



January 6, 2016

Jerry Menikoff, M.D., J.D.  
Office for Human Research Protections (OHRP)  
Department of Health and Human Services  
1101 Wootton Parkway, Suite 200  
Rockville, MD 20852

**Re: HHS–OPHS–2015–008 (Federal Policy for the Protection of Human Subjects)**

Dear Dr. Menikoff,

AcademyHealth, as the nonpartisan, professional home to more than 4,500 health services researchers, policy analysts, and practitioners, welcomes the opportunity to respond to the Notice of Proposed Rulemaking for the Federal Policy for the Protection of Human Subjects (HHS-OPHS-2015-0008), more commonly referred to as the “Common Rule.”

Human subjects research protections are a moral compass critical to the public good. Health services researchers—from an array of disciplines ranging from outcomes research to health economics—are subject to the Common Rule. Regardless of discipline, we all are committed to ensuring that individuals who participate in health services research are protected, and that the data with which we work are collected, used, and stored ethically and appropriately. Making changes to the Common Rule comes with the unique and difficult challenge of striking a balance between rigorously protecting human subjects without inadvertently creating administrative burdens that unnecessarily hinder scientific innovation and progress.

We support the U.S. Department of Health and Human Services’ (HHS) efforts to modernize regulations for those who are so critical to the research enterprise. To that point, we support the focus on attaining balance between the three ethical principles found within the Belmont Report. As we move forward in our scientific endeavors in this country—in particular with the nation’s energetic focus on the administration’s Precision Medicine Initiative—we owe human research subjects no less. Therefore, AcademyHealth supports the NPRM’s goals to: increase subject autonomy; reduce potential harm and increase justice; and increase beneficence by facilitating current and evolving types of research that offer promising approaches to treating and preventing medical and social problems. However, certain areas of the NPRM fall short on these stated goals and require additional clarification to ensure that the NPRM satisfies each of these principles to the greatest extent possible.

We are pleased to offer the following suggestions for your consideration as you work to finalize this policy. We will first summarize those areas where we offer general support, and follow with specific issues for future consideration before issuing the final rule.

## **General Support for Common Rule Enhancements**

Human subjects research protections apply to more than each primary study and data acquisition; data have many generations of utility for researchers. The rapid growth, landscape, and expansion of human subjects research in the advent of “big data” through health informatics and technology necessitates a revision of the Common Rule. AcademyHealth endorses revisions that set ethically and morally rigorous standards for conducting research and that protect human subjects from physical, psychological, and informational risks. In this regard, AcademyHealth applauds HHS for issuing this NPRM at this critical time of scientific transformation.

**AcademyHealth supports, in concept and intent, many of the proposed changes as described in the following sections of the current regulatory framework.**

- Streamlining IRB Review of Multi-Site Studies. Utilization of a single Institutional Review Board (IRB) review of record for domestic sites of multi-site studies—under clearly defined circumstances—would be a significant improvement to the current process, whereby the review processes and variations in determination associated with multi-site reviews can often delay for months and sometimes more than a year even low-risk projects. Moreover, the changes that one IRB makes sometimes require additional reviews by other IRBs—an administrative burden that rarely enhances the protection of human subjects. We recognize that this significant change will require substantial work with sites and clear guidance to minimize the likely resistance to relinquishing control that some institutions may exhibit. Nevertheless, this proposal will address unnecessary inefficiencies and redundancies in the current oversight process without compromising protections for human subjects.
- Harmonization of Agency Guidance. AcademyHealth supports any and all efforts to streamline Common Rule guidance across federal departments and agencies by requiring consultation among agencies that support research before any new guidance may be issued. Health services research is a multidisciplinary field, supported by myriad departments and agencies across the federal government. Inconsistencies in guidance issued by these departments imposes significant administrative and regulatory burden on health services researchers, in particular. Coordination of agency guidance across federal research funders, to the extent possible, will be a welcome improvement.

## **Items for Clarification within the Proposed Rule**

Despite AcademyHealth’s overarching support of HHS’s efforts to modernize the Common Rule, the NPRM proposes changes that—if promulgated as currently proposed—could inadvertently stymie data access and the production of rigorous evidence used to improve health care and ultimately, individuals’ health. AcademyHealth thus urges HHS to carefully consider the following suggestions when finalizing changes to the Common Rule.

- Expanding the Definition of Human Subjects to Cover Research with Nonidentified Biospecimens. The proposed changes would require for the first time that the obtaining, use, study, or analysis of biospecimens be covered under the definition of “human subjects” in the Common Rule. While this change will only apply to future care—starting three years after the publication of the final rule—during this time every caregiver who anticipates the use of biospecimens for future research will need to change their consent for treatment. While we are aware of others’ concerns with this section, we suggest that if HHS moves ahead in this

area, clear and concise boilerplate language that care providers can insert into their general consent for treatment should be developed by HHS. It is also important to note that patients' clinical circumstances change, and a patient may want to change their consent to allow use of biospecimens after a certain diagnosis, for example. To address this, HHS should also make available to care providers specific language to be shared with patients on how to reverse one-time, prospective consent.

- Explicit Exclusion of Activities from the Common Rule. In general, AcademyHealth supports the proposed exclusions and exemption categories and views the NPRM as a welcome improvement to the Advanced Notice of Proposed Rulemaking (ANPRM) of 2011. In particular, we support proposals to exclude activities related to public health surveillance, program improvement activities, survey procedures, use of existing data, federal evaluation and demonstration projects, and other “low-risk” activities. Nevertheless, two specific areas are in need of clarification and/or revision:
  - *Quality Improvement.* As currently drafted, the definition of quality improvement (QI) is too narrow—focusing on “altering the utilization of an accepted practice”—and would require many current QI activities to be classified as “research.” We fear this new requirement would ultimately discourage the pursuit of rigorous QI at the expense of patients and their health. For example, the NPRM suggests that a standard QI project to implement a checklist for central line insertion could only measure whether the checklist is followed (effect on utilization), not the rate of central line infections—an outcome routinely monitored at virtually every hospital in the country. Thus, the NPRM should not limit the ability of health systems and others to collect patient-level outcomes as part of rigorous QI.

A basic tenet of the “learning health system” is the expectation of continuous learning from routine care, which may in many instances be accomplished only by evaluating health outcomes. Thus the *intention to assess the outcomes* related to a QI activity by itself should not make the activity subject to the Common Rule. Similarly, the *dissemination* of QI results should not make the activity subject to the Common Rule, nor should *multi-institution collaborations* on routine QI activities. The protections on sharing of individual-level data under HIPAA afford sufficient protection for privacy.

We recommend the final rule make clear that QI programs involving implementation of accepted care practices, with the goal of increasing adherence to such practices, should not be subject to the Common Rule, whether or not they also measure the outcomes of that practice, and that *all* QI activities be excluded.

- *Secondary Research Use of Identifiable Private Information.* The NPRM is a welcome improvement over the ANPRM’s proposal regarding consent for future uses of data previously collected for research purposes. Nonetheless, further clarification of this provision is needed.

First, the risk to patients of secondary analysis of data (e.g., claims or electronic health record data) is minimal beyond risk of disclosure, which is covered under different regulations. The NPRM would give patients an “opt-out,” such that their

data could not be used for secondary analysis. Such an “opt-out” system would be administratively complex and result in markedly decreased validity of research in a setting where the potential for harm to the subject is minimal. For example, if more than 15 percent of subjects in a study “opt-out,” the population in the study may not be representative and could lead to biased inferences derived from the data, which would in turn make it difficult to apply the results of such research to even the care setting in which the data was generated. Given the administrative complexity and potential to undermine research, as well as the minimal to nonexistent risk to subjects, AcademyHealth recommends the Common Rule maintain the notification option as the minimum standard and not allow an “opt-out” of such data analysis.

Second, the distinctions between “biospecimens” and “identifiable private information” are blurred in this section. The interchangeable use of these terms is inconsistent with earlier text in “Expanding the Definition of Human Subjects to Cover Research with Nonidentified Biospecimens,” which discussed only the need for advanced consent for biospecimen reuse. AcademyHealth recommends that, at a minimum, the final rule clarify whether this section pertains to biospecimens exclusively (as previously indicated) or whether it pertains to both biospecimens and identifiable private information collected in prior research that was consented.

In addition, it would be helpful for HHS to explicitly define what is meant by “identifiable private information,” as this term is inherently broad. The assumption is that electronic medical records, insurance claims, and similar information addressed in the exclusion category of the NPRM are not included in this definition—even though these are in fact types of identifiable private information. Similarly, there is a host of new and emerging types of health information, including patient-reported outcomes and patient-generated health data from sensors that may need to be addressed in the Common Rule. AcademyHealth’s work convening the Electronic Data Methods (EDM) Forum and developing consent structures for research using such data may be a useful resource as you seek to clarify and specify the intent of this provision (for an example, visit: <http://blog.academyhealth.org/edm-forums-collaborative-network-pcor-and-apples-research-kit>).

- Streamlining IRB Review of Multi-Site Studies. Single IRB review would undoubtedly reduce administrative burden and enhance the timeliness of research, but in drafting future iterations of the rule HHS must address the political, administrative, and legal complexities. For instance, what criteria should be used to identify the single IRB in a multi-site study, e.g., principal investigator, location, IRB specialty, reputation, or existing relationships with an IRB? Many protocols currently direct subjects to contact the institution’s IRB with issues or questions. How do you address institutional accountability when there is a single IRB for a multi-site study? HHS must also address secondary consequences, such as how to allocate liability and whether an appeals process is necessary.

AcademyHealth encourages HHS to consider the experiences of IRB systems that have already implemented more centralized IRB review processes, such as the Veterans Administration (VA). After a four-year, deliberative phase-in process, the VA system is functioning effectively and integrating a local review level to respond to concerns that sites would be mandated by default to carry out activities to which they did not agree.

- Proposal to Extend the Common Rule to All Clinical Trials. The NPRM proposes to extend the Common Rule to cover clinical trials at all U.S. institutions, regardless of funder. AcademyHealth believes that all entities conducting research—regardless of research funder or type of research study—should be subject to the Common Rule. Most institutions already voluntarily extend the applicability of their Federalwide Assurance (FWA) or other assurance of compliance to all research conducted at their institution, as the Common Rule sets the standard for liability. In the interest of simplicity and efficiency, AcademyHealth believes that the Common Rule protections should be extended to all research with human subjects conducted in the United States, regardless of the funding source, as recommended by the National Academy of Medicine (formerly Institutes of Medicine), among others.
- Not currently addressed in the NPRM, AcademyHealth encourages HHS to incorporate a regular review of the Common Rule regulatory framework into the final rule to ensure that human subjects research protections are responsive and flexible to evolving research needs and practice. We hope that the current effort to revise the Common Rule is just the start of a continuous, national dialogue that succeeds in further protecting human subjects rights and incentivizing innovative health care research.

Thank you for the opportunity to submit these comments. We look forward to working with you to finalize and implement the proposed rule, and address our concerns and suggestions.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa Simpson". The signature is fluid and cursive, with a large initial "L" and "S".

Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P.  
President and CEO, AcademyHealth