Application to Obtain Protected DHCS Data for Research

This application is for requesting access to confidential and protected data held by the Department of Health Care Services (DHCS) for research purposes. **In addition to this application, requestors are required to submit the following to DHCSDRC@dhcs.ca.gov:**

- A copy of the research protocol submitted to the Committee for the Protection of Human Subjects (CPHS) and the CPHS approval letter
- A completed DHCS Data Use Agreement (DUA)
- A copy of the principal investigator's (PI) most recent curriculum vitae
- A completed Data Description Table

Applicant Information
Please select the institution type conducting the research: _____ **Note:** DHCS, under section 1798.24(t)(1) of the California Civil Code, can only grant data requests for PIs conducting scientific research for a nonprofit educational institution or an established nonprofit research institution performing health or social services research.
PI Contact Information Last Name: _____ First Name: _____ Title: _____ Institution: _____ Address: _____ City: _____ State: ____ Zip Code: _____ E-mail: _____ Phone Number: _____
Secondary Contact Information (project manager or subcontractor) Last Name: _____ First Name: _____ Title: _____ Institution: _____ Address: _____ City: _____ State: ____ Zip Code: _____ E-mail: _____ Phone Number: _____

Proposed Project Information

1. Project Title: _____

2. Please describe the background for the proposed project.

3. What are the hypotheses?

4. Describe the proposed project's research design (methodology). How will the hypotheses be tested?

5. Please describe the potential importance of the findings for the proposed project.

6. Please specify below how the proposed project will directly benefit the administration of the Medi-Cal Program.

Note: Section 1902 (a) of the federal Social Security Act (42 U.S.C. § 1396a (7)) restricts DHCS from disclosing protected information other than for purposes that are directly connected with the administration of the Medi-Cal Program.

Methodology
1. Identify <u>all</u> variables that will be analyzed related to the desired outcomes, as well as variables utilized for stratification and risk adjustment activities (data elements DHCS will provide).
2. Please provide a comprehensive Excel file of ICD-9-CM[1],ICD-10-CM[2], CPT-4[3] and/or HCPCS[4] codes required for the data analysis. The Data Description Table should include data sources, data elements, timeframes, and justifications. **<u>Note:</u>** These data elements will not necessarily be provided by DHCS but used to filter the data. Potential codes can be found on the DHCS webpage: https://www.dhcs.ca.gov/services/medi-cal/Pages/Rates.aspx

[1]International Classification of Diseases, Ninth Revision, Clinical Modification
[2]International Classification of Diseases, Tenth Revision, Clinical Modification
[3]Current Procedural Terminology, Fourth Edition
[4]Healthcare Common Procedure Coding System

3. Are you planning to interview individuals (or family members) as part of this research? _____

* If Yes, complete **Items 3A and 3B**.

3A. Justification for interviewing individuals (or family members).

3B. Describe the contact methodology for interviewing individuals (or family members).

Data Abstraction Workload

1. Approximate number of records: _____
2. Are you requesting the DHCS data be linked with a non-DHCS database? _____

2A. If Yes, please provide the non-DHCS database name: _____

3. Will a Finder File be provided? _____
4. If Question 2 response was Yes, complete Item 4A.

4A. Variables (in the below table, provide up to eight variables for linkage purposes)

Note: DHCS' policy does not allow linkages using protected data to be performed by non-DHCS personnel.

5. Will the proposed project require a one-time release of data? _____

* If Yes, complete **Items 6A and 6B.**

6. Will the proposed project require multiple releases of data? _____

* If Yes, complete **Items 6A and 6B.**

6A. Provide in the below table Medi-Cal service eligibility date(s) and desired deadline(s) to receive data file(s).

Date of Medi-Cal Service/Eligibility	Desired Deadline to Receive Data Files
Example: January 2020 – December 2022	Example: March 31, 2024

6B. Please provide any funding or other factors influencing the requested deadline(s) above.

Funding Sources

1. Please check all sources of funding for the proposed project.

☐ County ☐ State Government ☐ Federal Government
☐ Private Funds ☐ Non-Profit ☐ Other Institution

2. Please provide funding source(s) contact information.

Name	Address	Phone Number

3. Will the research assist in the development of a commercial product? _____

Note: If Yes is selected, the DRC will not consider this application for research that will lead to the creation of a product or tool that the researcher (or funder) intends to market.

Research Publishing

1. How will the research results be published? Check all that apply.

Note: If the project is approved by DHCS DRC; the project title, PI name and contact information will be posted on the DRC webpage.

If your findings are published in any reports (or scientific writings), as a result of research using DHCS data, you are required to provide the DRC with 1) citation and 2) publication copies within 30 days.

☐ Journal Article ☐ Report ☐ Conference Presentation
☐ Other: _____

DHCS Program Staff and Program Information

1. Data requests are reviewed by DHCS staff that work within Medi-Cal programs or other DHCS health program areas. Has DHCS program staff been contacted regarding this research project? _____

If Yes, please provide the contact information.

Last Name: _____ First Name: _____
Title: _____ E-mail: _____

2. Please check all DHCS program area(s) that would be appropriate to review your request.

Note: DHCS Program information is available on the DHCS webpage: www.dhcs.ca.gov

☐ Benefits	☐ Children's Medical Services	☐ Dental Services
☐ Eligibility	☐ Family Planning	☐ Health Care Financing
☐ Integrated Systems of Care	☐ Long Term Care	☐ Managed Care
☐ Mental Health / Behavioral Health / Substance Use	☐ Pharmacy	☐ Provider Enrollment
☐ Rural Health	☐ Other: _____	

Researcher Experience with DHCS Data

1. Have you used DHCS data for prior projects? _____

If Yes, please complete the information below for the last five projects (if available).

Project 1

Year Completed: _____ DUA Number: _____
Project Name: _____
DHCS Staff Name (who assisted): _____
E-mail: _____
DHCS Program Area: _____
Other DHCS Program Area: _____

Project 2

Year Completed: _____ DUA Number: _____
Project Name: _____
DHCS Staff Name (who assisted): _____
E-mail: _____
DHCS Program Area: _____
Other DHCS Program Area: _____

Project 3

Year Completed: _____ DUA Number: _____
Project Name: _____
DHCS Staff Name (who assisted): _____
E-mail: _____
DHCS Program Area: _____
Other DHCS Program Area: _____

Project 4

Year Completed: _____ DUA Number: _____
Project Name: _____
DHCS Staff Name (who assisted): _____
E-mail: _____
DHCS Program Area: _____
Other DHCS Program Area: _____

Project 5
Year Completed: _____ DUA Number: _____
Project Name: _____
DHCS Staff Name (who assisted): _____
E-mail: _____
DHCS Program Area: _____
Other DHCS Program Area: _____

Application Checklist

☐	A signed and scanned copy of this application
☐	A copy of the CPHS approval and research protocol
☐	A completed DHCS DUA *As of 2018, signatures on DUAs are collected via DocuSign. Once the "Application to Obtain Protected DHCS Data for Research" is approved, individuals listed on the submitted DUA will be contacted by DHCS requesting their electronic signature.
☐	A copy of the PI's most recent curriculum vitae
☐	A completed Data Description Table (must be in Excel format)

Note: CPHS approval is a separate application process. CPHS' website is https://www.cdii.ca.gov/committees-and-advisory-groups/committee-for-the-protection-of-human-subjects-cphs/

All items identified in the Application Checklist **must** be submitted to DHCSDRC@dhcs.ca.gov

Required Signatures

Principal Investigator

Last Name: _____ First Name: _____

Signature: _____ Date: _____

Responsible Official at your Institution

Last Name: _____ First Name: _____

Institution Name: _____

Phone Number: _____ E-mail: _____

Signature: _____ Date: _____