**OHS_logo_1_xs**

**Hospital Inpatient Discharge, Emergency Department and**

**Ambulatory Surgery Data**

**Data Request Form**

## Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 202\_\_\_\_\_\_ Record/Invoice Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Office of Health Strategy (OHS) maintains an acute care hospital inpatient discharge and ambulatory surgery databases, has access to ChimeData emergency department database and fills requests for patient data from all interested individuals, institutions and other government agencies. Data released to interested parties however are subject to the provisions of Connecticut General Statutes [§19a-654](https://www.cga.ct.gov/current/pub/chap_368z.htm#sec_19a-654), Connecticut Administrative Regulations [Section 19a-167g-94](https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_19aSubtitle_19a-167gSection_19a-167g-94/), the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other local, state and federal regulations relating to the maintenance of patient privacy.

Fees may be associated with responding to these requests. Only request forms that are fully completed will be processed.

Requests may be for aggregate or patient level data. Aggregate data are data combined with other data elements that exclude the identity of an individual. Note that Emergency department encounter data are available only in aggregate. For all aggregate data, discharge or encounter categories with fewer than six patients will be noted as less than six (<6).

To request:

1. Aggregate data – Fill out Sections A B, and C, click on the link to submit your request: <https://ohsct.govqa.us/WEBAPP/_rs>
2. Patient–level data – For patient identifiable/confidential and de-identified related to [Conn. Gen. Stat. §19a-654(d)(2)](https://www.cga.ct.gov/current/pub/chap_368z.htm#sec_19a-654) fill out Sections A and C, click on the link to submit your request: <https://ohsct.govqa.us/WEBAPP/_rs>
3. Patient–level data – For scientific or medical research as provided for by  [§ 19a-25-3](https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_19aSubtitle_19a-25Section_19a-25-3/) of the regulations of Connecticut state agencies, follow the instructions @ [DPH Human Investigations Committee](mailto:DPH%20Human%20Investigations%20Committee) or contact [Lou.Gonsalves@CT.gov](mailto:Lou.Gonsalves@CT.gov), Chair of the [Human Investigations Committee (HIC](http://www.ct.gov/dph/cwp/view.asp?a=3115&q=466698)) for the process and forms for patient identifiable/confidential and de-identified data requests.

After submitting your request for data, you will be notified within four (4) business days that:

1. the request has been approved for preparation;
2. the request has been denied because it involves confidential information or does not meet required thresholds; or
3. it cannot be readily determined until the report is prepared whether it meets required thresholds.

Please review the full text of [Section 19a-167g-94](https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_19aSubtitle_19a-167gSection_19a-167g-94/) of the regulations for an overview of the data request process, confidential data elements, and required thresholds **before** completing this request form. Refer to the attached data dictionary for a listing of data elements.

INFORMATION REQUESTED – (PLEASE FILL OUT THE RELEVANT SECTIONS AND ATTACH ADDITIONAL PAGES IF MORE SPACE IS REQUIRED)

SECTION A – GENERAL INFORMATION

1. **APPLICANT INFORMATION**

|  |  |
| --- | --- |
| **Applicant Information** | **Details** |
| Principal Investigator’s Name  and Title |  |
| Organization Name |  |
| Street Address, City/Town,  State, Zip Code |  |
| Email |  |
| Phone Number |  |
| Date of Application  (MM/DD/YYYY) |  |
| Project/Research Title |  |
| Project/Research Objective(s)  (100 words or less) |  |
| Project/Research Question(s) to be addressed via proposed research (if applicable, briefly) |  |
| Contact Name and Title |  |
| Contact Phone Number |  |
| Contact E-mail |  |
| 1.Other Accessing Data | 1. |
| 2. |
| 3. |
| 4. |

1. **PROJECT SUMMARY**

Briefly describe the purpose of this project and how the requested data will accomplish this purpose

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| --- |
|  |

SECTION B – AGGREGATE DATA REQUEST

1. **LIST OF DATA ELEMENTS TO BE INCLUDED** (Data Dictionary is provided):

|  |
| --- |
|  |

1. **TIME PERIOD FOR REQUESTED DATA**

(Data available by hospital fiscal years*: Inpatient (1991–2022), Emergency Department (1996-2021*) and *Outpatient Surgery Data (2016-2019)*

**Hospital Inpatient Discharge Data**

2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015  2016

2017 2018 2019 2020 2022

**Purpose:**

**Emergency Department Data**

2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015  2016

2017 2018 2019 2020 2021

**Purpose:**

**Outpatient Surgery Data**

2017 2018 2019

**Purpose:**

1. **DATA SELECTION CRITERIA** (See Appendix 1: Patient Data Dictionary and e.g. specify.ICD-9-CM, ICD-10-CM, CPT or MS-DRG codes, demographic variables, or at least two contiguous zip codes, if zip code information is being requested):

|  |
| --- |
|  |

1. **SAMPLE REPORT LAYOUT** (Must be attached)

|  |
| --- |
| 1. **SELECT TYPE OF MEDIA OR FORMAT FOR REPORT** |
| **Media**:  Email  Paper Report  CD-ROM  Portable USB Thumb Drive  **Format**:  Excel (.xls, xlsx)  ASCII (.txt)  Comma Separated Values (.csv) |

|  |
| --- |
| 1. **RETURN REQUESTED BY (please check one)** |
| Mail  Email  Fax  Pick up |

**Submission of this form serves as confirmation that the request conforms to the confidentiality provisions of CT Office of Health Strategy statutes and regulations.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **CONTACT INFORMATION** | | | | |
| Name: |  | | | |
| Street Address: |  | | | |
|  |  |  |  |

*City State Zip Code*

|  |  |  |
| --- | --- | --- |
|  |  |  |

*Telephone Fax*

|  |  |
| --- | --- |
| Email: |  |

|  |
| --- |
| 1. **INVOICE INFORMATION** |

**NTT INFORMATION**

|  |  |
| --- | --- |
| Files on CD @ $5 per file | $ |
| Paper Copies @ $0.25 per page | $ |
| Programming / Formatting fee @ $12.96 per quarter hour | $ |
| Postage & Shipping Charges (if applicable) | $ |
| **Total Amount Due** | $ |

**MAKE CHECK PAYABLE TO**:

***TREASURER, STATE OF CONNECTICUT***

**REMIT TO**: Attention: Attallah Roundtree

THE OFFICE OF HEALTH STRATEGY

450 Capitol Avenue, MS#51OHS

P.O.BOX 340308

Hartford, CT 06134-0308

***PLEASE BE SURE TO INCLUDE ONE COPY OF THIS BILL WITH YOUR PAYMENT***

**SECTION C: PATIENT IDENTIFIABLE/CONFIDENTIAL OR DE-IDENTIFIED DATA REQUESTS** related to [Conn. Gen. Stat. §19a-654(d)(2)](https://www.cga.ct.gov/current/pub/chap_368z.htm#sec_19a-654)

1. **RESEARCH PROTOCOL**
2. Provide a summary background, purposes and origin of the research (in 200 words or less)
3. Describe the organizational qualifications: Briefly describe your organizations experience with patient data
4. How will you ensure that prior to any publication of any analyses utilizing the patient that such release is incompliance with the requirements for attributes, including cell suppression rules, risk of inferential reidentification? Describe how you intend to comply with this requirement.
5. **TIME PERIOD FOR REQUESTED DATA**

|  |
| --- |
| **Hospital Inpatient Discharge Data**  2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015  2016  2017 2018 2019 2020 2022 |

1. **DATA SELECTION CRITERIA (Indicate on Appendix 1: Patient Data Dictionary)**
2. **DATA SECURITY AND INTEGRITY**
3. Where will the data be located physically? (Provide the delivery address for the data including the building and floor)
4. Provide the name and information of the organization that will host and manage the patient data, including the name of the custodian
5. Describe how you will maintain the inventory of patient data, derived analytics and scratch files and how you will manage physical access to data during the duration of the project.
6. Describe your organization’s patient data confidentiality policies for or agreement with the principal investigators, data custodian or others who will have access to this data. Provide supporting documents.
7. **TECHNICAL SAFEGUARDS**
8. Describe the policies you have in place to physically secure data such as site or office access controls, secured file cabinets, and locked offices?
9. What safeguards are in place to restrict data access among the research team? Describe your password protected access system
10. Describe your policies and procedures for ensuring the patient data is protected while stored on your server(s). Describe how your organization ensures that the patient data on servers cannot be copied to local workstations, laptops, smartphones and the media (CDs, DVDs, hard drives, thumb drives, etc.)Describe how you will maintain the inventory of patient data, derived analytics and scratch files and how you will manage physical access to data during the duration of the project.
11. Provide your organization’s written information security program (WISP) or its policies and procedures regarding security provisions, particularly security or privacy safeguards against unauthorized
12. **SIGNATURES**

By signing this application, you certify that the information enclosed herein is true and correct and if this Application is approved you agree to the terms and conditions of the Data Use Agreement and/or Memorandum of Agreement for the use of this patient Data.

|  |
| --- |
| For the Applicant: |
| Signature: |
| Name: |
| Title: |
| Date: |
| Organization: |

| **Appendix 1: Patient Data Dictionary** | | | | | |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **No.** | **Data Field** | **Data Field Description** | **Requested (Y/N)** | **Requestor**  **Questions, if any** |
| 1 | Address 1 | Hospital address, line 1 |  |  |
| 2 | Address 2 | Hospitals address, line 2 |  |  |
| 3 | Admit Date | Date of hospital admission/start of care |  |  |
| 4 | Admit Source | The circumstances associated with the patient's admission |  |  |
| 5 | Age | Age of patient in years at discharge |  |  |
| 6 | Age in Days | Age of patient in days |  |  |
| 7 | Age in months | Age of patient in months |  |  |
| 8 | Attending Physician | The CT license of practitioner primarily responsible for the patient's care during the admission |  |  |
| 9 | Birth Date | Date of patient's or provider's birth |  |  |
| 10 | Birth Weight | Birth weight of newborns in grams |  |  |
| 11 | Charge - ICU/CCU | Total intensive and coronary care charges for this admission. |  |  |
| 12 | Charge - Lab | Total laboratory charges for this admission. |  |  |
| 13 | Charge - Other | Total other charges for this admission. |  |  |
| 14 | Charge - Pharmacy | Total pharmacy charges for this admission. |  |  |
| 15 | Charge - Physical Therapy | Total physical therapy charges for this admission. |  |  |
| 16 | Charge - Radiology | Total radiology charges for this admission. |  |  |
| 17 | Charge - Respiratory | Total respiratory charges for this admission. |  |  |
| 18 | Charge - Routine | Total routine charges for this admission. |  |  |
| 19 | Charge - Supply | Total supply charges for this admission. |  |  |
| 20 | Charge - Surgery | Total surgery charges for this admission. |  |  |
| 21 | Charge Accommodation Total | Total accommodation charges for this admission. |  |  |
| 22 | Charge Ancillary Total | Total ancillary charges for this admission. |  |  |
| 23 | Charges Reported | Total charges for this admission. |  |  |
| 24 | Charges Total | Calculated total charges for this admission. |  |  |
| 25 | City | Provider's city |  |  |
| 26 | CT Provider Billing Identifier | Provider's billing identification number. |  |  |
| 27 | Diagnosis All Occurrences (1-10) | ICD-9-CM or ICD-10-CM codes for the primary and secondary diagnoses, 1 - 10, which exist at the time of admission or which develop subsequent to the admission which affect the patient's treatment or length of stay |  |  |
| 28 | Diagnosis All Occurrences (Description) | Description of diagnoses |  |  |
| 29 | Diagnosis Principal | The ICD-9-CM or ICD-10-CM code for the principal diagnoses which exists at the time of admission |  |  |
| 30 | Diagnosis Related Group (DRG/MS-DRG) | Clinically distinct categories developed by CMS as a proxy for resource utilization |  |  |
| 31 | Diagnosis Related Group (DRG/MS DRG) Description | Description of DRGs |  |  |
| 32 | Discharge date | Date of patient discharge |  |  |
| 33 | Discharge Disposition | The circumstance of the patient's disposition or status |  |  |
| 34 | Doctor Type | Submitted physician type |  |  |
| 35 | Ethnicity | Patient's ethnicity |  |  |
| 36 | First Name | Provider's first name |  |  |
| 37 | Fiscal year | Fiscal Year the patient's discharge date falls within (this is between October of a calendar year to September of the following calendar year) |  |  |
| 38 | Hospital County | FIPS County name |  |  |
| 39 | Hospital Name | Full name of Hospital (each sub-unit listed separately) |  |  |
| 40 | Hospital Name - All Units Combined | Full name of Hospital (all units of hospital rolled into one name) |  |  |
| 41 | Hospital Number | The 2 digit CT OHS hospital number |  |  |
| 42 | Hospital Provider Number | The last four digits of the Medicare provider number for the unit of the hospital from which the patient was discharged |  |  |
| 43 | Hospital State | Hospital's state code abbreviation |  |  |
| 44 | Length of Stay | Length of stay in days for this admission |  |  |
| 45 | License Type | Provider's license type |  |  |
| 46 | Major Diagnostic Category (MDC) | CMS Body symptom or disease related groupings of clinical conditions; may not be used to infer resource consumption |  |  |
| 47 | Major Diagnostic Category (MDC) Description | CMS MDC description |  |  |
| 48 | Patient Control Number | The unique number assigned to each patient/admission combination within a hospital. Unique to visit |  |  |
| 49 | Patient County | FIPS county name |  |  |
| 50 | Patient ID Number | Medical record number. A unique number assigned to each patient within a hospital; not specific to an admission. |  |  |
| 51 | Patient State | Patient's state abbreviation |  |  |
| 52 | Payer ID 1 | Payer name which identifies the payer organization from which hospital expects at time of discharge some payment for bill |  |  |
| 53 | Payer ID 2 | Payer name which identifies the payer organization from which hospital expects at time of discharge some payment for bill |  |  |
| 54 | Payer ID 3 | Payer name which identifies the payer organization from which hospital expects at time of discharge some payment for bill |  |  |
| 55 | Physician ID | Physician ID as submitted |  |  |
| 56 | Physician Name | Physician’s name |  |  |
| 57 | Previous Admit | Length of time between the admission date of this admission and the discharge date of the patient's most recent previous admission |  |  |
| 58 | Primary Payer - OHS | The payment source that was expected to provide the primary share of the payment for the hospitalization (e.g. Medicare, Medicaid, Commercial, Self-pay etc.) |  |  |
| 59 | Payer Description- OHS | State-specific payer plan code description |  |  |
| 60 | Procedure All Occurrences (1-10) | ICD-9-CM, ICD-10-CM or CPT code for significant procedures that are surgical in nature, carry procedural or anesthetic risk, or require specialized training or special facilities or equipment |  |  |
| 61 | Procedures All Occurrences (Description) | Description of PX codes |  |  |
| 62 | Procedure Principal | ICD-9-CM, ICD-10-CM or CPT code for the procedure most closely related to the principal diagnoses performed for the definitive treatment of the patient |  |  |
| 63 | Procedure Principal Date | The day in which the Principal procedure was performed |  |  |
| 64 | Provider's Zip Code | Provider's 5 digit zip code |  |  |
| 65 | Quarter | The quarter of the fiscal year that the patient's discharge date falls within |  |  |
| 66 | Race | Patient's race |  |  |
| 67 | Revenue Code Charges | Total Revenue Charges reported by Hospitals |  |  |
| 68 | Revenue Code | Revenue Code |  |  |
| 69 | Revenue Code Description | Revenue code description |  |  |
| 70 | Revenue Code Units | Number of units associated with each revenue code |  |  |
| 71 | Sex | Gender of the patient |  |  |
| 72 | Service | Hospital defined code identifying medical service within the hospital |  |  |
| 73 | Service Line | Assigned based on DRG grouping or CPT categories |  |  |
| 74 | Specialty Code | State-specific specialty for physician |  |  |
| 75 | State | Provider's state |  |  |
| 58 | Sub unit | Hospital units, i.e., acute, rehab or psych |  |  |
| 59 | Town | Town name and designation based on patient's zip code |  |  |
| 60 | Unique Provider ID Number (UPIN) | Unique physician identification number |  |  |
| 61 | UPIN Specialty Code | CMS provided specialty code |  |  |
| 62 | Zip Code | Patient's or provider's 5-digit zip code |  |  |