IRB ADVISOR

Your Practical Guide To Institutional Review Board Management

February 2012: Vol. 12, No. 2
Pages 13-24

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Study evaluates use of "debriefing" statements

Subjects felt positive about studies

A new study looks at an intriguing strategy for improving study subjects' understanding and knowledge of clinical research. After subjects finished participating in the study, they were given a "debriefing" statement that explained more fully what the study was about and how it would contribute to scientific knowledge.

The study found that debriefed participants were more likely to say they had learned something about the subject and that they felt positive about the educational value of research participation.1

"We have a psychology student participant pool," says **Darcy A. Reich**, PhD, associate professor in the department of psychology at Texas Tech University in Lubbock, TX.

"For part of their credit in class they engage in some research project the department is doing," Reich says.

The goal was to help psychology students understand the value of research, feel they had contributed to science in a meaningful way, and to empathize with what research subjects experienced.

"We're hoping to get them interested in the field so they may go on to be researchers," Reich says.

"After everything is finished, the researcher tells participants about what the purpose of the study is, the nature of the findings, and it gives participants a sense of how they might have contributed to the field," Reich says.

"We had research in seven different experiments with 475 university students, who were mostly freshmen and sophomores," she adds. "We debriefed participants and asked them questions."

They found student participants generally were very positive about research with 98% agreeing that they had contributed to science and 96% agreeing with a statement about how research was for a good cause, Reich says.

The debriefing statements thank subjects for their participation in the study and then discuss more fully what the study was about. They also talk about what researchers hope the findings will show and when results will be

made available.

An example of a debriefing statement is as follows:

"Thank you for your participation in this research on the effect of proximity and interview techniques on eyewitness memory. Two types of questions were used in this experiment. One was the cognitive interview and the other was a control interview similar to police questions. The cognitive interview uses four retrieval techniques to bring out the memory of an event. These techniques allow a person to express how they felt at the time of the event, recall the event in different orders, mentally change their perspective about the event, and finally report all information they remember — even if it seems unimportant (Geiselman et al., 1984). It was hypothesized that when testing eyewitness memory, the cognitive interview would elicit more accurate responses when compared to the control interview. It was also hypothesized that even if the participant was farther away from the event, they would still report more accurate information with the cognitive interview. If you would like to learn more about the cognitive interview, please see Geiselman et al. (1984).

"It was required for the experimenter to deceive you about the event — that is the person did not actually win a prize — because it more closely approximates an event in which an eyewitness would be necessary. Eyewitnesses often do not know they are hearing and seeing events that others will want them to remember. When we are trying to remember something, we often act differently. See Myers (1998) for a discussion of memory.

"Your participation was important in helping researchers learn whether the cognitive interview is better for obtaining more accurate information in eyewitness situations. The findings in this study should help to improve the accuracy of eyewitness interview situations. Improved eyewitness interviewing techniques may aid in solving future crimes in which an eyewitness is present. Also, by participating in this study you have firsthand knowledge of what it is like to be in a psychology experiment.

"Final results will be posted on the bulletin board outside of Stewart Hall 213 by the week of December 11. All results are grouped together; therefore, individual results are not available. Your participation will remain confidential."

The debriefing statement concludes with contact information for any additional questions and with a brief list of references.

"We think the debriefing is very important," Reich says. "I'm with the IRB at Texas Tech, and we look at the outcomes from cancer treatments and how people respond, and debriefing is really important there too."

The debriefings for cancer trials help participants realize their contribution is appreciated, and the debriefings give them more information about the disease process being studied, she adds.

"For a follow-up study, it would be a great idea to talk with participants about what was most useful in the debriefing," Reich says.

IRB Advisor (ISSN 1535-2064) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to IRB Advisor, P.O. Box 105109, Atlanta, GA 30348.

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REFERENCE:

1. Abbott CM, Reich DA, Cogan R, et al. Research participation as an educational experience: does debriefing matter? Poster presented at the 2011 PRIM&R Advancing Ethical Research Conference, held Dec. 2-4, 2011, in National Harbor, MD. ■

BEST PRACTICES SPOTLIGHT

Research program's RISE interviews avert problems

GCP presentations also help

Research institutions increasingly conduct internal research site reviews or audits as a way to improve research regulatory compliance and prevent problems. But one of the big issues they face involves how to conduct these audits in a resource-efficient way that best accomplishes these goals.

The human subject research office at the University of Pittsburgh (PA), like many research programs, began its quality assurance review program with full investigator site audits. These are the most resource-intensive.

In the 15 years since the audits began, the institution has transitioned to conducting RISE (Research Investigator Start-up Education) interviews, says **Kelly Dornin-Koss**, MPPM, RN, CIP, director of the education and compliance office for human subject research at the University of Pittsburgh.

"We like to do those reviews on studies recently approved by the IRB," Dornin-Koss says. "We sit and meet with the research team prior to their starting subject enrollment."

The RISE program has been a success with research teams and for the human subject research office's compliance goals, she notes.

It also accomplishes the goal of improving human subject research protection in a less resource-intensive way. Instead of identifying problems after they occur, RISE interviews prevent such problems through targeted education and compliance tools.

"We look at their protocol in depth, and we create protocol-specific forms that can be used as monitoring or audit tables," she says. "If the site by chance didn't have any study documentation tables created, this is something they can use for their own purposes."

The protocol-specific forms address eligibility screening, study procedures, follow-up procedures, and other areas.

When developing best practices in a program and documentation tools, it's important to have a talented and well-trained staff to assist with these projects, she notes.

"I have multiple staff members that have been instrumental with the development of our program," Dornin-Koss says.

"In particular, Nancy Nagel who has been with the office since 1998, as well as Cynthia Kern who now serves as the co-director of the office for investigator sponsored IND and IDE support, were very helpful," she adds.

The education and compliance office also continues to perform in-depth regulatory reviews. These encourage investigators to maintain all necessary files, including IRB approval letters, informed consent documents, lab certifications, training records of the research team, data safety monitoring minutes, and things like the signed financial disclosure forms and Food and Drug Administration (FDA reports) if the investigator doubles as sponsor.

"We also look for the occurrence of adverse events and unanticipated problems and make sure those are documented and reported appropriately," Dornin-Koss says. "We know we can't meet with every investigator, but we try to go out to each of the schools that are conducting research, including six schools of health sciences and schools of non-health sciences or other schools conducting human subject research."

At each of these schools, the education and compliance office staff provides other proactive compliance programs, such as good clinical practice (GCP) presentations and good research practice presentations. These types of programs help improve research compliance through preventive education and engagement with research sites. Dornin-Koss describes how they work:

• **GCP presentations:** "Several members of our staff meet with the research community, covering study preparation training, the informed consent process, study documentation, and drug and device accountability," Dornin-Koss says.

"This is a good research practice seminar," she says. "We send out an email notice to departments to see if they're interested in having us come in to do the presentation; it's not mandatory."

Attendance at GCP seminars varies per departments, but the advanced coordinator training has had up to 70 attendees. The advanced coordinator training program is among the most popular, she notes.

Sometimes IRB staff and education compliance

officers speak at the GCP presentations. Also, the education and compliance office has videotaped some of these presentations, leaving them available for review on the website, Dornin-Koss says.

"We have taped sessions on reporting unanticipated problems and when an IND is needed," she adds.

• **Orientation checklist:** "We have an orientation checklist for the research community and another one for our office," Dornin-Koss says. *(See sample orientation checklist, below.)* Ideally, new employees

Sample orientation checklist from University of Pittsburgh

The education and compliance office for human subject research at the University of Pittsburgh (PA) developed a six-page staff orientation checklist that is used when new staff members are hired.

Each item on the checklist table has a box for the date completed and the confirmed supervisor initials and date, as well as any additional comments.

Here are examples of some items included in the checklist:

- **RISE Interviews/Audits/O3IS Monitoring**
  - — RISE interview
  - — Observe RISE interview – read protocol and be familiar with study specific interview form and procedure tables
  - — Prepare study specific documents for a RISE interview, observe RISE interview, and write one section of the RISE report (to be determined by the lead)
  - — Lead a RISE interview - Prepare all study specific forms, conduct the interview and write the report
  - — Take responsibility for all correspondence and follow-up related to RISE interview
  - — If applicable, present RISE report at Executive Committee (EC) meeting
  - — Enter RISE data into the QA database
  - — Enter RISE summary into OSIRIS (electronic IRB application system)
  - — Organize and file hard copies of all documents
  - — Document participation in both biomedical and psychosocial protocols
- **Review of Regulations and Regulatory Agencies**
  - — Review Department of Health and Human Services regulations 45 CFR § 46, the "Common Rule" found at: http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm
  - — SUBPART A – Basic HHS Policy for Protection of Human Research Subjects
  - — SUBPART B – Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research
  - — SUBPART C – Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects
  - — SUBPART D – Additional Protections for Children Involved as Subjects in Research
  - — Review of Informed Consent Regulations
  - — Eight basic elements
  - — Six additional elements
  - — Detailed review of additional consent protections for pregnant women, human fetuses, neonates, children, prisoners and those adults unable to provide consent
  - — Review IRB Consent Checklist
  - — Review Consent Template in IRB Reference Manual
  - — Documentation of the Informed Consent Process
  - — Waivers of Informed Consent
  - — Waivers of Documentation of Informed Consent
  - — Observation of the Informed Consent Process
  - — Become familiar with the Office of Human Research Protections (OHRP) website at: http://www.hhs.gov/ohrp/
  - — Note the difference between guidance and regulations
  - — Review the Food and Drug Administration regulations:
  - — Review 21 CFR 50, 56, 312, 600 and 812. Found on the FDA website at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm
  - — Review FDA regulations pertaining to the informed consent process and waivers at 21 CFR § 50.25(a), 21 CFR § 50.25(b), 21 CFR § 50.27(a), 21 CFR § 50.27(b), 21 CFR § 56.111(a)(5)
  - — Waiver of consent for planned emergency use – 21 CFR § 50.24
  - — Review the International Conference on Harmonization (ICH) standards (international standards for research) found at: http://www.ich.org/cache/compo/276-254-1.html
  - — Focus on: E6 – http://www.fda.gov/downloads/RegulatoryInformation/Guidance/UCM129515.pdf

already will have some research experience, but the orientation program is designed to bring everyone up to speed, she says.

"Typically I hire trained clinical research coordinators with nursing degrees or others who have experience with industry and monitoring protocols," she explains. "They are required to work with another member of the staff and review certain types of studies."

New employees receive an orientation that includes reviewing a study that involves children, reading the Belmont report, and attending an IRB meeting, she says.

"They also begin with a RISE interview before they are on their own with the full review," Dornin-Koss says. "Depending on their background, it takes people three to six months in orientation." ■

Earlier testing of Alzheimer's drugs urged

Would require telling people about risk factors before symptoms are evident

In the fight against Alzheimer's disease dementia, researchers have long targeted beta-amyloid plaques, accumulated protein fragments in the brain that are a hallmark of the disease. The plaques are believed to contribute to the cognitive impairment associated with Alzheimer's disease.

Over the past decade, a number of trials of anti-amyloid therapies have proven unsuccessful. But researcher **Reisa Sperling** argues that these trials may be targeting the wrong population – people who already show signs of cognitive decline and are receiving the treatment too late.

Sperling, MD, MMSc, director of the Center for Alzheimer Research and Treatment at Brigham and Women's Hospital in Boston, says she and other researchers are planning trials with older patients who have evidence of amyloid accumulation but don't show signs of cognitive decline.

She makes a case for this line of research in a commentary in a recent issue of the journal Science Translational Medicine.

The proposed trials carry with them new ethical challenges for both researchers and IRBs.

Finding subjects will require screening for amyloid accumulation, probably through positron emission tomography (PET) imaging. One concern is what to tell subjects who are found to have these accumulations – Sperling says nearly one-third of everyone over age 70 shows evidence of amyloid buildup.

"Right now, for a given individual, we don't know whether amyloid means they will ever develop Alzheimer's dementia, or whether it's amyloid plus something else that's predictive," she says. "I feel strongly that ethically, we have to convey that uncertainty."

There are two types of investigations that researchers want to conduct. One type consists of natural history studies of both amyloid-positive and amyloid-negative individuals, to try to understand the progression of Alzheimer's disease. The other would be trials of anti-amyloid therapies which previously have been used in study populations who had more advanced stages of the disease.

These therapies may carry some risks to subjects. Development of semagacestat, believed to be a promising candidate against beta amyloid, was halted in 2010 by Eli Lilly and Co. after Phase III trials showed evidence of worsening cognition in subjects, as well as an increased risk of skin cancer.

Sperling says there are a small number of drugs for which there is adequate safety data to move forward with a three-year trial.

"Even though they have significant risks, we're getting a handle on what those risks are, to the point where I feel like from an IRB perspective, we can say here's what we have seen in people who have amyloid and dementia," Sperling says. "It is very likely that we'll see the same set of side effects in people who have amyloid and don't yet have dementia."

And she says that subjects who have no cognitive impairment are in a better position to make decisions about participation than patients with mild dementia, who often must have a study partner who can serve as a surrogate consenter as their disease progresses.

"These are normal people who likely will join this trial because they have seen their family members suffer with this," Sperling says. "They know, unfortunately, what this disease can be. And we will have to say there's significant risk. But again I think that's ethical, if people can make their own decision about this when they don't have cognitive impairment, which might really impact their ability to weigh the risk-benefit."

The key, she says, is ensuring subjects understand what scientists do and do not know about amyloid and Alzheimer's. She says that while researchers have experience conveying this uncertainty to people who already show signs of Alzheimer's disease dementia, it will be trickier to educate people who have amyloid

accumulation but no signs of impairment.

"We have to be very upfront, to say, 'We don't know whether having amyloid in the brain means you will develop Alzheimer's disease dementia or not,'" Sperling says. "What we can say is 'We want you to have this screening process to see if you would be eligible to take a medication to lower a protein, that, if we find it in your brain, we think may be an important risk factor.'"

As part of these studies, Sperling says researchers plan to survey subjects about what finding out their amyloid status means to them.

Sperling says she does not see IRB approval as a significant obstacle to getting these trials off the ground. More difficult, she says, will be crafting the partnerships necessary to carry them out — between public funding, industry and philanthropists.

But she says IRBs in general need to keep in mind the serious nature of Alzheimer's disease when weighing risks and benefits in a proposed study.

"We accept huge risks in cancer (research)," Sperling says. "But for a long time in Alzheimer's disease, we were unwilling to do that. People used to think, oh, Alzheimer's disease, that's just old and forgetful. But for many people, Alzheimer's disease is more devastating than cancer.

"I think from an IRB perspective, we need to really think about what level of risk we might be willing to tolerate and realize how devastating this disease is."

REFERENCE

Sperling RA, Jack CR Jr., Aisen PS. Testing the Right Target and Right Drug at the Right Stage. *Sci Transl Med*. 2011 Nov 30; 3(111):111cm33. ■

Alzheimer's testing less distressing than thought

Subjects should get education, counseling, but it need not be elaborate, researcher says

As genetic testing becomes better able to pinpoint risk factors for various diseases, is there potential harm to subjects in giving them test results, particularly when there are limited treatment and prevention options?

Current models of genetic testing and counseling are based on those created for Huntington's disease, says **J. Scott Roberts**, PhD, who studies health education and health behavior at the University of Michigan School of Public Health in Ann Arbor.

With Huntington's, "Pretty much, if you have the mutation, you're almost inevitably going to get the disease, and it's fatal, incurable, with an earlier onset," Roberts says. That's very different, he says, from genetic testing for conditions such as Alzheimer's disease.

Currently, for the most common form of Alzheimer's disease, the most prominent genetic marker is a variant of a plasma protein called apolipoprotein E. (APOE). However, existence of this variant is less predictive than the genetic marker for Huntington's.

Roberts and his colleagues set out to look at how subjects would respond to learning whether they had this APOE variant. The Risk Evaluation and Education for Alzheimer's Disease (REVEAL) study is a series of multisite trials that look at the result of APOE testing on more than 700 adults, some of them with immediate family history of Alzheimer's disease.

REVEAL's results can help inform researchers and IRBs as they deal with how to disclose potential genetic risks to research subjects for a variety of diseases, particularly in cases where doctors can't prescribe a prevention or cure.

"It's not like we can say, 'If you're at higher risk for Alzheimer's, here's a regimen that will lower your risk' — we're not at that point," Roberts says. "However, what we've found is that some of the speculated harms haven't come to fruition in our studies.

"We haven't found that people are reacting to bad news with the kind of psychological distress that I think some had been concerned about. I think it does suggest that if you have research participants who are particularly interested in this information and you have a research team with enough resources and inclination to disclose this, it might be something that could be considered."

In each of the four stages of the REVEAL study, researchers developed risk estimates for subjects, based on age, gender, family history and whether the subjects tested positive for a specific APOE allele (APOE-e4), which is a risk factor for late-onset Alzheimer's disease. Subjects were given various types of counseling — a full, face-to-face education, a condensed program or phone consultations. They were followed for a year to assess the impact of their risk assessment.

Roberts says researchers wanted to see if the extensive education and counseling model used with Huntington's testing was necessary for other testing situations.

"Our take is that we don't need to be that elaborate, when you're talking about something like

APOE, which is much less predictive," Roberts says. "It's not like our phone disclosure people were reacting with much greater distress.

"We think it's important to have some knowledgeable expert involved and we think it's important to have people try to think through the decision, but on the other hand, we think we can make some accommodations so we don't have to replicate a Huntington's model to do this."

Other issues that came up in the REVEAL study:

• **Ethnicity** – Roberts says epidemiological studies suggest that African Americans are at higher risk for Alzheimer's disease than whites, although it's unclear why. He says the risk estimates for African American subjects in the REVEAL study did reflect that difference.

"So that was a bit tricky because we were giving them higher numbers, but I think that does reflect the state of the science," Roberts says.

• **Insurance risks** – Although the Genetic Information Nondiscrimination Act (GINA) protects subjects from discrimination in employment and health insurance based on their genetic information, that protection does not extend to long-term care insurance. This is key in Alzheimer's testing, since many Alzheimer's patients spend many years in long-term care as their disease progresses.

In the one-year REVEAL follow-up, subjects who tested positive for APOE-e4 were about four times more likely to report having made changes in long-term care coverage. If that trend continues, it's possible that insurance companies will begin to ask about APOE testing. It's important that those insurance risks be spelled out in informed consent, Roberts says.

"Basically we often encourage people if they're going to make (insurance) decisions, to consider making them before they actually find out their genetic test results," Roberts says. "That way they can say they weren't influenced by their genetic test results. But our data suggests that people still do make decisions after the fact."

• **Preventative measures** – There is limited evidence about the effectiveness of lifestyle changes (diet, exercise, mental activity) in preventing or lessening the effects of Alzheimer's disease. However, subjects in the REVEAL studies tended to cite disease risk reduction a prime motivation for seeking a genetic test.

Scott says education to subjects did include lifestyle suggestions, but made it clear that there is no consensus on how effective they are.

"We've tended to frame it by saying, "There are no proven methods, however, some research has suggested these as possible ways,' and we point out that they have other health benefits as well," he says. "We don't want to give these people false hope. On the other hand, I don't think it's unreasonable for people to try these things because, what's the downside?

"And I think from a psychological point of view, people think, 'At least I'm doing something, I'm not just sitting here passively and waiting to see what happens.'"

Roberts says his own IRB required that his group document that it was using a CLIA-approved laboratory for the tests. They obtained a certificate of confidentiality from the National Institutes of Health and created an external advisory board of experts in genetics, bioethics and even insurance law, to review the study.

While not all studies may require an expert panel, he says, the other protections are not overly burdensome and make good sense.

He also notes that there are existing guidelines by bodies such as the National Heart, Lung and Blood Institute for returning genetic research results that can assist IRBs in reviewing these types of studies.

"Our take is there isn't enough empirical evidence to really guide us, but a lot of expert consensus statements," he says. "We need a little bit more empirical research to help us along as well."

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IRB takes on readability with staff education

Health literacy education, online training part of push to improve informed consent

Improving the readability of informed consent involves more than a one-time education of researchers or IRB staff — it's a process that requires ongoing commitment.

That's the view of **Hallie Kassan**, MS, CIP, director of the IRB office at the Feinstein Institute for Medical Research in Manhasset, NY. The office has undertaken staff education to help keep them focused on making informed consent more understandable.

"If you educate on something you need to revisit it — not just educate and talk about it and move on, but refresh people's memories and remind them to watch for these things," Kassan says.

Kassan says she was approached by head of the institution's Office of Diversity, Inclusion and Health Literacy, who also serves as an IRB member.

Marilyn Dienstag, RN, BSN, a clinical research analyst with the IRB, says the health literacy officer has focused on making improvements throughout the hospital — using more lay language in signage, for example.

"As a member of the IRB and reviewing consent forms herself, I think she was noticing that, obviously, they're not written at the seventh- or eighth-grade reading level," Dienstag says.

The health literacy officer gave a two-hour presentation for the IRB office on the difficulties of reading consent forms and steps that could be taken to make them more understandable. At the same time, staff members participated in a free online Program for Readability in Science and Medicine (PRISM), an education initiative by the Group Health Research Institute.

Kassan and Dienstag talked about their office's experience at the recent Advancing Ethical Research Conference sponsored by Public Responsibility in Medicine and Research.

Both the health literacy officer and the PRISM program emphasized that readability is not just about using smaller words, shorter sentences and translating medical jargon into lay language, Kassan and Dienstag say.

Other things that writers and reviewers of consent forms should consider include formatting issues such as:

• **Type style and size** – Text should be printed in a minimum 12-point type, so that the letters are large enough to read. The writer should use a font that includes serifs (small lines that make up the edges of letters such as those at the ends of the legs in the letter "A.") Studies have shown that serif fonts are easier to read than non-serif fonts.

• **Justification** – While word processing allows text to be printed so that the ends of lines line up neatly down both sides of the page (left and right justification), it's harder for people to read, Kassan says. Text should have a left-side justification, letting lines end naturally on the right side.

•**Other issues** – Adequate margins on the bottoms and sides of pages, headings and subheadings to break up text and bulleted lists all help lead a reader through the document more easily.

Kassan says she believes her staff weren't as familiar with these formatting issues before the education program. She created a checklist for staff to use as they review documents.

"I don't think anyone in my office was really aware of those types of formatting issues that are easy fixes."

And Kassan says the education program underlined the difference between basic literacy and health literacy.

"People may have college educations, but they have no scientific or medical background and they're not health literate," she says. "It's not just homeless people or uneducated people who are not health literate — it could be anyone."

Her office conducted a survey of consent forms both before and after the education program. Both sets of forms were run through basic readability tests, which found little difference in the in forms' readability.

Kassan and Dienstag say the results were not surprising. To an extent, they believe the forms before the education weren't that bad, and so little improvement was noticeable. Also, Dienstag says the readability test used may not have been the best measure.

But Dienstag herself found the training extremely valuable, and she says she uses it all the time as she reviews consent forms.

"I can tell you quite honestly it's been a great help," she says. "I don't need to look at the checklist anymore — I have it all in my head."

Kassan says the IRB office has put templates on its website, using the proper formatting, so that investigators can create documents that are correctly formatted before they ever reach analysts.

Dienstag notes that in the past, there were no templates, just suggested language, and investigators frequently cut and pasted that language into their documents.

"The new templates greatly improve things," she says.

Kassan says many institutions have health literacy officers who could help an IRB mount this type of project. She also recommended us of the PRISM program, which can be accessed at www.grouphealthresearch.org ■

'Stepping up' to bridge the researcher/IRB gap

Outreach programs include one-on-one advice and researchers educating IRB staff

As the human research protection program at Mount Sinai Medical Center prepared for accreditation in 2010, IRB Manager **Stacy Chandna**

says she and her colleagues knew they had a daunting task ahead.

"We were changing many things about how the office functions," says Chandna, MS, CIP. "We were changing all our previous forms to a new set of 117 new documents. We were changing the education requirements that the research community had already fulfilled to the CITI program, which required six-plus hours of online training."

All the changes were bound to cause confusion and difficulty for researchers, so the Mount Sinai Program for the Protection of Human Subjects in New York City embarked on an equally ambitious outreach program, seeking to engage researchers on their own turf and discuss issues of importance to them.

"We wanted to be seen as an office that provides regular training and education and consistent communication with our customers," Chandna says. "We really wanted to focus on our external customers, which were the investigators and research teams that we help to get their projects up and running."

The office added three components to its existing outreach program. The first, "Step Right Up," provides researchers with assistance as they prepare studies for review. "Research Grand Rounds" pairs reviewers with investigators to talk about important ethical issues in research. And "Bridging the Gap" invites a more intensive dialogue between researchers and IRB staff about specific areas of research that may cause problems in translation.

Chandna presented the results from Mount Sinai's efforts at the recent Advancing Ethical Research Conference sponsored by Public Responsibility in Medicine and Research.

The first component, Step Right Up, brings IRB staff to the main research building at Mount Sinai. Chandna says the IRB offices are located a few blocks away from the main medical campus. Once a week, for an hour, two analysts staff a table outside the cafeteria, to answer questions and accept submissions (Mount Sinai uses a paper-based system).

"We're there weekly, at the same time, same place, so it's very consistent," she says. Researchers can pop over and ask questions face to face."

Chandna says the analysts' table has regular customers now, who ask about their projects, submit forms or check on the status of submissions. They've also have been joined by representatives from the grants and contracts office, which, like the IRB office, is located away from the main campus.

In the beginning, she says, researchers' questions tended to focus on the specifics of the new forms.

"Now, they're asking more general questions — do we think they need any other materials to support their proposal?"

The IRB office schedules sessions that pair an investigator and a regulatory specialist to talk about specific issues of interest to the research community.

For one session, an IRB chair who is a psychiatrist partnered with an investigator who works with subjects who have cognitive impairment to talk about the ethical issues involved in research with that population.

"In some instances, there have been presenters who have had different opinions about what they think should be happening or what the best approach is," Chandna says. "Often, those are the most interesting discussions."

The sessions so far haven't been held regularly, primarily because of the difficulty in scheduling presenters. Chandna says she hopes eventually to have monthly Research Grand Rounds sessions at a regular time and place.

Many IRBs have ongoing issues with researchers in particular fields, who complain that the IRB doesn't understand the specifics of their work. Mount Sinai seeks to address those issues head on, by inviting researchers to give presentations to staff about their work — and sending IRB staff to the researchers to explain the regulatory process.

"We found that certain types of research projects caused some commotion within our office," Chandna says. "And there were some investigators who were full of complaints anytime you spoke with them. So we thought it would be helpful not only to figure out what is the cause of the complaint, but also to provide an educational opportunity for our staff."

In one instance, two investigators from the institution's department of rehabilitation medicine gave a presentation about research with subjects who have traumatic brain injuries. Chandna says that previously, analysts reviewing their studies had asked questions about determining capacity to consent.

"It was a recurring issue that kept cropping up on each of their projects," she says. "So we brought them in to talk about what they're doing and how they're assessing capacity."

Other topics at these sessions have included the use of deep brain stimulation and providing genetic testing results to participants. And IRB staff have delivered presentations to researchers help explain the best way to make submissions.

Chandna says that in some cases, her staff have approached investigators to ask them to give presentations; other times, investigators have volunteered to speak.

She says the presentations themselves have been very collegial.

"I think that sometimes prior to the actual session, they might not as been as collegial a discussion as we would have liked," she says. "But once they get to our office to do the presentation, I think that our interests have been aligned at that point. While they might provide criticism, I think it's meant to be helpful, rather than just providing negative feedback."

Chandna says that while so far, her office hasn't measured how many researchers are taking advantage of them. But there are plans to begin collecting such data in 2012. ■

COMPLIANCE CORNER

Update strategies after switch to electronic process

Goal was 100% transition in 2 years

Transitioning to an electronic submission process is challenging. It also is a time when IRBs need to pay close attention to current compliance practices with an eye on updating standard operating procedures to reflect the new electronic practices and processes.

"The first thing we did at UCSF after deciding to go to electronic submissions was to decide how to transition existing paper files into the electronic database," says **Lisa Denney**, MPH, CIP, CCRP, assistant director of the human research protection program (HRPP) at the University of California – San Francisco.

The questions to ask before beginning this change are: Do we transition existing paper studies into the electronic system or do we let those studies continue as paper files until they conclude? Do we have principal investigators continue with paper submissions, or do we have them begin with electronic submissions and manage their existing studies electronically from a starting point on?

The HRPP office opted for a full transition to electronic submissions and files with a goal of being 100% electronic within a two-year period that concludes in 2012, Denney says.

Once the paper transition process was decided, the next step was deciding how to handle the people transition process: "We had to decide how to transition IRB members from reviewing paper files to handling electronic submissions," Denney says.

The result has been a success, with about a 30% decrease in mean IRB review turnaround time, she adds.

"We were able to knock off about 30 days just because of [eliminating] the paper processing time," Denney says.

"Investigators used to have to make 18 copies when there were corrections," Denney says. "All of those mailings, paper processing and files disappeared when they could do it all on their computer."

Achieving this efficiency and success does take considerable preparation and effort. New standard operating procedures and training are needed. Denney provides these tips on improving electronic process compliance:

• Compliance Tip #1: Give investigators and staff a hard deadline and enforce it.

"We gave everyone a four-month time frame for submitting studies by paper, and we gave them a cut-off date," Denney says.

Any studies or continuing reviews after that date had to be submitted electronically, or they would not be able to move forward, she adds.

The goal was to have the system operate 100% electronically within a couple of years, she says.

"We wanted to manage all work for all studies in the electronic system with no paper copies for the IRB," Denney says.

This hard deadline prevents a long-term transition in which old studies continue to be submitted in paper format while all new ones are electronic.

"This way IRB staff and research staff do not have multiple ways of processing submissions," Denney says. "It streamlines the process."

• Compliance Tip #2: Ask for user input to improve buy-in.

"This was not an executive, authoritative decision we made from our office alone," Denney notes. "We brought together many users, principal investigators, and other people, who play many different roles in the campus, together."

Electronic technology has improved exponentially in recent years, and many investigators and other users have become familiar with sophisticated technology and applications created by companies that can afford more research and development involving user interface, Denney says.

"From a functional standpoint, the electronic IRB submission system will do what you need it to do, but it may not be as great as an Amazon-type pro-

gram with much more money to put into design," she explains. "Research coordinators who use the system frequently learn the system, but people who use it for one or two studies a year find it frustrating."

The key was to introduce the system to users and ask for feedback. At the same time, managers might note the new system's advantages, such as how it will save users' time. When investigators are asked to correct something in their IRB submission, they can correct it on the computer and send it electronically. This is far faster than having to correct it on paper and then make 18 copies to send to the IRB for distribution to the board, Denney explains.

• Compliance Tip #3: Make no exceptions on transitioning to full electronic submissions.

"We have four committees of 18 board members, and we said, 'This is the way we're going to do this,' and we held our ground on it," Denney says. "We had senior managers go in with every IRB member to train them."

They also created quick guides to using the system.

"We made an executive decision that each IRB member had to work in the system this way," she says. "We had only one member out of 72 IRB members who said, 'I can't do this.'"

For that one person, they send the IRB submissions by email as a pdf file, but it's still not turned into a paper document by the IRB, she adds.

During the transition process, Denney and IRB staff met with IRB members for 20 to 90 minute meetings to go over the electronic process.

• Compliance Tip #4: Invest in thorough, continuing training.

"We have ongoing classes in the computer lab, an introduction class, and an advanced class," Denney says.

Training began before the system went live. IRB staff, clinical research coordinators, and others learned how the system works and how to manage submissions.

Training was held with each campus unit, and the HRPP office offered to hold training sessions at any site that made the request.

"Three of us trained over 1,700 people," Denney says. "All we need is an Internet connection at the site, and we can give them a demonstration and a handout on using the system."

Training was a big undertaking, and it is a continuous process, she notes.

"We have ongoing classes, outreach, and we created quick user guides with screen shots in the system," she says. "We have a phone call line where someone is available to help users."

The electronic system was integrated with existing information technology systems, and many users found it was not an easy system to learn, she says.

"We found that people wanted you to hand-walk them through it and tell them how to do it rather than to read the guide," Denney says. "This time was well-spent on our behalf, and our staff was learning the system at the same time."

As the IRB trainers became more familiar with the system, they developed into better educators and have improved on the electronic system.

"In addition to helping people, we're making a lot of business decisions," she says. "There were some things we had to do differently, and we hadn't thought through every last detail until they came across our desk."

CNE/CME OBJECTIVES & INSTRUCTIONS

The CNE/CME objectives for IRB Advisor are to help physicians and nurses be able to:

- establish clinical trial programs using accepted ethical principles for human subject protection;
- apply the mandated regulatory safeguards for patient recruitment, follow-up and reporting of findings for human subject research;
- comply with the necessary educational requirements regarding informed consent and human subject research.

Physicians and nurses participate in this continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- ■ Improve education of IRB staff and CR team
- ■ Artificial neural networks might improve informed consent process
- ■ Small research programs can gain much from networking
- ■ New recommendations on protecting subjects from president's commission
- ■ Building a separate IRB for studies of pregnant women, babies and children

• Compliance Tip #5: Hire someone to handle new system.

It helps to have a lead person work with the electronic product's vendor during the transition period. The same person can run reports, which is one of the chief advantages to having an electronic IRB submission system.

"We created this new job in our office," Denney says. "She wrote all the applications and got the workflow done, and now she's the lead for running reports and for being the person who investigates complicated problems."

The information expert, who ideally has experience working in an IRB or clinical research office, also can answer users' more complicated questions, she adds. ■

CNE/CME QUESTIONS

1. When an IRB transitions to an electronic submission process, which strategy might work best in accomplishing the goals of quickly improving efficiency and reducing IRB review turnaround time?
   A. Begin all new studies in electronic format, but let continuing reviews and existing studies stay in paper format
   B. Set a deadline for complete transition to electronic format for new and ongoing studies
   C. Begin training researchers, IRB members, and research/IRB staff before the transition begins
   D. Both B and C

2. A sample staff orientation checklist might include all except which of the following points?
   A. Review IRB Consent Checklist
   B. Review Consent Template in IRB Reference Manual
   C. Designate office staff to handle kitchenette clean-up and prep work
   D. Documentation of the Informed Consent Process

3. True or False: Informed consent in trials of amyloid-reducing therapies should state that the presence of beta amyloid in the brain does not necessarily mean that a subject will develop Alzheimer's disease dementia.

4. Which of the following are factors to consider in the readability of an informed consent document:
   A. Language issues, such as length of words, length of sentences and use of lay language rather than medical jargon.
   B. Formatting issues, such as the font and size of type used, size of margins, and the justification of the type.
   C. Both A and B
   D. Neither A nor B.