

RESEARCH SERVICE

April 1, 2008

RESEARCH STANDING OPERATING PROCEDURES

Correspondence and Communication between the Research and Development (R&D) Office and Components of the Human Research Protection Program and Regulatory Agencies

1. **PURPOSE:** To outline the policy and procedures related to the lines of correspondence and communication between the various entities that are involved in the South Texas Veterans Health Care System (STVHCS) Human Research Protection Program (HRPP).
2. **POLICY:** Effective communication between the various components of the STVHCS HRPP is essential to the function of the HRPP and protection of human research subjects. The ACOS for Research and Development (ACOS for R&D), or designee, is the point of contact (POC) for all communications from the various components of the STVHCS HRPP, including the UTHSCSA Institutional Review Board (IRB). The POC at the STVHCS is responsible to communicate with the appropriate STVHCS officials.
3. **ACTION:**
 - a. **Communication with the IRB:** The IRB of the University of Texas Health Science Center at San Antonio (UTHSCSA; university affiliate) is the IRB of record for the STVHCS, as established by a Memorandum of Understanding. There are a number of instances when the IRB and the STVHCS must communicate, either under routine or urgent circumstances. In addition, as a general rule, the Office of the IRB (OIRB) and R&D Office will communicate any information to the reciprocal office as needed to ensure the protection of human subjects in research.
 - (1) Initial Protocol review:
 - (a) Administrative pre-review: The UTHSCSA IRB will notify the R&D Office when a VA research protocol is submitted to the IRB. The Staff Assistant or Program Assistant at the R&D Office will access the documents on the OIRB share folder (a direct UTHSCSA network line is in the R&D Office) and will conduct an administrative pre-review to ensure that the submitted documents (Consent form, VA 10-9012 form, etc.) are compliant with VA regulations. The Staff or Program Assistant will communicate the findings of the pre-review back to the Office of the IRB staff for incorporation into the pre-review stipulations that are provided by the OIRB to the investigator.
 - (b) IRB minutes: The OIRB staff post the minutes of the full-committee IRB protocol review meetings on the OIRB share folder that can be directly accessed by the STVHCS R&D Office staff. The minutes are printed and provided in the R&D Committee member's packet for review at the next R & D Committee meeting. For protocols

POLICY MEMORANDUM 08-37

reviewed by the expedited process, or determined by the IRB to be exempt, the Office of the IRB will forward to the R&D Office documentation of the approval.

(c) If a concern (or disagreement with the IRB's determination of exemption) related to the research protocol is raised in the R&D Committee review, information is discovered that the IRB should know about (e.g. issues related to human subject safety, protection of privacy, etc.) the Chair of the R&D Committee, or his/her designee, will promptly (within 2 working days) notify by phone or email, followed by paper copy, the Director of the IRB and provide the information necessary for the IRB to evaluate and take appropriate action.

(d) If the R&D Committee withholds approval because of stipulations that must be met in addition to the requirements of the IRB, the R&D Committee will inform the IRB (and PI) in writing of its additional stipulations.

(2) Continuing review:

(a) Continuing review by the R&D Committee will be coordinated with the Continuing Review by the IRB. If approval of a human subject research protocol expires at the IRB, its approval by the R&D Committee will expire simultaneously.

(b) In addition to the review of the STVHCS Continuing Review form, Continuing Review documents that are submitted by the PI to the IRB will be accessed by the STVHCS R&D Office staff through the OIRB share folder, printed, and provided to the R&D Committee members for review.

(c) A copy of the IRB minutes that document the Continuing Review will be retrieved from the OIRB share folder and provided to the R&D Committee members for review.

(d) The findings of the R&D Committee Continuing Review, based on the review of the documents submitted to the OIRB and the IRB minutes, will be communicated to the PI in writing and copied to the OIRB.

(3) Human subject research-related events: The UTHSCSA IRB follows its "Unanticipated Problems Involving Risk to Subjects or Others (UPIRSO) Policy and Procedure", "Non-compliance Policy and Procedure", and "IRB/OIRB Reporting Policy and Procedure" in addressing research-related events.

(a) Unanticipated Problems Involving Risk to Subjects or Others (UPIRSO): VA Research investigators must report an UPIRSO to the IRB. The timeline for reporting UPIRSOs is determined by the severity and significance of the unanticipated problem. UPIRSOs may include events such as adverse events, unexpected death, breach of confidentiality or privacy, compromise of VA Information Security, serious or continuing research non-compliance, or research misconduct. UPIRSOs must be reported by the IRB via encrypted email or phone, with follow-up paper copy, to the ACOS for R&D, or his/her designee, as soon as possible, but no later than 48 hours after the determination as a UPIRSO by the IRB. The IRB will submit a report to the STVHCS within 30 days from the date of determination of resolution of the UPIRSO. If the UPIRSO is an internal event (under the jurisdiction of the IRB) the STVHCS Director must submit a written report of the event to the Office of Research Oversight (ORO) within 10 days of the IRB's determination of an UPIRSO. If the STVHCS Research Office or Compliance Office

becomes aware of an UPIRSO that has not been reported to the IRB, the Principal Investigator will be informed of the requirement to notify the IRB in the appropriate timeframe, and will communicate with the IRB to ensure that this has been accomplished.

(1) Adverse events: Any adverse event (any untoward occurrence [physical, psychological, social, or economic] in a human subject), or an imminent threat of an adverse event, that does not constitute an UPIRSO does not need to be reported promptly to the IRB, but is reported to and reviewed by the IRB during Continuing Review. The exception to this is “unanticipated adverse device effects” (UADE), which are reported by the PI to the IRB, and in turn are reported to the ACOS for R&D within 48 hours, as described for UPIRSOs. If the UADE is an internal event the STVHCS Director must submit a written report of the UADE to the ORO within 10 days of the IRB’s determination.

(2) Unexpected death: Any unexpected death of a research subject must be reported immediately to the IRB. The IRB will notify the ACOS for R&D so that a written report can be submitted by the STVHCS Director to the Office of Research oversight within 24 hours after the IRB’s determination that the death was unexpected. An unexpected death is the death of a research subject in which a high risk of death is not projected, as indicated by the written protocol, informed consent form, or sponsor brochure. A subject’s death that is determined to be clearly not associated with the research is not an “unexpected death” for purposes of the reporting requirements.

(3) Breach of confidentiality or privacy: The IRB will report to the ACOS/Research, or the AO/Research should the ACOS/Research be unavailable, any real or suspected unauthorized use, loss, or disclosure of individually-identifiable information related to a VA research protocol. The initial notification will be immediately upon receiving the report, either by phone call or receipt-verifiable email, to be followed by delivery of a full report when available. The ACOS/Research or AO/Research will then immediately notify the STVHCS Privacy Officer of the breach of confidentiality or privacy.

(4) Compromise of VA information Security: The IRB will report to the ACOS/Research, or the AO/Research should the ACOS/Research be unavailable, any real or suspected violation of Information Security requirements related to a VA research protocol. The ACOS/Research or AO/Research will then immediately notify the STVHCS Information Security Officer of the compromise of VA information Security.

(b) Research non-compliance: The UTHSCSA Office of the IRB and the STVHCS R&D Office shall immediately report to the reciprocal office any allegation, suspicion, or evidence of serious or continuing research non-compliance involving VA research of which it becomes aware, including but not limited to human subject protection violations. Notification will be by email or telephone as soon as possible, but no later than 48 hours after becoming aware of the non-compliance. The OIRB will submit a report to the STVHCS within 30 days from the date the IRB determines resolution of the serious or continuing research non-compliance. Each office shall notify the reciprocal office if and when an oversight agency or organization initiates any action regarding noncompliance.

(c) Research Misconduct: Any allegation, suspicion, or evidence of research misconduct received by the IRB or STVHCS will be promptly reported to the reciprocal office. The

POLICY MEMORANDUM 08-37

ACOS for R&D is the STVHCS Research Integrity Officer, who handles allegations of research misconduct.

(4) Federalwide Assurance: The UTHSCSA Office of the IRB and STCHCS R&D Office will promptly inform the reciprocal office of changes in the institutions FWA status.

(5) IRB membership: The IRB will inform the STVHCS Research Office when any issues related to VA membership on the IRB arise (e.g. need for new members, absence of VA representation for a committee meeting, etc.). The STVHCS R&D Office will work with the IRB to ensure that adequate VA representation is maintained on the IRB.

b. Communication with the Subcommittee for Research Safety:

(1) The SRS will notify the R&D Committee of the results of subcommittee protocol (Research Safety Survey) reviews and committee actions through submission of written, signed minutes from its convened subcommittee meetings.

(2) The SRS will notify the Principal Investigator or his/her research staff of the results of subcommittee protocol (Research Safety Survey) reviews and committee actions in writing, either via paper copy or email.

(3) Any urgent research personnel safety issue that come to the attention of the SRS will be promptly reported by phone (with written follow-up communication) to the ACOS for R&D, the STVHCS Safety Officer, and R&D Committee Chair. If the research personnel safety issue involves a human subject study, the IRB Director will also be notified.

c. Communication with the Quality Assurance/Quality Improvement (QA/QI) Subcommittee:

(1) The QA/QI Subcommittee will notify the R&D Committee of the results of its review of QA/QI and compliance activities through submission of written, signed minutes from its convened subcommittee meetings.

(2) Any urgent research compliance issue that comes to the attention of the QA/QI Subcommittee will be promptly reported by phone (with written follow-up communication) to the ACOS for R&D and R&D Committee Chair. If the compliance issue involves a human subject study, the IRB Director will also be notified.

d. Communication with Investigators and research staff:

(1) The items that must be submitted to the R&D Committee for review of a new research protocol are identified in the Research Service SOP for Submission and Review of Protocols. The required forms for submission to the R&D Committee or its subcommittees are found on the R&D Office website (<http://www.vasthcs.med.va.gov/research/default.htm>) or can be obtained as paper copy through the R&D Office. Any questions related to submission of documents to the R&D Committee or one of its subcommittees should be addressed to the contact person listed at the end of this document.

(2) All official communication from the Principal Investigator or his/her research staff should be in writing, either via paper copy or email.

(3) All correspondence from the R&D Office to the Principal Investigator or his/her research staff will be in writing, either via paper copy or email. Phone communication, while helpful and efficient, should not be considered as official communication from the R&D Office.

(4) The R&D Committee or one of its subcommittees (via the Research Office) will, by email and in writing, notify Investigators of any decision(s) rendered by the R&D Committee or the subcommittee. Every attempt will be made by the Research Office to submit this correspondence to Investigators within 24 hours of the meeting.

(5) The Research Office will, by email (and phone if necessary), notify Investigators of upcoming deadlines, including deadlines for submission for Continuing Review and the required annual training.

(6) Anyone involved in STVHCS research is encouraged to contact the UTHSCSA IRB Office or the STVHCS R&D Office at anytime with any comments, suggestions, concerns, or questions regarding research.

e. Communication with Research Participants:

(1) The STVHCS HRPP maintains an open door policy. Any individual, including a past, current, or prospective research participant is welcome to contact the research office or any other component of the HRPP with a question, concern, complaint, comment, or suggestion. Contact information for the UTHSCSA IRB is provided in the Informed Consent document, and contact information for the R&D Office is listed on posted pamphlets and posters and the R&D Office website.

(2) The STVHCS R&D Office proactively reaches out to past, current, or prospective participants in research through the inclusion of contact information on posters and pamphlets displayed in public areas of the STVHCS and the R&D Office website.

(3) The ACOS for R&D is responsible for ensuring that complaints, concerns, allegations, questions, or requests for information related to research are reviewed and appropriate actions are taken.

f. Communication with the STVHCS Compliance Office:

(1) The STVHCS Compliance Office coordinates activities with, but works independently of, the R&D Office. The Compliance Office reports to the Director through the Compliance Board, but is an integral component of the Strategic Improvement / Quality Assurance / Quality Improvement program for the HRPP.

(2) The Compliance Office will notify Principal Investigators in writing when the investigator's protocol has been chosen for an audit. The investigator will be informed of the steps of the audit process and the documentation required by the Compliance Office. The Principal Investigator must respond to the request for information within the timeline specified by the Compliance Office, or must provide a reasonable justification for why the timeline cannot be met. Failure of the Investigator to comply with the request for information may be reported by the Compliance Office to the Director of the IRB and ACOS for R&D as non-compliance.

(3) Audit Reports: The reports from research protocol audits and audits of the IRB will be submitted to the QA/QI Subcommittee for review, discussion, and determination of the need for any actions. The assessment and recommendations from the QA/QI Subcommittee will be routinely forwarded to the R&D Committee.

(4) Significant findings: Compliance Office audits of research protocols that identify evidence of significant findings (serious or continuing research non-compliance, including but not limited to human subject protection violations) will be communicated immediately by the Compliance Officer via phone and/or encrypted email to the Principal Investigator, ACOS for R&D, R&D Committee Chair, and Director of the IRB. The Compliance Office will be copied on any communications related to any noncompliance-related evaluation and action of the IRB or R&D Committee.

g. Communication with the Information Security Officer (ISO)

(1) Protocol review: Prior to approval of a research protocol by the R&D Committee the ISO or Alternate ISO will review the “Requirements and Guidelines for Collection, Storage, and Use of VA-Sensitive Research Data” worksheet and provide comments to the R&D Committee. The ISO or a designated representative will attend the convened R&D Committee meetings to participate in discussion and offer expert advice in matters pertaining to research information security. A research protocol will not be approved by the R&D Committee without prior approval by the ISO or Alternate ISO.

(2) Any real or suspected violation or compromise of VA Information Security related to a VA research protocol will be reported immediately by ACOS/Research or AO/Research to the STVHCS Information Security Officer by phone or encrypted, verifiable email. Communication in writing will follow as appropriate.

h. Communication with the Privacy Officer

(1) Protocol review: Prior to approval of a research protocol by the R&D Committee the Privacy Officer, or Alternate Privacy Officer will review the protocol and provide comments to the R&D Committee. The Privacy Officer, or Alternate Privacy Officer will attend the convened R&D Committee meetings to participate in discussion and offer expert advice in matters pertaining to human subject privacy. No approval will be given by the R&D Committee until the protocol is approved by the Privacy Officer.

(2) Upon receipt of a report of any real or suspected unauthorized use, loss, or disclosure of individually-identifiable information related to a VA research protocol, the ACOS for R&D or AO for R&D will then immediately notify the STVHCS Privacy Officer by phone or encrypted, verifiable email. Communication in writing will follow as appropriate.

i. Communication with the Research Pharmacy

(1) Protocol review: Prior to R&D Committee review and approval of a research protocol that involves medications and/or investigational test agents, the Research Pharmacist will review the protocol, focusing on safety of the medication/test agent and adequacy of pharmacy resources needed to support the research. The Research Pharmacist will attend the convened R&D Committee meetings to participate in discussion and offer expert advice in matters pertaining to medications and/or investigational test agents. The R&D Committee will consider the input from the Research Pharmacist in its review of the protocol. The R&D

Committee cannot approve a proposal involving investigational drugs unless the research pharmacy documents that pharmacy resources are adequate for the conduct of the study, or satisfactory provisions have been made to reimburse pharmacy for the services provided.

(2) Following approval of a research protocol that involves medications and/or investigational test agents, the R&D Office will provide to the Research Pharmacy copies of:

- (a) The signed VA 10-9012 form(s)
- (b) Documentation of approval of the protocol by the IRB through the minutes of the IRB meeting where the protocol was approved, an approval letter signed by the IRB Chair, or VA form 10-1223 signed by the IRB Director
- (c) The R&D Committee approval letter.

j. Communication with Regulatory and Oversight agencies

(a) Research-related events may require notification of Regulatory and Oversight agencies. These include, but are not limited to, findings of serious or continuing noncompliance with the regulations for the protection of human subjects or with the requirements of the IRB; any unanticipated problems involving risks to subjects or others (e.g., death of healthy volunteers participating in research); and suspension or termination of IRB approval (e.g., associated with unexpected harm, research not being conducted in accordance with the IRB's requirements).

(b) Breaches in information security will be reported by the STVHCS ISO to the VHA Information Security Officer (ISO) as appropriate.

(c) Reports to regulatory agencies shall be made as soon as possible after recognition of a reportable event and within the maximum allowable time required by the applicable regulatory body.

(d) The IRB Director, or ACOS/R&D through the Medical Center Director as the Institutional Official for the HRPP, will report all actions requiring reporting to non-VA regulatory agencies such as the Office for Human Research Protections (OHRP), the Food and Drug Administration (FDA) if investigational devices or drugs are involved, and/or any other federal agencies overseeing research who require separate reports from OHRP. The ACOS/R&D through the Medical Center Director as the Institutional Official for the HRPP, will report all actions requiring reporting to Regional Office of Research Oversight (ORO) as specified in the Directive "What to Report to ORO". Reports to regulatory agencies by the STVHCS and UTHSCSA IRB will be copied to the reciprocal office. The procedure for reporting is as follows:

(e) The notification from the Medical Center Director will include the following information when not already included in the IRB letter to regulatory agencies [e.g. Office for Human Research Protections (OHRP), the Food and Drug Administration (FDA)]:

- (1) The nature of the event (e.g., unanticipated problem involving risks to participants or others, serious or continuing non-compliance, suspension or termination of approval of research).
- (2) Name of the institution conducting the research.

POLICY MEMORANDUM 08-37

- (3) Title of the research project or grant proposal in which the problem occurred.
 - (4) Name of the principal investigator on the protocol.
 - (5) Identification numbers of the research project as assigned by the UTHSCSA IRB and the STVHCS R&D Office and the identification number of any applicable federal award(s), grant, contract, or cooperative agreement.
 - (6) A detailed description of the problem including the findings of the organization and the reasons for the R&D Committee and/or IRB's decision.
 - (7) Actions that the UTHSCSA IRB has taken or plans to take to address the problem (e.g., requirement to revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).
 - (8) Additional actions that the STVHCS R&D Committee has taken or plans to take to address the problem (e.g., requirement to revise the protocol, suspend subject enrollment, terminate the research, revise the informed consent document, inform enrolled subjects, increase monitoring of subjects, etc.).
 - (9) Plans, including a timetable for completion of the investigation and/or corrective action if appropriate, for the UTHSCSA IRB to send a follow-up or final report.
 - (10) Plans, including a timetable for completion of the investigation and/or corrective action if appropriate, for the STVHCS R&D Committee to send an additional follow-up or final report.
- (f) The Hospital Director will send the notification to the following:
- (1) Director, Veterans Integrated Service Network 17.
 - (2) Regional VA Office of Research Oversight (ORO).
 - (3) VA Office of Research and Development, if the problem involved VA-funded research.
 - (4) Privacy Officer, if the report involves unauthorized use, loss, or disclosure of individually-identifiable patient information from the STVHCS.
 - (5) Information Security Officer, if the report involves violations of information security requirements of the STVHCS.
 - (6) Biomedical Research Foundation of South Texas Director, if applicable.
 - (7) VA Service Chief responsible for the investigator.

j. STVHCS R&D Office Contact Information:

R&D Administrative Office: (210) 617-5123

POLICY MEMORANDUM 08-37

Peter Melby, M.D., ACOS for R&D: (210) 617-5300, ext 15542

Kim Summers, Pharm.D., Assistant Chief for Clinical Research: (210) 617-5123

John Villalpando, Administrative Officer for R&D: (210) 617-5300, ext 15538

R&D website: <http://www.vasthcs.med.va.gov/research/default.htm>

5. **REFERENCES:** MOU; VHA Handbook 1200.5; What to Report to ORO
6. **RESPONSIBILITY:** Associate Chief of Staff for Research (151)
7. **RECISSION:** STVHCS Research Service Policy Memorandum 07-37, dated May 2, 2007
8. **RECERTIFICATION:** April 2011

//signed//

PETER MELBY, M.D.

ACOS for Research and Development