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| For Office Use Only | | | | | | | | | | | **Date Revised:** |  |
| Request #: | |  | | | | | | | | | **Date Received:** |  |
| §128766 of the Health and Safety Code gives OSHPD the legal authority to disclose patient-level data to hospitals, local health departments and local health officers, and certain federal agencies conducting a statutorily authorized activity. The law provides that the disclosure be consistent with limited data set standards and limitations under 45 CFR §164.514. Any hospital that receives data under §128766 shall not disclose the data to any person or entity except as required or permitted by the HIPAA medical privacy regulations. The hospital and its contractor(s) are prohibited from re-identifying or attempting to re-identify any information received pursuant to §128766. This form must be completed if you are requesting access to a limited data set from OSHPD. | | | | | | | | | | | | |
| Identification/Eligibility | | | | | | | | | | | | |
| Contact Information: | | | | | | | | | | | | |
| Hospital CEO or Administrator: | | |  | | | | | | | Please check applicable boxes and provide documentation: | | |
| Hospital: | | |  | | | | | | | Under HIPAA, the Hospital is a | | |
| License Number: | | |  | | | | | | | Covered Entity | | |
| Address: | | |  | | | | | | | Affiliated Covered Entity (ACE) pursuant to 45 CFR §164.105 (b) | | |
| City: |  | | | | | State: |  | ZIP: |  |  | | |
| Phone number: | | |  | | | | | | |  | | |
| Email Address: | | |  | | | | | | |  | | |
| Hospital’s Designated Point of Contact for Data Request (if different): | | | | | | | | | |  | | |
| Name of contact: | | | |  | | | | | | | | |
| Department: | | | |  | | | | | | | | |
| Address: | | | |  | | | | | | | | |
| City: |  | | | | | State: |  | ZIP: |  | | | |
| Phone number: | | | |  | | | | | | | | |
| Email Address: | | | |  | | | | | | | | |
| Hospital’s shipping address for data (if different): Please Note: this is only for providing an alternate address for either the hospital CEO/Administrator or the Designated Point of Contact. | | | | | | | | | | | | |
| Shipping contact: | | | | |  | | | | | | | |
| Address: | | | | |  | | | | | | | |
| City: |  | | | | | State: |  | ZIP: |  | | | |
| Phone number: | | | |  | | | | | | | | |
| Email Address: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| Purpose | | | | | | | | | | | | |
| Please indicate the purpose for which the data are requested: Health Care Operations  Research (additional submittals required; please contact HDR for more information)  Other (please specify): | | | | | | | | | | | | |
| Please describe the specific purposes for which the data are requested and how they will be used: | | | | | | | | | | | | |
| Receipt and Use of the Data | | | | | | | | | | | | |
| Within the hospital, please list the business units that will receive and use the data and provide the functional title of the individual who will be responsible for the data in each unit. | | | | | | | | | | | | |
| Outside of the hospital: Will the patient-level data be released outside of the hospital? If yes, please identify the entities or persons to whom the data will be released and check the basis under HIPAA for this use.    Basis for use (check all that apply):  Use within an Affiliated Covered Entity (ACE) \*  Disclosed to an outside Business Associate  Other (please specify): | | | | | | | | | | | | |

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| **\*If the data will be used within an ACE, please identify the member(s) of the ACE that will use the data and how the data will be accessed.**    If the data will be disclosed to an outside contractor, please identify the contractor and provide a current copy of your signed Business Associate Agreement with the contractor. If there is more than one contractor, please provide the required information for each contractor. | | | |
| **Contractor #1** | | | |
| Name of firm: |  | Telephone: |  |
| Primary Contact: |  | Email: |  |
| Title/Function: |  |  |  |
| Address: |  |  |  |
| City, State, ZIP: |  |  | |
| Please describe which dataset(s) will be provided and how the data will be provided to the contractor: | | | |
| **Contractor #2** | | | |
| Name of firm: |  | Telephone: |  |
| Primary Contact: |  | Email: |  |
| Title/Function: |  |  |  |
| Address: |  |  |  |
| City, State, ZIP: |  |  | |
| Please describe which dataset(s) will be provided and how the data will be provided to the contractor: | | | |
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| **Requested Data and Data Products** | | |
| ***Please Note:*** *Non-patient level data products developed using Limited Data Set confidential data are also available. Although these products are not patient level data, they are not de-identified and the requester must agree to treat the information they contain as Protected Health Information (PHI). See below to order.* | | |
| **Indicate the databases and/or products and years of data you are requesting:** | | |
| **Patient Discharge Data (PDD**) | Years: |  |
| Model Data Set (MDS)  Custom Data Set (please attach a Data Justification Grid) | | |
| **Emergency Department Data (EDD)** | Years: |  |
| Model Data Set (MDS)  Custom Data Set (please attach a Data Justification Grid) | | |
| ***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 results in a same-hospital admission, the EDD encounter will be combined with that inpatient record and no separate EDD record will 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”).* | | |
| **Ambulatory Surgery Data (ASD)** | Years: |  |
| Model Data Set (MDS)  Custom Data Set (please attach a Data Justification Grid) | | |
| ***Please Note:*** *Ambulatory Surgery (ASD) data includes 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 results in a same-hospital admission, the hospital-based ASD encounter will be combined with the inpatient record. A separate ASD record will 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.”* | | |
| **Additional Products** | | |
| Patient Origin/Market Share (PO/MS) Pivot Table – Model Dataset Version | Years: |  |
| ***Please Note:*** *This product is available by year, starting with 2008. Geographical subsets are available and provided in Excel format. The statewide product is only available in comma delimited format.* | | |
| AHRQ Prevention Quality Indicator (PQI) | Years: |  |
| Summary File, 2005-2015Q3 (Version 5.0); 2016 (Version 6.01) | | |
| AHRQ Prevention Quality Indicator (PQI) | Years: |  |
| Record-Level File, (2010, 2011, 2012, 2013, 2014, 2015-Q1-Q3) (Version 5.0);  2016 (Version 6.01) **with** PQI Summary File | | |
| ***Please Note:*** *PQI products (Summary and Record-Level Files) run under different Versions of the AHRQ PQI software are not comparable due to software updates. The PQI Summary File is automatically provided with the Record-Level File. The 2015-Q4 data is not available due to software changes resulting from the transition from ICD-9-CM to ICD-10-CM/PCS.* | | |

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| **Statewide or Geographic Subset of Data Set(s) or Products** | | | | |
| If you are requesting Statewide Model Data Set (MDS), provide a clear explanation why all patients are being requested.    If you are requesting a Geographic Subset Data Set or Product by county(-ies) or ZIP Code(s), please describe and explain the set of records you are requesting. | | | | |
| **Select Format for Data Set(s)** | | | | |
| Indicate the format you prefer for Model Data Set (MDS) and Custom Data Sets only: | | | | |
| SAS | | Comma Delimited | | |
| SAS PROC Format Code is available *\** | | Comma Delimited, Label *\** | | |
| *\*these formats available for years 2009 or later.* | | | | |
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| **Acknowledgements and Signatures** | | | | |
| **Please initial each of the following:** | | | | |
|  | Under HIPAA, limited data sets are Personal Health Information (PHI). | | | |
|  | The HIPAA Medical Privacy Rule applies to all limited data sets that I receive under this application. | | | |
|  | I agree to protect all nonpublic data products received from OSHPD, even if they do not contain patient level data, and to treat these products as PHI. | | | |
|  | Any data I receive pursuant to this request will be maintained in a secure environment. | | | |
|  | **If applying for data to use within an ACE, I certify that the applicant is an ACE.** | | | |
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|  | | | Date |  |
| Signature of Hospital CEO or Administrator | | | | |
|  | | |  | |
| Name of Hospital CEO or Administrator | | | | |

Thank you for completing this request. Please submit your completed form(s) to [DataAndReports@oshpd.ca.gov](mailto:DataAndReports@oshpd.ca.gov)