THE ORGANIZATIONAL STRUCTURE OF THE INSTITUTIONAL REVIEW BOARD

1. POLICY

The Birmingham VA Medical Center (BVAMC) Human Research Protection Program (HRPP) is committed to protecting the rights and welfare of human research subjects by outlining policies and delineating the organizational structure of the Institutional Review Board (IRB; also previously and elsewhere referred to as the Subcommittee on Human Studies). When veterans take part in VA research, they rely on the VA to keep them safe and they entrust the VA to safeguard the quality, safety and integrity of the research program.

It is the policy of the BVAMC HRPP to ensure that the applicable Federal, state, and local regulations are carried out in protecting the rights and welfare of subjects who voluntarily participate in investigational studies within this Medical Center. This Standard Operating Procedure (SOP) is written documentation of the organizational structure, process, roles, and responsibilities of the IRB.

This policy establishes procedures that ensure research at the BVAMC is conducted in accordance with the requirements of the BVAMC HRPP, as well as state and federal regulations. The Department of Veterans Affairs was one of 17 departments and agencies that agreed on August 19, 1991 to follow the Federal Policy for the Protection of Human Subjects [21 CFR 56.109(a)]. This policy is incorporated in [38 CFR 16, 17]. Each VA Medical Center that conducts human research is required to have an IRB, also called the Subcommittee on Human Studies [VHA Handbook 1200.05].

The Purpose of the IRB: It is acknowledged by the BVAMC that the purpose of the IRB is to review, approve, require modifications of (to secure approval), or disapprove all human research activities that are proposed to take place at the BVAMC regardless of whether research is funded or non-funded. The IRB assures that the rights and welfare of individuals involved as subjects of research under Federal auspices are being protected in accordance with federal regulations, VA [38 CFR Part 16,17], FDA [21 CFR Part 50,56] and DHHS [45 CFR Part 46]. This is in keeping with the commitment of the BVAMC to provide the highest quality care possible to those who authorize and entrust themselves to this institution for medical treatment.

Note: Research that has been classified as “classified research”, involving human subjects cannot be approved by a VA facility IRB or affiliate IRB or Research and Development Committee or performed at VA facilities.
Scope of Authority of the IRB Defined: The BVAMC has two IRB’s of record (at this time, UAB IRB is coming in the future) designated to review human research studies conducted at the BVAMC. One is the BVAMC IRB and the other is the VA Central IRB (CIRB). Both are organized and empowered to act under the authority of regulations specified by the Department of Veterans Health Administration, a Department of the United States Federal Government. Each of these IRB’s functions independently of other VA organizational entities in their role to protect participants enrolled in human research studies at the BVAMC. Both IRB’s, are designated by the BVAMC Director and the R&D Committee and are named in the BVAMC FWA, (note: an FWA is required for Department of Defense research activities, considered a certification to conduct research) and will prospectively review and make a decision concerning all human subject research conducted at the BVAMC, or by BVAMC employees or agents, or otherwise under the auspices of the BVAMC. Furthermore, each IRB has statutory authority to take any action necessary to protect the rights and welfare of human subjects in BVAMC’s R&D program.

Each IRB has the authority to approve, require modifications of, or disapprove a research study or modification to an approved research project; and to conduct continuing review of each study at intervals appropriate to the degree of risk, but not less than once per year. Each IRB has authority to suspend, or terminate, the enrollment and/or ongoing involvement of human subjects in the facility’s research as it determines necessary for the protection of those subjects. Each IRB has the authority to observe and/or monitor the BVAMC’s human subject research to whatever extent it considers necessary to protect human subjects. The scope of the authority includes all research involving human subjects conducted at, supported by or otherwise affiliated with the BVAMC [38 CFR 16, 17], FDA [21 CFR Part 50, 56] and DHHS [45 CFR Part 46].

Statutory Basis for IRB Authority: The statutory basis for these authorities is as follows:

- VA (Department of Veterans Affairs) regulations pertaining to protection of patient rights. [38 CFR 17.34 and 17.34a]
- VA (Department of Veterans Affairs) regulations pertaining to rights and welfare of patients participating in research. [38 CFR 16 - Federal Policy for the Protection of Human Subjects]
- VHA (Veterans Health Administration) Requirements for the Protection of Human Subjects in Research. [VHA Handbook 1200.05]
- FDA (Food and Drug Administration) regulations pertaining to rights and welfare of patients participating in research involving investigational drugs and devices. [21 CFR 50, 56]
- DHHS (Department of Health and Human Services) regulations pertaining to rights and welfare of patients participating in research supported by DHHS. [45 CFR 46]
2. RESPONSIBILITIES

The BVAMC Director is responsible for oversight of both the IRB and all VA investigators (compensated with VA appointment, WOC, or IPA); assurance that IRB members and investigators are appropriately knowledgeable to conduct research in accordance with ethical standards and all applicable regulations; and development and implementation of an educational plan for IRB members, staff and investigators. The BVAMC Director reviews all actions listed in the R&D Committee minutes.

The Director is also responsible for ensuring that IRB members, research staff and R&D Committee members are free from undue pressure or undue influence in fulfilling their responsibilities. If the IRB Chairperson, member, or staff person considers that the IRB has been unduly influenced by any party, he/she shall make a confidential report to the Director and/or ACOS/R&D. The Director or ACOS/R&D will be responsible for investigating the allegation and suggesting any recommendations regarding corrective action.

The Director will be responsible for determining any final recommendations required for corrective actions if needed. The Director cannot approve an action involving human research that has not been approved by the IRB. Additionally, the Director and all organizational officials are prohibited from approving any research that has not been reviewed and approved by the IRB and R&D Committee. The Director is responsible for ensuring that adequate resources for the IRB to fulfill its responsibilities are available.

Chief of Staff (COS) is responsible to the Director for oversight of the BVAMC Research program including the HRPP. The COS is responsible for determining (with the assistance of the IRB Chair) necessary actions to protect subjects if a study has been closed/expired/terminated or suspended.

The Research and Development (R&D) Committee reviews all activities of the IRB and recommends to the Director approval or disapproval of the actions of the IRB. The R&D Committee may not approve human research that has been disapproved by the IRB, but it may disapprove a previously IRB approved study. The R&D Committee is responsible, through the BVAMC Chief of Staff to the Director, for maintaining high standards throughout the R&D program and for the adequacy of the IRB’s policies and procedures.

BVAMC Institutional Review Board (IRB) is a subcommittee of the R&D Committee and reports directly to the R&D Committee. However, the IRB functions independently and is responsible for the initial evaluation and subsequent progress reviews of investigational studies involving humans. The IRB has the responsibility and specific authority to approve, require modifications (in order to secure approval), disapprove, suspend, or terminate approval of any BVAMC human subject research activity. The IRB has the specific authority to observe, or have a third party observe, the consent process or the research activities. Within the review process, the IRB is responsible for safe-guarding human subjects in the areas of informed consent, voluntary participation, confidentiality, and ensures that human experimentation is performed under stipulation and procedures of the written protocol as approved. All protocols involving human research must be reviewed and
approved by the IRB prior to submission to the R&D Committee for final review and acknowledgment. Initiation of human research studies may proceed only after review and approval by the IRB and final acknowledgement from the ACOS, R&D that the R&D Committee and all subcommittees have reviewed the study and approved if appropriate.

**VA Central Institutional Review Board (CIRB)** is a committee set up by the VA to review human research that is sponsored by Co-Operative Studies (CSP) and other multi-site studies. The CIRB will report to the BVAMC R&D Committee any research approvals or reviews it conducts for the BVAMC Research Program. For more information about CIRB please see the MOU in place with the BVAMC and/or the Standard Operating Procedures of the CIRB located at the CIRB website.

**University of Alabama at Birmingham (UAB) IRB** is a committee set up to review human research and once approved with an updated FWA, will be one of the BVAMC IRB’s of record. UAB IRB will report to the BVAMC R&D Committee any research approvals or reviews it conducts for the BVAMC Research Program. For more information about UAB please see the MOU in place with the BVAMC, the BVAMC/UAB SOP and/or the Standard Operating Procedures of the UAB IRB located at their website.

**The IRB Chairperson** is responsible for chairing IRB meetings in an orderly manner with procedures defined by Robert’s Rule of Order and following the SOPs as published. The IRB Chairperson (or designee) is responsible for assisting investigators in determining when studies meet the regulatory definitions of human research and require IRB review. Additionally, the IRB chair or designee determines if submitted research can be approved using expedited procedures or if the study meets federal regulations for an IRB exemption. Once determined, the IRB chair is responsible for conducting the expedited review, and forwarding exempt research to the R&D Committee. See SOP #4 Expedited Review and #5 Exempt Research for more details. Additionally, the IRB Chair is responsible for reviewing each protocol submitted to the IRB to evaluate and assure there is at least one IRB member who is knowledgeable or experienced with such participants who may be vulnerable to coercion or undue influence. If subjects are at risk due to a suspended/expired/terminated or closed study, the IRB Chair is responsible for notifying the COS and working together to determine what is necessary to protect the subjects. Additionally, the IRB Chair evaluates all adverse events reported to the IRB to determine the seriousness of the event and whether or not it meets the criteria for reporting to the BVAMC Director and ORO as outlined in VHA Handbook 1058.01 Research Compliance Reporting Requirements.

**IRB Members** are responsible for following all HRPP SOPs in regard to review of research activities, requirements for continuing education, requirements to disclose potential conflict of interests, and other requirements set forth in the HRPP SOPs. Members are to submit a conflict of interest form annually or sooner if significant changes emerge during the year.

**Investigators (Principal and Co-investigators)** are responsible for conducting their research in accordance with all agreements with the IRB and all HRPP SOPs. Investigator responsibilities are detailed in BVAMC SOP # 13. All investigators are required to comply with all relevant research-related policies and procedures. All requests to conduct research
involving human subjects must be submitted in accordance with the requirements set forth in the BVAMC HRPP SOPs.

**The Principal Investigator (PI)** is responsible for submitting the proposal and all relevant documentation, to the IRB for evaluation and approval before the research can be initiated. Under no circumstances may an investigator begin a study involving human participation without approval from the IRB and R&D Committee. Final acknowledgement will be forwarded by the ACOS that all subcommittees have reviewed (approved if appropriate) the study for research. The IRB recognizes one Principal Investigator (PI) for each project. The PI has ultimate responsibility for his/her research project; all official IRB correspondence is addressed to the PI. Co-investigators communicate with the IRB through the PI. Students can serve as an investigator either under the supervision of a VA investigator (Part Time (PT), Full Time (FTE), or WOC [Without Compensation] appointed) or if the student is located at one of the affiliate universities. All investigators (PI and co-investigators) must have a VA-approved appointment while participating in a BVAMC research project.

**The BVAMC IRB Administrator** carries out the mission of the IRB and reports directly to the Administrative Officer for Research at the BVAMC. The IRB Administrator for the CIRB carries out the mission of the IRB and reports to the Director of the PRIDE program. The duties include maintenance of all IRB files (including the update of IRB membership roster, as needed), correspondence, and documents, taking and preparing minutes of IRB meetings, maintaining electronic files/systems, tracking files for review and signatures from responsible individuals, and other duties described below.

**Research Compliance Officer (RCO)** conducts quality improvement activities to measure, assess, and improve compliance with institutional HRPP and IRB policies and practices to protect human research subjects. These activities include a periodic evaluation of investigator compliance with VA HRPP and IRB requirements, annual evaluation of IRB performance (i.e. minutes, IRB study files), audits of Conflict of Interest notifications, and review of any audits done by other organizations such as Federal agencies, or other internal auditing processes. All RCO audit reports are submitted to the IRB and R&D Committee for their review. The RCO is the CIRB liaison for CIRB studies conducted at BVAMC.

**Other Committees:** The IRB may require projects to be reviewed and approved by the Safety Committee, Radiation Safety Committee or the Financial Conflict of Interest Committee.

**Other Institutions:** The IRB has no authority over or responsibility for research conducted at other institutions. At this time, the BVAMC has two IRB’s of record and both are listed on the BVAMC FWA. If future affiliations are needed or requested, the BVAMC’s IRB SOP and FWA would need modifications to address the nature of the relationships.

**Regulatory Agencies:** The IRB and R&D records are subject to regulation and inspection by accreditation agencies and governmental regulatory agencies, e.g. Food and Drug Administration (FDA), General Accounting Office (GAO), Veterans Administration Inspector General (VAIG), Office for Human Research Protections (OHRP), the VA Office of Research Oversight (ORO), Department of Defense (DOD) (if applicable) and the VA
Office of Research and Development (VA ORD). Copies of any reports or correspondence to and from such agencies concerning the VAMC’s HRPP must be provided to the IRB and to the R&D Committee, which shall determine if any additional notifications are necessary. The BVAMC IRB and R&D Committees will comply with the VHA Handbook 1058.01 Research Compliance Reporting Requirements, dated June 15, 2015 regarding what to report to ORO.

3. DEFINITIONS

See SOP #24 – HRPP Definitions

4. PROCEDURES

a. Determination of When Studies Meet the Regulatory Definitions of Human Research: For most research studies, it will be obvious and the investigator will seek appropriate approvals for the research. If there is a question of whether it is “human subjects research or research at all, the investigators should send a memo to the IRB chair requesting a determination. It is also recommended that investigators utilize the OHRP Decision Chart. The IRB Chair or Vice Chair will review this information and determine if it is research and/or if it is “human subjects’ research”. In questionable situations, the IRB chair may consult with the Associate Chief of Staff, Research and Development (ACOS, R&D), the RCO, the convened IRB, Office of Research Oversight or VA Office of Research and Development. The IRB Chair will make a conservative determination and may require IRB review of the work. This determination will be reported to the Investigator in writing by the IRB. The HRPP provides overview for all activities that meet the definition of human research and each project must go through one of the mechanisms outlined in separate HRPP SOPs, i.e. initial review, expedited review, or review of exempt research.

b. Substantive amendments to approved DOD research must undergo scientific review by DOD prior to IRB review and approval.

c. The Membership of the IRB (38 CFR 16.107; VHA Handbook 1200.05): The IRB membership shall consist of a minimum of five members. Membership is selected to ensure appropriate sensitivity to community issues and/or attitudes with respect to the rights and welfare of human research subjects and to assure appropriate diversity. The membership will promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. The membership shall possess the professional competence necessary to review the types of research activities that are submitted to the IRB. The IRB shall have individuals with the appropriate scientific or scholarly expertise required to review the protocols. The IRB shall be able to ascertain the acceptability of proposed research in terms of medical center commitments and policies, applicable law, and standards of professional conduct and practice, and therefore will include persons knowledgeable in these areas. No single investigator shall be responsible for the selection of members who will review his/her investigational studies. The IRB chair, members, and
staff must have the knowledge, skills, and abilities (KSAs) appropriate to their respective roles.

**Note:** IRB meetings may not commence unless the non-scientist/community member/perspective subject representative, is present. The presence of this person is tracked using the IRB attendance rooster (attached to all IRB minutes).

**The membership roster** is maintained in an Excel spreadsheet (and in an electronic database) and includes sufficient information about members to permit appropriate representation at the meeting for each protocol under review. The IRB’s roster contains the individuals’ name, alternate names (with corresponding regular member name for whom they serve), specialty qualification, and area of scientific or scholarly expertise and whether they are a non-scientist member, a non-affiliated member, knowledgeable about or experienced in working with participants vulnerable to coercion or undue influence, or a representative of the perspective of research participants. Individuals with cultural diversity, knowledge of community values, and experience with vulnerable populations, medical expertise, and whom colleagues respect are represented in IRB membership. The IRB Administrator shall ensure that the current IRB membership roster is maintained.

The following are requirements for the IRB composition and individual members may fulfill more than one of these requirements;
- Membership consists of more than one profession.
- Membership is diversified with regard to race, gender and cultural background.
- Membership includes a physician for review of FDA regulated products.
- Membership includes one member whose background is in non-scientific areas and who represents perspective research subjects.
- Membership includes one member whose background and knowledge is in scientific areas.
- Membership includes at least one individual who is experienced with and/or who works with categories of subjects that are considered vulnerable to coercion or undue influence.
- Membership includes one member who is not affiliated with the VA or who is not part of the immediate family of a person affiliated with the VA.
- One IRB member must be a member of the R&D Committee.
- Each member is appointed for a period of three years and may be reappointed without any lapse in time.
- The IRB Chair must have a VA appointment.
- The Privacy Officer (PO) or designee, Information Security Officer (ISO) or designee, attends meetings as non-voting ex-officio members.
- Other staff such as the Research Compliance Officer attends meetings as needed in a consulting, nonvoting role.

**d. Appointment of Chairperson and Vice Chair, Length of Service, and Duties:** (VHA Handbook 1200.05). The IRB may nominate the Chair and Vice Chair from the IRB membership by a simple majority of the membership. After the qualifications and experience of the person have been assessed by review of their curriculum vitae and
determined to be appropriate for the position, the R&D Committee endorses the nominee and forwards the nominee to the Director. The individuals selected at the BVAMC IRB will hold a VA appointment of the BVAMC. The BVAMC IRB Chair must be appointed by the Director for a term of three years and may be re-appointed indefinitely. The Vice Chair must be appointed by the Director for a term of three years and may be re-appointed indefinitely. The Chairperson has primary responsibility for conducting IRB business. He/she directs IRB proceedings in accordance with institutional and federal requirements. He/she works with IRB members, institutional officials, and investigators to ensure that the rights and welfare of research subjects are protected. He/she is the signatory official for official IRB correspondence. He/she works with the Research Compliance Officer to orient new IRB members to their responsibilities as members of the IRB. The IRB Chair distributes educational materials to the IRB members with respect to changes in the laws and regulations governing either experimentation involving humans or laws and regulations governing the composition and procedures for IRB. The Vice Chair has the primary responsibility for conducting IRB business in the absence of or at the request of the Chair, or in the event of the Chair’s removal until a new Chair is elected. The R&D Committee may remove the Chairperson and/or the Alternate Chair with the concurrence of the Director for failure to perform the duties defined above.

e. Appointment of IRB Members, Length of Service, and Duties: (VHA Handbook 1200.05). IRB members are nominated by the IRB and/or R&D Committee, approved by the R&D Committee and appointed by the Director. Other VA personnel may submit names to the IRB or R&D Committee to be forwarded to the Director for consideration. The Director must officially appoint members in writing. Members of the IRB must be appointed by the Director for a period of 3 years and may be re-appointed indefinitely. The members must have the knowledge, skills, and abilities appropriate to their respective roles, as determined by a review of their curriculum vitae (CV).

f. Alternate IRB Members: Alternate members are nominated by the IRB and/or R&D Committees, approved by the R&D Committee and appointed by the Director. These alternate members replace regular IRB members who are unable to attend convened meetings of the IRB. IRB members have assigned alternate(s). The selection, length of term, duties, removal, grounds for removal, resignation terms, education requirements, compensation, liability coverage and conflict of interest policies of the alternate(s) are the same as a regular IRB member. An alternate may only substitute for his/her designated member.

g. The Periodic Review of the IRB Membership: The IRB membership and composition are periodically (at least annually) reviewed by the IRB Chair and the R&D Committee. The IRB Chair presents an annual report to the R&D Committee to ensure that the IRB is meeting regulatory and organizational requirements. This report includes review of the IRB membership to determine if the membership is appropriate including the expertise required; and whether the board meets with sufficient frequency to review the amount and type of research conducted at the BVAMC. If an investigator proposes research in a specialty not regularly represented on the IRB, the IRB Chair may request consultants for a specific time frame or suggest to the R&D Committee a change in membership to
include the specialty area. The review of the membership composition and any suggested changes in membership are documented in the R&D Committee minutes and thereby communicated to the appropriate institutional officials.

h. **Attendance Requirements and Membership Removal:** IRB members are required to attend regularly scheduled meetings. Each member is responsible for notifying the Chair and/or IRB Administrator and their designated alternate at least one week, or as soon as possible in advance of an anticipated absence. The R&D Committee may remove IRB members with the concurrence of the Director. An IRB member may be removed if 1) there are unexcused absences for more than three meetings in one year, 2) the member knowingly provides the IRB with false information, or 3) the member fails to accept and perform responsible assignment of IRB tasks as determined by the Chair or Alternate Chair. Any member may resign from the IRB at any time, by notifying the Chair in writing. The R&D Committee will (if IRB members are not meeting their obligations) officially terminate the member and then submit the termination to the Director, through the Chief of Staff via the R&D minutes.

i. **Member Orientation:** Initial and continuing research ethics education is required for all personnel who conduct, review, approve, oversee, support, or manage human subjects research for the VA and for the Department of Defense (DOD). The IRB Chairperson or the Research Compliance Officer orients new members on all federal, VA and DOD regulations regarding research. IRB members and investigators receive the BVAMC HRPP SOPs, and the BVAMC pertinent Medical Center Memoranda, and a copy of the Department of Defense regulations regarding Research if DOD research is or will be conducted at the BVAMC. The Internet web site references will be provided for the VHA Handbook 1200.05, VHA Handbook 1200.01, The Belmont Report, the 1998 FDA Information Sheets, the Institutional Review Board Guidebook (DHHS), as well as FDA [21 CFR 50,56] and DHHS [45 CFR 46]. All reference materials are available in the Research office.

j. **Continuing Education:** All IRB members and IRB staff must receive training on the protection of human subjects in research and Good Clinical Practices every year or as required by Federal agencies, (including the DOD) and the FWA and outlined in SOP #12. Attendance at formal training courses is encouraged for all members.

k. **Consultants:** The IRB is authorized to obtain the services of ad hoc reviewers, outside peer review or consultation when additional expertise is required to adequately review a specific protocol. Specifically, the convened IRB will defer to another meeting or obtain consultation if there is not at least one person on the IRB with appropriate scientific expertise to conduct an in depth review of the protocol.

An IRB may, at its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB. The need for such an individual may be identified by the IRB Chair prior to the initial IRB review or by the IRB members at the time of initial IRB review. In addition, the IRB Chair can identify consultants in specific areas, when needed, from known
colleagues or experts in the field. These individuals are sent the study submission materials to review in advance of the next scheduled IRB meeting. The criteria for selection include, but are not limited to, known or credentialed expertise in the area of concern, availability and willingness to serve in this capacity within a timely manner, and no conflict of interest with the study under review. These individuals are subject to the same conflict of interest policies as IRB members and are expected to fill out the same conflict of interest forms, prior to the actual review of any IRB study the consultant is being asked to review. These individuals may send a written report to the IRB regarding their review and recommendations or they may personally attend the IRB meeting to deliver their written report and communicate their review and recommendations verbally. These individuals may not vote; however they may participate in the IRB discussions. Legal counsel (such as VA Regional Counsel) may be retained on a consultant basis, if needed. The IRB office maintains a file of consultants (that were utilized) and their curriculum vitae/bio-sketch for future reference.

1. **Conflict of Interest(s):** All IRB members and consultants must complete a financial disclosure form (as described in SOP # 9A), which will be kept on file with their curriculum vitae (CV) and certification of education on the protection of human subjects in research. In addition to financial conflicts of interest, a conflict of interest would exist if an IRB member or consultant were an investigator or co-investigator, research assistant, or spouse of an investigator on a specific protocol under review.

   At the beginning of every meeting, the IRB Chair shall ask the IRB members and consultants to disclose any potential conflict of interest(s) related to any protocols that the IRB is about to consider. This question will be asked (and documented in the IRB minutes) of consultants each time their services are requested. The IRB minutes will document identified conflict of interests. An IRB member or consultant who is identified as having a conflict of interest may not participate in the IRB’s initial or continuing review discussion or vote on the project in which a member has a conflicting interest, except to provide information requested by the IRB. IRB members or consultants who have a conflict of interest are required to recuse themselves from the meeting room during deliberations and voting, abstain from voting, and not be counted towards a quorum for voting purposes. Abstentions are recorded in the IRB minutes. In addition, IRB members or consultants with a conflict of interest on a specific protocol are not allowed to participate in the approval process for its continuing review, expedited procedures, review of modifications, review of unanticipated problems involving risks to participants or others, or review of non-compliance with the regulations or the requirements of the IRB.

   The Chair of the FCOI subcommittee will annually review all R&D and IRB members' conflict of interest forms and bring any pertinent positive or negative findings to the R&D Committee for full review and discussion. Any identified vulnerabilities of conflict of interest (including financial) or a negative report would then be communicated by memo to the member as well as recorded in the R&D minutes. A conflict of interest is acceptable as long as remedies are in place and appropriate to minimize or negate these potential conflicts of interest in R&D matters.
m. **IRB Primary Reviewer Assignment System:** At this time BVAMC does not utilize a primary review assignment system. If this should change in the future and a primary reviewer system becomes necessary an SOP will be written at that time to meet this need. For initial and continuing reviews, the IRB members review all submissions to the IRB.

n. **IRB Meetings, Minutes, Materials and Documentation:** The IRB is required to conduct initial and continuing reviews of all non-exempt research at convened meetings at which a majority of the members are present, unless the research falls into one or more categories for expedited review.

1) Prior to the convened meeting, all members of the IRB shall be provided with sufficient information to substantially and meaningfully evaluate the proposed research and determine appropriate action during the convened meeting. Investigator responsibilities are detailed in BVAMC SOP # 13. The agenda and all supporting documentation to be reviewed are made available to all IRB members at least 4 days in advance of the meeting.

2) The IRB meets on the second and fourth Wednesday of each month. Scheduled meetings will be canceled or rescheduled for federal holidays, for lack of a quorum, or at the discretion of the Chair.

3) All canceled meetings must have a brief written explanation for doing so recorded in the minutes of the next meeting. The Chair will give notification to members in a timely manner of any rescheduled meeting.

4) As deemed necessary to accomplish the responsibilities of the IRB, the Chair may call additional meetings.

5) In order for research to be approved, it must receive the approval of a majority of members present at the meeting and must have the following to meet VA regulations:

   a. At least one non-scientific member present
   b. More than half of the membership present (i.e. a simple majority or quorum), even during actions in which a member(s) are recused due to conflict of interest(s).
   c. At least one licensed physician present for review of protocols utilizing FDA regulated test items.

6) Although not required, a non-affiliated member is highly recommended at convened meetings. Frequent absence of the non-affiliated member is unacceptable.

7) Quorums can be lost if a member or members have to leave a meeting early or recuse themselves due to conflicts of interest. In such circumstances, affected projects may be deferred until a quorum can be re-established or postponed until the next meeting. Votes by proxy are not permissible.
8) The conditions for an appropriately convened meeting are documented in the IRB minutes. Minutes of the meeting shall be prepared by the IRB Administrator, and forwarded to the Administrative Officer of Research and Development, for review prior to distribution. Although not required, the Associate Chief of Staff of Research and Development and the Chief of Staff, review and sign the IRB minutes. Once the minutes are approved and signed, copies will be distributed to IRB members and the R&D Committee. All IRB findings and actions are communicated in the IRB minutes and forwarded to the investigator in memorandums. The IRB minutes and approved activities are forwarded to the R&D Committee for their review and final approval then attached to the R&D minutes for review by the ACOS/R&D, Chief of Staff and the BVAMC Director.

9) Meetings may take place via teleconferencing. IRB minutes must include documentation that members participating via teleconferencing received the identical documents and were given time to participate during the meeting.

10) If the CIRB has reviewed any human research studies for the BVAMC the minutes of these actions will be sent to the BVAMC R&D Committee as well.

o. IRB Actions: The BVAMC IRB and/or the CIRB have specific authority to approve, require stipulations, contingencies, or modifications (in order to secure approval), table, disapprove, suspend, or terminate approval of any BVAMC human subject research activity, at any point in the course of submission or course of the study, i.e. initial review, expedited review, continuing review, or elsewhere during the course of the study. For studies of greater than minimal risk research that the IRB approved contingent upon substantive modifications or clarifications to the protocol or the informed consent, IRB approval must not occur until subsequent review by the convened IRB of the materials the PI submitted.

p. IRB Record Keeping and Required Documentation: The IRB Administrator will document and maintain all IRB records as they are received in the IRB office. The BVAMC CIRB Liaison will maintain copies of studies reviewed at the CIRB. The IRB must retain all records pertaining to research studies involved with human use indefinitely at this time, until instructions are provided and approved by the National Archives and Records Administration and are published in VHA’s Record Control Schedule. This includes IRB records of studies that were approved but never enrolled any subjects. These records are contained in a secure area to protect the confidentiality of subject information. Access is limited to authorized representatives of VA and other Federal regulatory agencies. Requests for information from study records retained in the IRB office must be in writing and document the reason for such request and by whom and addressed to the IRB Administrator. The IRB Administrators will provide the DOD with DOD IRB records upon completion of a study if they require archiving at the DOD.

IRB records are the property and the responsibility of the local research office and are maintained and/or stored as required to protect the privacy and confidentiality of subjects. IRB records of active studies are stored in locked filing cabinets in the locked IRB office with limited access keys. Files of closed IRB projects (including those that did not have
active enrollment) are stored at a VA approved storage site indefinitely at this time. Access to the IRB records may be granted to the following: ACOS for R&D, R&D Administrative Officer (AO), RCO, Chair or Alternate chair of IRB, IRB members, Chair R&D, R&D Committee members, IRB Administrator, Director, accrediting agencies, Federal (OHRP, FDA), State, or VA (local, VISN 7 RCO, ORO, OIG) authorized persons.

Research investigators shall be provided reasonable access to files related to their research, with access supervised by the IRB Administrator. All other access to IRB records is limited to those who have legitimate need for them, as determined by the Director, the ACOS of R&D, the R&D AO, the RCO, R&D or IRB Chair person, and VA Central Office. Appropriate accreditation bodies shall be provided access and may recommend additional procedures for maintaining security of IRB records. Records are accessible for inspection and copying by authorized representatives of VA and other Federal regulatory agencies at reasonable times and in a reasonable manner.

The IRB controls access to protocol files and the IRB Administrator tracks the following by written log:

1) who, other than IRB members and office staff, accessed the files,
2) what files were accessed,
3) when the files were accessed, and
4) for what purpose the files were accessed.

IRB records include written IRB standard operating procedures, IRB membership rosters, training records, IRB correspondence, IRB research application files, active research tracking system, documentation of exemptions and informed consent exceptions, documentation of expedited reviews, IRB minutes, FWA, serious adverse event reports, and/or resumes.

q. **IRB Correspondence:** The IRB Administrator shall ensure that accurate records are maintained of all correspondence to or from the IRB. IRB correspondence regarding a specific study is kept in the specific study file. All IRB decisions are reported to the investigator and the appropriate institutional officials in writing (memo or email). All correspondence will be maintained in a computer database or study specific file, and will be easily retrievable. The IRB may request (by memo, letter, or email) additional information from the PI or sponsor to enable appropriate review or to clarify any information that has been submitted to the IRB. For correspondence with CIRB, please see MOU with CIRB.

r. **General Correspondence:** For answers to questions, comments, suggestions etc. regarding the IRB forms or procedures, investigators are encouraged to contact the IRB administrator who will either respond, or relay the information to the IRB Chair or full board as needed who will respond by phone, email or memo. For questions, suggestions, comments about the HRPP or any aspect of research investigators may contact the RCO, the ACOS, R&D or the AO, and each will respond either by email, phone or memo to the investigator. If the question, suggestion, or concern involves research and data security or privacy the investigator is encouraged to contact the Information Security Officer or the
Privacy Officer who will respond by email, phone or memo to the investigator. Contact information for each of these individuals is located in Outlook and is distributed during the monthly training, which is conducted for the HRPP.

s. **Correspondence to the Investigator Conveying IRB Decision:** IRB actions and all decisions about a research protocol (including the determination of whether it is or is not research) are promptly conveyed to the PI in writing. Written communications convey stipulations for approval or reasons for disapproval/tabling and include the reasons for non-approval and may suggest changes to the protocol and/or consent form as needed before approval will be reconsidered.

If a study has been disapproved or tabled and the IRB requires additional information to conduct a thorough review, the PI may be requested to attend an IRB meeting to clarify study specific information and/or materials. If a study has been tabled and the PI does not understand the stipulations they may ask to attend the next IRB meeting to clarify stipulations and/or to provide additional information to the IRB members.

For documentation purposes, correspondence to the IRB from an investigator should be in writing. The PI has 60 days to respond to stipulations outlined in the IRB memo, (contingency or disapproval) after the 60 days has lapsed, the study must be re-submitted as a new submission for review. PI responses (written) are submitted to the convened IRB unless the stipulations were minor in nature and met expedited criteria. Expedited reviews/approvals are presented at the next convened IRB meeting for full board review. All communications from an investigator to the IRB are reviewed and discussed at the next convened IRB meeting by the members. All IRB actions and communications are maintained in a study specific file and are easily retrievable. After any and all stipulated changes are made to the protocol and/or Consent Form and are verified by the Chair or Alternate Chair, a formal IRB Approval Memo is issued to the PI. If a submission is disapproved a written memo is issued to the PI, outlining specifically why it was disapproved. The study may then be revised and resubmitted.

t. **IRB Letter of Assurance:** includes the Conditions of IRB Approval and the Penalties for Noncompliance.

u. **Correspondence to the Institutional Administration Conveying IRB Decision:** The IRB submits reviewed and approved minutes that report all decisions of the BVAMC IRB (relating to BVAMC research) to the BVAMC R&D Committee. The R&D Committee minutes are reviewed, approved and signed by the Chair R&D Committee, Chief of Staff and the Director. Terminations and suspensions are reported to individuals and federal agencies outlined in HRPP SOP #18 Reporting Requirements (pages 8-9). Lapse of IRB approval for an individual study does not constitute a termination or suspension per VA and OHRP guidance. The expired study DOES NOT need to be reported beyond the R&D Committee.

v. **Correspondence to Sponsor of Research Conveying IRB Decision:** The PI serves as the communications link between the IRB and the sponsor. For FDA regulated test
articles the sponsors and PIs agree to such linkage when they sign Form 1572.

w. **IRB Research Application Files:** Each IRB Administrator shall maintain a separate file for each research study application. Each application is assigned an IRB number. Each IRB research study file contains the following materials: protocol (including DHHS approved if applicable), scientific evaluations, revised and approved versions of informed consents (VA form 10-1086), (and if applicable the DHHS approved consent form), sponsor’s protocol or Investigator’s Brochure, any grant applications, any findings required under regulations, advertising or recruitment materials, correspondence of protocol amendments or modifications, reports of unanticipated problems involving risks to subjects, reports of SAEs, any protocol deviations/violations, Data and Safety Monitoring Board (DSMB) reports (if any), results of any internal or external quality control and monitoring activities, all IRB correspondence to and from the investigator, approval letters, (including how approved, i.e. expedited with criteria, full board review) study related forms, continuing review forms and information, and final study close-out correspondence (SOP # 3 Initial Review, lists items needed for a full review and all are kept on file). Final correspondence includes a final report from the investigator to include a premature completion of the study if applicable. In addition to the above all IRB determinations are filed with each study, i.e., risk review and analysis for initial and continuing review, authorizations and IRB determinations for waivers (of HIPPA, informed consent or written consent) and the frequency of continuing review.

x. **Research Study Tracking System:** The IRB Administrator shall maintain a tabulated tracking system of all research protocols, which will include a minimum of the PI, protocol name, date of initial protocol review and approval, and date of latest continuing review.

y. **Research Flagging System:** The IRB is charged with assessing each study that is submitted to the IRB to determine if the study should be “flagged” in the CPRS electronic patient system within the BVAMC. The IRB determines whether the medical record had to be flagged to protect the participant’s safety by indicating participation in the study and the source of more information on the study or have the IRB consider lifting the requirements to flag the medical record when VA requirements were met. This information is then conveyed to the investigator as a stipulation for approval of the research. The investigator is responsible for submitting the required verbiage of the flag to the IRB. The IRB administrator will contact the CPRS coordinator at the facility who will place the flags on electronic records for each patient flagged in a study.

The IRB determination for flagging must be noted in the IRB minutes.

z. **Documentation of Exemptions:** The R&D Office maintains a file of each study submitted for an IRB Exemption and the determination of applicable exemption category. The file includes R&D Committee approval letters and any other material of relevance under federal regulation (for more details see SOP #5 Exempt Research).

aa. **Documentation of Exceptions/Waivers from Informed Consent:** Each IRB maintains
documentation of protocols submitted in writing by the investigator, as well as the IRB and R&D approval of exceptions/waiver of informed consent status on appropriate studies. The IRB must approve the exception/waiver of informed consent status and communicate that status in writing to the investigator and note it in the IRB minutes. See HRPP SOP#7 Research Informed Consent.

bb. **Documentation of Expedited Reviews:** Each IRB must maintain documentation of submitted expedited reviews and the status or approval of such a review. The actions are communicated in writing to the investigator and noted in the IRB minutes. (i.e. copy of the memo with approval or disapproval indicated). See HRPP SOP #4 Expedited Review.

c. **Documentation of Expired Approval:** Each IRB must maintain documentation of a study’s failure to meet Continuing Review (SOP #6) requirements and subsequently expire. If the requirements are not met and the study expires, documentation of the expiration must be noted in the IRB minutes. The documentation must include:

   1) The investigator was notified, in writing, of the expiration,
   2) The investigator was notified to cease all research activities,
   3) The investigator was asked to provide a list of research subjects who could be harmed by stopping study procedures (if, applicable) and
   4) The investigator was notified re-view must be completed within 90 days of the expiration date.

If, after 90 days of lapse of approval, the Investigator does not submit Continuing Review documents to the IRB, the study will be administratively closed and noted in the IRB minutes. The Investigator’s Service Chief will be notified of the closure.

dd. **Report forms and Documentation that the IRB Reviews such Reports:** All Deviation/Violation, Miscellaneous and Protocol Amendment Forms, are reported by the investigator on the appropriate form, signed by investigators, and reviewed by the IRB Chair or Vice Chair.

e. **IRB Review of Serious Unanticipated Problems and Unanticipated SAEs:** Within 5 business days after a report of a serious unanticipated problem involving risks to subjects or others, or of a local unanticipated SAE, the convened IRB or a qualified IRB member-reviewer must determine and document whether or not the reported incident was serious, unanticipated, and related to research

   a. If the convened IRB or the qualified IRB member-reviewer determines that the problem or event is serious and unanticipated and related to the research, the IRB Chair or designee must notify ORO via telephone or e-mail within 48 hours and report the problem or event directly (without intermediaries) to the facility Director within 5 business days after the determination.

      a) The report must be made in writing, with a simultaneous copy to the ACOS/R&D and the R&D Committee. (see Attachment A)

      b) The facility Director must report the problem or event to the appropriate ORO RO within 5 business days after receiving such
notification.

2. If the convened IRB or the qualified IRB member-reviewer determines that the problem or event was serious, unanticipated, and related to the research, a simultaneous determination is required regarding the need for any action (e.g., suspension of activities; notification of subjects) necessary to prevent an immediate hazard to subjects.

3. All determinations of the qualified IRB member-reviewer (regardless of outcome) must be reported to the IRB at its next convened meeting.

4. If it was determined that the problem or event is serious, unanticipated, and related to the research, the convened IRB must determine and document whether or not a protocol or informed consent modification is warranted.

5. If the convened IRB determines that a protocol or consent modification is warranted, the IRB must also determine and document the following:
   a) Whether or not previously enrolled subjects must be notified of the modification and, if so,
   b) When such notification must take place and how such notification must be documented.

ff. **Statements of Significant New Findings Provided to Subjects:** The "new findings" statement is included in the Consent Form template provided to investigators. The IRB verifies that this statement is included in the approved Consent Form. The method and urgency of conveying significant new findings varies depending on safety specifics. For example, if new information indicates that study medication is harmful then subjects will be contacted immediately. In less urgent cases, for example a change in PIs, written notification may be appropriate. A phone call in addition may be appropriate. A revised Consent Form and re-consenting all affected subjects may be necessary. All actions will be maintained in the IRB's investigator project file.

gg. **Documentation of Convened IRB Meeting Minutes:** The IRB Administrator prepares meeting agendas and minutes for each convened IRB and meeting. IRB minutes must be written and presented for approval to the full convened board within three weeks of the previous meeting. Once approved by the members at a subsequent meeting, minutes may not be altered by a higher authority. Minutes include documentation of:
   • Members present, absent/excused or by video conference or teleconference (members attending by videoconference or teleconference must document all pertinent information has been received and reviewed)
   • Separate deliberations for each action of the IRB
   • Alternate(s) present, and which primary member they are replacing
   • Any others who are present at the meeting, visitors etc.
   • Number of members present and statement of quorum requirements to transact business (including a non-scientific member)
   • Conflict of interest disclosure (and circumstances in which members with conflicts of interest did not participate in deliberations or voting)
   • Approval/modifications of prior meeting minutes
   • Old business
   • Previously TABLED items identified
- For initial and continuing review, the approval period and basis for approval period (3, 6, 9, 12 months or other but at least annually) based upon the degree of risk.
- Items reviewed (Abstract, Protocol, Consent Form, Data Security Form, etc.) including dates and version of items reviewed.
- Reports, approvals, etc. from other sites if multi-study (see SOP #3 Initial Review).
- New business.
- Initial reviews to include all submitted materials highlighted in SOP# 3 Initial Review.
- The approval of research contingent on specific minor conditions by the chair or designee, in the minutes of the first IRB meeting that took place after the date of approval.
- The determination of the level of risk based on pertinent discussions including risk and benefit analysis, assessment of informed consent document, controverted issues and their resolution.
- The minutes summarize the discussion of any controverted issues.
- Discussions of appropriateness and rationale for elements requiring special attention, if any.
- Minutes provide a summary of the justification for including non-veterans as subjects.
- Minutes provide a summary of the discussion when real social security numbers (SSN’s), scrambled SSN’s or the last four digits of SSNs will be used in the study. The summary needs to include the security measures that are in the place to protect the SSN instances embedded in the study.
- The approval is documented in the minutes of the first IRB meeting that takes place after the date of the approval.
- Justification of any deletion or substantive modification of information concerning risks or alternative procedures contained in the DHHS-approved sample consent document.
- The basis for requiring change prior to final approval, if any.
- Determinations required by the regulations and protocol specific findings justifying those determinations for waiver or alternation of the consent process unless those determinations were documented in the IRB records.
- Determinations required by the regulations for Exempt research.
- Approval/Contingent Approval/Table/Disapproval actions taken by the IRB and the basis for each of these items.
- IRB minutes must include the rationale for significant risk/non-significant risk device determinations.
- Records of voting (number of members for, against, abstained, recused, and excused on each action) that meets the required quorum to be present for each vote, including a non-scientific member.
- Expedited reviews or reviews of Exempt Research and actions taken (e.g. advertisements, amendments, Investigator Brochure updates, protocol deviations, modifications, notifications, Sponsor SAEs, BVAMC SAEs).
- Members who recused(excused themselves by name.
- Investigational Device Exemption, if applicable.
- Risk Analysis for investigational devices, if applicable.
- Additional records of receipt for investigational devices in the custody of the PI.
• Noncompliance or complaints, if any
• Research Audit reports from the CQI team (Research Compliance Officer, Information Security Officer and Privacy Officer)
• Educational materials or In-service discussion, if any
• Flagging of records for research purposes
• Documentation of expiration of study approval

hh. **Other IRB records** include the following: progress reports submitted by investigators; reports of injuries to participants; investigator brochures; any supplemental information; all correspondence; and any other records relevant to IRB business or review of the research studies.

ii. The IRB members, staff, consultants and alternate IRB members must be free from undue influence to make decisions regarding the ethics and safety of human subjects in research. If at any time members are unable to conduct IRB business because of undue influence they should report to one of the following: (depending on where the influence is generated from) the Research Compliance Officer, ACOS, R&D, Chair IRB, Chair, R&D Committee, COS, or the Medical Center Director. All allegations will be investigated (assigned accordingly by the Director) with submitted written reports to the Medical Center Director and/or other regulatory agencies as required and outlined in SOP #18.

jj. **IRB Functions:** Each IRB has and follows written policies and procedures that are specifically described in separate SOPs and include the following functions:

• To conduct initial reviews of research studies (SOP#3, SOP#7, SOP #8, SOP#9A, SOP #10, and SOP#12) to ensure that all safeguards and requirements for ethical research and protection of vulnerable subjects are met prior to approval
• To conduct continuing reviews of research studies and to determine which projects require continuing review more often than annually (SOP#6)
• To conduct review of proposed informed consent forms/process involving human subjects and review proposed exemptions to informed consent (SOP#7)
• To conduct review of modifications and amendments to previously approved research; to ensure that changes in approved research are not initiated without IRB review and approval; and to determine whether projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review (SOP #11 and SOP #17)
• To conduct reviews by the expedited process, when appropriate (SOP #4)
• To conduct review of study closures (SOP#6)
• To conduct review of and ensure that unanticipated problems involving risks to subjects, protocol deviations, and adverse effects, whether research related or not, are promptly reported to the IRB (SOP #11 and SOP #17)
• To conduct review of allegations and findings of noncompliance (SOP #18)
• To conduct review of participant recruitment and outreach materials (SOP #8 and SOP#14)
• To conduct review of safety issues, compliance audits, and quality improvement activities (SOP #17 and SOP #19)
To determine if an investigational device is of significant risk or can be categorized as a non-significant risk device (SOP # 22)

5. REFERENCES

VHA Handbook 1200.05 Requirements for the Protection of Humans in Research
VHA Handbook 1058.01 Research Compliance Reporting Requirements
Medical Center Memorandum 151-03, Subcommittee on Human Studies (IRB)
BVAMC Federal Wide Assurance
Title 38 CFR 16, 17; 21 CFR 50, 56; 45 CFR 46
DHHS Title 45 CFR Part 46

6. ATTACHMENTS

Membership Roster

7. RESECISSIONS


8. REVIEW DATE

January 1, 2020

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Louis Dell ‘Italia, MD
ACOS, Research and Development