|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **For Office Use Only** | | | | | | | **Date Revised** |  |
| **Request #:** | |  | | | | | **Date Received:** |  |
| **I.** | **Identification/Eligibility** *please include complete contact information for each requestor* | | | | | | | |
| **Name, Address, Phone numbers** | | | | | | **Type of Organization** | | |
| Requestor Name: | | |  | | | Government Entity  Law Enforcement Agency  Regulatory Agency  Other:  Nonprofit Educational Institution  University of California  Other: | | |
| Name of Project: | | |  | | |
| Organization: | | |  | | |
| Address: | | |  | | |
| City: | | | | State: | ZIP: |
| Phone #: | | |  | | |
| FAX #: | | |  | | |
| E-Mail Address: | | |  | | |
| **Statutory Mandate** | | | | | |
| **Request is a statutorily mandated activity**   * **Legal citation:** | | | | | | | | |
|  | | | | | | | | |

1. **Project Description**

**Purpose**

* Clearly state the general purpose of your project. *(Brief summary explaining questions to be answered, similar to a research abstract. This is a point of entry problem statement.)*
* Provide a broad overview of how the data you are requesting will be used to achieve the purpose of this project.*Please include a description of both the study population and any control groups that are utilized, similar to the brief description of methods in a research abstract.*

1. **Requested Data:**

**Indicate the databases and years of data you are requesting**

|  |  |
| --- | --- |
| Patient Discharge Data (PDD) | Years |
| Ambulatory Surgery Center Data (ASD)  **Please Note:** Ambulatory Surgery (ASD) data include encounters from general acute care hospitals and licensed freestanding ambulatory surgery clinics, during which at least one ambulatory surgery procedure is performed. If a hospital-based ASD encounter resulted in a same-hospital admission, the hospital-based ASD encounter would be combined with the inpatient record. A separate ASD record would not be reported for that encounter. When analyzing ASD records, you may want to include the PDD records for which the route in the Source of Admission is noted as Ambulatory Surgery and the Licensure of Site is noted as “This Hospital.” | Years |
| Emergency Department Data (EDD)  **Please Note:** Emergency Department Data (EDD) includes encounters from hospitals licensed to provide emergency medical services. EDD services include basic, standby, or comprehensive. Urgent care should not be automatically considered an EDD encounter. If the EDD encounter resulted in a same-hospital admission, the EDD encounter would be combined with that inpatient record and no separate EDD record would be reported. When analyzing EDD records, you may want to include the PDD records for which the route in the “Source of Admission” is noted as the hospital’s own emergency room (“Your ER”). | Years |
| Linked PDD/ED/AS/Birth Cohort Data | Years |
| CA Coronary Artery Bypass Graft (CABG) File (2006-Most Recent Year Available) | Years |
| Probabilistic-Mortality linkages to Patient Discharge Data | |
| **Linked Patient Discharge Data and Vital Statistics Death Statistical Master File (VS-DSMF)** | |
| Version A – (death records are linked to the last PDD discharge record, regardless of level of care —1990-Most Recent Year Available) | Years |
| Version B – (death records are linked to the last PDD discharge record for acute level of care — 1990-Most Recent Year Available) | Years |
| **Deterministic-Heuristic – mortality linkages to Patient Discharge Data** | |
| Linked PDD and VS-DSMF (2005-Most Recent Year Available) | Years |
| Linked EDD and VS-DSMF (2005-Most Recent Year Available) | Years |
| Linked ASD and VS-DSMF (2005-Most Recent Year Available) | Years |

**Indicate the format you prefer**

SAS

Comma Delimited (TXT, CSV)

* Briefly explain why the years of data being requested are necessary for your research**.**

### Have you done a statistical power calculation? Yes No

* What is the required sample size you need to test your hypothesis?

* Describe and justify the subset of records you are requesting. For example, a geographic subset (county), age-specific subset (under 18 years of age), or gender-specific subset (female).

* If you are requesting all records, provide a clear explanation why subsets cannot be utilized.

***Please attach Variable Justification Grid and complete Justification Reasons/Each Variable***

1. **Applications**

**Will the requested data be used in any of the following ways?**

|  |
| --- |
| Geographic Information System(GIS) Yes No  * If yes, please describe.    Combination/merge/coordination with other data set(s) or databases Yes No  * If yes, please describe, including a description of the data variables within other data sets or databases (for example census data, hospital level demographics, socioeconomic indicators, etc.)  Linked patient-level information Yes No  * If yes, please: Describe this patient-level information, including a list and description of the data variables that comprise it (including OSHPD data). *Please complete the section for any type of patient level linkage, including within OSHPD data (example: use of RLN)*  * Describe the linkage methodology.    List the data variables that will be used to accomplish the link.   **Note:** Approvals to use these data sources other than OSHPD files must be provided (see Approvals below) |

1. **Products**

**Note:** Patient-level data cannot be contained in any product that is distributed beyond the requestor

* What products will be developed from this project? *(Example: reports or articles.)*

* If the end product is an article, please provide the name of the journal(s) you plan to submit it to.

* Please include a brief description of each product including the level of detail to be contained in any charts, graphs, tables, or maps.

**Describe how you will treat small cells within the data products to avoid identifying individuals.** (Note: Small cell is considered <15.)

1. **Security** a letter from authorizing sponsor agency from IT department is a requirement.

*For Internal Use Only: The OSHPD Data Exchange Security Questionnaire Form ISO 5305.8-F will be sent to the contact on this request for completion once this request has been reviewed.*

### Are interim files created in the processing of the data? Yes No

**If yes, please describe what data elements are included in each file and what variables are dropped or masked**.

**Note**: Describe, in detail, the security measures under which you propose to use, maintain, and store the requested data. Address each of the main categories below. Please see the appendix called “Recommended Practices for Safeguarding Access to Confidential Data” for guidelines.

* **System:** (i.e. stand alone, host based, networked)

* **Hardware/Software:**

* **Access Control**:

* **Physical Environment**:

* **Data Storage**:

* **Encryption**:

1. **Access to Data**

Who will have access to the Patient-Level data?

* **List all. Include Name, Location, Role, Data Use Activity.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * **Will an outside contractor(s) or external collaborator be used?**  Yes  No | | | | | |
| **If yes, please provide the following information for each data user outside of the University sponsored system. System, Hardware/Software**, **Access Control, Physical Environment,** **Data Storage, Mode of Accessing Data** and **Encryption.** Please see the attached “Recommended Practices for Safeguarding Access to Confidential Data” for guidelines. (If you are using more than three outside contractors, please complete the same information for all outside contractors. Add additional sheets as needed.) Please include contracts, MOU, interagency (example: IA between two universities) or other agreements establishing contract or collaboration between two data users. | | | | | |
| **Contractor/Collaborator #1** | | | | | |
| Name: |  | | Telephone: | |  |
| Organization: |  | | Fax: | |  |
| Address: |  | | E-mail: | |  |
| Function: |  | | | | |
| **Describe which data will be provided to this external data user (contractor/collaborator) and describe data access and use. Include contract with request. Note: All patient level data must be stored at the Sponsoring University, must be on servers owned and operated by the university, and cannot be copied or downloaded.**  **Note:** Address each of the main categories above. | | | | | |
| **Contractor/Collaborator #2** | | | | | |
| Name: |  | Telephone: | |  | |
| Organization: |  | Fax: | |  | |
| Address: |  | E-mail: | |  | |
| Function: |  | | | | |

### **Describe which data will be provided to this external data user (contractor/collaborator) and describe data access and use.**

### **Note: All patient level data must be stored at the Sponsoring University, must be on servers owned and operated by the university, and cannot be copied or downloaded.**

1. **Approvals**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * **Approval(s) to use other database(s) is/are:** | | | | |
| Attached  Pending approvalExpected approval date:  Not required or applicable | | | | |
| **IX.** | | **If this request is subject to CPHS review** | | |
| * **CPHS approval is**:   Attached   * **Project Number:** * **Date current CPHS protocol expires**: * **Pending approval**   Attached   * **Expected approval date**:   Draft(with initial data request submission) | | | | |
| **Note:** The CPHS recommendation and protocol must accompany the final request. You must maintain a current approved CPHS protocol for the full period of time you wish to hold the OSHPD data and provide copies to OSHPD of each letter of approval from CPHS for annual renewals of your project protocol. Your organization’s Internal Review Board (IRB) cannot be a substitute for CPHS approval. | | | | |
| **X.** | Data Due Date:  Data CDs must be returned, SFTP Files must have a letter of destruction signed by authorizing IT personnel at sponsoring university stating clearly that the data was removed from the network server and on what date this occurred.  Data due date can be extended if CPHS protocol is current and data is necessary for continuing research. | | | |
| NOTE: Data, including the original files provided by OSHPD and any interim files that contain patient-level data created during the project, must be returned to OSHPD by the earlier of the expiration date of your CPHS protocol or the data return deadline set forth above. You may request an extension of time on your data request to OSHPD if the protocol with CPHS is current and approved. Provide copies of any letters of approval from CPHS for annual renewals of your project protocol until data is due.  To request an extension of time on your OSHPD data request, please send a letter asking to extend the return date along with a current CPHS approval letter and current protocol to: OSHPD/HDR 2020 W. El Camino Blvd. Ste 1100 Sacramento CA 95833. Upon approval of this request OSHPD will send a letter confirming the revised extension date. | | | | |
| Signature of Requestor | | | | Date |
| Requestor Name (Please Print) | | |  | |
| **For Student Requestors only:** | | | | |
| Signature of Faculty Advisor | | | | Date |
| Faculty Advisor Name (Please Print) | | | | |

Thank you for completing this request. When returning the completed form(s), choose one of the following:

E-mail: [DataAndReports@oshpd.ca.gov](mailto:DataAndReports@oshpd.ca.gov)

Mail: OSHPD-HDR 2020 W. El Camino Blvd. Ste. 1100 Sacramento Ca 95833