

#### Johns Hopkins HealthCare LLC

**Data Request Application**

**Project/Study Title:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**IRB Approval Date:**      \_\_\_\_\_\_\_

**Project Lead/Principal Investigator:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Institutional affiliation:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Position/Title:**      \_\_\_\_\_\_\_\_\_\_\_\_ **Tel. No.:** \_\_\_\_\_\_\_ **Email:** *\_\_\_*  **Date:**      \_\_\_\_\_

**Contact Person (if different from PI):**

**Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. No.:** **\_\_\_\_\_\_\_\_\_ Email:** *\_\_\_\_\_\_\_\_\_\_*

**Please provide the following documentation:**

[ ]  IRB Research Application for the project (i.e., eForm A)

[ ]  Letter of IRB approval or exemption from IRB review

***As applicable*, please provide copies of:**

[ ]  Approval of Waiver of Authorization or Partial Waiver

[ ] [ ]  Signed Informed Consent Forms/HIPAA authorizations of each person for whom PHI is

 requested. Please also submit a complete list of the names of the subjects who have signed

 consent forms in an Excel spreadsheet (last name, first name, MI).

[ ] [ ]  IRB approval for review preparatory to research or for PHI about a decedent

**Purposes of the project/study:**

**1.** The data is being requested for:

[ ]  Pilot Project preparatory to research

[ ]  Proposal for funded research Funding agency (ies): *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Grant Number:      \_\_\_\_\_\_\_

[ ]  Non-funded academic (including thesis work)

[ ]  Commercial and proprietary

**2.** Do you plan to make contact with enrollees as part of the study? Yes [ ]  No [ ]

**3.** It is required that a JHHC employee be a co-investigator or consultant on all projects. How is JHHC involved in the study/project for which the data is being requested?

[ ]  JHHC Care Management programs are the basis of the study

[ ]  JHHC personnel are involved as co-investigators or consultants in the study

 Names: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**4.** Do you agree to provide JHHC with the results of your study/project within six months of the completion of the analysis of the data? Yes [ ]  No [ ]

# Services Requested of JHHC

**5.** Indicate those data-related services that you are requesting from JHHC:

 [ ]  Mining and providing data only

 [ ] [ ]  Mining and analysis of data

 [ ]  Design, mining and analysis of data

**6.** What is the desired date on which you would like to receive the data from JHHC?

 \_\_\_\_\_\_\_\_\_

**7.** If your application is approved and the specifics of your request clearly delineated, are you prepared to compensate JHHC for requested services according to the current JHHC Fee Schedule? (Contact Nicola Martin 410-762-1595 for current fee schedule).

 Yes [ ]  No [ ]

**7A.** If no, are you requesting a waiver of the fee schedule for providing data?

 Yes [ ]  No [ ]

**Specifics of the data requested**

**8.** Date of service (DOS) range of data: From: *\_\_\_\_\_\_\_\_\_\_* to *\_\_\_\_\_\_\_\_\_\_\_*

**9.** Please estimate the number of cases for which you are requesting data:

**10.** For which programs do you seek member data?

[ ]  Employee Health Program

[ ]  Priority Partners MCO

[ ]  U.S. Family Health Plan (TriCare)

**11.** How individually identifiable is the data you require according to HIPAA regulations?

[ ]  De-Identified

[ ]  Limited Data Set

[ ]  Personal Identifiers

 What identifiers are included in your data request?      \_\_\_\_\_\_\_\_\_\_\_\_\_

**12.** What variables/fields are you requesting? *(Use an attachment if necessary.)*

|  |  |
| --- | --- |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**13.** Are you requesting repeated measurements of data? Yes [ ]  No [ ]

 If yes, please describe: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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**14.** What type of data are you requesting?

 [ ]  Text Delimited

 [ ] [ ]  Text Fixed Length

 [ ]  Excel

 [ ] [ ]  Other: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**15.** For what software application are you requesting the data? *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***The next steps:***

***The purpose of this application is to provide the JHHC Data Sharing Committee with sufficient information to evaluate your request. Additional approvals may be required depending on the Line of Business and type of data requested.***

*Secondly, a JHHC data analyst will contact you to establish the definitions of the data and the services that you are requesting. When this is completed and the data analyst has approval to collaborate in your data project, you will be expected to sign an agreement regarding the data deliverables from JHHC and any compensation owed to JHHC for the services.*

If your data is a limited data set, you will be expected to enter into a HIPAA compliant Data Use Agreement with JHHC.

*Should you have any questions about this process, please contact:*

Sarah Kachur, Pharm.D., MBA, BCACP

Director, Population Health Research and Development

Johns Hopkins HealthCare

6704 Curtis Court

Glen Burnie, Maryland 21060

(410)424-4673 (phone and fax)