HealthFacts Rhode Island Application for Custom REQUESTS

# (Copy of Online Application)

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Please be advised that applicants are unable to save and return to the online application form, and therefore must complete the full application at one time. We strongly recommend applicants review this copy of the application to ensure they have the necessary information and documentation before beginning the online application.

## Instructions

## The Rhode Island Department of Health (RIDOH) may release data from HealthFacts RI, Rhode Island's All-Payer Claims Database (RI APCD) to a person or organization engaged in improving, evaluating or otherwise measuring health care provided to members.

This application is for custom requests only. Custom requests are for data that is not already available publicly on the HealthFacts RI website, and for which standard claims extracts are not appropriate. This may include custom and/or aggregated reports, or custom extracts. Please refer to the HealthFacts RI webpage ([www.health.ri.gov/data/healthfactsri](http://www.health.ri.gov/data/healthfactsri)) prior to completing this application to confirm that neither the publicly available data nor the Standard Claims Extracts meet your needs.

All requesters must complete this application specifying their request and what type of data is needed. Some requests will require a further review process by the Data Release Review Board and approval by the Director of the Department of Health. This review process is required when one or more of the following is requested:

* Individual claims with member level detail (e.g. unique member ID, 5-digit zip code, etc.)
* Cells based on fewer than 11 members are *not* suppressed
* Data will be linked to another data source that increases the risk of member re-identification

To make a custom request, follow the steps below:

## Review the PDF copy of the online application and gather all necessary documentation before beginning the online application. PLEASE NOTE: YOU CANNOT SAVE AND RETURN TO THE ONLINE APPLICATION ONCE YOU HAVE BEGUN.

## 2. Complete the online application.

## 3. Attach a signed Data Use Agreement to this application, if applicable.

## 4. Complete the Application Fee Remittance form and mail check to RIDOH (see Application Fee information below).

## 5. Once application and fee are received, a member of the HealthFacts RI team will contact you regarding any issues with your application and next steps.

## 6. The application is posted to http://www.health.ri.gov/data/healthfactsri/ for public comment for at least 10 business days.

## 7. If a data management plan is required, the APCD Data Release Review Board Data Security Committee reviews the data management plan and makes a recommendation to the full Board.

## 8. If applicable, the RI APCD Data Release Review Board reviews the application to ensure patient privacy is protected, and makes a recommendation to the RIDOH Director.

## 8. The Director approves or denies the request based on the Board’s recommendation.

## 9. If approved, the applicant completes the Data Acquisition Fee Remittance Form (Exhibit D of the Data Use Agreement) and mails a check to RIDOH.

## 10. The State transfers data to the applicant (30-45 days after request is approved).

FORMS AND ATTACHMENTS: All forms and application attachments associated this application can be found at http://www.health.ri.gov/data/healthfactsri. Please submit all attachments in document or PDF format. The following file types are not accepted: .html, .exe, .dll, .php, .php3 or .phps. Attachments are limited to 10 MB.

## APPLICATION FEE: Along with submission of the online application, all applicants must mail in the Application Fee Remittance Form and a non-refundable $100 application fee (in the form of a check). DATA REQUESTS WILL NOT BE CONSIDERED UNTIL BOTH THE ELECTRONIC APPLICATION AND THE REMITTANCE FORM/APPLICATION FEE ARE RECEIVED. The Application Fee Remittance Form and mailing address can be found on the RIDOH HealthFacts RI webpage (www.health.ri.gov/data/healthfactsri).

DATA RELEASE REVIEW BOARD: HealthFacts RI staff will determine if the application requires review by the APCD Data Release Review Board and notify the requester. Any application that requires review by the Board will be posted to the HealthFacts RI webpage for at least 10 business days. The Board reviews requests to ensure patient privacy will be adequately protected by evaluating the following criteria:

* Appropriate privacy and security protections are in place to protect patient privacy
* Applicant will adhere to cell size suppression policy
* Access to data is necessary to achieve project's intended goals (there is an obvious link between the project and data)
* Applicant is qualified to protect and responsibly handle data

## If a data management plan is required, the application will also be reviewed by the Data Release Review Board Data Security Committee for adherence to HealthFacts RI data security guidelines.

## This review is strictly for privacy protection purposes and is not a scientific review. Applicants are encouraged to participate in the Board meeting during which their application is being reviewed.

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## DATA ACQUISITION FEE:

## If your request for APCD data is approved, a member of the HealthFacts RI team will contact you about payment. Price of custom requests is determined on a case by case basis.

## For questions regarding the data request process or this application, please contact DOH.HealthFactsRI@health.ri.gov or Alyssa Harrington, APCD Project Manager at aharrington@freedmanhealthcare.com or 617-243-9509 Ext. 204.

## Per the RI APCD Regulations, parts of this application will be posted on the RIDOH HealthFacts RI website for public comment.

## Questions marked with \* are required.

## General Information

TO BE COMPLETED BY ALL APPLICANTS.

**2.1 Today’s Date:**

**2.2 Project Title:**

**2.3 Organization Name:**

**2.4 Organization Type (check one):**

* Academic Researcher
* Government Agency
* Data Submitter to RI APCD
* Other (please specify)

**2.5 Project Lead (Principal Investigator, Project Director, etc.):**

**2.6 Project Lead Title:**

**2.7 Other project personnel from your organization who will have access to RI APCD data:**

### Contact Information

This section of the application will not be posted publicly.

**2.8 Project Contact:**

**2.9 Project Contact Title:**

**2.10 Phone Number:**

**2.11 Email:**

**2.12 Mailing Address:**

## Project Details

TO BE COMPLETED BY ALL APPLICANTS.

Refer to the RIDOH HealthFacts RI webpage (www.health.ri.gov/data/healthfactsri) for information about the publication submission and review process.

### Project Description

**3.1 Provide a description of your project, including the following information (attach additional pages if needed):**

* Project purpose
* Research questions (if applicable)
* Why the data you are requesting is necessary to accomplish the project’s purpose.
* If requesting the Extended Extract, please justify why service date and 5-digit zip codes are required for the project.
* If requesting payer (i.e. United Healthcare, Aetna) identifiable information (i.e. payer name), please justify why these elements (table provided in *Appendix A*) are required for the project.
* If requesting provider (i.e. institution, physician) identifiable information (i.e. hospital name, physician name, physician specialty), please justify why these elements (table provided in *Appendix A*).

**3.2 Attach additional project description information, if needed.**

### Distribution of Project Findings

**3.3 Describe how project findings/results that will be disseminated and to whom (e.g. peer-reviewed publication, organization newsletter, program evaluation report, etc.)**

Note: If requesting individual claims data, or an aggregate report with small cells displayed, all findings/results which will be publicly distributed must be submitted to the RI Department of Health at least 15 days prior to any release to ensure that the conditions of the Data Use Agreement (i.e. cell suppression) are being met (see Section 10 of the Data Use Agreement for further details).

**3.4 Attach additional information about how findings will be distributed, if needed.**

## Data Requested

TO BE COMPLETED BY ALL APPLICANTS.

\*\*Please note: Medicare FFS data can only be released to projects being directed and at least partially funded by the State of Rhode Island.

**4.1 Indicate the type of data requested:**

* Aggregate data (e.g. counts, percentages, sums, etc.)
* Individual claims data

**4.2 If requesting aggregate data on more than 4 data elements, or using any filters on subsets of the population, it is possible that some percentage of the cells will based on fewer than 11 members. These cells will be suppressed unless the application is reviewed by the Data Release Review Board and approved by the Director of RIDOH. Will you need the results of these cells?**

* Yes
* No

**4.3 Describe the request in as much detail as possible, including the following information:**

* Years of data requested (2011 – 2020 available)
* The data to be included (for requests for individual claim lines, specify the data elements requested. Refer to the Standard Claims Extracts Data Dictionary on the RIDOH HealthFacts RI webpage ([www.health.ri.gov/data/healthfactsri](http://www.health.ri.gov/data/healthfactsri)) for a list of all available elements).
* For aggregate data, how the data should be stratified (e.g. by gender, age group, county, etc.)
* Whether custom analytics are required, such as applying attribution methodologies, calculating quality metrics, applying custom groupers, etc.
* If tracking a specific population, such as an evaluation cohort, specify the number of individuals included in the cohort.

**4.4 Attach additional request description, if needed.**

**4.5 Explain why the requested data elements are necessary for this project.**

**4.6 Does this request require tracking a specific population of individuals (i.e. an evaluation cohort)?**

* Yes
* No

**4.7 If yes, explain why tracking this specific population is necessary for the project.**

**4.8 How often will the data be updated?**

* This is a one-time request
* Quarterly
* Annually

**4.9 Attach any data specifications, explanations of methodologies, and/or report templates that may be used to develop the custom file(s).**

### Data Linkages

TO BE COMPLETED ONLY IF REQUEST IS FOR INDIVIDUAL CLAIMS DATA.

RI APCD data may only be linked to other data sources that are specified in this application and for purposes approved by RIDOH. Applicants may not link APCD data to another data source for the purpose of identifying a member. If this project requires linkage to another data source (e.g. Census data), the applicant must provide a justification for why this linkage is necessary.

**4.10 Will RI-APCD data be linked to another data source?**

* Yes
* No

**4.11 If yes, will the data be linked to patient level data, individual provider level data, facility level data, or aggregate level data? (Check all that apply.)**

* Individual patient data
* Individual provider data
* Facility level data
* Aggregate level data

**4.12 If yes, provide a justification for each linkage indicated above and the steps you will take to prevent identification of individual members.**

**4.13 If yes, attach additional information about linkage, if needed.**

## Data Security

TO BE COMPLETED IF REQUEST IS FOR INDIVIDUAL CLAIMS DATA, OR AGGREGATE DATA IN WHICH CELLS BASED ON FEWER THAN 11 MEMBERS ARE DISPLAYED.

This section of the application will not be posted publicly.

### Data Management Plan

**5.1 Attach a completed Data Management Plan template.**

The Data Management Plan Template can be found at [www.health.ri.gov/data/healthfactsri](http://www.health.ri.gov/data/healthfactsri).

**5.2 Attach any standard Data Privacy and Security Policies and Procedures from your organization.**

**5.3 Attach additional organizational Data Privacy and Security documents (if applicable)**

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### Use of Third Party Agents or Vendors

**5.5 Are you contracting with any third-party vendors who will store the data on-premise or on their own network (separate from the applicant)?**

* Yes
* No

**5.6 If yes, list the name(s) of the third-party vendor(s):**

**5.7 If yes, list the services to be provided by third-party vendor(s):**

**5.8 If yes, attach a completed Data Management Plan template for the third-party vendor.**

**5.9 If yes, attach any standard Data Privacy and Security Policies and Procedures from the third-party vendor.**

While documentation from contracted third-parties is not required, it may be requested at any time during the review process.

**5.10 Are you using any third-party data warehouse/storage solutions that will have access to the data?**

* Yes
* No

**5.11 If yes, will the third-party warehouse solution have access to decrypted data?**

* Yes
* No

### Applicant Qualifications

**5.12 Describe the qualifications of your organization and key personnel to implement the proposed data management plan with fidelity and to adhere to the Data Use Agreement.**

## Application Documentation

TO BE COMPLETED IF REQUEST IS FOR INDIVIDUAL CLAIMS DATA, OR AGGREGATE DATA IN WHICH CELLS BASED ON FEWER THAN 11 MEMBERS ARE DISPLAYED.

### Data Use Agreement

**6.1 Attach a signed Data Use Agreement form. The Data Use Agreement will be appended to include the data covered by the agreement and the application upon approval of the data request.\***

### The Data Use Agreement can be found at the RIDOH HealthFacts RI webpage ([www.health.ri.gov/data/healthfactsri](http://www.health.ri.gov/data/healthfactsri)).

### Checklist

**6.2 Verify that all required documents are attached.**

* Completed Data Management Plan Template
* Signed Data Use Agreement

### Signatures

By entering a name below, the Applicant attests that all information contained in this application is true and the Applicant will adhere to the restrictions and requirements outlined in the Data Use Agreement, to be executed between the Applicant and the Department of Health upon approval of this data request.

**6.3 Name:\***

**6.4 Title:\***

**6.5 Organization:\***

**6.6 Date:\***