Commonwealth of Massachusetts
Center for Health Information & Analysis (CHIA)
Non-Governmental Application for Case Mix Data

This form is required by all Applicants, except Government Agencies as defined in 957 CMR 5.02. All Applicants must also complete the Data Management Plan, attached to this Application. The Application and the Data Management Plan must be signed by an authorized signatory of the organization. This Application and the Data Management Plan will be used by CHIA to determine if your organization may receive CHIA data. Please be sure the documents are completed fully and accurately. You may wish to consult the Evaluation Guide that CHIA will use to review your documents. Prior to receiving CHIA Data, the organization must execute the Data Use Agreement. You may wish to review that document as you complete these forms.

NOTE: In order for your application to be processed, you must submit the required application fee. Please consult the fee schedule for the appropriate fee amount. A remittance form with instructions for submitting the application fee is available on the CHIA website.

All attachments must be uploaded to IRBNet with your Application. All applications documents can be found on the CHIA website in Word and/or PDF format.

I. GENERAL INFORMATION

APPLICANT INFORMATION	
Applicant Name:	Michael K. Dexter
Title:	Chief, Center for Health Systems Policy and Regulation
Organization:	Rhode Island Department of Health
Project Title:	Certificate of Need Review: Rhode Island Hospital BMT
IRBNet ID:	924152-1
Mailing Address:	3 Capitol Hill (Room 410), Providence, RI 02908
Telephone Number:	(401) 222-2788
Email Address:	Michael.Dexter@health.ri.gov
Names of Co-Investigators:	
Email Addresses of Co-Investigators:	
Original Data Request Submission Date:	06/17/2016
Dates Data Request Revised:	08/12/2016; 08/15/2016
Project Objectives (240 character limit):	This data will be utilized in a review of RI Hospital's Certificate of Need Application for a Bone Marrow Transplant facility. The review aims to assess the need for an additional adult and pediatric bone marrow transplant facility in the state of Rhode Island.
Project Research Questions (if applicable) Business Use Case(s):	1. Are adult and pediatric bone marrow transplant procedures performed at Massachusetts facilities growing or declining? 2. Where do Rhode Island residents receive bone marrow transplants? 3. Is there any variation in where Rhode Island residents receive bone marrow transplants by payor?

II. PUBLIC INTERST & PROJECT SUMMARY

1. Briefly explain why completing your project is in the public interest.

Rhode Island Hospital has submitted a Certificate of Need Application to the RI Department of Health for an adult and pediatric Bone Marrow Transplant facility. The application is being reviewed according to the need, affordability, and clinical competence criteria articulated under RIGL 23-15 *Health Care Certificate of Need Act of Rhode Island*. The Certificate of Need Application review is intended to support the recommendations of the RI Health Services Council to the RI Department of Health.

The Certificate of Need review is conducted primarily to prevent unnecessary duplication of medical services and ensure access and affordability. The purpose of this review is to discover if the proposed Bone Marrow services by Rhode Island Hospital are both needed and affordable for the public.

The CHIA data for Bone Marrow Transplant procedures performed in Massachusetts is a critical element of an assessment of need for an additional Bone Marrow Transplant facility in Rhode Island. This data will allow for an understanding of the rate of growth or decline in regional procedure volumes, and provide insight into where Rhode Island patients receive bone marrow transplant services.

2. Has an Institutional Review Board (IRB) reviewed your project?

☐ Yes, a copy of the approval letter and protocol must be **attached** to this Application

☒ No, this project is not human subject research and does not require IRB review.

3. If your project has not been reviewed by an IRB, please **attach** a brief (1-2 page) description of your project including the methodology, objectives, and research questions.

See Attachment.

III. DATA FILES REQUESTED [*Applicants seeking 2015 data only should skip to Question 2*]

1. *FY 2004 – 2014 Data*: Please indicate the Case Mix files from which you seek data, the Level(s), the year(s) of data requested, and your justification for requesting *each* file. Please refer to the Case Mix Data Specifications for details of the file contents.

CASE MIX FILES	Levels 1 – 6	Years Available 2004 - 2014
Inpatient Discharge	☐Level 1 – 3 Digit Zip Code ☒Level 2 – Unique Physician Number (UPN) + 5 Digit Zip Code ☐Level 3 – Unique Health Information Number (UHIN) ☐Level 4 – UHIN and UPN ☐Level 5 – Date(s) of Admission; Discharge; Significant Procedures ☐Level 6 – Date of Birth; Medical Record Number; Billing Number **PLEASE PROVIDE JUSTIFICATION BELOW FOR REQUESTING THE CHOSEN LEVEL:** **Request for adult and pediatric BMT procedure volume data. Specifically the request is for aggregate allogeneic and**	**Year(s) of Data Requested:** **All years (2004 – 2014)**

	autologous BMT procedure volumes by year, facility, patient residence, payer, and patient age. **The week, month and year of patient admission and discharge is needed for analysis of rates of growth or decline in procedure volumes since 2004.** **5-Digit Zip Code of patients' residence is needed to understand where Rhode Island residents are receiving this specific procedure in Massachusetts.**	
Outpatient Observation	☐Level 1 – 3 Digit Zip Code ☐Level 2 – Unique Physician Number (UPN) ☐Level 3 – Unique Health Information Number (UHIN) ☐Level 4 – UHIN and UPN ☐Level 5 – Date(s) of Admission; Discharge; Significant Procedures ☐Level 6 – Date of Birth; Medical Record Number; Billing Number **PLEASE PROVIDE JUSTIFICATION BELOW FOR REQUESTING THE CHOSEN LEVEL:**	**Year(s) of Data Requested:**
Emergency Department	☐Level 1 – 3 Digit Zip Code ☐Level 2 – Unique Physician Number (UPN) ☐Level 3 – Unique Health Information Number (UHIN) ☐Level 4 – UHIN and UPN ☐Level 5 – Date(s) of Admission; Discharge; Significant Procedures ☐Level 6 – Date of Birth; Medical Record Number; Billing Number **PLEASE PROVIDE JUSTIFICATION BELOW FOR REQUESTING THE CHOSEN LEVEL:**	**Year(s) of Data Requested:**

2. *FY 2015 Data*: Beginning *with ficsal year 2015, Massachusetts Acute Care Hospital and Case Mix and Charge Data (collectively Case Mix Data) are released in* ***Limited Data Set (LDS) files***. Please refer to the Case Mix Data Specifications for details of the file contents.

Please indicate the Case Mix files from which you seek data, the year(s) of data requested, and your justification for requesting *each* file.

CASE MIX LIMITED DATA SET FILES	Year(s) Of Data Requested Current Yrs. Available ☐ 2015
☐ Inpatient Discharge	Please describe how your research objectives require Inpatient Discharge data:
☐ Outpatient Observation	Please describe how your research objectives require Outpatient Observation data:
☐ Emergency Department	Please describe how your research objectives require Emergency Department data:

Sections IV-IX must be completed by all Applicants requesting 2015 data. Applications that only include requests for prior years of data can skip to Section X.

IV. GEOGRAPHIC DETAIL

Please choose *one* of the following geographic options for MA residents:

☐ 3 Digit Zip Code (Standard)	☐ 3 Digit Zip Code & City/Municipality ***	☐ 5 Digit Zip Code ***	☐ 5 Digit Zip Code & City/Municipality ***
***Please provide justification for the chosen level of geographic detail if requesting something other than 3-Digit Zip Code only. Refer to specifics in your methodology:			

V. DEMOGRAPHIC DETAIL

Please choose *one* of the following demographic options:

☐ Not Requested (Standard)	☐ Race & Ethnicity***
*** If requested please, provide justification for requesting Race and Ethnicity. Refer to specifics in your methodology:	

VI. DATE DETAIL

Please choose *one* option from the following options for dates:

☐ Year (YYYY)(Standard)	☐ Month (YYYYMM) ***	☐ Day (YYYYMMDD)***
***Please provide justification for the chosen level of date detail if requesting Month or Day. Refer to specifics in your methodology:		

VII. PHYSICIAN IDENTIFICATION NUMBERS (UPN)

Please choose *one* of the following options for Provider Identifier(s):

☐ Not Requested (Standard)	☐ Hashed ID ***	☐ Board of Registration in Medicine # (BORIM) ***
***If requested please, provide justification for requesting Hashed ID or BORIM #. Refer to specifics in your methodology:		

VIII. HASHED UNIQUE HEALTH IDENTIFICATION NUMBER (UHIN)

Please choose *one* of the following:

☐ Not Requested (Standard)	☐ UHIN Requested ***
*** If requested please, provide justification for requesting UHIN. Refer to specifics in your methodology:	

IX. HASHED MOTHER'S SOCIAL SECURITY NUMBER

Please choose *one* of the following:

☐ Not Requested (Standard)	☐ Hashed Mother's SSN Requested ***
*** If requested please, provide justification for requesting Hashed Mother's SSN. Refer to specifics in your methodology:	

X. DATA LINKAGE AND FURTHER DATA ABSTRACTION

Note: Data linkage involves combining CHIA Data with other databases to create one extensive database for analysis. Data linkage is typically used to link multiple events or characteristics that refer to a single person in CHIA Data within one database.

1. Do you intend to link or merge CHIA Data to other datasets?

☐ Yes

☒ **No linkage or merger with any other database will occur**

2. If yes, please indicate below the types of database to which CHIA Data be linked. [Check all that apply]

☐ Individual Patient Level Data (e.g. disease registries, death data)

☐ Individual Provider Level Data (e.g., American Medical Association Physician Masterfile)

☐ Individual Facility Level Data level (e.g., American Hospital Association data)

☐ Aggregate Data (e.g., Census data)

☐ Other (please describe):

3. If yes, describe the data base(s) to which the CHIA Data will be linked, which CHIA data elements will be linked; and the purpose for the linkage(s):

4. If yes, for each proposed linkage above, please describe your method or selected algorithm (e.g., deterministic or probabilistic) for linking each dataset. If you intend to develop a unique algorithm, please describe how it will link each dataset.

5. If yes, please identify the specific steps you will take to prevent the identification of individual patients in the linked dataset.

XI. PUBLICATION / DISSEMINATION / RE-RELEASE

1. Describe your plans to publish or otherwise disclose CHIA Data, or any data derived or extracted from such CHIA Data, in any paper, report, website, statistical tabulation, seminar, conference, or other setting. All publication of CHIA Data must comply with CHIA's cell size suppression policy, as set forth in the Data Use Agreement. Please explain how you will ensure that any publications will not display a cell less than 11, and no percentages or other mathematical fomulas will be used if they result in the display of a cell less than 11.

The Certificate of Need Application review including the aggregate CHIA data requested will be made publicly available through the Rhode Island Department of Health. The application review is intended to inform the recommendations of the RI Health Services Council to the RI Department of Health; as such the review will also be presented at a public meeting of the RI Health Services Council.

The RI Department of Health will not disaggregate data below the cell size limitation stipulated by MA CHIA.

2. Do you anticipate that the results of your analysis will be published and/or publically available to any interested party? Please describe how an interested party will obtain your analysis and, if applicable, the amount of the fee, that the third party must pay.

Yes, the Certificate of Need Application review will be made publicly available via the RI Department of Health. There is no fee associated with obtaining the report and analysis.

3. Will you use CHIA Data for consulting purposes?

☒ Yes
☐ No

4. Will you be selling standard report products using CHIA Data?

☐ Yes
☒ No

5. Will you be selling a software product using CHIA Data?

☐ Yes
☒ No

6. Will you be reselling CHIA Data in any format?

☐ Yes
☒ No

If yes, in what format will you be reselling CHIA Data (e.g., as a standalone product, incorporated with a software product, with a subscription, etc.)?

7. If you have answered "yes" to questions 4, 5 or 6, please describe the types of products, services or studies.

8. If you have answered "yes" to questions 4, 5, or 6, what is the fee you will charge for such products, services or studies?

XII. APPLICANT QUALIFICATIONS

1. Describe your qualifications (and the qualifications of your co-investigators) to perform the research described.

The RI Department of Health is a state health department accredited by the Public Health Accreditation Board. One duty of the Center for Health Systems Policy and Regulation of the RI Deparment of Health is to prevent unncecessary duplication of medical services, facilities and equipment through the Certificate of Need review process. Additionally, the RI Department of Health maintains a statewide Hospital Discharge database.

2. **Attach** résumés or curricula vitae of the Applicant/principal investigator, and co-investigators. (These attachments will not be posted on the internet.)

XIII. USE OF AGENTS AND/OR CONTRACTORS

Please note: by signing this Application, the Organization assumes all responsibility for the use, security and maintenance of the CHIA Data by its agents, including but not limited to contractors.

Third-Party Vendors. Provide the following information for all agents and contractors who will work with the CHIA Data.

Company Name:	Faulkner Consulting Group
Contact Person:	Olivia Burke
Title:	Consultant
Address:	PO Box 113 Barrington, RI 02806
Telephone Number:	(401) 524-2834
E-mail Address:	olivia@faulknerconsultinggroup.com
Organization Website:	http://www.faulknerconsultinggroup.com/

1. Will the agent have access to the CHIA Data at a location other than your location, your off-site server and/or your database?

☐ Yes, a separate Data Management Plan must be completed by each agent who will store CHIA Data
☒ **No**

2. Describe the tasks and products assigned to this agent for this project; their qualifications for completing the tasks; and the Organization's oversight of the agent, including how the Organization will ensure the security of the CHIA Data to which the agent has access.

Faulkner Consulting Group is responsible for creating a written report assessing the need of the proposal by Rhode Island Hospital and delivering a presentation to the RI Health Services Council highlighting the key findings of this report. To conduct this analysis, Faulkner Consulting Group must evaluate the data of current providers of Bone Marrow transplantation services to residents of Rhode Island.

Faulkner Consulting Group is an experienced health policy consulting firm with expertise in national and local trends in health policy. The RI Department of Health has utilized the services of Faulkner Consulting Group for other similar projects.

The RI Department of Health and Faulkner Consulting Group are in frequent communication regarding the activity and actions relevant to the Certificate of Need review project. The Department reviews and may amend all reports and presentation materials prior to the release to the public or interested parties. The Department will ensure the security of the CHIA Data by allowing access to the CHIA data only at the Department's office location within the secure servers as outlined in the Data Mangement Plan. All individuals accessing data will sign the Confidentiality Agreement required by MA CHIA.

XIV. FEE INFORMATION

Please consult the fee schedules for Case Mix Data and select from the following options:

☒ **Single Use**
☐ Limited Multiple Use
☐ Multiple Use

Are you requesting a fee waiver?

☐ Yes
☒ **No**

If yes, please refer to the Application Fee Remittance Form and submit a letter stating the basis for your request (if required). Please refer to the fee schedule for qualifications for receiving a fee waiver. If you are requesting a waiver based on the financial hardship provision, please provide documentation of your financial situation. Please note that non-profit status alone isn't sufficient to qualify for a fee waiver.

By submitting this Application, the Data Applicant attests that it is aware of its data use, privacy and security obligations imposed by state and federal law *and* is compliant with such use, privacy and security standards. The Data Applicant further agrees and understands that it is solely responsible for any breaches or unauthorized access, disclosure or use of any CHIA Data provided in connection with an approved Application, including, but not limited to, any breach or unauthorized access, disclosure or use by its agents.

Applicants requesting data from CHIA will be provided with data following the execution of a Data Use Agreement that requires the Data Applicant to adhere to processes and procedures aimed at preventing unauthorized access, disclosure or use of data.

By my signature below, I attest to: (1) the accuracy of the information provided herein; (2) that the requested data is the minimum necessary to accomplish the purposes described herein; (3) the Data Applicant will meet the data privacy and security requirements describe in this Application and supporting documents, and will ensure that any third party with access to the data meets the data use, privacy and security requirements; and (4) my authority to bind the organization seeking CHIA Data for the purposes described herein.

Signature: (Authorized Agent)	
Printed Name :	
Title:	
Applicant's Signature:	Michael K. Dexter
Name:	Michael K. Dexter
Title:	Chief, Center for Health Systems Policy and Regulation
Original Data Request Submission Date:	06/17/2016
Dates Data Request Revised:	08/12/2016; 08/15/2016

Attachments. Please indicate below which documents have been attached to the Application and uploaded to IRBNet:

☒ 1. IRB approval letter or summary of project (if applicable)

☒ 2. Resumes of Applicant and co-investigators

☒ 3. Data Management Plan (for each institution that will store CHIA Data)