

Procedures for Clinical Service Cost Reimbursement

1. If Clinical Support Services will be involved in the performance of a research project, the Director/Manager of that Service or Department will be given a copy of the abstract and protocol and consent form. Anticipated research related costs, i.e. cost over and above routine patient care, are determined by each individual Service/Department Director/Manager.
2. At the time an investigator submits a research proposal, he/she must complete and sign a "Request for Cost Impact" containing the following statement: **"The attached research protocol utilizes one or more of the Medical Center's Clinical Support Services. The Principal Investigator must obtain the cost impact from the Directors/Managers of the Services involved. THIS FORM MUST BE COMPLETED AND SIGNED BY THE APPROPRIATE DIRECTORS/MANAGERS BEFORE SUBMISSION TO THE RESEARCH AND DEVELOPMENT COMMITTEE FOR APPROVAL." *SIGNATURES ARE ONLY REQUIRED IF THERE IS A COST IMPACT.**
3. Cost Impact statements are to be returned to the Research & Development (R&D) Administration office (151) and submitted with the proposal to the Research and Development Committee for review. If for any reason the cost impact statement has not been submitted prior to the R&D meeting, R&D approval is contingent upon receipt.
4. Every proposal is reviewed by at least two individuals on the R&D Committee. If the cost impact statement appears inadequate, or if additional cost impact statements are required, the investigator will be notified in writing, and will be advised that a final approval letter will not be issued until a satisfactory response has been received.
5. Copies of cost impact statements are maintained in the office of the Executive-Director of the Tuscaloosa Research and Education Advancement Corporation (TREAC). The Executive-Director is, therefore, aware of each Investigator who requires support from Clinical Support Services to carry out his/her research. At this VAMC, most Clinical Support Services' Departments cannot determine, after-the-fact, whether procedures have been performed in the course of standard clinical care, or for research related purposes. Therefore, the investigator is instructed on a quarterly basis to inform the TREAC Executive-Director of any funds due the VAMC as a result of services, other than standard clinical care, that have been provided in support of each research project. If no cost has been incurred on a particular project, a negative report is required.
6. The TREAC Executive-Director will advise the TVAMC Financial Management Department Director of dollar amounts due to services rendered by TVAMC according to the investigator's quarterly reports. The Financial Management Department Director generates a Bill of Collection to TREAC for each clinical service rendered by TVAMC. Upon receipt of payment from TREAC, the Financial Management Department Director will deposit these funds into the appropriate fund control point of the Clinical Support Services Department concerned.

TUSCALOOSA VA MEDICAL CENTER
ASSESSMENT OF CLINICAL IMPACT

The attached research protocol utilizes one or more of the following Medical Center's Clinical Support Services. The Principal Investigator must obtain the cost impact from the Directors/Managers of the Services/Departments involved. THIS FORM MUST BE COMPLETED AND SIGNED BY THE APPROPRIATE SERVICE/DEPARTMENT DIRECTORS/MANAGERS BEFORE SUBMISSION TO THE RESEARCH AND DEVELOPMENT COMMITTEE FOR APPROVAL.

TITLE: _____

SPONSOR: _____

Principal Investigator: _____

Anticipated starting date: _____

Anticipated closing date: _____

Planned # of research patients (veterans): _____

Planned # of non-veteran subjects requiring procedures: _____

Will this research study require support from VA patient care Service(s)/Department(s) that is above and beyond that necessary to the patient care treatment needs for subjects in any of the following categories:

1. Inpatient care for research study: Yes___ No___
(If **yes**, state anticipated # of patient days x # of patients x cost/day for research purposes)

_____ patient days X _____ patients X \$_____/day = \$_____

Ward: _____

Comments:

Director, Service Line (Print Name)

*Signature of Director, Service Line

2. Clinical Laboratory Procedures: Yes___ No ___

| # of Pts | Procedure | Procedure/Pt | Cost/Procedure | Total Cost |
|-------------|-----------|--------------|----------------|------------|
| _____ | _____ | X _____ | X _____ | = \$ _____ |
| _____ | _____ | X _____ | X _____ | = _____ |
| _____ | _____ | X _____ | X _____ | = _____ |
| _____ | _____ | X _____ | X _____ | = _____ |
| Grand Total | | | | = _____ |

Comments:

Manager, Laboratory and Radiology Department (Print Name)

*Signature of Manager, Laboratory and Radiology Department

3. Radiology and Imaging Procedures: Yes___ No ___

| # of Pts | Procedure | #/Pt | Cost per procedure | Total Cost |
|-------------|-----------|---------|--------------------|------------|
| _____ | _____ | X _____ | X _____ | = \$ _____ |
| _____ | _____ | X _____ | X _____ | = _____ |
| _____ | _____ | X _____ | X _____ | = _____ |
| Grand Total | | | | = _____ |

Comments:

 Manager, Laboratory and Radiology Department (Print Name)

 *Signature of Manager, Laboratory and Radiology Department

4. Pharmacy: Yes___ No ___

of Pts _____ # of anticipated prescription refills/patient: _____
 Drug Cost: \$ _____
 Administrative Cost: \$ _____
 Total Projected Cost: \$ _____

Comments:

 Director, Pharmacy Department (Print Name)

 *Signature of Director, Pharmacy Department

5. Specialty Tests/Procedures (EKG/EEG/EMG/ Endoscopy): Yes___ No ___

| # of Pts | Procedure | Procedure/Pt | Cost/procedure | Total Cost |
|----------|-----------|--------------|----------------|------------|
| _____ | _____ | X _____ | X _____ | = \$ _____ |
| _____ | _____ | X _____ | X _____ | = _____ |

Comments:

 Department Director (Print Name)

 *Signature of Department Director

6. Other Costs (required in addition to established research clinic support): Yes___ No ___
 If yes, check one and describe:

____ Mental Health
 ____ Primary Care

Describe:

Director, Service Line (Print Name)

*Signature of Director, Service Line

7. Summary of patient participation and projected research-related costs:

Duration of study/schedule of research-related procedures/identification of VA services and external sources to be utilized, etc.

Additional pertinent information:

Principal Investigator (Print Name)

Signature of Principal Investigator

Date

8. Review and Comments:

Chair, Research and Development (Print Name)

Signature of Chair, Research and Development

Date

Coordinator of Research and Development (Print Name)

Signature of Coordinator of Research and Development