    - (ii) The scientific soundness of the investigational plan; or
    - (iii) The rights, safety, or welfare of the human subjects involved in the investigation.
PROCESS FLOW (AMs)

PROCEDURE FOR CLOSE-OUTS

- **Studies where the Emory Sponsor/S-I holds a significant risk IDE**

Once a close-out request is submitted, the IRB analyst will ensure that the Emory Sponsor/S-I holding a significant risk IDE provides: 1) a copy of the final IDE report (which is due to the FDA within 6 months after the completion or termination of the investigation) and 2) confirmation that they have submitted the report to the FDA.

If a final IDE report is not available, then the study team must keep the study open until they confirm that the Final Report has been submitted to the FDA. If the study approval lapses, even if a close-out is submitted prior to expiration, the study will be considered to have lapsed, and an RE will also be required for completion of the close-out. Once all supporting documentation is submitted (final FDA report, RE if necessary), then the study can be closed-out using normal close-out procedures (see **Close-out Processes**).

- **Studies where the Emory Sponsor/S-I holds an IND**

Once a close-out is submitted, the IRB analyst will ensure that the Emory Sponsor/S-I holding an IND provided a timely annual report to the FDA (if one is required).

PROCESS FLOW (Close-outs)
REFERENCES

- 21 CFR § 312
- 21 CFR § 812
- IRB policies and procedures
- Emory Sponsor IND Responsibility Checklist
- Emory Sponsor IDE Responsibility Checklist
- Emory Sponsor Responsibility Checklist Continuing Review Update
- Emory Sponsor Responsibility Checklist Multi-site Trials

LOG OF SIGNIFICANT CHANGES

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<td>6/1/2015</td>
<td>Update in definition and process to reflect current practices</td>
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<tr>
<td>9/16/2016</td>
<td>Updated to include close-out process</td>
</tr>
<tr>
<td>5/5/2017</td>
<td>Clarified that changes of PI/SI do not need to go to FB</td>
</tr>
<tr>
<td>2/21/2018</td>
<td>Adding the need to ask for additional information when we are provided with an IND letter pending contingencies. Adding a clarification that a DSMB report is required at CR, if applicable</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Process changes to align with new eIRB system</td>
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**PURPOSE**
The purpose of this document is to describe the additional IRB submission requirements for studies where the sites include both the Atlanta VA and Emory University or its affiliates, without a PI credentialed at both sites.

**SCOPE**
The SOP applies to studies with both a site at the Atlanta VA and a site at Emory University or its affiliates, without a PI credentialed at both sites.

**RESPONSIBILITIES**
- **VA liaison**: IRB analyst in charge of guiding teams through the process of submitting a VA study via the eIRB system
- **Study team**: in charge of making revisions to their submissions and to follow the VA liaison instructions
- **IRB Director**: receives notification from VA liaison and assigns non-VA version of study to RPA with additional instructions
- **Emory RPA**: collaborates with the VA liaison to make sure that both studies are reviewed at the same meeting, if possible

**PROCEDURE**
- If consulted before approval, the VA liaison will let study teams know that the PI of a study taking place at the Atlanta VA must be credentialed at the VA. If the overall study PI is not so credentialed at VA, there must be a separate VA credentialed PI (local site investigator) for the VA site. In general a separate eIRB submission is preferred for that PI/site; however, if the VA credentialed PI is listed on the grant application and the data is to be combined as part of a collaborative project, an exception can be requested through the VA Research Office and the IRB Director.
- If the VA liaison is assigned a study that, despite the above, takes place at both VA and non-VA sites, and indicates that there two separate PI’s, (for example, via listing different PI names in the consent forms) or has a single PI who is not credentialed to serve at the Atlanta VA, he will log the following as a comment in the study history:
  - “Dear study team: My name is X and I will be conducting the initial review of your study. I noticed that this study has [non-VA site(s)] and the Atlanta VA as sites, but does not have a PI credentialed to conduct research at both sites. If this is correct, we require that you submit separate submissions for each site, as the Atlanta VA requires a PI with valid VA credentials. Please confirm if this is your case, and provide the name of the person serving as PI at the VA, and a research coordinator. To prevent additional work on your part, we will clone the study and provide it to you in “pre-submission” status so it can be submitted to the correct department head right away. Make sure you specify in the protocol the work that will be done at each site, so it is clear for both
submissions. In the event that this is a collaborative study and you wish to continue with one IRB submission, you will need to request a consult with the VA Human Research Protection Group. The Group will discuss with the IRB you request and make a determination if the systems are in place to properly manage this as one IRB submission. Let us know if you have any questions”.

• In the event that the study requires two submissions, and after obtaining the names for the PI and coordinator for the VA site, the VA liaison will do the following:
  o Click on “clone study”. The system will ask for a name and they should name the study “Emory-CURRENT_STUDY_NAME”.
  o Locate the newly created study. You can locate the newly created study by searching for the short title under the Projects tab using the name assigned to the new study.
  o Once you navigate to the newly created study, click on “Admin View”.
  o Put the study back in “Pre-submission” under “Status”, and change the name of the study PI and coordinator.
  o Log a comment in the new study indicating that this study should be reviewed concurrently with the VA version of the study (provide IRB study number).
  o Once the study is submitted to the IRB, the IRB Director will let the new study’s RPA know that this study is similar to one submitted for the VA, and instruct the RPA to communicate with the VA Liaison.

• The RPA will let the VA liaison know the Emory study has been submitted, and to ask him which meeting will review the VA study, if already known, and attempt to assign it to the same meeting. If not already assigned, RPA and VA Liaison should work together to have the studies reviewed at the same future meeting., with Agenda Notes indicating that they are the same protocol at two different sites.

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PURPOSE
To detail the type of determinations and reviews that can be made by a qualified IRB staff. The IRB Director shall decide when IRB staff is qualified, based on length of experience and demonstrated expertise.

SCOPE
New studies, continuing reviews, and Modifications submitted to the IRB office for review.

PROCEDURES
Reviews Permitted by IRB Staff (without involving an IRB member):

1. Determining whether a study qualifies as research involving human subjects (NR/NHSR)
2. Determining whether a study should be reviewed as Exempt
3. Approving Exempt reviews that do not involve HIPAA Privacy Rule waivers or authorizations. Only staff authorized by the IRB Director to approve exempt studies can do so. For more information about exempt research that can be reviewed by staff or staff designated reviewers, review this guidance.
   a. Modifications: similar to new exempt study submissions, Modifications submitted for exempt studies can be reviewed only by staff authorized by the IRB Director to approve exempt studies.
4. Approving certain minor administrative changes.
5. Approving an Modification submitted only to transition a study to the Revised Common Rule-no other changes requested. If the Modification is also updating the consent form to align with the new elements in the Revised Common Rule, that Modification should be reviewed by an IRB member (staff or faculty member).

Minor Administrative Changes: Some minor administrative changes may be approved by qualified IRB staff. These changes are exclusively limited to the following:

- Change of contact information
- Addition or deletion of junior level personnel (not co-investigator, principal investigators)
- Addition of co-investigator
- Addition or removal of co-investigator for minimal risk studies
- Title change that does not reflect a change in study
- Corrections of typographical errors
- Reformating of unchanged text
- Errors in completion of the IRB application, as confirmed with study staff as appropriate (as long as the study was initially reviewed with the correct impression)
- Removal of study sites that were never activated
- Change of funding status from “pending” to “approved” (if federal grant application was previously approved as pending by the IRB, and it is not a new funding source)
REFERENCES

- Emory IRB P&Ps, chapter 28 (IRB Protocol Triage and Assignment of Review Category)
- Emory IRB P&Ps, chapter 30 (Exempt Research)
- Emory IRB P&Ps, chapter 40 [Protocol Modifications (Modifications)]

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<td>Added a Purpose and Scope sections.</td>
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<tr>
<td>9/16/2016</td>
<td>Added P&amp;P reference</td>
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<tr>
<td>5/5/2017</td>
<td>Clarified the type of changes in funding staff can approve</td>
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<tr>
<td>1/20/2019</td>
<td>Adding that staff can review Mod only requesting the transition of a study to the Revised Common Rule if it does not include any other changes but the transition.</td>
</tr>
<tr>
<td>2/1/2019</td>
<td>Added that Mod to exempt studies can be reviewed by staff authorized by the IRB Director</td>
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Background/Policy: IRB Staff can perform reviews within the scope described below only if they are appointed as IRB members, and have been designated by an IRB Chair as authorized to perform expedited reviews.

Note that all IRB staff, including those appointed as IRB members, can review minor administrative changes as described in the IRB Policies and Procedures, “Modifications” chapter. Those types of changes are not listed in this SOP. All IRB staff may also review certain contingency responses, as well as any close-out request.

A. NEW STUDIES
1. Minimal risk expeditable studies involving only the following, and including advertisements:
   a. F (5) (e.g. chart reviews or specimen analyses, whether retrospective or prospective)
   b. F (7), but only as a last resort when faculty DRs are particularly busy or unavailable.
      Before such assignment can occur, the study analyst should consult a TL or Director to
      make sure there are no other available reviewers to help. In addition, the staff DR
      should have enough expertise to be comfortable with such reviews.
      If staff IRB member is not comfortable with children populations or sensitive studies, forward
      to faculty DR.
2. Exempt Studies: Staff designated reviewers can review all exempt categories except D2 (iii) if the study involves sensitive information and international sites. Sensitive information examples include use of illicit drugs, mental health issues, sexual preferences or research that could put participants at any risk of liability (e.g. criminal activities, studies affecting employability, studies conducted at abortion clinics, needle exchange or distribution). Remember: Do not use D4 for chart reviews because of our HIPAA policy does not covers this type of studies. Use F (5) instead. In addition, if you feel uncomfortable reviewing any exempt category, feel free to consult an IRB faculty member or forward the review to them. For more information about exempt research that can be reviewed by staff or staff designated reviewers, review this guidance.
3. Contingency reviews (full board and expedited studies):
   a. ICF revisions as specifically requested by IRB Committee
   b. Smartform revisions as specifically requested by IRB Committee
   c. Confirmation of full board’s stated assumption (i.e. not new information from study
      staff)
      Note that all IRB staff can do contingency reviews for Cost and In Case of Injury options, as
      well as ancillary committee approvals where no changes were required.

B. MODIFICATIONS
1. Changes of any kind to studies that Staff DR could have approved at initial review (see section
   above), unless the changes move the study outside that scope. For example, F5 studies.
2. Changes to informed consent that are made solely to update template language
3. Changes to PI on minimal risk studies where the PI is NOT the IND/IDE holder

4. Deletion of Co-Investigators on more-than-minimal risk studies
   a. Deletion of Co-investigators: inquire about replacement of expertise

5. Updates of other documents insofar as they are needed to reflect changes 2-4 above

6. Change to ICF, protocol, or other study documents that are limited to corrections or factual updates (i.e. not changes to protocol risk, benefit, design; not clarifications to parts of protocol that were not clear); simplification for lay-friendlier language, or reflecting completion of a pending issue the IRB knew was in process (such as Cert of Confidentiality, funding). (See “Minor Administrative Changes” list in Emory IRB P&Ps for subset of corrections/factual/administrative updates that all IRB staff may review.)

7. Adding funding sources (but not deleting them)

8. Adding Emory-affiliated sites (includes EHC, CHOA if not also adding minors for first time, St Joseph’s/Johns Creek, Grady)

9. Expeditable increase or decrease of N if same type of population already approved, OR to allow more consents/screen failures - both on MIN RISK studies only (P&Ps say what levels of increase are expeditable). If new population or more than min risk, send to faculty.

10. Changes in data collection instruments (questionnaires, surveys, chart abstraction forms, CRFs) as long as expertise is not needed to assess risk-level change

11. Advertisements and other recruiting materials

12. Retention materials, newsletters, blasts, reminder cards, health tips related to disease being studied, participant alert cards, other miscellaneous items that do not involve changes to compensation,

13. Sensitive study determination requests, if not done when application was initially submitted

14. Translated versions of approved documents, requests to enroll non-English speaking subjects, and the addition of Short Form consents in other languages if the population to be studied (for example, patients with leukemia) is the same.

C. CONTINUING REVIEWS

1. All chart reviews, secondary data analyses, and research on existing specimens - F(5)

2. All F(7)

3. Data analysis only (DAO):
   a. For full board studies (i.e. F8c) – but not first year that study has entered DAO stage. Those should go to faculty reviewer because there may have been significant new information in the past year before subject interaction ended.
   b. For all other categories of expedited studies with no restriction on how long the study has been in DAO.

D. REPORTABLE NEW INFORMATION SUBMISSIONS

1. Acknowledgements per Associate or Assistant Director review (based on Emory IRB P&Ps)

2. Finalizing decisions made by Compliance Review team or chairs (document)

STAFF DRS REVIEWING THEIR OWN ITEMS:

- CAN review their own:
  - Continuing Reviews and Modifications that would fall under “minor administrative changes” per P&Ps
  - Truly retrospective F(5) new studies
• **CANNOT** review their own:
  
  - Exempt studies (need to obtain second opinion on exempt status)
  - Prospective F(5) new studies (need to get second opinion on consent/HIPAA waivers)

In general, all staff should consider the benefit of sending other Modifications to another reviewer, but may use their own judgment.

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<tr>
<td>2/11/2015</td>
<td>Clarified when staff DRs should send their own submissions to others instead of reviewing for themselves (end of SOP), clarified what kinds of “data analysis only” Staff DRs can handle (now includes all expeditable studies as well, not just F8c).</td>
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<tr>
<td>2/18/2015</td>
<td>Clarified what Data Analysis Only renewal reviews can be done by staff DR</td>
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<tr>
<td>4/2/2015</td>
<td>Added that Staff DR can approve new Emory-affil study sites. Also CR’s F(5) applies to secondary data analysis in general, not just retro chart reviews. Also reworded Mod’s for increase N to make clearer.</td>
</tr>
<tr>
<td>2/18/2015</td>
<td>Changed title (Designated REVIEWERS, instead of Designated MEMBERS) and added Background/Policy. Clarified Modifications section. Removed any listing of items that all IRB staff can actually review. Can now review adding Grady as site. Took off items that actually all IRB staff can approve (minor admin changes).</td>
</tr>
<tr>
<td>9/16/2016</td>
<td>Minor corrections</td>
</tr>
<tr>
<td>12/20/2016</td>
<td>Clarified that Staff DR’s can review all expedited studies in Data Analysis Only (had been stated already, but not clearly)</td>
</tr>
<tr>
<td>1/20/2019</td>
<td>Added information for Exempt Categories review-Revised Common Rule</td>
</tr>
<tr>
<td>2/1/2019</td>
<td>Provided more clarification about exempt category review, specifically studies that should be sent to a faculty reviewer instead than to a staff member.</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to detail the steps to follow before assigning a new submitted study to an IRB analyst.

SCOPE
The SOP applies to studies submitted to the Emory IRB

PROCEDURE

- Open “New Study Assignments [Year]” spreadsheet in Box
  - If not yet created, create new sheet on spreadsheet for the current week, by copying the previous week’s spreadsheet and renaming it, and deleting study titles and previous assignments
- Go to your inbox, and filter the studies using the following filters:
  - ID: Type “Study”
  - State: “Pre-review”
  - Ensure that there are no coordinators assigned to the study
- Copy and paste the study title hyperlink onto the Excel spreadsheet starting at the top row (and if desired, enter IRB study number)
- Use data in the “# assigned” column and the columns further to the right (which, if updated, display the volume of submissions each analyst received the preceding week) to decide how many items to assign each analyst. Also fill in and/or refer to “Status” column to note who is on vacation etc. and should not receive new assignments.
- Open each study to determine basic information, including:
  - If not using our current protocol template: click “add private comment” to let the analyst know that the team is not using our current protocols and to send this back immediately back to them to use before we can review.
  - Ancillary reviews: review the last page of the submission to see if they need any ancillary reviews. Add it using the “Manage ancillary review” option.
    - For Department- Always required. Click on the name of the PI under the study history to find their department. Then find the department, click “department review” under questions 2, and say this is a required review.
  - Whether VA is a site: assign to VA liaison
  - Whether it is a CHOA-only medical record review: ask study team to withdraw and submit to CHOA IRB instead
  - Whether is an expanded access: assign to a senior member of the Q team
  - Whether is an expanded access taking place at CHOA (even with Emory physicians): ask study team to withdraw and submit to CHOA IRB instead
  - WIRB studies: assign to analyst assistants in rotation
    - If it looks like an industry-sponsored trial without investigator COI, likely should have gone to WIRB instead. Assign to Analyst Assistant and log comment to study team alerting them
that we are determining if it should go to WIRB and ask if they had a reason for not WIRBing.

- CIRB studies: assign to analyst assistants in rotation
- XIRB: assign to Reliance RPA per Director instructions
- If this is a Sponsor-Investigator study: needs to be assigned to an S-I RPA
- If study involves REMS or a controlled substance: alert the analyst who will be reviewing the study via private comment.
- If study involves ICH-GCP: alert study analyst, and let OSP and Director (if not the one assigning) know

- In Excel spreadsheet, write down very short note about the type of study if you have time (e.g. “MCCT” for Multi-center clinical trial, “Observational Peds Study”, “VA study”, “Chart review”…)
- If the study is an investigator-initiated clinical intervention study, write “Y” in the column titled ‘Refer to MH/SD?’ (this is to alert the right people that the study team may benefit from an education session before starting the study; no further action is needed on our part as MH/SD can view the spreadsheet)
- One you have chosen the analyst to assign the study to, enter their name in the “Assigned To” column (this column is coded to accept only the names in the “RPA” column, so names must be entered accurately).
- Check the time-off calendar or right-hand columns to see if an analyst is OOTO or on sick leave.
- In eIRB, use “Assign Coordinator” to assign the study to an analyst.
- Then do “Add Private Comment” to inform the analyst that the study has been assigned to them, perhaps with a brief reference to the type of submission, and any other items you wish to alert them based on your scanning of the smartform prior to assignment.
- If the study submission is in drastically bad shape, you may choose to assign the study to an analyst but then immediately request changes to have major revisions made before the IRB starts their real screening.

Note: Studies should be assigned each business day.

PROCESS FLOW

IRB Director or designee review studies, under Director role on eIRB

Study goes through basic review to determine if needs to be assigned to a designated person

Document assignment in excel sheet

Assign to analyst and leave a note with information
**DURING STUDY CONDUCTION**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/31/2019</td>
<td>Replaced “reliance specialist” with “reliance RPA”</td>
</tr>
<tr>
<td>2/12/2020</td>
<td>Updated to align with new system</td>
</tr>
</tbody>
</table>

**SOP Title:** Over-Enrollment Via Consent (No Research Activities including during Screening)  
**SOP Category:** Study Management  
**Established:** 5/15/2012  
**Last Revision:** 10/27/2017

**PURPOSE**  
The purpose of this SOP is to explain the process to follow if over-enrollment took place in a study, when the subjects enrolled beyond informed consent (hereafter referred to as “over-enrollment via consent”). It may also be used if researchers also did basic screening with those subjects, i.e. reviewed those subjects’ charts or asked them for private information.

**SCOPE**  
This SOP only applies when over-enrollment was due to consenting more subjects than had been approved by the IRB. It does not apply to cases in which the over-enrollment included subjects who completed any study-driven interventions (even if done for screening or if the activities are considered minimal risk), or post-screening study activities. These activities may include fasting for blood test and medication withdrawal before informed consent was obtained.

**RESPONSIBILITIES:**  
- **IRB Analyst:** log over-enrollment in log located under the QA folder (see folder name below)  
- **IRB Team Q designated member:** will periodically trend the data in the spreadsheet to identify potential continuing noncompliance and send monthly reports to CoRe.

**PROCEDURE:**  
Cases should be maintained in a running record sorted by PI. No need for CoRe to review individually unless there is evidence of continuing noncompliance. Team Q is responsible for reviewing records to identify trends of persistent over-enrollment. Persistence of over-enrollment after the issue has already been identified and pointed out to the PI could be continuing noncompliance and should be sent to CoRe. Team Q will review the spreadsheet monthly and report all instances of potential continuing noncompliance to the CoRe team. Other general trends (e.g., departmental patterns) will be reported to the CoRe team and the Associate or Assistant Directors.

**Analyst**
If enrollment is close to the cap, but not over it, analyst should recommend a review and, perhaps, an increase in enrollment cap. If an analyst identified a case (e.g. at continuing review), he/she will contact the PI providing:

- A description of the noncompliance (the number approved vs. the number consented)
- A corrective and preventive action plan that includes:
  - The submission of an Modification to increase enrollment (if the study is closed to enrollment, the NC should be acknowledged, but no Modification is necessary).
  - Portfolio-wide audit of enrollment numbers (See Guidance to PIs Regarding Self-Audits)
  - Education by the analyst about the issue with references to IRB P&Ps (p. 155 defines enrollment in Chapter 43, Informed Consent, under Procedures)

The analyst should follow up to make sure the Modification is submitted (using Outlook calendar or other ticklers). If it is not submitted by the time of review, it becomes a pending issue. The analyst should enter the issue into the over-enrollment tracking sheet. The tracking sheet is in the QA working files main folder. H:\IRB\General\QA Working Files

**Guidance to PI’s Regarding Self-Audits**

*Paste as a Logged Comment:*

- If over-enrollment via consent is not present in any other studies, there is no need to report this.
- If over-enrollment via consent is discovered in other studies, please submit an Modification to increase enrollment and explain why (i.e. discovered as part of audit).
- If over-enrollment is found that was not due to solely to consenting more subjects than had been approved, but included exposing subjects to screening or procedures beyond the consent, report the over-enrollment as a protocol deviation in the Reportable new information submissions module for the specific study in eIRB.
  - On the “Protocol Violation/Deviation” page, check yes for question #1, “Is this a substantive deviation from the protocol as approved by the IRB?”
  - For the second question, indicate that the deviation/violation adversely affects: the rights/welfare of subjects and the safety of subjects

**PROCESS FLOW**

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
</table>

Page 245 of 266
PURPOSE
To explain the steps to be taken if a study is transferring data or patients between sites

SCOPE
Studies approved by the Emory IRB

ABBREVIATIONS
- OTT: Office of Technology Transfer
- ORC: Office of Compliance
- DTA: Data transfer agreement

DEFINITIONS
- Data transfer agreement: agreement used when transferring protected health information (PHI), including limited data sets, from one party to another.

PROCEDURE

For Patient transfer

- Study team should refer to the OTT/ORC guidance for data transfer agreements. The information can be accessed at [http://www.orc.emory.edu/hipaa/index.html](http://www.orc.emory.edu/hipaa/index.html).
  - Outgoing DTA: To initiate routing and initiation of the appropriate DTA, Emory investigators should complete an Outgoing DTA Questionnaire (provided at [http://www.med.emory.edu/research/resources/index.html](http://www.med.emory.edu/research/resources/index.html) or [http://www.ott.emory.edu/forms/index.html](http://www.ott.emory.edu/forms/index.html)) and email the questionnaire to somdta@emory.edu.
  - Incoming DTA: OTT manages all DTAs covering receipt by an Emory investigator of human subject data to be used for research purposes not involving a clinical trial or human subject interaction/intervention by the Emory investigator. All OTT-managed incoming DTAs should be forwarded to OTT for approval, along with a completed Incoming DTA Questionnaire (see “Incoming DTA Questionnaire” on the OTT website at [http://www.ott.emory.edu/forms/index.html](http://www.ott.emory.edu/forms/index.html)). Faculty members should forward these documents via email to mta@emory.edu.
• Note: data must not be transferred until the subjects who are transferring have signed the new HIPAA authorization
• Any subjects currently on study have to be notified about these changes and offered the option of transfer or study termination, with appropriate referrals if needed.

• Study team should submit an Modification to the Emory IRB for a revised or new HIPAA authorization to cover the transfer of PHI from Emory to the new site for research purposes. The requirement to complete an appropriate DTA for a transfer of human subject data is in addition to, and not a substitute for, obtaining appropriate applicable informed consent, HIPAA authorization, or IRB approval for any research activity. Contact Kris West and the IRB Director for information about the HIPAA form information.
• Subjects will need to sign both a new ICF and a new HIPAA authorization with the other site.
• Study team should close out the study with the Emory IRB after all the transfer activity has been done and no more activity with PHI is active.

*This SOP will also apply if subjects transfer to a new site without a study closing at Emory (e.g. because the subjects are moving far away and there is another site closer to their new home)

For Data Transfer
• Study team should refer to the OTT/OC guidance for data transfer agreements. The information can be accessed at http://www.compliance.emory.edu/hipaa/index.html.
• Outgoing DTA: To initiate routing and initiation of the appropriate DTA, Emory investigators should complete an Outgoing DTA Questionnaire (provided at http://www.med.emory.edu/research/resources/index.html or http://www.ott.emory.edu/forms/index.html) and email the questionnaire to somdta@emory.edu.
• Incoming DTA: OTT manages all DTAs covering receipt by an Emory investigator of human subject data to be used for research purposes not involving a clinical trial or human subject interaction/intervention by the Emory investigator. All OTT-managed incoming DTAs should be forwarded to OTT for approval, along with a completed Incoming DTA Questionnaire (see “Incoming DTA Questionnaire” on the OTT website at http://www.ott.emory.edu/forms/index.html). Faculty members should forward these documents via email to mta@emory.edu.
• Note: the IRB staff should let study team know but the submission process (Modification, new study) should continue.
• The approval letter should indicate that data must not be transferred until the agreement is completed.

LOG OF SIGNIFICANT CHANGES

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<tr>
<th>DATE</th>
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<tr>
<td>10/3/2014</td>
<td>Updated information after OTT/ORC revised guidance</td>
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<tr>
<td>2/15/2017</td>
<td>Changed title and move comment to the end to avoid confusion about subject matter covered by SOP</td>
</tr>
<tr>
<td>10/26/2017</td>
<td>Adding information about data transfer, purpose, definitions, etc.</td>
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CONTINUING REVIEW

**SOP Title:** Continuing Review: CR reassignment  
**SOP Category:** Study Management  
**Established:** 9/22/2016  
**Last Revision:** 2/24/2020

**PURPOSE**
The purpose of this SOP is to describe the process that research protocol analysts (RPAs) will follow when assigning continuing review (CR) submissions to their designated analyst assistants (AAs). In addition, this SOP will also cover the overall timeline for the process of these submissions.

**SCOPE**
The SOP applies to CRs assigned to AAs.

**RESPONSIBILITIES**
- **AA** – will review and process CRs as assigned by an RPA
- **RPA** – will assign CRs to AAs following this SOP

**PROCEDURE**

**CR Assignments**
- RPAs will assign CRs to the AAs in succession, one CR per analyst until all the CRs has been reassigned. We require that the RPA keeps a tally of the reassignment to make sure all the AAs receive a similar amount of CRs per week.
- CRs with a MOD that only includes changes to personnel can be reassigned to an AA.
- Every day, RPAs will go through their inboxes to assign CRs to the AAs. RPAs should aim for 2 business days to accomplish this task. If an RPA is out of the office for any reason, the RPA will contact their Associate or Assistant Director for CR assignment before the leave.
- After re-assigning the CR, the RPA will log a comment to the study submission (if applicable):
  - Private comment: In this comment, the RPA will notify the AA if the study is conducted at Grady (because the ROC deadline would apply). They analyst may include any additional or urgent detail that seems important for the review as they see fit.
  - Comment to Study Team: with this comment, the AA may notify the study team that the CR was received and it is in process. Suggested language: *Thanks for your submission. The continuing review application has been reassigned to me for further handling, and I will contact you if any questions arise during the review of your submission. If there are any urgent items that need addressing, please list them in a logged comment to the IRB staff.*
- The AA will make sure CRs are reviewed under the following timelines when CR’s are submitted to the IRB at least a month prior to expiration (if CR’s are submitted late, timeframes may be shifted accordingly):
  - For Full board CRs: The CR should be screened no later than 3 to 4 weeks of expiration and assigned to a committee meeting accordingly. Please choose a CR meeting no later than 2 weeks before expiration unless not possible.
  - For Expedited CRs: The CR should be screened and assigned to a reviewer no later than 2 weeks before expiration.
o For studies conducted at Grady: Because Grady studies need a subsequent approval by the Grady Research Oversight Committee, which meets once a month, these submissions should be screened and sent for review as soon as they are received (even if far in advance of expiration).

- FDA regulated studies, which are also actively enrolling subjects, submitted after expiration or 5 business days before expiration cannot be reassigned.

Procedure for when an AA is on a planned leave (e.g. vacation leave)

- One week before the vacation leave, the AA will email the RPAs to let them know.
- The RPA should not reassign CRs that would expire between the vacation leave to one week after the person is back to the office. For example, if an AA is going on vacation between May 12 to 16 (Monday-Friday) and the CR arrived on May 12 and would expire on a date between May 12 to 23 (M-F), the CR should not be reassigned to the AA.
- AAs will reassign back to the RPAs CRs that were already processed but that will be reviewed at an FB meeting on the week of the vacation leave. In addition, AAs will reassign back CRs waiting for DR review if the review was not completed before the vacation leave. If the RPA is unable to release an approval letter during the vacation time or a CR was not reviewed by the DR during the vacation leave, the CR submissions can be reassigned back to the AA.
- This procedure is designed to prevent approval lapses and to provide approval letters in a timely manner.

PROCESS FLOW FOR CR ASSIGNMENT

RPA assigns CR to AA in 2 business days

RPA logs private comment if Grady Study

AA reviews CR per designated time

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/18/2016</td>
<td>Revisions after RPA-TL meeting</td>
</tr>
<tr>
<td>2/6/2017</td>
<td>Revisions to reflect current re-assignment process</td>
</tr>
<tr>
<td>2/24/2020</td>
<td>Clarifying that RPAs can assign CRs with MODs that only include changes to study team members to the AAs</td>
</tr>
</tbody>
</table>
Menu
- Studies wishing to transition to the revised common rule
- CR Screen Process Pre-review
- Expedited Review
- Full Board Committee Review
- Finalizing Submission

Studies transitioning to the revised common rule
Check this information to learn what we mean by the pre-revised common rule and the revised common rule. You may transition a study using the continuing review application.

- For studies required to transition per the guidance above (under “Emory IRB Transition Plan”): should be transitioned using the CR submission. Review the answers to the CR, ensuring the studies are not FDA regulated or DOJ supported. Follow the instructions below under the “Pre-review” section 1a.
  o Please consult with a Director if it is not clear if a study is FDA regulated. Remember than any drug, device, biologic, software or app (considered devices) are FDA regulated even if previously FDA-approved.
- For studies wishing to transition: The study team needs to submit the Guidance and Attestation form with the continuing review. If the study is still enrolling subjects, they need to revise the consent to align with the revised common rule requirements by submitting a modification.

CR Screen Process
2. You can find the CRs assigned to you in your inbox, including CRs you have sent back to the study team for clarification. Use the Huron IRB Staff Quick Reference for technical information.
3. Have the Continuing Review Worksheet accessible while reviewing a CR application. In addition, review the “Staff Quick Reference document” for eIRB technical steps starting on sections “Complete a Pre-Review”. You do not need to take ownership of this CR, as it was probably done for you. Check last year’s CR and Mod submissions (go back at least 2 years) to give you an idea if the study should be routed to the full board or designated review. To see these past submissions, navigate to the main study page using the breadcrumbs ( ) and then click on the “follow on submissions” tab. For additional information, refer to page 27 of the Staff Quick Reference document.
4. Review Training for study members. See Training Verification SOP for more information.

Pre-review
- Complete your pre-review. For technical instructions, review the Staff Quick Reference document, page 14.
a. Revised common rule question (only shows for studies under the pre-2018 common rule): there is no mechanism to change this answer, so once a study has transitioned to the revised common rule, it cannot be moved back. Make sure you have ensured this is not an FDA regulated study, or under DOJ funding. See the Studies wishing to transition to the revised common rule for more information.

b. For these questions 1-4 (or 2-5 if your first question was about transitioning to the revised common rule), leave the same checks. Do not make any changes, unless this is also a modification/CR combined submission. Add missing materials (question 5) and notes, if any.

c. For the last question (Are you ready to submit this pre-review?), do not click yes if you are absolutely ready to route this to a reviewer or FB. If you click no, your responses will save but you will be able to return and finish later.

- If the submission requires changes, click on “request pre-review clarification”. You can find technical steps on page 15. Use page 16 to compare the documents you are receiving, if any.
- Complete our pre-review (saying yes to question 8) before routing to a designated reviewer or to the Full Board.
- For information about the required selections under Pre-review or verifying appropriate ancillary reviewers, please read this SOP. If the selections are already made, just leave the selections from the previous review (unless this is a MOD/CR with changes to the study).
- If the study shows as transitioned to the 2018 rule but this is not correct, log a comment to the reviewer explaining this discrepancy, so they do not say the study does not require a CR in the future.

**Expedited Review**

- Select the reviewer based on their specialty, if possible. For example, give cancer, sickle cell, or infectious disease studies to the reviewers who specialize in those areas. If choosing a Staff designated reviewer, make sure you follow the SOP entitled: “Categories of Research Reviewable by IRB Staff as IRB Designated Members”. Follow the Staff Quick Reference document, page 22 for additional steps.
- Send the CR to the reviewer at least 3 weeks before expiration (if possible due to CR submission). When assigning, you may suggest review categories based on your review, the prior years’ reviews. Make sure that you do not imply that is the category to be used as the member should do their own review. Add this information under question 2 when assigned to a reviewer. If the category from previous years is obviously wrong, or not listed, contact your TL or Director about this.
- After the CR has been reviewed, follow the post-review activities detailed on Page 25 of the Huron Staff Quick Reference document.
- If clarifications are requested by the designated reviewer, draft a letter to send to the team with the required changes. Make sure to follow up if a response is not received in a sensible time. When the answer is received, email the study link to the designated reviewer
- The designated reviewer can click on “Review Required Modifications” to document the changes made are adequate.
• If the designated reviewer has any difficulties, you can complete the step above. Make sure you attach a confirmation that the reviewer agrees the changes as submitted are adequate (this could be an email communication).

• Ensure that the designated reviewer has selected the right approval/expiration dates, specially after a pending review. You can submit a review yourself to correct the issue, adding a comment of why you are resubmitting. If unsure, ask one of the TLs.

• After the designated review is received you can close the submission. Go to the “Finalize Submission” section for the additional steps.

Full Board Committee Review
1. If a study requires review at the full board, after screening, assign it to the appropriate committee agenda four weeks before expiration. Committees should be chosen by specialty present at the meeting if possible.
   a. Click “Assign to Meeting” and choose from the options. Choose a committee date that is ideally a couple of weeks before expiration (one week may not be enough, as there may be pending issues). Screen CR upon receipt to avoid delays in the review or missing items (such as required reports).
   b. Click on “Edit Pre-review” and add the following information under “Notes”:
      a. Document if the enrollment numbers are under compliance with IRB approved enrollment numbers in the protocol.
      b. If this is a Sponsor-Investigator study:
         a. Indicate whether the S-I responsibility form is included in the submission with an S-I consult approval (This is required before the CR can be approved) (if not, pending issue)
         c. Any Committee member conflicts you are aware of
      d. If not clean why coming to full board, explain (e.g. list research interventions still ongoing)

2. Once the meeting Pod has reconciled the meeting notes and pre-review forms and let the IRB team know you can write your letter, review the “Committee Review Submitted” information under the CR history

3. If the CR is pended or deferred:
   i. Write a letter to the study team, using the appropriate template. Make sure you include all the required changes noted in the “committee review submitted” information. Click “Send letter” to end this part of the process.
   ii. Once the study team has submitted the requested changes, review materials to assess that the changes have been made.
      1. If Deferred issues have been addressed, schedule the Deferred CR to be reviewed by the same committee that conducted the initial review of the CR application (i.e. if CMTE B1 reviewed the CR in January meeting and deferred it, send to the next available meeting for CMTE B1). If the Deferred issues are approved at FB, you may issue the approval letter and release updated consent/HIPAA documents.
      2. If pending issues were addressed, email the meeting chair with a link to the study so they can verify the changes were addressed.
      3. Email the study link to the vicechair
4. The designated reviewer can click on “Review Required Modifications” to document the changes made are adequate.

5. If the designated reviewer has any difficulties, you can complete step 4 above. Make sure you attach a confirmation that the reviewer agrees the changes as submitted are adequate (this could be an email communication).

**Finalizing Submission**

*Note: Due to the Revised Common Rule, studies in data analysis only and in long term follow up (not under FDA or DOJ regulations), or doing research with secondary data or biospecimens, that were approved after 1/21/2019 or that transitioned to the Revised Common Rule, will not require continuing review in the future. In the approval letter, add a reminder that Modifications, reportable new information submissions and a close out are still required. In addition, if the status of the study changes during the year, they need to submit a Modification (for example, if reopening accrual).*

1) Go to page 25 of the “Staff Quick Reference document” for technical steps for this part of the process.

2) On “Finalize Documents” click on the protocol, and consent forms.

3) Click on “Prepare Letter”.

4) Generate the appropriate letter. Remember to include the PIs post-nominal (degree – MD, Ph.D., MPH, etc.). If this information is not clear in the submission, you can check the last approval letter, or you can search on the Emory Online Directory.

5) Review the letter to make sure all the information added by the system is correct. Delete template language that does not apply and put your name and title at the end of the letter. Save a copy on your computer to upload a revision. The option to upload the revision can be found under the ellipses in the Draft letter space. When done, click Ok.

6) Click “Send Letter”, review the letter and dates one more time, and click Ok.

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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</thead>
<tbody>
<tr>
<td>12/2/2016</td>
<td>Clarified how to determine expiration date; what to put in CR approval letter [removed some bullets]; referred to 30-day window SOP</td>
</tr>
<tr>
<td>5/5/2017</td>
<td>Clarified some steps in the process and added required language under FB approval letter</td>
</tr>
<tr>
<td>7/14/2017</td>
<td>Formatting and additional guidance on letter writing, comment logging.</td>
</tr>
<tr>
<td>5/17/2018</td>
<td>Revamp for readability</td>
</tr>
<tr>
<td>11/1/2018</td>
<td>Added location for the over enrollment log excel sheet (link does not work); added information about when is OK to send a study to an expedited reviewer or to full board when finding expired research training</td>
</tr>
<tr>
<td>8/31/2019</td>
<td>Updated customer service link.</td>
</tr>
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<td>2/11/2020</td>
<td>Updated CR to align with new eIRB</td>
</tr>
<tr>
<td>2/13/2020</td>
<td>Updated links to checklists</td>
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<tr>
<td>3/4/2020</td>
<td>Added that the pre-review note should indicate the enrollment numbers at the time to assign a study to FB</td>
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<tr>
<td>3/13/2020</td>
<td>Updates in the information that needs to be added for CRs going to full board in the pre-review notes</td>
</tr>
<tr>
<td>3/23/2020</td>
<td>Updates in the revised common rule transition plan and addition of timelines to send to DR or FB</td>
</tr>
<tr>
<td>4/14/2020</td>
<td>Updates in process for expedited review that were incorrect. More detail provided for contingency review</td>
</tr>
</tbody>
</table>
**SOP Title:** Continuing Review: Applying 30-day window

**SOP** Study Management

**Established:** 10/14/2012

**Last Revision:** 2/11/2020

**GLOSSARY**

**Review date:** date on which expedited reviewer finally approved, or full board meeting occurred

**Effective date/Approval date:** first day of an approval period (for purposes of 30-day rule)

**Expiration date:** last day of an approval period (study expires at end of that day, at midnight).

*Note:* For stamping ICF/HIPAA documents, this will also apply if the study team requests an expiration date in their documents.

**SCOPE**

All IRB staff may use the 30-day rule in the event of the following:

1. Study is no longer recruiting subjects, so they do not need restamped informed consent/HIPAA documents **and**
2. Approval of the CR happens to occur during the same approval period as the year before (no need to intentionally hold review until 30 day period arrives).

**Scenario using the 30-day rule**

- Current approval period: 7/2/2011 – 7/1/2012
- Renewal approved by the expedited reviewer on 6/26/2012 (within 30 days before 7/1/2012)
- New effective approval period: 7/2/2012 - 7/1/2013

**PROCEDURE**

- Step 1: After the designated reviewer has completed his/her review approving the study, click on “submit designated review” to update the Approval Date and Effective Date.
- After finishing updating the dates, click on OK.
- Be sure to check the approval period granted by the reviewer/full board, if less than one year
- Make sure that the expiration date populated. Revised the letter as usual.
- Add the following language to the letter:

> Because this study was reapproved [with conditions] within 30 days of its expiration date, is closed to new enrollment, and thus consent forms no longer need to be stamped, we are applying guidance from OHRP and FDA (see http://www.hhs.gov/ohrp/policy/continuingreview2010.html#section-g3 and http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM294558.pdf) in order to retain the approval and expiration anniversaries from the previous approval period.

**LOG OF SIGNIFICANT CHANGES**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/30/2015</td>
<td>Major overhaul, limits scope of when to use 30-day rule</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Revised language to mirror eIRB</td>
</tr>
<tr>
<td>1/31/2018</td>
<td>Date fix in example</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updating to align to new eIRB system</td>
</tr>
</tbody>
</table>
PURPOSE: To explain what safety/compliance-related documents, submitted by the study team with a renewal application, should instead be submitted via the Reportable new information submission (RE) form; and when such documents should be removed from the Continuing Review (CR) application.

SCOPE: Continuing Review submissions in eIRB – expedited and full board.

RESPONSIBILITIES:
- IRB Analyst: Screen the Continuing Review (CR) application and review the RE/PDs/Noncompliance and Monitor Reports per the guidelines below
- Team Q Lead (QTL): Receive alerts when study teams have been asked to submit REs, and follow up to ensure they are submitted as applicable
- IRB Director: Escalate request for REs with study team as needed

RATIONALE: Leaving reports in the renewal application opens the IRB to liability when the IRB member(s) do not adequately review those documents to determine whether they represent unanticipated problems (UPs) or serious or continuing noncompliance.

OVERVIEW

<table>
<thead>
<tr>
<th>Summary of Reporting Timelines</th>
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</thead>
<tbody>
<tr>
<td>Unanticipated problems</td>
</tr>
<tr>
<td>Reportable protocol deviations</td>
</tr>
<tr>
<td>Internal deaths considered related</td>
</tr>
<tr>
<td>Internal deaths considered unrelated</td>
</tr>
<tr>
<td>Internal related events (not UPs)</td>
</tr>
<tr>
<td>External* SAEs that are not UPs</td>
</tr>
<tr>
<td>External* deaths not related or UPs</td>
</tr>
<tr>
<td>Noncompliance</td>
</tr>
</tbody>
</table>

*Remember that external events under the oversight of an Emory S-I should be assessed as internal events.

PROCEDURE: IRB Analyst screening a CR submission should open every attachment to make sure that only items that are properly reported at CR are remain in the submission, and that they are in the correct form. Any items that required prompt reporting must be reported via a reportable new information submission, if not previously reported. Other attachments should be removed from the submission or modified to comply with IRB requirements of reports at CR.

What should be reported in the CR?
- The study team should submit periodic reportable new information submissions in a summary.
If not done, or the information provided was not clear, ask the study team to fill out our summary form (if the information they provided is complete, this is not needed). Use our template at: http://www.irb.emory.edu/documents/Sample_RE_summary.xls.

- If the study team indicated that events did occur (by checking ‘yes’ to Questions 3-6 on page 1) and/or submitted descriptions of individual events in the last approval period, check to see if the summary of events contains the following:
  - A list of previously reported UPs
  - A list of internal, expected (anticipated) and related events from the last approval period
  - A list of internal, unrelated deaths
  - List of expected and related events and/or unrelated deaths for any external site under the oversight of an S-I
- For any UPs, make sure that the UPs listed were previously reported to the IRB via a Reportable new information submission. In order to check for previously reported items, go to the “AM-CR-RE-Term” tab in the study record
- If the IRB Analyst is unclear whether events are reportable (promptly vs. periodical) or not, please consult the QTL and the website guidance

What should be removed from the CR and submitted as a RNI (unless the event is merely part of a summary of events that were already reported via RE)?

- 483 reports (FDA inspection findings)
- Any event/death/protocol deviation/noncompliance report that met the criteria for being promptly reportable:
  - Unanticipated problems (including external deaths that are considered a UP)
  - Reportable protocol deviations
  - Internal deaths considered related to the research
  - Noncompliance
  - Any report that indicates an increase in risk for the rights, welfare or safety of subjects
- If the study team submits a spreadsheet with mixed information (SAEs reportable at CR and events that are not reportable), ask them to remove the events that are not required and submit in a reportable new information submission.

Procedure for handling CRs with items that require a RE:

- If the study is close to expiration:
  - Remove the promptly reportable items from the submission
  - Email the study team and CC the QTL, asking them to submit in an RNI within 2 weeks
  - Log a private comment in the CR documenting the email.
  - Process the rest of the CR as usual
- If the study is not close to expiration (e.g. more than three weeks for expedited, or longer for full board studies):
  - Send the CR back to the study team asking them to submit the list in a RNI instead of in the CR, and to submit the CR back after they have submitted their RE
  - Email QTL to alert Q
  - Log a private comment in the CR documenting email to QTL
  - If the study team does not respond and the study may expire, check with the QTL for next
steps

What should be removed from the CR with notification by logged comment to study team, but no RNI required?

- Any items that are not periodically or promptly reportable
- Minor protocol deviations (per the study team)
  - If the study team needs an acknowledgment for protocol deviations, they need to submit a separate RNI form.
- External deaths: if they are not UPs (per the study team)
- Site Monitor’s Report (not to be confused with a DMC/DSMB report)
  - Monitoring reports should be submitted to CTAC, not IRB. Email the monitoring report(s) to CTAC/Stephanie deRijke at smickle@emory.edu or ctcompliance@emory.edu, CC the study team.
  - Remove the monitoring report and log a comment to study team saying you removed the monitoring report, and have emailed it to CTAC
- Example language: “Dear study team, we have removed document(s) X from your submission, as it is not a document required for this review. If you need an acknowledgment, please submit document X as a reportable new information submission submission”

LOG OF SIGNIFICANT CHANGES

<table>
<thead>
<tr>
<th>DATE</th>
<th>SUMMARY OF SIGNIFICANT CHANGES</th>
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</thead>
<tbody>
<tr>
<td>10/3/2014</td>
<td>Added step of removing monitor report from submission; updated links</td>
</tr>
<tr>
<td>8/12/2015</td>
<td>Revamped this SOP to include what to report and what not to report at CR, as well as procedures to deal with events</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Administrative updates and suggested language for notifying teams of information removal of information</td>
</tr>
</tbody>
</table>
SOP Title: Continuing Review: Processing study staff noncompliance with CITI and Clinical Research Training (formerly Key Concepts/Intro to CR) requirements

SOP Category: Study Management
Established: 4/30/2015
Last Revision: 4/20/2017

PURPOSE
The purpose of this document is to outline required actions when IRB staff confirms missing or incomplete training (Clinical Research Training [CRT] for investigators and coordinators) while processing a continuing review. Currently, during screening for a continuing review, the IRB staff check CITI training for all study team members, and check CRT only for researchers who were added within the past approval period via the IRB website's staff-change form.

SCOPE
The SOP applies to all studies approved by the Emory IRB.

RESPONSIBILITIES
- IRB analyst – to review CR information and confirm the completion of training requirements. The IRB analyst will forward NC issues to Team Q
- Team Q: - to review any Reportable new information submission that is required

PROCEDURE
- Researcher did not have current CRT: the CR should not be sent to an expedited reviewer while the training is being completed. The study can be placed on a FB committee agenda but this issue should be included in the omnibus form under pending items. The study team could also remove the person with the expired CITI from the submission (if not critical to study and PI agrees). This person may be added back after they certify. Report the person to Bridget Strong at BSTRONG@emory.edu. Have the study submit a RE.
- Researcher is found to have never had CITI training from Emory or any other institution: Have the team submit a reportable new information submission. When submitting the event, study team should be asked to clarify whether the staff in question engaged in human subjects’ research, and, if the online Staff Change web form was used, to identify who added the uncertified staff person to the study. Follow additional procedures as indicated in the Training Verification SOP.
- Researcher was added via web-form during the past approval period, but does not have current CRT or/and current Biomedical or Socio-behavioral CITI training: Have the team submit a reportable new information submission. When submitting the event, the study team should be asked to clarify whether the staff in question is/was engaged in human subjects’ research.
- Researcher had Emory CITI certification but it was expired: the CR should not be sent to an expedited reviewer while the training is being completed. The study can be placed on a FB committee agenda but this issue should be included in the omnibus form under pending items. The study team could also remove the person with the expired CITI from the submission (if not critical to study and PI agrees). Person may be added back after they certify. A reportable new information submission is not required.
• **Researcher never had Emory CITI certification, but was CITI certified at another institution:** the CR should not be sent to an expedited reviewer while the training is being completed. The study can be placed on a FB committee agenda but this issue should be included in the omnibus form under pending items. The study team could also remove the person with the expired CITI from the submission (if not critical to study and PI agrees). Person may be added back after they certify. A reportable new information submission is not required.

• **Researcher had the wrong Emory CITI training (Biomed/SHB):** the CR should not be sent to an expedited reviewer while the training is being completed. The study can be placed on a FB committee agenda but this issue should be included in the omnibus form under pending items. The study team could also remove the person with the expired CITI from the submission (if not critical to study and PI agrees). Person may be added back after they certify. Review [Step-by-Step Guidance for Selecting Required Courses and Obtaining a CITI Account](#) along with a description of the research activities to determine if they really took the wrong course. No RNI required in any case.

• **Researcher had an incorrect Emory CITI training (GCP or RCR, and never took Biomed/SHB):** Have the team submit a reportable new information submission. When submitting the event, study team should be asked to clarify whether the staff in question engaged in human subjects’ research and who added the staff to the study (if the online form was used). The CR should not be sent to an expedited reviewer while the training is being completed. The study can be placed on a FB committee agenda but this issue should be included in the omnibus form under pending items. The study team could also remove the person with the expired CITI from the submission (if not critical to study and PI agrees). Person may be added back after they certify.

### LOG OF SIGNIFICANT CHANGES

<table>
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<tr>
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<tbody>
<tr>
<td>8/5/2015</td>
<td>Clarified that studies should not be sent to the expedited reviewer if training is not complete. OK to send to FB but study will be pending until training is completed. Added link for guidance on the website</td>
</tr>
<tr>
<td>9/16/2016</td>
<td>Updated terminology for the Clinical Research Training (formerly Key Concepts)</td>
</tr>
<tr>
<td>4/20/2017</td>
<td>Clarified what “correct” meant</td>
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</table>
CLOSE OUT

SOP Title: Close-Out Processes
SOP Category: Study Management
Established: 7/21/2014
Last Revision: 2/12/2020

PURPOSE
To outline the processes for closing out a study in eIRB, including:
1. Close-outs initiated by a PI
2. Steps in eIRB to process the close-out

SCOPE
Applies to all IRB staff personnel responsible for processing close-out requests. For S-I studies go to SOP entitled: “Review of Studies Involving an Emory Sponsor/Sponsor-Investigator at Emory Holding an IND/IDE”.

PROCEDURE
NOTE: Close – Out applications will start in the form of a Continuation Renewal Application.

1. Review the printer version of the renewal application. If all of the first 4 items in question 4 are checked it indicates that the research is completed and the study is ready to close out.

2. Continue reviewing the submission for accuracy
   • Are the study numbers correct?
• Did they provide a summary, DSMB reports, etc.? We will require a summary but if the study has been in data analysis since the last approval period, we do not need DSMB reports.
• Have all requested reportable events been submitted? If applicable; this applies if the study was still enrolling or doing research activities in the last approval period.

4. Once the submission is ready to be assigned to a reviewer (yourself). Click Submit Pre-Review. The Pop up window will allow you to capture all of the details of the study as well as make any relevant notes.

5. Assign the study for review. If the study is expeditable/minimal risk study “Assign Designated Reviewer”.

7. Prepare the letter. From the drop down menu. Select “IRB Study Closure” if the study is being administratively closed by the IRB. Select “PI Study Closure” if the PI is closing the study.
8. Send the letter. Click Ok.

9. The Continuing Renewal state will be listed as approved and the main study state should change to closed.

LOG OF SIGNIFICANT CHANGES

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</thead>
<tbody>
<tr>
<td>8/15/2014</td>
<td>Merged 3 separate close-out related SOPs into one single SOP, but no significant content changes</td>
</tr>
<tr>
<td>11/1/2017</td>
<td>Adding FDA and Non FDA studies, and other administrative changes</td>
</tr>
<tr>
<td>2/11/2020</td>
<td>Updated to align with new eIRB</td>
</tr>
<tr>
<td>2/12/2020</td>
<td>Remove steps that were not needed</td>
</tr>
</tbody>
</table>
PURPOSE
The purpose of this document is to detail the process of informing study teams that their studies will be closed out.

SCOPE
The SOP applies to expired studies approved by the Emory IRB.

RESPONSIBILITIES
- IRB Staff Leadership- have “IRB Director” role.
- IRB analyst: Informs the staff leadership to close a study using the “close Study (Admin)” function.

PROCEDURE
Before study expiration
- If a study is identified as one that may expire in the next 2 weeks, the IRB analyst will log the following comment and sent via email:

  Dear team,

  Your study (IRB#, Short name-INSERT LINK) expires on DATE. Please submit a continuing review application as soon as possible, as we need time to review it before approval. If the study has an approval lapse, you will be required to submit a reportable event for noncompliance. Please, refer to our timelines for review of studies for additional information.

  Alternatively, if all human subject research activities are complete, please Indicate in your submission that you would like to close the study.

  If your study is expired more than two weeks and no action is taken, your study may be closed administratively.

  If you have any questions, please contact your analyst directly.

  Best regards,

  YOUR NAME

Less than 90 Days Expired
- If the study expired less than 90 days with a continuing review in pre-submission:
o Reach out to study team via email (copying analyst) and logged comment, telling them they have 5 business days to submit the (CR as appropriate) or explain why more time is needed.
  ▪ Here is a suggested text for when a CR has been created but not submitted:
    Dear study team,
    This study expired on [DATE]. Let us know if you have conducted any research during the approval lapse. If so, please submit a reportable event. If this study is FDA regulated, you will need to submit a reportable event even if research activities were not conducted during the lapse. If you plan to continue with this research study, please submit a continuing review application (you created one on [DATE] that has not been submitted yet). If you are no longer conducting research activities, please submit a close out submission. Stop all research, including data analysis until you secure reapproval. If we do not receive a continuing review application, we will close out this study administratively in the next two weeks. If you have questions or concerns, email or call your analyst: [insert analyst name, email, number].
  ▪ Here is a suggested text for when a close out has been created but not submitted:
    Dear study team,
    This study expired on [DATE]. Let us know if you have conducted any research during the approval lapse. If so, please submit a reportable event. If this study is FDA regulated, you will need to submit a reportable event even if research activities were not conducted during the lapse. If you plan to continue with this research study, please submit a continuing review application (you created one on [DATE] that has not been submitted yet). If you are no longer conducting research activities, please submit a close out submission (you created one on [DATE] that has not been submitted yet). Stop all research, including data analysis until you secure reapproval. If we do not receive a continuing review application, we will close out this study administratively in the next two weeks. If you have questions or concerns, email or call your analyst: [insert analyst name, email, number].
  • If the study expired less than 90 days without a CR created:
    o Reach out to study team via email, copying the analyst-owner of the study (if not you), and as a logged comment in eIRB, letting them know they have 5 business days to submit a continuing review application.
  • If an IRB analyst has a study that has been expired more than 3 months, they will inform the staff leadership to close the study using the “Close Study (Admin)” option.
## LOG OF SIGNIFICANT CHANGES

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<tbody>
<tr>
<td>2/11/2020</td>
<td>Removed items that cannot be executed in new IRB system.</td>
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</tbody>
</table>