General

Is my project subject to review by the IRB?

IRBs review research that involves human subjects. The types of research that are covered include clinical trials, behavioral research, epidemiological and survey research, outcomes research, anthropological research, educational research, field and international research, oral histories, and psychological research. Research can range from a clinical trial to the use of human cell lines. In addition, quality assurance activities may or may not also be considered to be research activities.

How the results will be used affects whether or not a project is research. If there is any intent to publish or otherwise make known the results in a research journal, and the project involves human subjects, the project likely should be submitted to the IRB. For example, if the project is being undertaken with the notion that a paper or journal article may be published, or that a poster or paper may be presented at a conference or community gathering that is not specifically designated as quality improvement, the project may qualify as research and thus would be subject to review by the Institutional Review Board.

If you are unsure about your project, please check with the IRB staff to help you determine if it is "research" involving "human subjects" as defined by the institution and federal regulations.

When is research involving human subjects not subject to review by the IRB?

Certain types of human subjects research may qualify as exempt from IRB review. In order to be exempt, research must meet specific, federally-designed criteria, including that the research involve only minimal risk to human subjects. Exempt research under the purview of the BSD IRB cannot involve either sensitive data (data linked to specific individuals that may be painful or embarrassing to reveal) or certain special populations (such as prisoners). Research involving children may be exempted under certain circumstances.

Per University policy, the IRB must make the final determination regarding exemption. Investigators should not begin any human subjects research until the IRB has determined that it is (1) approved or (2) exempt from IRB review.

In addition, if you have received approval or exempt determination from a non-University of Chicago IRB, please contact the U of C IRB office to determine submission requirements at our site.

The 6 exempt categories allowed by local policy are described at45CFR46.104(d)(1-6).

What is minimal risk?

Minimal risk is defined in the federal regulations as situations wherein "the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests" (45CFR46.102(j)).

I'd like to publish a case report. Do I need to submit anything to the IRB?

Federal regulations define research as "a systematic investigation … designed to develop or contribute to generalizable knowledge." Research is usually designed with the intent to publish the results of a research hypothesis being tested.

However, physicians at the University of Chicago Medical Center occasionally come across a patient who presents with a unique condition or whose stay at the hospital presents an interesting discrepancy from the normal course of treatment or reaction to treatment. In these instances, a physician may wish to publish a case report on this one patient in order to contribute to medical knowledge.

Although this case reporting does involve the intent to publish results, it does not involve the intent to ask or answer a specific research question. Consequently, the wish to publish a single case report is not considered to be research and the IRB does not require the submission of a protocol in order to publish the case report.

If more than one case occurs of the specific condition or medical anomaly, or the investigators begin to formulate a hypothesis or attempt to gather further information on cases of this type with the intent to publish, activities cross into what could be considered "research" and it becomes necessary to submit a research proposal to the IRB.

Although publishing a case report may not require submission to the IRB, investigators should be aware of the use of individually identifiable health information in their publications. Under HIPAA, the disclosure of an individual's protected health information must be authorized by that individual. In other words, if a case report contains any identifiers as defined by the HIPAA regulations, authorization to disclose this information in a publication should be sought from the individual whose information is being disclosed. The subject or a designated representative should sign a consent form (HIPAA authorization) to disclose this information.

It should be noted that case reports often involve reporting on a rare disorder, condition, or course of treatment. In such cases, individuals may be more easily identified as being the subject of a publication than individuals with a more common disease or condition. Consequently, this rare disorder may fall under the category of "any other unique identifying characteristic" under the HIPAA regulations, and thus be considered Protected Health Information. Physicians and other researchers should then obtain a subject's authorization before publishing a report, even when no other identifiers are being disclosed, because the subject may be able to be identified by their disorder.

When deciding whether or not to submit a proposal to the IRB, it is important to consider the intent of the potential publication. Medical or educational activities are not considered to be research. However, once medical activities become methodical evaluation, "designed to develop or contribute to generalizable knowledge," this is research as defined by the federal regulations.

Identifiable, Coded, and De-Identified Data/Samples: When are these definitions appropriate?

Identifiable data can fall under two categories: PHI and PII.

PHI stands for "Protected Health Information" and under the HIPAA Privacy Rule, includes elements such as:

Name (includes initials)	Dates (including dates of birth)	Medical record numbers
Ages over 89	Address (All geographic subdivisions smaller than a state, except for the initial three digits of a zip code)	Telephone/Fax numbers
E-Mail addresses	Social security numbers	Health plan beneficiary numbers
Account numbers	Certificate/License numbers	Device identifiers/Serial numbers
Full-face photographic images/any comparable images	Web universal resource locators (URLs)	Internet protocol (IP) address numbers
Biometric identifiers (including fingerprints and voiceprints)	Vehicle identifiers and serial numbers (including license plate numbers)	Any other unique identifying number, characteristic, or code (unless otherwise permitted by the Privacy Rule for re-identification)

PII stands for "Personally Identifiable Information," which refers to information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

PII is a term that applies to data that are or are not regulated by the HIPAA Privacy Rule, while PHI is a term used for HIPAA-regulated data.

Identifiable data is study data that contains PHI or PII.

Coded data are study data that are separated from identifiers but CAN be linked back using a code (words, letters, figures, symbols, or a combination that is NOT derived from/related to the personal information). With these data, a spreadsheet or similar is created that links the code to identifiers (i.e. a "key"). This is the most typical method of collecting data/samples.

De-identified data are study data that do not contain PHI or PII and can never be linked back to a subject.

Questions to consider:

- What identifiers do I need to use in order to conduct my research? Keep in mind, this includes using identifiers to access medical records.
- Are these identifiers needed throughout my entire study? Can they be deleted at a certain point (i.e. can data be removed or "stripped" of identifiers at the end of the study)?
- Is there a way for me to keep these identifiers separate from the data/samples that I want to collect?
- If I am sharing data with others who are not a part of my institution, how will the data be transferred? Will I send identifiers to the collaborating institution?
- What is the source of the data? Am I directly collecting data from the medical record, or am I obtaining data from another source, such as the Clinical Research Data Warehouse (CRDW) through the CRI?
- Sometimes, you can have more than one type of data to be used for your study. This is typically in the event that data and/or specimens are shared with collaborators. When this is the case, it is helpful to make the distinction for how the data and specimens will be shared. For example, the data that you collect may be identifiable or coded, but how will the researchers at the collaborating institution receive these data? Will the researchers at the collaborating institution receive coded data as well? De-identified? Depending on how these data and specimens are shared and if there is a contract, it is possible that a Data Use Agreement (DUA) or Materials Transfer Agreement (MTA) may need to be executed through URA.

For more information or any questions about your study, please feel free to contact a BSD IRB administrator.

For more information:

1. https://hhs.gov/answers/hipaa/what-is-phi/index.html
2. https://www.gsa.gov/reference/gsa-privacy-program/rules-and-policies-protecting-pii-privacy-act
3. https://ura.uchicago.edu/page/data-sharing-agreements
4. https://ura.uchicago.edu/page/material-transfer-agreement

Are there requirements for use and storage of data?

Please access the following resources for guidance on use and storage of research data.

OCR Guidance (UChicago intranet) -- includes guidance on involvement of Center for Research Informatics (CRI)

UChicago Sensitive Data Usage Guide

University of Chicago Research Data Protection Policy

UChicago Secure Research Data Usage Guide

Data Classification Policy and Handling Procedures (UCMC intranet link)

Minimum Security Standards - IT Responsibilities and Standards (UCMC intranet link)

I plan to use a web app or new software to collect data for my clinical research study. Do I need to ask the BSD Information Security Office to assess the software?

The BSD Information Security Office has a process in place to assist Information System Owners with conforming to security best practices and ensuring systems align with organizational cyber security policies.

Any planned, new or existing information systems that support BSD research activities are expected to complete the Security Assessment and Authorization process.

Please see the BSD ISO website for information on the SAA process:
https://security.bsd.uchicago.edu/bsdsaa/

Please also see BSD Guidelines for Use of Software with Research Health Information:
https://bsdis.uchicago.edu/sites/bsdis/files/2024-03/Guidelines-for-Use-of-Software-with-RHI.pdf

I would like to pay or otherwise compensate my subjects. Is there a policy regarding payment?

The University has a published policy on payments to research subjects. This includes clarification on when gift cards rather than checks may be used as payment.

See University policy at
http://finserv.uchicago.edu/payroll/independent/subjects.shtml

Highlights:

- Payments to subjects over $100 per occurrence must be paid directly to the individual via University check. Gift cards, gift certificates or in-kind payments over $100 per occurrence are not permitted as remuneration for participation in a research study.
- Payments $100 and under per occurrence can be processed via University check or other methods including petty cash, gift cards or in-kind payments.
- Reimbursement for parking, meals, and/or transportation to and from study visits are not taxable. Reimbursement may be made only if a receipt for the expense is provided by the subject. Reimbursements for subjects' time are taxable.

Note, if subjects will be entered in a raffle/drawing to win a gift with value of at least $100, the researchers need to record the name of the individual receiving the gift.

If total amount of payment may exceed $600, the University will need to issue a W9, and therefore name and social security number will need to be collected. If total amount is expected to be less than $600, researchers should maintain a log of payments, including name of payee.

Questions? Contact University of Chicago Financial Services Office.

Questions about petty cash? Contact cash-management@uchicago.edu.

Please describe any planned payment/compensation for research subjects in the AURA IRB submission form.

Why does the IRB ask so many questions during initial review of a protocol?

The IRB is charged with the protection of human subjects in research. In order to fulfill that responsibility, the IRB must ensure that research studies comply with applicable federal, state, local, and institutional regulations and policies, as well as with the IRB Committee's own ethical guidelines. At the federal level, the regulations the IRB must follow are mainly codified at 45CFR46 (DHHS), 21CFR11, 50 and 56 (FDA), and 45CFR164 (HIPAA).

The University of Chicago IRBs must abide by Illinois state laws applicable to research as well as by any city or local rules. Examples of applicable state law include the IL Health Care Surrogate Act and Medical Patient Rights Act (concerning those who cannot consent for themselves), IL Genetic Information Privacy Act, and IL AIDS Confidentiality Act. Examples of city or other local regulations include the requirements for approval or acknowledgement of research when conducting research at specific sites, such as the Chicago Public Schools.

These federal, state, and other requirements are addressed by the IRB mainly through the protocol submission form. Many of the submission form questions employ language taken directly from the federal regulations. Other questions address University of Chicago/Biological Sciences Division/UCMC requirements. One example of an institutional requirement is the need for CTRC review of any study involving cancer patients. Review by the PBUC, IBC, or other institutional committees may also be needed.

Thus it is to your advantage to fill out these forms as completely as possible when submitting to the IRB, as additional information may be requested if there is insufficient justification or description provided for the IRB to make a required finding.

Specific Types of Studies

I'm planning a chart review. What do I need to do?

Chart reviews are a common method of gathering information on a specific medical condition or set of patient characteristics. Although chart reviews do not involve direct interaction with subjects, chart reviews fall under IRB review because they involve obtaining private information about human subjects. Federal regulations define a human subject as "a living individual about whom an investigator … conducting research (i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens, or (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens." [45 CFR 46.102(e)(1)]

When submitting a chart review proposal to the IRB, a protocol narrative is needed. This narrative may be brief, but should include a defined purpose for the data collection. The narrative must also include the beginning and end dates of collection. For example, if you plan to review the medical record of every asthma patient seen in clinic in 2023, you should state exactly what information you are obtaining about the patients, explain the data you hope to find, and specify the beginning and end dates of data collection. These dates are the dates during which the data were originally recorded, such as "January 1, 2023 through December 31, 2023."

Chart reviews may be prospective or retrospective, or a combination of the two. To qualify as retrospective, all information must be collected from a time period prior to the date the study is reviewed. Thus, if you expect IRB review on March 17, 2024, the endpoint of data collection must be on or before March 16, 2024 in order to be considered "retrospective." Investigators are advised to provide justification for a waiver of consent for the retrospective review of medical records. Note that the decision to grant a waiver of consent is the IRB Committee's; in certain cases, the Committee may require that an attempt be made to obtain written consent from potential subjects, even if the information was previously collected in the chart and no prospective collection is anticipated.

In general, prospective collection of information from medical records will require written consent/authorization. Ethical guidelines indicate that if it is possible to obtain consent from potential subjects, the attempt should be made to do so. The IRB Committee will usually require that a written consent/authorization form be prepared to prospectively collect data from medical records. This includes outcomes data that has not yet occurred (e.g. you want to record 1 year follow up data on a surgery that occurred yesterday).

The Committee is also mindful of "protocol creep." In other words, amending the protocol in the future to include information that would be retrospective then but is prospective now is not generally allowed. For example, your original protocol is approved in March 2022 to examine information from March 2018 to February 2022. Eventually, you will also want to examine the charts from March 2022 to February 2025. Rather than submit an amendment in a year, if you know now that you will want the 2022-2025 data, this request should be included in your current proposal.

CRDW: Use of data from the CRDW may or may not require IRB review. If data are provided in a de-identified format, and the research team will not be accessing medical records for additional information, the research may not require IRB review. However, if the research team will receive ANY identifying information from the CRDW and/or will access medical records directly to supplement CRDW data, then IRB review will likely be needed.

My study may involve use of a device. What do I need to do?

Devices can include traditional devices (syringes, shunts, pacemakers, etc.) as well as assays, software and mobile applications. If the product in question is not a drug, and it is intended for use in diagnosis or treatment, mitigation, or prevention of disease in humans, it could be a medical device under the FDA regulations. If you are submitting a new study and are uncertain whether to list a product to be used on study as a device in the device section in AURA-IRB, please consider the attached flowchart.

Device decision tree *updated 2024*

My study involves cancer patients. Is there anything special I need to submit?

Most studies involving cancer patients or their data must be reviewed by the Clinical Trials Review Committee (CTRC). Please note that with rare exceptions, protocols must be reviewed by the CTRC **before** they are reviewed by the IRB. For more information on the CTRC submission process or to find out if your protocol requires CTRC review, please contact Amber Burnett in the Cancer Research Center at 4-0357 or aburnett@medicine.bsd.uchicago.edu.

If a study has PBUC review, is CTRC review also required?

If the study uses existing materials ("on the shelf"), review by the Pathology Biospecimen Utilization Committee (PBUC) review is sufficient and additional review by the CTRC is not required. On the other hand, for any study with cancer related objectives proposing to obtain prospective tissue samples, the study would require CTRC review in addition to PBUC review.

My study involves nursing staff. Is there anything special I need to submit?

Nurse investigators wishing to implement clinical research involving nursing staff and/or nursing care are required to obtain approval from the Nursing Research Committee (NRC) (NERC) as well as from the IRB before proceeding with their study. Nurses who are hired to do research and collect data for physicians' research or those hired as Clinical Research Associates are not required to submit proposals to the NRC. Nurses who are doing research independent of this are required to submit their proposal to the NRC. NRC approval **must** be obtained prior to

submitting a proposal to the IRB, and a copy of the NRC approval should accompany the IRB submission.

For more information on the NRC submission process or to find out if your protocol requires NRC review, please contact Dr. Nicole (Pierce) Bohr, Manager of Nursing Research, in the University of Chicago Medical Center or email nursingresearch@uchicagomedicine.org .

The NERC submission form is available here: https://redcap.link/8yjz6qwb

Approval Process

How long will it take for my new protocol submission to be approved? What happens between submission and approval?

In order for a new submission to be accepted for IRB processing, certain elements must be included as noted in the Accepted for IRB Processing Checklist.

Within a week after a study is accepted for IRB processing, the IRB administrators conduct a pre-review. Often, this pre-review will result in a request for additional information or documentation. Certain documents are required before the Committee can review a protocol and the IRB administrators will inform you as soon as possible if your submission is missing any such required elements. The submission will not be reviewed by the Committee until all required elements are received, regardless of the date of the original submission. Please see the Ready for Review Checklist. If you do not wish to respond to certain comments, or if you would like to provide an alternative response, please document this when submitting back to the IRB so that the IRB is aware of any issues that should be considered during its review.

Administrators will also make other suggestions for revisions. While you are not required to submit these other revisions prior to the Committee meeting, it has been the IRB's experience that Committee members generally incorporate administrator suggestions into their own review by including these suggestions in the pending conditions for study approval. For this reason, we recommend responding to all pre-review comments prior to the IRB meeting in order to reduce the time necessary for review and approval of your study.

If, at the meeting, the Committee feels that further information or documentation is needed before approval can be granted, the protocol will be given "deferred" or "pending-conditional" status. The Principal Investigator will receive a letter detailing the outstanding issues after the meeting, usually within the following one to two weeks. If a protocol is deferred, it must be reviewed again at a scheduled meeting. Additional information may still be required after the second meeting, and a second deferral or a pending-conditional letter may be sent. Pending-conditional studies can be approved without returning to a meeting once all pending issues have been appropriately addressed, although the Committee may review a pending-conditional response at another meeting at its discretion.

Generally, non-expeditable studies require at least one month from day of submission to approval. Two months is an expected timespan from submission to approval. If a study is deferred, or pending comments are not adequately addressed, approval can take several months or more. Studies that can be expedited generally require about 2-3 weeks.

I submitted a protocol for expedited review. Why haven't I received an approval letter yet?

During a pre-review, the IRB administrators and IRB reviewer will determine if they believe your study can be expedited. Many studies are not granted expedited review even when it is requested. **The IRB, not the investigator, has the final decision on whether a study can be expedited**.

In addition, expedited review is determined not by a need for quick approval but rather by the minimal level of risk and specific nature of the research. Only studies of minimal risk falling into one of the federally-defined, IRB-approved categories are eligible to be expedited.

The following may be a reason why you have not received approval:

- the study has not been accepted for IRB processing. Your submission may be missing a required documentation element.
- your study is not eligible for expedited review. The IRB staff will notify you at the time of pre-review if this is the case.
- the IRB staff or chair has requested further information, which has not yet been received. Check with other members of the study team to see if they are working on a response.

The IRB staff makes every effort to expedite qualifying protocols as quickly as possible. However, due to the large volume of protocols, we are not always able to immediately process expedites. If you submit a study you believe qualifies for expedited review, and you do not hear anything after two weeks, please contact one of the IRB administrators to check on the status of your protocol.