



January 6, 2016

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Office for Human Research Protections  
Department of Health and Human Services  
1101 Wootton Parkway, Suite 200  
Rockville, MD 20852

Submitted via regulations.gov

**Re: Comments on the Notice, Docket no. HHS-OPHS-2015-0008: Federal Policy for the Protection of Human Subjects**

On behalf of the Association of Public Health Laboratories (APHL), please accept the following comments concerning docket number HHS-OPHS-2015-0008 on the notice of proposed rulemaking (NPRM) and request for comments on the Federal Policy for the Protection of Human Subjects. APHL is concerned that the Office of Human Research Protections (OHRP) has sacrificed advancements in public health and lifesaving research that pose little to no risk on human subjects for a perception of autonomy over de-identified biospecimens.

**APHL is deeply concerned that:**

1. The NPRM overvalues autonomy at the detriment of life saving research and scientific advancement. This imbalance will disrupt the Nation's network of public health laboratories to utilize residual de-identified specimens from clinical encounters to develop, validate and implement new life saving tests. OHRP has publicly stated that the NPRM was not written to address risks or the threat of a specimen's identifiability, but to provide autonomy to the human subject. If risk and harm to the subject is not the central concern, a better balance needs to be achieved to allow advancements in science and public health. The Secretary's Advisory Committee for Human Research Protections has discussed the option for an opt-out model which would allow patient empowerment and control through education and transparency. APHL believes that a meaningful opt-out model in the case of biospecimens collected at clinical encounters would value and protect autonomy and research equally.
2. The NPRM does not specifically list storage of biospecimens under the public health surveillance exclusion, yet storage and secondary use, as well as collection and testing, is necessary to protect the public's health. When public health laboratories obtain biospecimens from clinical encounters, residual biospecimens are often stored for a variety of secondary purposes

including validation or verification of an assay, further clinical testing as requested by the patient or family, quality improvement, quality assurance and potential future research to develop new tests. The storage of biospecimens in the NPRM is written on the premise that the healthcare provider, laboratory personnel or the investigator initially knows that a biospecimen will be utilized for research. In public health laboratories, the secondary use of a biospecimen may not be known at the time of storage, thus it is important to have a repository of specimens to fulfill the functions of a public health laboratory. Based on NPRM, this leaves public health laboratories in the position of collecting informed consent for every biospecimen stored regardless if the biospecimen is ever used in future research, or to retroactively seek informed consent once the public health laboratory determines the biospecimen will be utilized for research. The former would be burdensome and the latter almost impossible especially if the biospecimen has been de-identified. It is clear that the NPRM has been written towards institutions who have the primary intent of research for stored biospecimens. Because public health laboratories are multi-functional and provide a wide array of public health services, including research, the NPRM's informed consent storage parameters do not work without overly burdening the public health laboratory. To assist public health laboratories, OHRP should allow storage of biospecimens for public health purposes outside the scope of the Common Rule.

3. Requiring broad informed consent for biospecimens collected during clinical encounters will deplete the quantity and diversity of biospecimens available to public health laboratories. In addition to the required Secretary's broad consent form, many states and institutions will be required to develop their own informed consent forms to cover their individual interests. This will lead to inconsistencies in informed consent practices at the community and state level and may necessitate the patient to complete multiple informed consent forms required by different entities. Quality research depends on having a representative sample from across the community, and APHL is concerned that varying informed consent practices will lead to under-representation or over-representation of specific populations, which could skew the performance of a test. Under-representation and over-representation of specific populations (e.g. based on race, ethnicity, educational level, etc.) would also diminish "justice," which is the ethical concept that all populations share both in the benefits and burdens of research.
4. Virtually all biospecimens submitted to public health laboratories are collected in a clinical setting during a patient encounter. Not only is research not the primary purpose of the collection, but it is frequently the case that the public health significance of the biospecimen and requirements for submission to the public health laboratory is not known to the health care provider at the time of collection. The NPRM provides no incentive for physicians or clinics to routinely obtain broad consent for all biospecimens, and because of this additional administrative burden, it is likely very few clinical providers will obtain consent. While the NPRM language indicates that specimens may be collected and submitted for testing under the public health surveillance exclusion, the NPRM does not specify that storage of the excluded

biospecimens is permitted. OHRP should exclude storage of biospecimens of public health interest from the broad consent requirement with the stipulation that genomic testing to generate information about the subject is prohibited.

5. While APHL appreciates the exclusion of public health surveillance from the Common Rule, we are concerned that OHRP's definition does not fully realize the scope and depth of public health surveillance (NPRM Question 8). As written, the surveillance definition and the examples provided are focused on acute infectious disease surveillance. While this is a critical component of public health surveillance, it is not the only surveillance activity should be excluded from the Rule. Chronic disease surveillance and biomonitoring for toxic chemical compounds and metabolites in humans are critical public health practices and should not be limited by the Common Rule exclusion. Similar to infectious disease surveillance, chronic disease surveillance monitors the prevalence and incidence of chronic diseases, determines risk factors to inform prevention practices and informs public health professionals and policy makers on decision making. These activities may use residual de-identified biospecimens for non-research purposes and would be similarly adversely impacted by the required informed consent practices outlined in the Common Rule. APHL encourages OHRP to reconsider and broaden the definition of public health surveillance to include the practice of chronic disease surveillance.
6. Even if broad informed consent was obtained in clinical settings, documenting such informed consent will require public health laboratories to develop a system to collect and track the information. The information systems of most public health laboratories are specimen-based and are not configured to track informed consent, requiring an investment in information technology. Determining whether healthcare providers, clinical laboratories, or institutions have obtained broad informed consent and tracking of consented and unconsented specimens will be overly burdensome and cost prohibitive to implement.

**Overall, APHL urges OHRP to consider the following recommendations when finalizing the changes to the Common Rule:**

1. Add prohibitions to prevent re-identification of de-identified biospecimens
  - In public health practice, it is necessary for public health laboratories to identify individuals who have reportable diseases, conditions or exposures for public health practice purposes. However, when public health laboratories conduct research, de-identified biospecimens are used, and there is no intent to identify individuals whether it is for infectious disease testing, newborn screening, biomonitoring or next generation sequencing of pathogens. Public health research is primarily focused on new test development; research in which the identity of the individual is of no interest to the public health laboratory. If there is public concern about re-identification of biospecimens that were initially collected during a clinical encounter, OHRP should develop an exclusion category that would allow the storage and use of de-identified

biospecimens if institutions declare they have no intent or use to re-identify. Additionally, the NPRM should develop and address penalties for any wrongful attempt to re-identify an individual from a residual biospecimen.

2. Clearly define biospecimen (NPRM Question 2)

- It is inappropriate to determine the definition of biospecimens simply by the presence of human nucleic acids as suggested in the NPRM. The simple presence of human nucleic acids leaves the definition too broad, as human DNA can be found in many objects that would not be considered biospecimens. For example, a recent news story reported finding human DNA in hot dogs and sausages.<sup>1</sup> If OHRP means to address the concerns of the public over autonomy and identifiability, the intended research use of the biospecimens must be a factor.
- Specific intent to identify the individual from a de-identified biospecimen should be the main criteria in which OHRP defines a biospecimen.

3. Add clarifying language that excludes the development and use of test methods for metagenomic whole genome sequencing when the intended use is to identify bacterial, viral or microbial pathogens from the Common Rule.

- At OHRP's October 20, 2015 Town Hall, APHL submitted a question to clarify if the Common Rule's scope oversees sequencing that intends to only detect and analyze pathogens (any human genomic data would be filtered out). The answer APHL received was that if human genomic data were to be filtered out and sequences were only going to be used to identify pathogen genomic data, this would not be considered human subject research and would fall outside the scope of the Common Rule. APHL would like to see this formalized as a clarifying statement in OHRP's revisions.

4. Broad consent to secondary research use of information and biospecimens collected for non-research purposes should be permissible without a time boundary (NPRM Question 61). The proposed 10 year time limit will create an unnecessary administrative burden for public health laboratories to track and catalogue informed consent expiration dates.

5. The proposed changes need to explicitly define "research," what research activities fall under the purview of the Common Rule, and if the Common Rule only addresses federally funded research.

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<sup>1</sup> <http://abcnews.go.com/Health/hot-dogs-sausages-studied-human-dna-report/story?id=34739080>

- It is essential for OHRP to heed the difference between basic research, translational research and public health practice.<sup>2,3</sup>
  - APHL recommends that the definition of basic research be defined on the intent of producing generalizable knowledge and studies that are deemed investigational, not translational or relevant to public health practice.
6. APHL recommends an exclusion or exemption from the Common Rule when public health authorities determine the need to develop new testing methods in relation to a public health emergency declared by a local, state or federal public health entity. When public health laboratories need to respond rapidly to emerging pathogens or major environmental disasters, it is necessary to define a pathway in which de-identified biospecimens can be utilized to allow a prompt public health response. Any delays or barriers caused by the requirement of the public health laboratory to collect informed consent would have major consequences on the public health response.
7. When state or local authorities determine there is a public health need to mandate testing and a public health laboratory must develop a test to fulfill the mandate, APHL recommends that this type of translational research be excluded from the Common Rule.
- In this situation, the end result of such activity is to establish a testing method to be validated for screening and diagnostic use and not generalizable knowledge. There are cases in which a state’s legislature will mandate a public health laboratory to implement a screening program for a specific genetic condition. Sometimes, these mandates do not consider whether there are accurate and reliable testing methods currently available, which will leave public health laboratories responsible to develop and validate a method from scratch. When the public health laboratory is responding to a government mandate under a compressed timeframe, and the primary intent of the activity is to comply with the mandate, it should be excluded from the Common Rule.

**APHL appreciates OHRP:**

- Excluding validation, verification and proficiency testing activities
- Excluding quality assurance, quality control and quality improvement activities
- Allowing the storage and use of known “positive” or “negative” biospecimens to be utilized in test development without obtaining consent

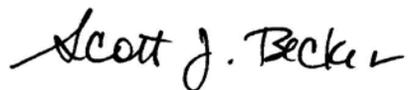
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<sup>2</sup> Centers for Disease Control and Prevention. (2010). *Distinguishing public health research and public health non-research*. Retrieved from <http://www.cdc.gov/od/science/integrity/docs/cdc-policy-distinguishing-public-health-research-nonresearch.pdf>

<sup>3</sup> Council of State and Territorial Epidemiologists. (2004). *Public health practice vs. public health research: a report for public health practitioners including cases and guidance for making distinctions*. Retrieved from <http://www.cste.org/pdffiles/newpdffiles/CSTEPHResRptHodgeFinal.5.24.04.pdf>

APHL appreciates the opportunity to provide recommendations to OHRP and to help shape revisions to the Common Rule. For more information, please contact Celia Hagan, APHL's Senior Specialist of Public Policy at [celia.hagan@aphl.org](mailto:celia.hagan@aphl.org) or 240-485-2758. APHL looks forward to continue conversations with OHRP as modifications are made to the Common Rule.

Sincerely,

A handwritten signature in black ink that reads "Scott J. Becker". The signature is written in a cursive style with a checkmark at the end.

Scott J. Becker, MS  
Executive Director  
Association of Public Health Laboratories

*APHL works to strengthen laboratory systems serving the public's health in the U.S. and globally. APHL's member laboratories protect the public's health by monitoring and detecting infectious and foodborne diseases, environmental contaminants, terrorist agents, genetic disorders in newborns and other diverse health threats.*

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# About APHL

## **What is APHL?**

APHL is the national nonprofit representing governmental laboratories that protect the public's health by detecting and monitoring health threats, such as the "H1N1" flu. Members include state, territorial and local public health labs; state environmental testing labs; state agricultural and food safety labs; and individual scientists, public health officials and academicians.

## **How do these 'governmental laboratories' help the American public?**

Public health labs across the country work to detect, identify and monitor:

- Infectious disease outbreaks.
- Chemical contaminants in people and the environment.
- Foodborne illness clusters.

## **What else do they do?**

- Screen newborns for genetic and metabolic conditions.
- Respond to natural disasters, industrial accidents and suspected biological, chemical or radiological terrorism.
- Support enforcement of water, food, dairy and environmental safety laws through testing.
- Monitor disease trends and develop new laboratory technologies.
- Contribute to the formulation of state and national health policies.

## **How does APHL support these labs?**

APHL is the nexus for the country's network of laboratories with public health mandates: a hub for information exchange among members and between the APHL membership and external partners. By linking these partners, APHL safeguards the public's health. The association has longstanding relationships with the Centers for Disease Control and Prevention (CDC) and other federal health agencies. In 1999, APHL, CDC and the FBI founded the Laboratory Response Network—an integrated group of public and private sector laboratories that function as laboratory first responders to terrorism, emerging infectious disease and other public health crises.

## **How does APHL contribute to the formulation of state and national health policies?**

APHL bridges the gap between science and public health policy through its education and advocacy program. APHL is known in Washington, DC, as an authoritative voice on laboratory-related health issues, including emerging infectious diseases, human exposure to environmental toxicants, genetic testing, terrorism preparedness and others.

## **Why is ongoing laboratory training critical in public health labs, and how does APHL meet that need?**

Not only are technological advances making older laboratory techniques obsolete, health threats themselves are evolving at a rapid rate. The cutting-edge science practiced in public health, environmental-testing and agricultural laboratories requires a highly trained and adaptable workforce. APHL has a 20-year history

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as a provider of high quality education. While there are other continuing education providers, APHL fills a crucial niche by focusing on topics of fundamental public health importance. Some—like rabies testing—are addressed nowhere else. Each year, the National Laboratory Training Network—co-sponsored by APHL and CDC—delivers hundreds of courses to tens of thousands of scientists on topics ranging from parasitic diseases to chemical terrorism. APHL and CDC also cosponsor two fellowship programs.

### **Other than training, is APHL involved with public health laboratory workforce issues?**

The US is in the midst of a severe shortage of laboratory scientists, a development that threatens the operations of public health laboratories. Alarming, the shortage is most acute for technical and managerial positions at the top of the career ladder. An entire cohort of highly trained government scientists is retiring while fewer students are entering the profession. The result is a serious leadership gap.

Anticipating this challenge, in 2003 APHL launched the National Center for Public Health Laboratory Leadership. Its mission is to attract new laboratorians into public health and to prepare current and emerging laboratory leaders with the skills needed to succeed in a rapidly evolving field.

### **What is APHL's role in development of laboratory science and laboratory systems?**

Science is the heart of the laboratory and an important focus for APHL. The association and its members routinely coordinate or collaborate in the development of new assays and testing algorithms to capitalize on

scientific advances and to find alternatives to conventional methods when needed.

Because quality laboratory practice is APHL's overarching goal, it supports the proven route to quality: a systems approach to laboratory practice that treats discrete functions and entities as part of a larger, integrated system. This applies equally to systems within individual laboratories, between partner institutions and across laboratory networks. APHL bolsters laboratory systems through model practices, research and network support.

### **Do APHL's efforts stop at the US border?**

Because our nation's health is affected by global events, strengthening national laboratory systems worldwide is at the core of APHL's mission. APHL's Global Health Program, its largest initiative, works with national health systems in more than 20 resource-constrained nations in Asia, Africa, South America and the Caribbean to extend the reach of laboratory-based disease surveillance, advance in-country health objectives and reduce the burden of endemic diseases such as HIV/AIDS and TB. It develops and supports training programs, strategic planning, collaborations and other services to build the capacity and capability of national laboratory systems to provide accessible, quality testing services and support timely disease monitoring and response.

## **MORE INFORMATION**

For more information on the Association of Public Health Laboratories, contact Jody DeVoll, 240.485.2753, [jody.devoll@aphl.org](mailto:jody.devoll@aphl.org); check our website [www.aphl.org](http://www.aphl.org); read our blog [www.aphl.org/lablog/Pages/default.aspx](http://www.aphl.org/lablog/Pages/default.aspx)  and follow us on Twitter <http://twitter.com/APHL> .

To find out more about public health laboratories, view our fact sheet.

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