

SOP 603A: Veterans Affairs Medical Center

1. POLICY (Applies to HSC only)

Under an agreement between the Board of Regents of the University of Oklahoma Health Sciences Center (HSC) and Veterans Affairs Medical Center (VAMC) Oklahoma City, the HSC Institutional Review Board (IRB) has been designated as an IRB of record for review of human participant research conducted at the VAMC in Oklahoma City. The agreement establishes the provision of services provided by the IRB to the VAMC and outlines the responsibilities of the IRB and VAMC.

Under a separate agreement between HSC and Jack C. Montgomery VA Medical Center in Muskogee (Muskogee VAMC), the HSC IRB has been designated as an IRB of record for review of human participant research conducted at the Muskogee VAMC. The agreement establishes the provision of services provided by the IRB to the Muskogee VAMC and outlines the responsibilities of the IRB and Muskogee VAMC.

The Oklahoma City and Muskogee VAMC's have a separate agreement with the VA Central IRB (VA-CIRB) in Washington DC for the approval of VA-funded clinical trials. The VA-CIRB is listed on all applicable FWA's.

It is the policy of the HSC IRB to apply the requirements of 38 CFR Parts 16 and 17 and all applicable VHA Handbook provisions to all VA-regulated research.

Veterans Affairs (VA) research is defined as research that is approved by the VA Research and Development Committee (R&DC) and conducted by VA investigators including Principal Investigators (PIs), Co-Principal Investigators (Co-PIs), and Site Investigators on VA time (serving on compensated, without compensation [(WOC)], or Intergovernmental Personnel Agreement [(IPA)] appointments), utilizing VA resources (e.g., equipment), or on VA property including space leased to and used by the VA. The research may be funded by VA, by other sponsors or be unfunded. Research conducted by non-VA investigators that does not utilize VA resources and that occurs on space, or with equipment, leased from VA or covered under a use agreement between the VA and a non-VA entity is not considered VA research.

Classified research involving human participants cannot be approved by a VA facility, IRB, or Research and Development Committee or performed at VA facilities.

Specific Policies

1.1 OUHSC IRB and VAMC Research and Development

A. Proposed research to be conducted at the Oklahoma City or Muskogee VAMC requires prospective approval by both the HSC IRB and the Oklahoma City VAMC (OKCVAMC) Research and Development Committee (R&D), per applicable SOPs 401: Research Exempt from IRB Review; SOP 402: Expedited Review; or SOP 403: Initial Review – Criteria for IRB Approval.

B. Continuing review of and modifications to on-going research conducted at the Oklahoma City or Muskogee VAMC are subject to SOP 404: Continuing Review; and SOP 405: Modifications; respectively.

C. Research projects involving international sites are subject to SOP 502K and VHA Handbook 1200.05.

1.2 Consent Requirements for VA Research Projects

1.2.1 General VA Consent Requirements

A. VA Form 10-1086

1. For VA Research, consent is documented through the use of VA Form 10-1086, VA Research Consent Form. The requirement to utilize VA Form 10-1086 to document informed consent applies to all VA-approved research including, but not limited to, studies in which VA investigators working on VA research enroll subjects at the affiliate hospital or other sites outside VA (e.g., community centers or shopping malls).

2. The VA Form 10-1086 must include all elements required by the Common Rule, as well as any additional elements required by the IRB. It includes VA required language and the requirements for the signature and date of the participant and the person obtaining consent. The signature and date of the witness may be included if required by the sponsor, IRB, the investigator, or others. The witness is required to observe only the participant's or participant legally authorized representative's signature, not the consent process, unless the Sponsor or IRB requires the witness to observe the consent process. The witness cannot be the person who obtained consent from the participant, but may be another member of the study team or may be a family member. A witness signature is always required when a short form consent is employed (see subparagraph. 33f(2) VHA Handbook 1200.05).

3. The most current IRB-approved version of VA Form 10-1086 for each study (or the most current IRB-approved electronic version of VA Form 10-1086) must be used as the informed consent document. The only exception to requiring the use of VA Form 10-1086 is that a DoD consent document may be employed for active duty military personnel participating in VA research at DoD sites when VA-specific language is not necessary.

4. IRB approval of the VA informed consent document is documented through the use of a stamp on each page of the VA Form 10-1086 that indicates the date of the most recent IRB approval. The IRB approval must be documented in the IRB minutes or IRB research project files for those studies reviewed by the expedited process. IRB correspondence with the investigator must clearly indicate which version of the informed consent document has been approved (e.g., see the example in subparagraph 33a(2) VHA Handbook 1200.05). The IRB approval date must be documented by the use of a stamp or preprinted box on each page of the informed consent documents. This stamp or preprinted box must indicate the most recent date of IRB approval of the informed consent documents. The IRB must maintain a copy of the approved informed consent documents in its records.

B. Additional consent elements:

1. In addition to the elements for informed consent required by the 38 CFR Part 16 and the IRB, the VA requires the following elements for informed consent:
 - a) The Name of the study.
 - b) The Name of the PI. The name of the PI and, in multi-site studies, the name of the Local Site Investigator (LSI).
 - c) The Sponsor of the study.
2. When appropriate, the VA requires one or more of the following elements of information be provided to each participant. Also, when any of these additional elements are appropriate, the VA requires them to be documented in the IRB-approved informed consent document, unless documentation of informed consent is waived.
 - a) Commercial Product. If applicable, that the investigator believes that the human biologic specimens obtained could be part of, or lead to the development of, a commercially valuable product.
 - b) Future Use of Specimens. If the specimens are to be retained after the end of the study for future research, where the specimens will be retained, who will have access to them, and how long they will be retained. Current applicable institutional, VA, and other Federal requirements must be met for handling, use, and storage of biologic specimens and data (see VHA Handbook 1200.12).
 - c) Future Use of Data. If any of the data will be retained after the study for future research, where the data will be stored and who will have access to the data (see VHA Handbook 1200.12). Current applicable University, VA, and other federal requirements must be met for use and storage of data (see VHA Handbook 1200.12).
 - d) Re-contact. If the participant will be re-contacted for future research, whether within VA or outside VA.
 - e) Payment for Participating in the Study. If appropriate, a statement regarding any payment the subject is to receive for participating in the study and how the payment is to be made (see paragraph 59).
 - f) Disclosure of Results. If the participant will receive a report of the aggregate results or any results specific to the participant.
 - g) Treatment to a participant injured by participation.
 - 1) Although the Common Rule at 38 CFR 16.116(a)(6) requires that the informed consent contain information on research-related injury only if the study is more than minimal risk, VA regulations (38 CFR 17.85) require the VA to provide care for all research-related injuries including those studies that are considered minimal risk.
 - 2) All VA Forms 10-1086 must include the required verbatim paragraph found on the local VA Form 10-1086 template. The

consent document needs to include language explaining the VA's authority to provide medical treatment to research participants injured by participation in a VA research project. The VA is required to provide care for all research-related injuries including those studies that are considered minimal risk even if a statement is not included in the consent document for research involving no greater than minimal risk.

- 3) A veteran-participant will not be required to pay for care received as a participant in a VA research project except in accordance with federal law and that certain veterans are required to pay co-payments for medical care and services provided by VA. Pursuant to 38 CFR 17.102, participants in VA-approved research cannot be charged, nor can their insurance be billed, for research-related interventions or procedures (e.g., tests, drugs, clinic visits, hospital admissions, transportation) that are required by the research project. If medical services are furnished to a person who is not eligible for medical services as a Veteran, the medical care appropriation will be reimbursed from the research appropriation.

h) Photographs, or voice or video recordings. If the research involves photographs, or voice or video recordings, the consent document for research must include a discussion of why photographs, or voice or video recordings are being taken for the research, the individuals who will have access to them, and what their disposition will be after the research is completed. The signed VA Form 10-3203 must be obtained and placed in the participant's medical record, as required in Section 1.2.3.1.b.14 below, even if the IRB has waived documentation of consent for research.

3. If someone other than the investigator conducts the informed consent process and obtains informed consent from a subject or the subject's Legally Authorized Representative (LAR), the investigator must formally and prospectively designate, in writing in the research project and/or the application for IRB approval, the individual who will have this responsibility (see subparagraph 9(j)(1) VHA Handbook 1200.05). The person(s) must be designated by utilizing the VA Delegation of Authority log. The person so designated must have received appropriate training to perform this activity. This person must be knowledgeable about the research to be conducted and the consenting process and must be able to answer questions about the study.
4. The original signed and dated informed consent form (see subparagraph 30(d)(2), VHA Handbook 1200.05) must be filed in the investigator's research file for that participant so that it is readily accessible for auditing. A copy of the signed and dated informed consent documents must be provided to the subject or the subject's LAR (38 CFR 16.117(a)). Where applicable, a copy of the signed and

dated informed consent documents must be placed in the medical record in accordance with VHA Handbook 1907.01.

5. All regulations pertaining to the participation of veterans as participants, including requirements for indemnification in case of research-related injury, pertain to non-veteran participants enrolled in VA-approved research.

C. Master List

1. Researchers are required to maintain a master list of all participants from whom consent has been obtained whether the IRB granted a waiver of documentation of consent.
2. Researchers must not add a participant's name to the master list of all participants until after:
 - a. Consent has been obtained from that participant, and
 - b. When appropriate, consent has been documented using an IRB-approved consent document.
3. The Researcher must secure the master list appropriately in compliance with all VA confidentiality and information security requirements in the Researcher's file for each study.
4. The IRB may waive the requirement for the investigator to maintain a master list for a given research project if both of the following conditions are met:
 - a. There is a waiver of documentation of the consent process, and
 - b. The IRB determines that including the participants on such a master list poses a risk to the participants from a breach of confidentiality.
5. If IRB waives the requirement to maintain such a master list, IRB must provide written documentation in the IRB minutes or IRB protocol file justifying the waiver.

1.2.2. VA Requirements for Written Consent Document (Short Form)

- A. The consent may be in the form of a short form written consent document stating that the elements of informed consent required in 38 CFR 16.116 have been presented orally to the subject or the subject's LAR (38 CFR 16.117(b)(2)). When this method is used, this process includes the following:
 1. There must be a witness to the oral presentation (38 CFR 16.117(b)(2)).
 2. The IRB must approve a written summary of what is to be said to the subject or the LAR (38 CFR 16.117(b)(2)).
 3. Signatures are to be obtained as follows:

- a) The short form is to be signed by the witness, and the subject or LAR (38 CFR 16.117(b)(2)).
 - b) The copy of the summary is to be signed by the witness and the person actually obtaining consent (38 CFR 16.117(b)(2)).
 - c) The IRB cannot waive the requirement for a witness or witness signature when the short form consent is employed.
4. A copy of the summary and a copy of the short form are to be given to the subject or the LAR (38 CFR 16.117(b)(2)).
 5. The original signed short form and summary must be filed in the investigator's research file for that subject.
 6. Where applicable (see VHA Handbook 1907.01), a copy of the signed short form must be placed in the medical record in accordance with VHA Handbook 1907.01.
 7. The investigator must file all original signed and dated short forms in the investigator's research file for that subject, so that they are readily accessible for auditing.

1.2.3 Progress Note Documenting the Consent Process

- A. A VHA health record must be created or updated, and a progress note created, for all research subjects (veterans or non-veterans) who are admitted to VA facilities as in-patients, treated as outpatients at VA facilities, or when research procedures or interventions are used in the medical care of the VA research subject at a VA facility or at facilities contracted by VA to provide services to Veterans (e.g., contract Community Based Outpatient Clinics "CBOCs" or contract nursing homes) (see VHA Handbook 1907.01).
 1. Health Record. A health record is required:
 - (1) When the research requires use of any clinical resources, such as radiology, cardiology (e.g., electrocardiogram, stress test, etc.), clinical laboratory, and pharmacy; or
 - (2) If the research intervention may lead to physical or psychological adverse events (see VHA Handbook 1907.01).
 2. What a Health Record Must Include. At a minimum, the health record must include the following information for an approved research study:
 - (1) The name of the study;
 - (2) The person obtaining the participant's informed consent;
 - (3) A statement that the participant or the participant's LAR was capable of understanding the informed consent process;
 - (4) A statement that the study was explained to the participant or the participant's LAR;
 - (5) A statement that the participant or the participant's LAR consented before participation in the study began;

- (6) A statement that the participant or the participant's LAR was given the opportunity to ask questions;
 - (7) A copy of the signed and dated research informed consent form (i.e., VA Form 10-1086) in accordance with VHA Handbook 1907.01;
 - (8) A copy of the HIPAA authorization for data use or disclosure (see VHA Handbook 1907.01);
 - (9) A copy of the initial enrollment progress note and other applicable progress notes (see VHA Handbook 1907.01);
 - (10) Information on possible drug interactions and/or toxicity of the pharmaceutical agents that are being administered to the subject because of the research (i.e., investigational drugs) (see VHA Handbook 1907.01);
 - (11) VA Form 10-9012, Investigational Drug Information Record, or superseding forms for investigational drugs as defined in VHA Handbook 1108.04 (see VHA Handbook 1907.01);
 - (12) A copy of any research results that are used for medical care (see VHA Handbook 1907.01);
 - (13) Information on all research and experimental interventions including potential risks, indications, and applicable progress notes see (see VHA Handbook 1907.01); and
 - (14) VHA Form 10-3203, Consent for Use of Picture and/or Voice, if applicable (see paragraph 54 VHA Handbook 1200.05).
- 3. Identifying Research Clinic Visits. A method to identify clinic visits solely for research (such as a note title) must be used to differentiate those visits from any other clinic visits. The research titled note may be included in the Crisis, Warnings, Allergies and/or Adverse Reactions, and Directives (CWAD) alerts (see VHA Handbook 1907.01).
 - 4. Non-Billing Events. Clinic visits and inpatient care for research purposes must be coded as non-billing events (see VHA Handbook 1907.01).
 - 5. When Access to Patient Health Records is No Longer Required for a Study. When access to patient health records is no longer required for a study, the study has been completed, or when authorization is revoked, the investigator or designee, must notify the facility Health Information Manager "HIM" program manager and, if applicable, the Information Security Officer "ISO" (see VHA Handbook 1907.01).
 - 6. Flagging a VHA Health Record. The IRB is required to determine whether the medical record must be flagged to protect the participant's safety by indicating participation in the research project and the source of more information on the research project. (See VHA Handbook 1907.01).

(1). Mandatory Flagging

- (A) The patient health record must be flagged if the subject's participation in the study involves:
- (a) Any invasive research procedure (e.g., muscle biopsy or bronchoscopy);
 - (b) Interventions that will be used in the medical care of the subject, or that could interfere with other care the subject is receiving or may receive (e.g., administration of a medication, treatment, or use of an investigational device);
 - (c) Clinical services that will be used in the medical care of the subject (e.g., orders for laboratory tests or x-rays ordered as a part of the study), or that could interfere with other care the subject is receiving or may receive; or
 - (d) The use of a survey or questionnaire that may provoke undue stress or anxiety unless the IRB determines that mandatory flagging is not in the best interests of the subject (e.g., an interview study of victims of sexual assault).
- (B) In other situations, the IRB determines if flagging is necessary.

(2) The IRB does not require medical records to be flagged if:

- (A) Participation in the research project involves only one encounter.
- (B) Participation in the research project involves the use of a questionnaire or previously collected biological specimens.
- (C) Identification as a participant in a particular research project (if the research project is not greater than minimal risk) would place the participant at greater than minimal risk.

(2). Flagged Health Record Contents If IRB determines and documents that the patient health record must be electronically flagged in Computerized Patient Record System (CPRS) as participating in a research study then, in accordance with VHA Handbook 1907.01, the health record must:

- (1) Identify the investigator, as well as contact information for a member of the research team who would be available at all times. **NOTE:** *The research team must have an appropriate member available (on-call) at all times.*
- (2) Contain information on the research study or identify where this information is available.

(3). Duration of Flagging. The duration of flagging is determined by local policy.

1.2.4 VA Research Involving Adults Who Lack the Ability to Consent/Surrogate Consent

A. Under appropriate conditions, the VA does allow investigators to obtain consent from the LAR of a subject (i.e., surrogate consent). Surrogate consent involving VA patients requires the approval of the VA Chief of Staff. (See VHA Handbook 1200.05 Section 36 for more requirements). If an Investigator is likely to approach adults who lack decision-making capacity, the IRB will evaluate the following:

- the proposed plan for the assessment of the capacity to consent is adequate,
- if assent of the participant is a requirement and if so, whether the plan for assent is adequate, and
- if a re-consenting process is necessary for participants with fluctuating decision-making capacity or those with decreasing capacity to give consent.

B. Investigators' Responsibilities for Surrogate Consent-Investigators must:

(1) Provide the IRB with a description of the procedures to ensure that subjects' LARs are well informed regarding their roles and obligations to protect persons who lack decision-making capacity and provide an explanation of the appropriate procedures for respecting their dissent.

(2) Provide information and disclosures (i.e., informed consent process and HIPAA authorization) to the subjects' LARs that would ordinarily be required by VHA Handbook 1200.05 to be made to the subjects themselves if they had decision-making capacity. The LAR shall be advised that the LAR's obligation is to try to determine what the participant would do if able to make an informed decision. If the prospective participant's wishes cannot be determined, the LAR shall be advised that the LAR is responsible for determining what is in the participant's best interest.

(3) If feasible, the investigator must explain the proposed research to the prospective research subject even when the surrogate gives consent. Although unable to provide informed consent, some persons may resist participating in a research (i.e., if they dissent) protocol approved by their representatives. Under no circumstances may a subject be forced or coerced to participate in a research study even if the LAR has provided consent.

C. Capacity to Consent

1. For VA research, an individual is presumed to have decision-making capacity unless the prospective participant is incompetent or has impaired decision-making capacity, as determined and documented by one or more of the following:

- a. A qualified practitioner documents in the individual's medical record in a signed and dated progress note that the individual lacks capacity to make the decision to participate in the proposed study. **NOTE:** *The qualified practitioner may be a member of the research team.* or
- b. The individual has been ruled incompetent by a court of law.

D. Who can be an LAR

1. For VA research, the LAR is defined as the following persons in the following order of priority:

- a. Health care agent (i.e., an individual named by the individual in a Durable Power of Attorney for Health Care (38 CFR.17.32(a)(iii));
- b. Legal guardian or special guardian;
- c. Next of kin in this order: a close relative of the patient 18 years of age or older, in the following priority: spouse, child, parent, sibling, grandparent, or grandchild; or
- d. Close friend.

NOTE: *The VA order of priority for next-of-kin differs from the order of priority under Oklahoma law. Check with VA Regional Counsel for state or local requirements for surrogate consent for research that may supersede VA requirements.*

2. An individual who is qualified as an LAR to provide informed consent on behalf of a prospective research subject may not always qualify as a personal representative for purposes of consent to use or disclose a human subject's PHI (i.e., signing a HIPAA authorization). Therefore, in circumstances involving authorization for use or disclosure of a human subject's PHI, the investigator must ensure the LAR meets the requirements of a personal representative (legal guardian or power of attorney) in HIPAA and the Privacy Act of 1974 prior to the LAR's signing a HIPAA authorization (A personal representative is a person who, under applicable law, has authority to act on behalf of another individual. This may include power of attorney, legal guardianship of an individual, the executor of an estate of a deceased individual, or someone under Federal, state, local, or tribal law with such authority (e.g., the parent of a minor) (See VHA Handbook 1605.1).

E. Capacity Questionable

1. If there is any question as to whether or not a potential adult subject has decision-making capacity, and there is no documentation in the medical record that the individual lacks decision making capacity, and the individual has not been ruled incompetent by a court of law, the investigator must consult with a qualified practitioner (who may be a member of the research

team) about the individual's decision-making capacity before proceeding with the informed consent process.

2. The IRB requires that the determination that a participant is incompetent or has an impaired decision-making capacity to be made by a legal determination or by a practitioner, after appropriate medical evaluation, that the prospective participant lacks decision-making capacity and is unlikely to regain it within a reasonable period of time.

3. Individuals who, because of a known condition, are at high risk for temporary (e.g., head trauma) or fluctuating (e.g., schizophrenia) lack of decision making capacity must be evaluated by a qualified practitioner (who may be a member of the research team) to determine the individual's ability to provide informed consent. This evaluation must be performed as described in the IRB-approved research project. If the individual is deemed to lack decision-making capacity at the time of participation in the research project, a LAR must provide informed consent. If the research participant regains decision-making capacity, the investigator or investigator's designee must repeat the informed consent process with the research participant and obtain consent to continue with the research project.

4. The IRB requires that, when feasible, the practitioner explain the proposed research to the prospective participant, even when the surrogate gave consent.

F. Criteria to Enroll Subjects Without Capacity

1. No individual who lacks decision-making capacity may participate in VA research until the IRB has reviewed and approved that individual's, or that class of individuals', participation in a given research project. Individuals who lack decision-making capacity may be enrolled in a VA research project if:

- a. The proposed research entails:
 - i. No greater than minimal risk to the participant as determined by the IRB; or
 - ii. If the research presents some probability of harm, there must be at least a greater probability of direct benefit to the participant; or
 - iii. Greater than minimal risk and no prospect of direct benefit to individual participants, but is likely to yield generalizable knowledge about the participant's disorder or condition that is of vital importance for the understanding or amelioration of the participant's disorder or condition.

- b. The disorder (e.g., Alzheimer's) leading to the individual's lack of decision-making capacity is being studied whether or not the lack of decision-making itself is being evaluated (e.g., an individual who lacks decision-making capacity as the result of a stroke can participate in a research project studying cardiovascular effects of a stroke), but only if the research project cannot be performed with only persons who have decision-making capability.
 - c. The subject of the research project is not directly related to the individual's lack of decision-making capacity, but the investigator can make a compelling argument for including individuals who lack decision-making capacity in the research project (e.g., transmission of methicillin-resistant *Staphylococcus aureus* [(MRSA)] infections in a nursing home where both individuals with, and those without, decision-making capacity are affected).
 - d. If the enrollment criteria mentioned above are met, the IRB may approve the inclusion of individuals who lack decision-making capacity in VA research studies on the basis of informed consent from LARs. Before approving the research project, the IRB must:
 - i. Ensure the research project include appropriate procedures for respecting dissent;
 - ii. Consider whether or not the research project needs to include procedures for obtaining assent; and
 - iii. Determine whether any additional safeguards need to be used (e.g., consent monitoring).
2. The IRB must document in the IRB minutes its deliberations and the enrollment criteria used to approve inclusion of individuals who lack decision-making capacity.

1.3. Reporting requirements

1.3.1 Unanticipated problems involving risks to participants or others or unanticipated serious adverse events

A. Within five business days of becoming aware of any local (i.e., occurring in the reporting individual's own facility) unanticipated problems involving risks to participants or others or any unanticipated serious adverse events in VA research, members of the VA research community are required to ensure the problem or event has been reported in writing to the IRB.

1. This requirement is in addition to other applicable reporting requirements (e.g. reporting to the sponsor under FDA requirements).
2. The unfounded classification of a serious adverse event as "anticipated" constitutes serious non-compliance.

3. Examples of serious unanticipated problems involving risks to participants or others include:

- Interruptions of participant enrollments or other research activities due to concerns about the safety, rights, or welfare of human research participants, research staff, or others.
- Any work-related injury to personnel involved in human research, or any research related injury to any other person, that requires more than minor medical intervention (i.e., basic first aid), requires extended surveillance of the affected individuals, or leads to serious complications or death.
- Any VA National Pharmacy Benefits Management (PBM) Bulletins or Communications (sometimes referred to as PBM Safety Alerts) relevant to one or more of the VA facility's research projects.
- Any data monitoring committee, data and safety monitoring board or data and safety monitoring committee report describing a safety problem.
- Any sponsor analysis describing a safety problem for which action at the VA facility might be warranted.
- Any unanticipated problem involving substantive harm, or a genuine risk of substantive harm, to the safety, rights, or welfare of human research participants, research staff, or others.
- Any problem reflecting a deficiency that substantively compromises the effectiveness of the VA facility's HRPP.

B. Within five business days after a report of a serious unanticipated problem involving risks to participants or others, or of a local unanticipated serious adverse event, the convened IRB or IRB Chair/IRB designee shall determine and document whether the reported incident was serious and unanticipated and related to the research.

1. If the problem or event is determined to be serious, unanticipated, and related to the research, the IRB chair or designee shall notify the VA Regional Office of Research Oversight (ORO) via telephone or e-mail within 48 hours of the IRB determination and report the unanticipated problem or event within five business days after the determination to:

- VA Medical Center Director
- Associate Chief of Staff for Research
- Research and Development Committee
- The Office of Research and Development, if VA-funded
- ORO RO
- The VA Privacy Office, when the event involves unauthorized use, loss, or disclosure of individually identifiable patient information. (UP)

- The VHA Information Security Officer when the event involves violations of VA information security requirements.(UP
2. If the IRB or IRB Chair/IRB designee determines that the problem or event was serious, unanticipated, and related to the research, the IRB shall also determine if additional action is required (e.g., suspension of activities; notification of participants) necessary to prevent an immediate hazard to participants in accordance with VA regulations.
 - “Related” for purposes of VA research means the event or problem may reasonably be regarded as caused by, or probably caused by, the research.
 3. Any determinations of the IRB Chair/IRB designee shall be reported at the next convened IRB meeting. If it was determined that the problem or event is serious, unanticipated, and related to the research, the convened IRB must determine and document:
 - a) Whether a protocol or consent document modification is warranted.
 - b) Whether previously enrolled participants must be notified of the modification.
 - c) When such notification must take place and how such notification must be documented.

1.3.2 Serious or Continuing Non-compliance:

A. Within five business days of becoming aware of any apparent or possible serious or continuing non-compliance or with any other possible serious or continuing noncompliance with VA or other federal requirements related to human research or with IRB requirements or determinations, the investigator and research staff are required to ensure that the non-compliance has been reported to the IRB in the IRB electronic submission system, as well as to the ACOS/R&D. The IRB shall review the report of non-compliance at its next convened meeting.

B. Should the IRB determine that the reported incident constitutes serious non-compliance or continuing non-compliance, within five business days after the determination by the IRB, the HRPP Director shall notify the Oklahoma City VA Medical Center Director directly (without intermediaries) with a simultaneous copy to the ACOS/R&D, the RCO, and the R&D Committee, and to the VA Privacy Office, when the report involves unauthorized use, loss, or disclosure of individually identifiable patient information and to the VHA Information Security Officer when the report involves violations of VA information security requirements).

1. The IRB must reach a determination that serious or continuing non-compliance did (or did not) occur within 30-45 days after receiving a report of apparent non-compliance.

2. Remedial actions involving a specific study or research team must be completed within 90-120 days after the IRB's determination.
3. Remedial actions involving programmatic noncompliance must be completed within 120-180 days after the IRB's determination, unless remediation requires substantial renovation, fiscal expenditure, hiring, or legal negotiations.

1.3.3. Other Reportable Events: For VA research projects involving other reportable events, the HRPP Director shall notify the Oklahoma City VA Medical Center Director directly (without intermediaries) with a simultaneous copy to the ACOS/R&D, the RCO, and the R&D Committee) within five business days after the determination of the following:

- A. When the IRB determines an event is an unanticipated problem involving risks to participants or others (UP);
- B. When IRB accreditation problems, to include failure to obtain accreditation or any change in the IRB's accreditation status, occur; or
- C. When suspension of IRB approval, termination or IRB approval, or interruptions of subject enrollments or other research activities due to concerns about the safety, rights, or welfare of human research participants, research staff, or others occurs. This does not include a lapse of IRB approval from continual review.

1.3.4. Reporting HIPAA/Privacy Events: The VA research community shall notify the VA Information Security Officer (ISO), VA Privacy Officer (PO), ACOS/R&D, and RCO within 1 hour of becoming aware of any:

- A. Unauthorized use, disclosure, transmission, removal, theft, loss, or destruction of VA research-related protected health information (PHI), individually identifiable private information, or confidential information, as defined by the HIPAA Privacy Rule, the Common Rule, the Privacy Act, or 38 U.S.C. §§5701, 5705, and 7332;
- B. Suspension or termination of VA research related to concerns about research information protection;
- C. Findings of noncompliance related to research information security or privacy regarding VA Research;
- D. Other deficiency(ies) that substantively compromise the effectiveness of the VA facility's research information protection program.

1.3.5. Misconduct. Any allegation of research misconduct shall be reported to the ORO via telephone or email promptly.

1.3.6. Expired Research. For VA research that expires because continuing review is not completed, the IRB shall notify the sponsoring agency, private sponsor, Office of Research and Development, Office of Research Oversight, and other Federal agencies, as appropriate.

1.3.7. Suspensions and Terminations

- A. Suspensions and terminations do not include:

1. Interruptions in research resulting solely from the expiration of a protocol approval period.
2. Administrative holds or other actions initiated voluntarily by a VA facility official, Researcher, or Sponsor for reasons other than those described in preceding items.
 - a. Administrative Hold
 1. An administrative hold is a voluntary interruption of research enrollments and ongoing research activities by an appropriate VA facility official, Researcher, or Sponsor (including the ORD when ORD is the sponsor).
 2. The term “administrative hold” does not apply to interruptions of VA research related to concerns regarding the safety, rights, or welfare of human research participants, research investigators, research staff, or others.
 3. An administrative hold must not be used to avoid reporting deficiencies or circumstances that otherwise require reporting by federal agencies.

B. Reporting Suspensions and Terminations

1. Any termination or suspension of research(e.g., by the IRB or other research review committee, or by the associate chief of staff or research or other VA facility official)related to concerns about the safety, rights, or welfare of human research participants, Research Staff, or others must be reported in writing within five business days after the termination or suspension occurs to:
 - a. Medical center director.
 - b. Associate chief of staff for research.
 - c. Research and Development Committee.
 - d. IRB.
 - e. Other relevant research review committee.
2. IRB approval of suspensions and terminations shall be promptly reporting to:
 - a. The Office of Research and Development, if VA-funded.
 - b. The Regional Office of Research Oversight.
 - c. The Privacy Office, when the report involves unauthorized use, loss, or disclosure of individually identifiable patient information.
 - d. The Information Security Officer when the report involves violations of information security requirements.
 - e. IRBs of academic affiliates that are the IRB of record for a VA facility must follow these requirements.

3. The medical center director must report the termination or suspension to the appropriate Office of Research Oversight research officer within five business days after receiving such notification.

1.4 Additional VA requirements

1.4.1. **Usual Care:** When a research project involves “usual care” in the protocol or a separate document in the IRB application the investigator must clearly designate the individual or entity (e.g., the appropriate research personnel versus the subject’s health care provider) responsible for relevant aspects of both the research and the usual care.

1.4.2. **Required at Continuing Review.** At statement signed by the investigator shall be included in the status report for continuing review of a research project. The statement shall certify that all participants entered on the master list of participants for the research project signed the consent document prior to undergoing any study interactions or interventions, unless the IRB has granted a waiver of the consent process or a waiver of the requirement for a signed consent document.

1.4.3. **Additional Vulnerable Populations.** Individuals or populations that might be temporarily or permanently vulnerable for purposes of VA research include, but are not limited to, those who:

1. Are susceptible to coercion or undue influence (e.g., the homeless, prisoners, students, patients with limited or no treatment options, socially and economically disadvantaged).
2. Lack comprehension of the research and its risks(e.g., educationally disadvantaged, dementia, schizophrenia, or depression).
3. Have increased susceptibility to harm from the procedures of the specific study under review(e.g., individuals who would have to answer study survey questions about their sexual assault).
4. Are at risk for economic, social, or legal consequences from the study (e.g., individuals who would have to answer study survey questions about their drug use or HIV status).

1.4.4. **Non-Veteran Enrollment.** Non-veterans may be entered into VA-approved research studies only when there are insufficient veterans available to complete the study or when the investigator can present a compelling argument to the IRB for the inclusion of non-veterans (e.g., survey of VA employees; study of active duty military; study involving veterans’ family members), and the research is relevant to the care of veterans or active duty military personnel.

1.4.5 **Compensation.**

A. Investigators shall not compensate participants to participate in research when the research is integrated with a patient’s medical care

and when it makes no special demands on the patient beyond those of usual medical care.

B. Compensation to participants is permitted when:

1. The research is not directly intended to enhance the diagnosis or treatment of the medical condition for which the participant is being treated, and when the standard of practice in affiliated non-VA institutions is to pay participants in this situation.
2. The research is a multi-institutional study and participants at collaborating non-VA institutions are paid for the same participation in the same study at the same rate proposed.
3. In the opinion of the IRB or EC, payment of participants is appropriate in other comparable situations.
4. The participant will incur transportation expenses that would not be incurred in the normal course of receiving treatment and are not reimbursed by another mechanism.

1.4.6. Trainees

A. Students and other trainees (including residents and fellows), including VA employees, from schools with an academic affiliation agreement consistent with current VHA policy, may serve as Investigator within a VA facility, or use data, or human biological specimens that have been collected within VA for clinical, administrative, or research purposes.

B. A Investigator sufficiently experienced in the area of the trainee's research interest must serve as principal Investigator or co-principal Investigator and is responsible for oversight of the research and the trainee.

2. SCOPE

This SOP applies to all research involving human participants conducted at the VAMCs located in Oklahoma City and Muskogee, unless the research is reviewed and approved by the VA-CIRB.

3. RESPONSIBILITY

3.1 The OUHSC IRB is Responsible For:

- 3.1.1 Protecting the rights and welfare of human participants who participate in VA-regulated research.
- 3.1.2 Including two or more VA employees as voting members of the IRB on each IRB that reviews VA research. The Oklahoma City VAMC will provide two or more VA employees to serve as voting members of the IRBs that review its research and the Muskogee VAMC will provide two or more VA employees as voting members of the IRBs that review its

research. One of these members from each VAMC for each IRB must have scientific expertise, and at least one member must be present at a convened IRB meeting during the review of their respective facility's research. Attendance via video or telephone conferencing or similar is permissible.

3.1.3 Reporting to the VA with regard to VA Research:

- A. Initial and continuing review of research and reports its findings and actions to the investigator, the Associate Chief of Staff for Research and Development "ACOS/R&D", and the Research and Development Committee "R&DC". After the IRB has approved a study, it must not be initiated until the investigator has been notified in writing by the ACOS/R&DC that all applicable approvals have been obtained and the study may be initiated;
- B. The IRB must notify in writing the investigator and the VA Office of Research Administration of the IRB's decision to approve, disapprove, or require modifications to approve any modifications;
- C. The IRB must notify in writing the investigator, the R&DC, and the VA Office of Research Administration of the IRB's decision to approve any VA research including children, prisoners, or international research. This VA research requires a waiver from the Chief Research and Development Officer (CRADO), Office of Research and Development (ORD). VA facility director must approve any request for permission to conduct international research prior to forwarding it to the chief research and development officer;
- D. If IRB approval expires and the investigator submits a list of research subjects who could be harmed by stopping research project procedures, the IRB Chair or IRB designee, with appropriate consultation with the VA Chief of Staff, determines if subjects on the list may continue participating in the research interventions or interactions;
- E. Any suspension or termination of research project activities related to safety, rights, or welfare of subjects or other. The IRB Chair or IRB designee must notify the facility Director within 5 University business days after the determination. The report must be made in writing, with a simultaneous copy sent to the ACOS/R and the R&DC;
- F. Any determination of an unanticipated problem involving risks to subjects or others, or of a local unanticipated SAE. The IRB Chair or IRB designee must notify the Office of Research Oversight "ORO" regional office via telephone or e-mail within 48 hours and report the problem or event directly (without intermediaries) to the facility director within 5 University business days after the determination. The report must be made in writing, with a simultaneous copy to the ACOS/R and the R&DC;
- G. Any determination of serious or continuing noncompliance. The IRB Chair or IRB designee must notify the facility director within 5 University business days after the determination. The report must be

made in writing, with a simultaneous copy sent to the ACOS/R and the R&DC;

- 3.1.4 Determining that the investigator and key personnel have met all HSC IRB educational requirements.
- 3.1.5 Reporting to the VA Privacy Official, within a reasonable time upon becoming aware, any unauthorized use, loss, or disclosure of individually identifiable participant information.
- 3.1.6 Reporting violations of VA information security requirements, within a reasonable time upon becoming aware, to the appropriate VHA facility Information Security Officer and adhering to the processes and timeframes in the incident reporting policies published in the VHA Handbook 1058.01 .
- 3.1.7 The IRB staff prepares a confidentiality agreement for the VAMC R&D members to sign prior to providing copies of the HSC IRB meeting minutes to the VAMC R&D.
- 3.1.8 Providing copies of the HSC IRB meeting minutes to the VAMC R&D for approval within three weeks of the IRB meeting.

3.2 VAMC R&DC is Responsible For:

- 3.2.1 Assisting the VA Medical Center director in fulfilling responsibilities for the facility's research program.
- 3.2.2 Ensuring the effective operation of the research program through oversight of the R&DC's subcommittees and making appropriate recommendations, including space and resource needs, to the VA Medical Center director based on the R&DC's oversight and evaluation of the research program.
- 3.2.3 Identifying and recommending qualified VA employees to serve on the HSC IRB.
- 3.2.4 Providing the VAMC Research Compliance Officer (RCO) to serve as a non-voting consultant to the HSC IRB, as needed. The RCO may not serve as a voting or nonvoting member of the IRB. The RCO may attend meetings of the IRB when requested by the IRB.
- 3.2.5 Approving HSC IRB minutes for VA-regulated research projects.
- 3.2.6 Establishing policy to ensure that all research in which the VAMC is to be engaged has been reviewed and approved for the ethical use of human participants; protection of human participants (including privacy and confidentiality); and the implementation of adequate safety measures for research participants and personnel and security of VA data and VA sensitive information, as well as acting on any findings of non-compliance.
- 3.2.7 Providing a final VA Approval Memorandum from the ACOS/R to investigators after formal approval from the VAMC R&DC is secured.
- 3.2.8 Providing a copy of the VA R&DC Approval Memorandum to the HSC IRB.

3.2.9 Monitoring VA-regulated research activities.

3.3 Investigators Proposing to Conduct VA-regulated Research are Responsible For:

- 3.3.1 Prospectively submitting research projects, including exempt determinations for review, to the VAMC R&DC prior to submission to the HSC IRB.
- 3.3.2 Submitting research projects to the HSC IRB once VAMC R&DC has been submitted.
- 3.3.3 Not initiating VA research until after the IRB has approved the research project and the investigator has been notified in writing by the ACOS/R&D that all applicable approvals have been obtained.
- 3.3.4 Disclosing all conflict of interest to the HSC IRB and VA R&DC.
- 3.3.5 Ensuring the research has adequate resources.
- 3.3.6 Ensuring all research project personnel are qualified to perform their research project duties and have been approved by the HSC IRB and VA R&DC.
- 3.3.7 Promptly reporting all changes to the approved research to the HSC IRB before implementing those changes and notifying the R&DC of the IRB's approval.
- 3.3.8 Overseeing the research and all research project staff. The PI is the investigator solely responsible for the conduct of the research.
- 3.3.9 Implementing the research as it is approved, and maintaining adequate and accurate research records, to include the original informed consent documents and HIPAA Authorization. The PI will make available these records for audit as requested by the RCO, IRB, R&DC, research project sponsor, and any other entity charged with oversight of the research.
- 3.3.10 Using the appropriate VA form 10-1086 consent document and local VA HIPAA Authorization for Research to consent VA Research participants.
- 3.3.11 Performing participant outreach. The PI will make every reasonable effort to make available the informational brochure, "*Volunteering in Research – Here Are Some Things You Need To Know*" (<http://www.research.va.gov/programs/pride/veterans/tri-fold.pdf>), to potential research participants in settings where investigators may recruit participants (e.g., clinic waiting areas), and to prospective participants and their surrogates, where applicable, when the individuals are approached to take part in a research project.
- 3.3.12 Ensuring appropriate telephone contact with participant. Research team members are prohibited from requesting Social Security numbers by telephone. No "cold calling" is allowed. During the recruitment process, the PI is responsible for ensuring the research team makes initial contact with the potential participant in person or by letter prior to initiating any telephone contact, unless there is written documentation that the participant is willing to be contacted by telephone about the research project in question or a specific kind of research (e.g., if the potential

participant has diabetes, the participant may indicate a desire to be notified of any diabetes-related research studies). The initial contact must provide a telephone number or other means that the potential participant can use to verify the research project constitutes VA research.

- 3.3.13 Maintaining a master list of all participants consented unless the IRB waives this requirement as outlined above.
- 3.3.14 Reporting modifications, continuing reviews, problems, deviations/violations, AEs/SAEs, unanticipated problems or others, and any other issue related to VA research in accordance with local SOPs and VHA regulations.
- 3.3.15 Completing training and education in good clinical practice and the ethical principles on which human research is to be conducted before participating in human participants research as outlined in SOP 102B: Key Study Personnel Education.

4. APPLICABLE REGULATIONS AND GUIDELINES

38 CFR 16, 17

Department of Veterans Affairs, VHA Handbook 1058.01

Department of Veterans Affairs, VHA Handbook 1200.01

Department of Veterans Affairs, VHA Handbook 1200.05

Department of Veterans Affairs, VHA Handbook 1200.12

Department of Veterans Affairs, VHA Handbook 1907.01

Department of Veterans Affairs, VHA Handbook 1605.01

5. REFERENCES TO OTHER APPLICABLE SOPS

SOP 301: Research Submission Requirements,

SOP 302: Administrative Review and Distribution of Materials

SOP 401: Research Exempt from IRB Review

SOP 402: Expedited Review

SOP 403: Initial Review – Criteria for IRB Approval

SOP 404: Continuing Review

SOP 405: Modifications

6. ATTACHMENTS

603A-A VA R&D Approval Memorandum

603A-B VA Form 10-1086 Consent Form Template

603A-C VA Form 10-9012 Investigational Drug Information Record

603A-D VA Memorandum of Understanding-OKC

603A-E VA Memorandum of Understanding-Muskogee

305-C New Study Approval Checklist

7. PROCESS OVERVIEW

- 7.1 The investigator prospectively submits a research project to the VAMC R&D Committee for evaluation for scientific or scholarly validity when the investigator utilizes VA resources and/or recruits VA patients as participants in the project. This may be done concurrently with submission to the HSC IRB.
- 7.2 The IRB processes documents submitted to the IRB per SOP 301: Research Submission Requirements; and SOP 302: Administrative Review and Distribution of Materials.
- 7.3 If review of the research per SOP 401: Research Exempt from IRB Review; and SOP 402: Expedited Review; indicates the research project qualifies for convened IRB review, the IRB Administrator processes the research project per SOP 403: Initial Review – Criteria for IRB Approval, and forwards the agenda to the VAMC RCO.
- 7.5 The VAMC RCO audits VAMC-regulated research projects to ensure VA regulations have been followed and ensures that the VAMC research projects have been submitted to the VAMC R&D for review. The RCO may attend IRB meetings in a consultant capacity upon IRB request to suggest changes to VAMC research projects in order to assist the IRB in complying with VHA regulation.
- 7.6 Final IRB approval is issued when all requested changes have been made and verified by the IRB Administrator and the IRB Chair or IRB designee.
- 7.7 IRB meeting minutes are forwarded to the Research Administration Officer and R&DC Manager for presentation to the VA R&D Committee no more than three weeks after each IRB meeting.

APPROVED BY: _____ **DATE:** 08/31/2014

NEXT ESTABLISHED REVIEW DATE: AUGUST 2016