OFFICE OF HEALTH ANALYTICS
All Payer All Claims Data Reporting Program

Kate Brown, Governor

421 SW Oak Street, Suite 850
Portland, OR 97204
oregon.gov/oha/HPA/ANALYTICS

**APAC Data Use Agreement Amendment – Limited of Custom Data Sets**

**Instructions**

Use this form for amendments or renewals of Limited or Custom All Payer All Claims (APAC) data request applications that have been submitted, approved, and have an executed Data Use Agreement. If you have not received an Application Number and wish to make changes to your submitted application, please contact Apac.Admin@dhsoha.state.or.us.

The Application Number and Applicant Name must match the information from the original application and Data Use Agreement. Please list changes in the appropriate section and provide sufficient details to allow staff to evaluate the request. All changes supersede the original application and Data Use Agreement.

Send this completed form to:

APAC.Admin@dhsoha.state.or.us
Or
Office of Health Analytics - APAC
421 SW Oak Street, Suite 850
Portland, OR 97204

If you have questions while completing this application, please follow these steps:

1. Visit the APAC website for more information about the APAC Reporting Program at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

2. Visit the APAC Data Request page for more information about the data request process at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/APAC-Data-Requests.aspx.

3. Review the APAC Frequently Asked Questions to determine if your question has been answered there.

4. If you still have questions,
    a. Direct questions about APAC or this application to: APAC.Admin@dhsoha.state.or.us
    b. Direct data privacy questions to: dhsprivacy.help@state.or.us
    c. Direct data security questions to: dhsinfo.security@state.or.us

**SECTION 1: PROJECT INFORMATION**

**1.1 Contact Information:** Please provide the project contact information below.

Applicant name: Annick Benson
(must be the same applicant of original project)

Application Number APAC20150001-Schafer_PublicHealth
(example: APACYYYYXXXX or XXXX_description_of_project):

Organization: Oregon Health Authority, Public Health Division, Center for Public Health Practice, HST Section

Address: 800 NE Oregon St., Suite 1105

City: Portland State: Oregon Zip: 97232

Phone: 971-673-0142

Email: annick.benson@dhsoha.state.or.us

Original Application Date: April 17, 2015

**Is this an *amendment* (changes to the application—including revising project staff, request of additional data not specified in original application, etc.) or a *renewal* of an expiring Data Use Agreement or Institutional Review Board approval without any changes to the original application? Please choose only one. An amendment will also renew the Data Use Agreement.**

Amendment ■ Please continue to Section 2

Renewal ☐ Please continue to Section 3

**SECTION 2: AMENDMENT**

(Skip this section and proceed to Section 3 if you are renewing an executed Data Use Agreement that is about to expire and not requesting further changes to the content of the original application. This amendment form may only be used to add or remove staff members working on the project or to request additional data.)

**2.1 List any additional staff that will be working on the project.**

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

_____ _____
Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

_____ _____
Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

_____ _____
Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

_____ _____
Signature Date

**2.2 List any staff that will no longer be working on the project:**

Name: Role:

Name: Role:

Name: Role:

Name: Role:

Name: Role:

**2.3 What is the reason for the amendment?**

Requesting a refresh of the data to include 2016.

**2.4 Did the original application include an Institutional Review Board review and approval?**

Yes ☐ No ■

(If no, proceed to question 2.7)

**2.5 Is the amendment within the scope of the original IRB approval?**

Yes ☐ No ☐

If yes, please explain:

If no, requestor must submit new application, not an amendment.

**2.6 Is an amended IRB approval attached?** (An amended IRB approval is ***required*** for any amendments to the scope of the project.)

Yes ☐ No ☐

Date amended IRB approval expires: _____

**2.7 Are you requesting additional data files, data elements, or years of data?**

Yes ■ No ☐

(If yes, proceed to questions 2.8-11. If no, skip questions 2.8-11.)

**2.8 Limited Data Sets:** In the table below, indicate which additional data file(s) you are requesting. Refer to the Data Element Workbook for more information about the data elements included in each Limited data set. *Please note:* OHA will only provide the minimum necessary required data for the project at hand. In other words, you will only receive those data elements that you request and adequately justify.

a. Are you requesting a Limited data set?

☐ Yes ■ No

*If yes, please complete parts b and c below.*

b. In the table below, indicate which Limited data file(s) you are requesting (refer to Question 2.11 for the cost of each file).

| | | Payer | | | | | |
|---|---|---|---|---|---|---|---|
| | | All Payers[1] | Medicaid | Medicare Advantage | Commercial Insurance | OEBB/ PEBB | Medicare FFS[2] |
| Claims Data File | Episodes of Care[3] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | All Medical Claims[4] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Hospital Inpatient Claims | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Emergency Department Claims | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Ambulatory Surgery Claims | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Ambulatory Outpatient Claims | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | All Pharmacy Claims[5] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

c. Please indicate the year(s) requested for the data files selected above.

☑ 2011 ☑ 2012 ☑ 2013 ☑ 2014 ☑ 2015 ☑ 2016

[1] All Payers includes Medicaid, Medicare Advantage, and Commercial Insurance (including OEBB/PEBB).
[2] Medicare FFS data will only be given to projects in which OHA is funding and directing. Projects requesting Medicare FFS data will also need to be approved by requester's Institutional Review Board.
[3] Episodes of Care file contains all medical claims, all pharmacy claims, and fields from the Medical Episode Grouper (MEG). MEG is a proprietary grouping algorithm that creates episodes that describe a patient's complete course of care for a single illness or condition. If requesting Episodes of Care file, no other data file is needed.
[4] All Medical Claims file includes hospital inpatient, emergency department, ambulatory surgery and ambulatory outpatient claims, and other hospital treatment settings. If requesting all medical claims, you do not need to request these other data sets.
[5] All Pharmacy Claims file contains only pharmacy claims.

**2.9 Custom Data Sets:** Refer to the *Data Elements Collected by APAC* section of the Data User Guide for a list of data elements available. Please note: OHA will only provide the minimum necessary data for the project. In other words, you will only receive those data elements that you request and adequately justify.

a. Are you requesting a Custom data set?

■ Yes ☐ No

**2.10 Data Element Workbook:** For both Limited and Custom data set amendment requests, please complete the Data Element Workbook according to the instructions on the "Instructions" tab and attach it to this amendment.

■ Data Element Workbook completed and attached, including justifications for each element requested and payers tab completed.

**2.11 Cost of Data:** If requesting additional data from the Limited data set, please calculate the cost below. (This table should match the files/years selected in Questions 2.8b and 2.8c.) ***Please include payment with the application.*** Checks should be made to Oregon Health Authority and will not be cashed until application is approved. If requesting a Custom data set, an invoice will be sent if/when OHA approves request.

| | | Payers | | | | | |
|---|---|---|---|---|---|---|---|
| | | All Payers | Medicaid | Medicare Advantage | Commercial Insurance | OEBB/ PEBB | Medicare FFS |
| Claims Data File | Episodes of Care | ☐ $3,000 | ☐ $1,000 | ☐ $1,000 | ☐ $1,000 | ☐ $1,000 | ☐ $1,000 |
| | All Medical Claims | ☐ $1,500 | ☐ $500 | ☐ $500 | ☐ $500 | ☐ $500 | ☐ $500 |
| | Hospital Inpatient Claims | ☐ $375 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 |
| | Emergency Department Claims | ☐ $375 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 |
| | Ambulatory Surgery Claims | ☐ $375 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 |
| | Ambulatory Outpatient Claims | ☐ $375 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 | ☐ $125 |
| | All Pharmacy Claims | ☐ $1,500 | ☐ $500 | ☐ $500 | ☐ $500 | ☐ $500 | ☐ $500 |
| | a. Total each column | | | | | | |
| | b. Add column totals | | | | | | |
| | c. Enter number of years of data requested (Q2.8.c) | | | | | | |
| | d. Multiply rows b and c | | | | | | |
| | e. OHA Production Cost | $560 | | | | | |
| | f. Add rows d and e for Total Payment | | | | | | |

☐ **Check box if payment is not included because Custom data set is requested.**

■ **Check box if payment is not included for another reason. Please explain.**

OHA entity

**SECTION 3: RENEWAL**

Please check the appropriate boxes. This section is for those renewing an existing Data Use Agreement or Institutional Review Board approval that is about to expire without requesting further changes to the content of the original application.

☐ OHA Data Use Agreement Renewal (for applicants in which the OHA Data Use Agreement is about to expire)

By checking the above box, applicant hereby attests that the project shall continue to be conducted as specified in the Data Use Agreement referenced in Section 1 and the project has been renewed by Principal Investigator's Institutional Review Board, if applicable. (If original application required Institutional Review Board approval, an amended Institutional Review Board approval is ***required*** for renewal outside the original Institutional Review Board approval timeframe.)

Amended Institutional Review Board approval documentation is attached. ☐
Original Institutional Review Board approval is still valid for more than 3 months. ☐
Original application did not include Institutional Review Board approval. ☐

☐ Institutional Review Board Approval Renewal (for applicants in which the OHA Data Use Agreement is still valid, but the original Institutional Review Board approval is about to expire)

By checking the above box, applicant hereby attests that the project shall continue to be conducted as specified in the Data Use Agreement referenced in Section 1 and the project has been renewed by applicant's Institutional Review Board. (Amended Institutional Review Board approval is ***required*** for renewal outside the original Institutional Review Board approval timeframe.)

Amended Institutional Review Board documentation is attached. ☐

**Section 4: Signatures**

Except as expressly amended above, all other terms and conditions of the Data Use Agreement and any previous amendments are still in full force and effect. Data Recipient certifies that any representations, warranties and certifications contained in the Data Use Agreement are true and correct as of the effective date of this amendment and with the same effect as though made at the time of this amendment. This amendment shall be effective as of the date signed by OHA. The ability of Data Recipient to use the Data under this amendment is valid for two years from the effective date.

SIGNATURES:

Annick J Benson-Scott Digitally signed by Annick J Benson-Scott
DN: cn=Annick J Benson-Scott, o=Oregon Health Authority, ou=HIV/STD/TB, email=annick.benson@state.or.us, c=US
Date: 2018.05.21 10:31:02 -07'00'

| | |
|---|---|
| *Data Recipient authorized signature* | *Date* |
| Annick Benson-Scott | HST Section Manager |
| *Printed name* | *Title* |
| | |
| *OHA authorized signature* | *Date* |
| | |
| *Printed name* | *Title* |

Return completed form to APAC.Admin@dhsoha.state.or.us.

Completed form may also be printed and mailed to:
APAC Program Manager
Office of Health Analytics
421 SW Oak St., Suite 850 - APAC
Portland, OR 97204