

The Ohio State University Combined Consent to Participate In Research and HIPAA Research Authorization

Study Title: The BE WELL study: Black Raspberry Beverage Working to Prevent Lung Cancer

Principal Investigator: Daniel Spakowicz

Sponsor: Intramural Research Program, The Ohio State University and National Institutes of Health (NIH)

- 4
- 5 **This is a consent form for research participation.** It contains important information
6 about this study and what to expect if you decide to participate. Please consider the
7 information carefully. Feel free to discuss the study with your friends and family and
8 to ask questions before making your decision whether or not to participate.
 - 9 **Your participation is voluntary.** You may refuse to participate in this study. If you
10 decide to take part in the study, you may leave the study at any time. No matter what
11 decision you make, there will be no penalty to you and you will not lose any of your
12 usual benefits. Your decision will not affect your future relationship with The Ohio
13 State University. If you are a student or employee at Ohio State, your decision will
14 not affect your grades or employment status.
 - 15 **You may or may not benefit as a result of participating in this study.** Also, as
16 explained below, your participation may result in unintended or harmful effects for
17 you that may be minor or may be serious depending on the nature of the research.
 - 18 **You will be provided with any new information that develops during the study
19 that may affect your decision whether or not to continue to participate.** If you
20 decide to participate, you will be asked to sign this form and will receive a copy of the
21 form. You are being asked to consider participating in this study for the reasons
22 explained below.

23 24 Key Information About This Study

25 The following is a short summary to help you decide whether or not to be a part of this study.
26 More detailed information is listed later in this form.

27
28 *The purpose of this research:*

29 To test whether black raspberry nectar can have positive effects on your health. In particular,
30 whether they will change the bacteria in your gut in a way that reduces inflammation.

31
32 *The study duration:*

33 10 weeks total. For four weeks you'll drink two juice boxes per day, then take two weeks off,
34 then another four weeks of 2 juice boxes per day.

35

36 *The research procedures to be followed:*

37 You'll be asked to avoid berries and a few other foods in your diet for the duration of the
38 study. There are four study visits, where we'll collect (1) stool, (2) urine, (3) blood, weight,
39 heart rate and blood pressure. Stool will be collected at home and brought into clinic. Urine
40 will be collected for 24 hours prior to the study visit. We ask that you do not quit or start
41 smoking during this period.

42

43 *The most important risks or discomforts:*

44 This is a food product with low risks. You may experience some upset stomach or diarrhea,
45 and there is a low risk of an allergic reaction.

46

47 *The reasonably expected benefits:*

48

49 The anticipated benefits of this study are to provide scientific information regarding the
50 effects of a black raspberry beverage on reducing inflammation, which may one day be
51 part of a strategy to reduce the risk of developing lung cancer.

52

53 1. Why is this study being done?

54 The study is being conducted to examine whether a black raspberry beverage can affect
55 the bacteria in your gut (your microbiome) and reduce inflammatory processes that may
56 lead to lung cancer. We will examine the impact of diet and smoking on gut bacteria and
57 inflammation in order to gain insight into the early steps in cancer development.

58

59 2. How many people will take part in this study?

60 Up to 96 participants will be recruited to take part in this study. 42 individuals will be
61 randomized by gender and current smoking status (does not include vaping) so that 21
62 individuals are in the Berry Intervention group and 21 in the Placebo group for the first 4
63 weeks, followed by a 2-week washout period, and then everyone will cross over to the
64 opposite group (Berry or Placebo) for the next 4 weeks.

65

66 3. What will happen if I take part in this study?

67 At the lung cancer screening visit, study staff will explain the study and will
68 inform you if you qualify for this study. If you decide to participate in this study,
69 the researcher will explain all details of the study and answer any questions you
70 might have. Once you have provided consent, we will set up several follow-up
71 appointments. You will then be scheduled for a randomization visit where you will
72 be randomly assigned (like the "flip of a coin") to either a control beverage
73 (containing berry flavor) or a test beverage (containing black raspberry
74 components); however, you will not be told which beverage you have received, but
75 the study staff will know the results of randomization. The study will require that
76 you drink $\frac{3}{4}$ cup of the beverage twice each day and follow a special diet that
77 excludes all types of berries and berry products (like strawberry jam) and limits the
78 amount of a few other foods (you will keep track of this using a checklist form).

79 An additional 4 visits to The Ohio State University, will include measuring your
80 weight and blood pressure, drawing blood and swabbing your nasal cavity, as well
81 as dropping off the stool and urine samples that you will bring with you. You will
82 receive reminders and detailed instructions prior to each visit.

83
84 *A detailed breakdown of study activities for each study visit can be found below:*
85

86 **Visit 0: Screening and Consent, Week -4-0 (30 minutes)**

- 87 • Sign informed consent, complete questionnaires
- 88 • Receive a urine collection container, stool collection materials and paperwork which will need to
89 be completed by next visit

90 **3 Days prior to Visit 1:**

- 91 • Begin dietary compliance form

92 **1 Day prior to Visit 1:**

- 93 • Begin urine collection: collect for 24 hours
- 94 • Collect stool

95 **Visit 1: Start of Trial, Phase I, Week 0 (30 minutes)**

- 96 • Submit a completed 24-hour urine collection
- 97 • Submit stool collection tube
- 98 • Blood collection (3 tubes, ~4.5 teaspoons)
- 99 • Nasal swab
- 100 • Vital Signs (blood pressure, heart rate, and respiratory rate)
- 101 • Body measurements (weight, height)
- 102 • Receive a urine collection container, stool collection materials and paperwork which will need to
103 be completed by next visit
- 104 • Receive nectar or placebo drink
- 105 • Receive \$50 compensation

106 **Begin Daily Beverage Compliance Form (to be completed each day of the study while drinking
107 beverage)**

108 **3 Days prior to Visit 2:**

- 109 • Begin dietary compliance form

110 **1 Day prior to Visit 2:**

- 111 • Begin urine collection: collect for 24 hours
- 112 • Collect stool

113 **Visit 2 End of Phase I, Begin Washout Period:**

- 114 • Submit a completed 24-hour urine collection
- 115 • Submit stool collection tub and tube
- 116 • Blood collection (3 tubes, ~4.5 teaspoons)
- 117 • Nasal swab
- 118 • Vital Signs (blood pressure, heart rate, and respiratory rate)
- 119 • Body measurements (weight, height)
- 120 • Receive a urine collection container, stool collection materials and paperwork which will need to
121 be completed by next visit
- 122 • Receive \$50 compensation

123 **3 Days prior to Visit 3:**

- 130 • Begin dietary compliance form
131

132 **1 Day prior to Visit 3:**

- 133 • Begin urine collection: collect for 24 hours
134 • Collect stool
135

136 **Visit 3: Phase II, Week 6 (30 minutes)**

- 137 • Submit a completed 24-hour urine collection
138 • Submit stool collection tube
139 • Blood collection (3 tubes, ~4.5 teaspoons)
140 • Nasal swab
141 • Vital Signs (blood pressure, heart rate, and respiratory rate)
142 • Body measurements (weight, height)
143 • Receive a urine collection container, stool collection materials and paperwork which will need to
144 be completed by next visit
145 • Receive nectar or placebo drink
146 • Receive \$50 compensation

147 **3 Days prior to Visit 4:**

- 148 • Begin dietary compliance form
149

150 **1 Day prior to Visit 4:**

- 151 • Begin urine collection: collect for 24 hours
152 • Collect stool
153

154 **Visit 4: End of trial, Week 10 (30 minutes)**

- 155 • Submit a completed 24-hour urine collection
156 • Submit stool collection tub and tube
157 • Blood collection (3 tubes, ~4.5 teaspoons)
158 • Nasal swab
159 • Vital Signs (blood pressure, heart rate, and respiratory rate)
160 • Body measurements (weight, height)
161 • Receive \$50 compensation

162 **4. How long will I be in the study?**

163 The study will require 4 visits over 10-week period. At your lung screening the study
164 coordinator will determine if you qualify for the study. If you qualify, you will be enrolled
165 for the full 4-visit study. Each visit will last about 30 minutes and will include collection
166 of study materials, drawing blood, a nasal swab, body measurements and giving out new
167 materials. Home preparation before each visit will require no more than 1 hour.
168

169 **5. Can I stop being in the study?**

170 You may leave the study at any time. If you decide to stop participating in the study, there
171 will be no penalty to you, and you will not lose any benefits to which you are otherwise
172 entitled. Your decision will not affect your future relationship with The Ohio State
173 University.
174

175 **6. What risks, side effects or discomforts can I expect from being in the study?**

178 The physical risks associated with this study are believed to be low. There are no known
179 side effects of the diet in this study. The beverages contain black raspberries, or products
180 approved by the FDA for use in foods and found in beverages such as Kool-Aid™. The
181 beverages may cause temporary discoloration of teeth; short-term gastrointestinal side
182 effects, such as diarrhea; and there is a small chance of an allergic reaction. Symptoms of
183 an allergic reaction include throat tightness; itching or tingling mouth; skin rashes, such
184 as hives or eczema; itchy skin; wheezing; cough; congestion; nausea; stomach pains;
185 vomiting; diarrhea; dizziness; lightheadedness. There is a reported association between
186 red food dye and hyperactivity in some children. The dose used in this study has been
187 demonstrated to be safe in previous human research.

188
189 The nasal swab can result in minimal bleeding and irritation that resolves in 1-2 days.
190 Risks of blood draws may include lightheadedness or fainting, as well as localized pain,
191 bleeding/bruising, swelling, or infection at the blood collection site.

192
193 Though it is a food product, the effect of these beverages on an embryo or fetus is
194 currently unknown. You cannot take part in this study if you are pregnant or
195 breast-feeding a child. You must agree not to become pregnant while you are in
196 this study.

197
198 Research using your specimens will include measuring your RNA (transcriptome
199 sequencing), which could potentially identify you. However, no genetic test results will be
200 shared with you, released to your physician or be included as part of your medical record.

201
202 **7. What benefits can I expect from being in the study?**

203 You may not benefit directly from participating in this study, as the benefits of the berry
204 products are still being investigated and modest at best over such a short period of time.
205 Rather, the greatest benefits likely will be to scientific research and the greater public
206 with regards to information about berry products' effects on the microbiome,
207 inflammation and lung cancer risk.

208
209 **8. What other choices do I have if I do not take part in the study?**

210
211 You may choose not to participate without penalty or loss of benefits to which you are
212 otherwise entitled.

213
214 **9. What are the costs of taking part in this study?**

215 All study-related procedures and tests will be performed at no cost to you. This includes
216 paid parking at each of your four study visits.

217
218 **10. Will I be paid for taking part in this study?**

219 Yes, you will receive a \$50 in Amazon or Walmart gift cards for completing each visit
220 (Week 0, 4, 6, 10). In total, you will earn \$200.

221
222 By law, payments to participants are considered taxable income
223

224 **11. What happens if I am injured because I took part in this study?**

225
226 If you suffer an injury from participating in this study, you should notify the researcher or
227 study doctor immediately, who will determine if you should obtain medical treatment at
228 The Ohio State University Wexner Medical Center.

229
230 The cost for this treatment will be billed to you or your medical or hospital insurance. The
231 Ohio State University has no funds set aside for the payment of health care expenses for
232 this study.

233
234 **12. What are my rights if I take part in this study?**

235
236 If you choose to participate in the study, you may discontinue participation at any time
237 without penalty or loss of benefits. By signing this form, you do not give up any personal
238 legal rights you may have as a participant in this study.

239
240 You will be provided with any new information that develops during the course of the
241 research that may affect your decision whether or not to continue participation in the
242 study.

243
244 You may refuse to participate in this study without penalty or loss of benefits to which
245 you are otherwise entitled.

246
247 An Institutional Review Board responsible for human subject research at The Ohio State
248 University reviewed this research project and found it to be acceptable, according to
249 applicable state and federal regulations and University policies designed to protect the
250 rights and welfare of research participants.

251
252 **13. Will my de-identified information and bio-specimens be used or shared for
253 future research?**

254
255 Yes, de-identified data will be made publicly available upon publication to support the
256 reproducibility of the published analyses.

257
258 **14. Will my study-related information be kept confidential?**

259
260 Efforts will be made to keep your study-related information confidential. However, there
261 may be circumstances where this information must be released. For example, personal
262 information regarding your participation in this study may be disclosed if required by state
263 law.

265 Also, your records may be reviewed by the following groups (as applicable to the
266 research):

- 267 • Office for Human Research Protections or other federal, state, or international
268 regulatory agencies;
- 269 • U.S. Food and Drug Administration;
- 270 • The Ohio State University Institutional Review Board or Office of Responsible
271 Research Practices;
- 272 • The sponsor supporting the study, their agents or study monitors; and
- 273 • Your insurance company (if charges are billed to insurance).

274
275 We will work to make sure that no one sees your survey responses without approval. But,
276 because we are using the Internet, there is a chance that someone could access your online
277 responses without permission. In some cases, this information could be used to identify
278 you. Your data will be protected with a code to reduce the risk that other people can view
279 the responses.

280
281 The NIH has issued a Certificate of Confidentiality for this study. This Certificate provides
282 extra protection for you and your study information, documents, or samples (blood, tissue,
283 etc.). The Certificates are issued so that we cannot be required to disclose any identifiable,
284 sensitive information collected about you as a part of this study in a lawsuit or legal
285 proceeding. We are also prevented from releasing your study information without your
286 consent. This is a layer of protection over and above the already existing protections in
287 place for you and your information, documents, or samples.

288
289 However, these protections do not apply in some situations. For example, we may have to
290 release your information if a law requires us to do so, the Agency that is funding this study
291 requests the information, or if the FDA tells us to release this information. We may also use
292 your information to conduct other scientific research as allowed by federal regulations.

293
294 Study information that has health implications may be placed in your medical record where
295 authorized employees may see the information. Further, authorized requests for your
296 records (medical record release for continuity of care) may result in research-related
297 information being released.

298
299 Please talk to your study team, or contact the Office of Responsible Research Practices at
300 614-688-8641, if you have questions.

301
302 A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as
303 required by U.S. law. This website will not include information that can identify you. At
304 most, the website will include a summary of the results. You can search this website at any
305 time.

308 **15. HIPAA AUTHORIZATION TO USE AND DISCLOSE INFORMATION FOR**
309 **RESEARCH PURPOSES**

311 **I. What information may be used and given to others?**

- 313 • Past and present medical records;
- 314 • Research records;
- 315 • Records about phone calls made as part of this research;
- 316 • Records about your study visits;
- 317 • Information that includes personal identifiers, such as your name, or a number
318 associated with you as an individual;
- 319 • Information gathered for this research about:
 - 320 HIV / AIDS
 - 321 Hepatitis infection
 - 322 Sexually transmitted diseases
 - 323 Other reportable infectious diseases
 - 324 Physical exams
 - 325 Laboratory, x-ray, and other test results
 - 326 Diaries and questionnaires
 - 327 The diagnosis and treatment of a mental health condition

329 **II. Who may use and give out information about you?**

330 Researchers and study staff.

333 **III. Who might get this information?**

- 335 • Authorized Ohio State University staff not involved in the study may be aware that
336 you are participating in a research study and have access to your information;
- 337 • If this study is related to your medical care, your study-related information may be
338 placed in your permanent hospital, clinic, or physician's office record;

340 **IV. Your information may be given to:**

- 342 • The U.S. Food and Drug Administration (FDA), Department of Health and Human
343 Services (DHHS) agencies, and other federal and state entities;
- 344 • Governmental agencies in other countries;
- 345 • Governmental agencies to whom certain diseases (reportable diseases) must be
346 reported; and
- 347 • The Ohio State University units involved in managing and approving the research
348 study including the Office of Research and the Office of Responsible Research
349 Practices.

351 **V. Why will this information be used and/or given to others?**

- 352
- 353 • To do the research;
 - 354 • To study the results; and
 - 355 • To make sure that the research was done right.

356 **VI. When will my permission end?**

357 There is no date at which your permission ends. Your information will be used
359 indefinitely. This is because the information used and created during the study may be
360 analyzed for many years, and it is not possible to know when this will be complete.

362 **VII. May I withdraw or revoke (cancel) my permission?**

363 Yes. Your authorization will be good for the time period indicated above unless you
365 change your mind and revoke it in writing. You may withdraw or take away your
366 permission to use and disclose your health information at any time. You do this by
367 sending written notice to the researchers. If you withdraw your permission, you will not
368 be able to stay in this study. When you withdraw your permission, no new health
369 information identifying you will be gathered after that date. Information that has already
370 been gathered may still be used and given to others.

372 **VIII. What if I decide not to give permission to use and give out my health
373 information?**

375 Then you will not be able to be in this research study and receive research-related
376 treatment. However, if you are being treated as a patient here, you will still be able to
377 receive care.

379 **IX. Is my health information protected after it has been given to others?**

381 There is a risk that your information will be given to others without your permission. Any
382 information that is shared may no longer be protected by federal privacy rules.

384 **X. May I review or copy my information?**

386 Signing this authorization also means that you may not be able to see or copy your study-
387 related information until the study is completed.

390 **16. Who can answer my questions about the study?**

393 For questions, concerns, or complaints about the study, or if you feel you have been
394 harmed as a result of study participation, you may contact **Dr. Marisa Bittoni at (614)**
395 **398-1032.**

396
397 For questions related to your privacy rights under HIPAA or related to this research
398 authorization, please contact **Kathleen Ojala at (614) 293-6482 or**
399 **Kathleen.Ojala@osumc.edu**

400
401 For questions about your rights as a participant in this study or to discuss other study-
402 related concerns or complaints with someone who is not part of the research team, you
403 may contact **the Office of Responsible Research Practices at 1-800-678-6251.**

404
405 If you are injured as a result of participating in this study or for questions about a study-
406 related injury, you may contact **Dr. Steve Clinton at 614-293-2886.**

407
408

409 Signing the consent form

410
411 I have read (or someone has read to me) this form and I am aware that I am being asked to
412 participate in a research study. I have had the opportunity to ask questions and have had them
413 answered to my satisfaction. I voluntarily agree to participate in this study.

414
415 I am not giving up any legal rights by signing this form. I will be given a copy of this
416 combined consent and HIPAA research authorization form.

417

Printed name of participant

Signature of participant

AM/PM

Date and time

Printed name of person authorized to consent for
participant (when applicable)

Signature of person authorized to consent for participant
(when applicable)

AM/PM

Relationship to the participant

Date and time

418
419
420 Investigator/Research Staff

421
422 I have explained the research to the participant or his/her representative before requesting the
423 signature(s) above. There are no blanks in this document. A copy of this form has been given
424 to the participant or his/her representative.

425

Printed name of person obtaining consent

Signature of person obtaining consent

AM/PM

Date and time

426
427
428 Witness(es) - May be left blank if not required by the IRB

Printed name of witness

Signature of witness

AM/PM

Date and time

Printed name of witness

Signature of witness

AM/PM

Date and time

429