

# DELAWARE HEALTH STATISTICS CENTER

## APPLICATION FOR HOSPITAL DISCHARGE LIMITED DATA FILES

All information provided in these sections and in the separate data element forms is required. This information will serve as criteria for decisions regarding release of the data set. Access to Limited Use Data Sets will be approved only for the purposes of health related research, public health, or health care operations.

*Delaware hospital discharge data are based on inpatient hospitalizations and do not include outpatient, clinic, or emergency room data. Data are derived from the Uniform Claims and Billing Form (UB-04) data elements for inpatient hospitalizations submitted annually by each acute care hospital in Delaware.*

Contact Name:		Date:
Contact Title:		
Organization:		
Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email Address:		
Principal Investigator (if different from contact):		
P.I. Phone:	P.I. Email:	

Data will be shipped via UPS or FedEx Next Day Delivery, unless otherwise stated. Please provide your UPS or FedEx billing number and any other pertinent shipping information.

UPS:

FedEx:

Shipping information if different than address given in Section A:

## DATA REQUESTED

File Type: *Inpatient, Short-term, Acute Care Hospital Discharge*

Year(s) Requested:

File format:  Comma delimited (\*.csv)  
 Tab delimited (\*.dat)  
 SPSS (\*.sav)

Variables Requested:

Project or Study Title:

***Use as much space as necessary to answer the following questions. If you are not completing the application electronically, include an attachment with your numbered responses.***

1. List the primary project or study objectives, including a description of the health, medical, or other problem addressed by the proposed project. How will this project or study benefit Delawareans and/or public health in general?

2. Describe the qualifications, or attach resume(s), of all staff who will have access to the data files (include personnel, subcontractors and affiliated agencies).

3. Describe the project background and design, including why hospital discharge data are necessary to the project, how the data will be used, research design and methodology, and the intended research date. If the research protocol is available, you may attach that and reference it in response to this question and the one regarding data security.

4. Describe how the data files will be used, stored, protected, and dealt with at the completion of the project.

## Data Use Agreement for Delaware Hospital Discharge Data

Any individual ("data recipient") seeking to obtain or use Delaware Hospital Discharge data from the Delaware Health Statistics Center (DHSC), must sign and submit this Agreement to DHSC before access to the data may be granted.

**Data recipients may use Delaware Hospital Discharge data only for approved research projects.**

**No Identification of Persons**—Any effort to determine the identity of any person contained in the data (including but not limited to patients, physicians, and other health care providers), or to use the information for any purpose other than for research, analysis, and aggregate statistical reporting, would violate the DHSC data use agreement. Recipients of the data set are prohibited from releasing, disclosing, publishing, or presenting any individually identifying information obtained under this Agreement. DHSC omits from the data set all direct identifiers that are required to be excluded from limited data sets as defined by the HIPAA Privacy Rule. It may be possible in limited situations, through deliberate technical analysis, and with outside information, to ascertain from the limited data sets the identity of particular persons. Considerable harm could ensue if this were to occur. Therefore, any attempts to identify individuals are prohibited and information that could identify individuals directly or by inference must not be released or published. In addition, users of the data must not attempt to contact individuals for any purpose, including verifying information supplied in the data set. Any questions about the data must be referred exclusively to DHSC.

**The undersigned gives the following assurances with respect to the DHSC Hospital Discharge data:**

*Please initial.*

\_\_\_\_\_ Commercial use, i.e. sale or distribution for profit, of the requested health data is not permitted.

\_\_\_\_\_ I will not use and will prohibit others from using or disclosing the data set (or any part), except for research, analysis, and aggregate statistical reporting, and only as permitted by this Agreement.

\_\_\_\_\_ I will not release or disclose, and will prohibit others from releasing or disclosing, the data set (or any part) to any person who is not a member or agent, except with the approval of the DHSC.

\_\_\_\_\_ I will ensure that the data are kept in a secured environment and that only authorized users will have access to the data.

\_\_\_\_\_ I will not sell, release, or disclose, and will prohibit others from releasing or disclosing, any data that are individually identifiable under the HIPAA Privacy Rule, or any information that identifies individuals, directly or indirectly.

\_\_\_\_\_ I will require others employed in my organization (specified below), and any agents or contractors of my organization, who will use or will have access to the data set, to sign a copy of this Agreement (specifically acknowledging their agreement to abide by its terms) and I will submit those signed Agreements to DHSC before granting access.

\_\_\_\_\_ I will not attempt to link, and will prohibit others from attempting to link, the discharge records of persons in the data set with individually identifiable records from any other source.

\_\_\_\_\_ I will not attempt to use and will prohibit others from using the data set to learn the identity of any person included in the data set or to contact any such person for any purpose.

\_\_\_\_\_ I will not contact and will prohibit others from contacting establishments or persons in the data set to question, verify, or discuss data in the DHSC Hospital Discharge databases.

\_\_\_\_\_ I will indemnify, defend, and hold harmless DHSC and the data organizations that provide data to it from any or all claims and losses accruing to any person, organization, or other legal entity as a result of violation of this Agreement. This provision applies only to the extent permitted by Federal and State law.

\_\_\_\_\_ I will make no statement and will prohibit others from making statements indicating or suggesting that interpretations drawn are those of the data sources or DHSC.

\_\_\_\_\_ I will acknowledge in all reports, publications, and/or presentations based on these data that the source of the data is the "Delaware Hospital Discharge Data, Delaware Health Statistics Center, Division of Public Health, Delaware Health and Social Services."

**Safeguards.** I agree to use appropriate safeguards to prevent use or disclosure of the data set other than as permitted by this Agreement.

**Permitted Access to Limited Data Set.** I shall limit the use or receipt of the data set to the individuals who require access in order to perform activities permitted by this Agreement. This Agreement must be signed by all such individuals and submitted to DHSC before access to the data set may be granted.

**Re-disclosure.** I will not re-disclose (i.e., share) the data set (or any part).

**The HIPAA Privacy Rule.** I agree not to use or disclose the data set in any manner that would violate the HIPAA Privacy Rule if I were a covered entity under the Privacy Rule.

**Agents and Contractors.** I shall ensure that any agents, including contractors and subcontractors to whom I provide the data set, agree in writing to be bound by the same restrictions and conditions that apply to me with respect to the limited data set.

**Reporting Violations of this Agreement.** I agree to report any violations to DHSC within 24 hours of becoming aware of any use or disclosure of the limited data set in violation of this Agreement or applicable law.

**Term, Breach, and Termination of this Agreement.** This Agreement shall continue in full effect until the data recipient has returned all copies of the data set to DHSC. Any noncompliance by the data recipient with the terms of this Agreement will be grounds for immediate termination of the Agreement if, at the sole determination of DHSC, the data recipient knew or should have known of such noncompliance and failed to immediately take reasonable steps to remedy the noncompliance.

I understand that this Agreement is requested by the Delaware Health Statistics Center to ensure compliance with its statutory confidentiality requirement. My signature indicates my Agreement to comply with the above-stated requirements. **Note:** Only original signatures will be accepted.

Signed:		Date:
Print or Type Name of Data Recipient:		
Title:		
Organization:		
Address:		
City:	State:	ZIP Code:
Phone Number:	E-mail:	

The information above is maintained by DHSC for the purpose of enforcement of this Agreement.

**Note to Requestor:** Shipment of the requested data product will only be made to the person who signs this Agreement.

Please mail the completed application to the following address: Attn: Doug Rich  
Delaware Health Statistics Center  
Delaware Division of Public Health  
417 Federal Street  
Dover, DE 19901