

**Maryland Department of Health**  
**Behavioral Health Administration**  
**Protocol for**  
**Public Behavioral Health System's Data Requests**

This document is for the submission, review, and approval of requests to obtain Public Behavioral Health System (PBHS) data. This includes requests related to the following data:

- Eligibility Data
- Claims Data
- Authorization Data
- Provider Data
- Outcomes Measurement System (OMS) Data
- Pharmacy Claims Data
- Consumer Perception of Care Survey Data
- Other data sets owned by the Behavioral Health Administration

This document pertains to the following data requests:

- Identified or de-identified data sets or subsets
- Results from a specified analysis or existing analyses on a specified PBHS subpopulation.
- Other data sets or subsets

### **Protocol**

The data request process involves several steps. The steps include:

- Completion and submission of a data request form, outlining the purpose of the data request, information regarding the data requested, and the requestor's contact information.
- A review process by those familiar with the data systems.
- An approval by designated administrators with Behavioral Health Administration (BHA).
- Completion of data analyses/data set compilation and dissemination.

#### **1. Completion of a PBHS Data/Analysis Request Form**

The PBHS Data Request Form (Word document) includes two parts. The first part must be completed for all requests. This part must also include information such as: who is requesting the data; the reason for the request; what data is being requested; and other details needed in order to review and process the request (if approved). Please note, if a data request is for Patient Health Information (PHI), all efforts to protect the patient's identity and confidentiality will be taken into consideration.

The second part of the data request form must be completed by the individuals requesting raw data sets. This section pertains to information regarding data security and confidentiality.

The PBHS Data/Analysis Request Form must be submitted as a Word document.

## 2. Data Request Review Process

The PBHS Data/Analysis Request Form will be reviewed by those familiar with the data systems involved.

A review of each data request will be conducted using the following as evaluation criteria:

- Is the data/analysis requested already available publicly and does not require a special analysis?
- Is the data/analysis requested available to the public? If not, do we expect it to become available?
- Is the analysis appropriate to perform? If not, are there suggestions for alternative analyses that might be useful?
- Does the data/analysis requested answer the questions proposed? If not, are there suggestions for refining the request to include other available data?
- How does this request fit with other priorities designated by the BHA?
- What is the completion date? [Note: this would not be a determination for a recommendation of acceptance/rejection but would affect the timeliness with which the work could be completed.]

The data request will be determined based on one of the four recommendations:

- Approved as requested
- Approved with revisions (revisions will be suggested)
- Approved with conditions (conditions will be suggested)
- Disapproved (reasons will be included)

## 3. BHA's Administrator Approval

The BHA Data/IT unit will submit the PBHS Data/Analysis Request Form, along with one of the four recommendations above, to the BHA Executive Director or designee for final approval/disapproval. If approved, the Data/IT unit chief will contact the appropriate party with notification to begin the data request process. The data request will be approved if the BHA administrators, who reviewed the data request form, have approved it. Please note, BHA Executive staff set the priority level of all ad hoc data requests and, at any time, due to case workload, that priority can be given a lower level status.

## 4. Completion of Request/Data Dissemination

For approved data requests, the BHA or assigned parties will be responsible for conducting the data compilation or analysis. The BHA Data/IT unit will be responsible for disseminating the data or analyses to the requestor.

## Documentation

The BHA Data/IT unit will maintain a tracking log of all requests, their disposition, and results. The table will be organized by fiscal year and will include:

- Date Request Received
- Requestor Name
- Requestor Agency/Organization
- Date Request Reviewed
- Request Review Recommendation
- Date of BHA Executive Approval
- BHA Decision (must be unanimous approval if two BHA administrators review)
- Date Data/Analysis Disseminated/ by whom (Systems Evaluation Center (SEC), Administrative Services Organization (ASO), BHA, etc.)

The BHA Data/IT unit will maintain a file of the PBHS Data/Analysis Request Forms and the accompanying approval or disapproval documents. These files will be maintained up to a period of five years. The files will be destroyed after five years.

**Maryland Behavioral Health Administration**  
**Public Behavioral Health System**  
**Data/Analysis Request Form**

**Please return completed forms to:**

Susan Bradley  
Director of Data and Analysis/IT  
Behavioral Health Administration  
SGHC 55 Wade Avenue, Dix Building  
Catonsville, Md. 21228  
[Susan.Bradley@maryland.gov](mailto:Susan.Bradley@maryland.gov)  
Telephone: 410 402-8323 Fax: 410 402-8306

**PART I: TO BE COMPLETED FOR ALL DATA REQUESTS:**

1. **Name:** Click here to enter text.
2. **Position:** Click here to enter text.
3. **Organization:** Click here to enter text.
4. **Street Address:** Click here to enter text.
5. **City:**Click here to enter text.      **State:** Click here to enter text.    **Zip Code:** Click here to enter text.
6. **Phone:** Click here to enter text.
7. **Email:** Click here to enter text.
8. **Date of Request:** Click here to enter text.
  
9. **Indicate the type of data or analyses that are being requested:** Click here to enter text.
  
10. **Brief statement of goals of the project/hypotheses to be tested, etc.:** Click here to enter text.
11. **Expected use of data (indicate all that apply):**
  - a. Grant Proposal       Due Date:
  - b. Evaluation
  - c. Administration
  - d. Research
  - e. Other  (please specify) Click here to enter text.
  
12. **Is this request for (indicate all that apply):**
  - a. Data Analyses
  - b. Raw Data Set  (Must complete Part II of this form)

**13. Indicate the source(s) of data for the request (if known) (indicate all that apply):**

- a. Eligibility
- b. PBHS Claims
- c. Authorization
- d. Providers
- e. Outcomes Measurement System (OMS)

*(available only for consumers ages 6-64 served in outpatient mental health clinics or substance use Level 1 outpatient or Medication Assisted Treatment services )*

- f. Pharmacy Claims
- g. Consumer Perception of Care Survey
- h. Other  Click here to enter text. (please specify)  Click here to enter text.

**14. Indicate the types of data/data elements which will be involved in the analysis (indicate all that apply):**

a. Consumer

- Gender
- Race
- Ethnicity
- Age
- County of residence
- County of treatment
- Treatment type
- Diagnosis
- Medicaid Status/Eligibility type
- Service utilization
- Living Situation
- Employment
- Veteran Status
- Other  (please specify)  Click here to enter text.

b. Mental Health Service Agency/Provider

- Type  Click here to enter text.
- County  Click here to enter text.
- Other  (please specify)  Click here to enter text.

c. Substance Use Service Agency/Provider

- Type  Click here to enter text.
- County  Click here to enter text.
- Other  (please specify)  Click here to enter text.

d. Outcomes

Aggregated data from the Outcomes Measurement System (OMS) is available at the Beacon Health Options website

([http://maryland.beaconhealthoptions.com/services/OMS\\_Welcome.html](http://maryland.beaconhealthoptions.com/services/OMS_Welcome.html)).

Please review this website prior to placing a request for OMS data because the data may be available. OMS Data is available regarding living situation, functioning, symptoms, social connectedness (youth caregivers only), legal system involvement, employment, somatic health, school performance (children and adolescents only), and alcohol and substance use.

**If the data you are requesting is not available through the website, please describe the outcomes data you are requesting:**

- 15. Project Sponsor(s)/Funder(s) (e.g., MDH, NIMH, SAMHSA, CMS, AHRQ):** Click here to enter text.
- 16. Please indicate all Institutional Review Boards (IRBs) that will be reviewing the project:** Click here to enter text.
- 17. Other pertinent information:** Click here to enter text.

**PART II: TO BE COMPLETED IF A RAW DATA SET IS BEING REQUESTED:**

**17. Consumer identifiers requested:**

- a. No consumer identifiers are being requested
- b. Non-specific, but unique consumer identifiers are being requested (consumer identity not included)  **(please specify)**
- c. Specific consumer identifiers are being requested (consumer identity included or consumers are potentially identifiable)  **(please specify)** Click here to enter text.

**18. Provider identifiers requested:**

- a. No provider identifiers are being requested
- b. Non-specific, but unique provider identifiers are being requested (provider identity not included)  **(please specify)** Click here to enter text.
- c. Specific provider identifiers are being requested (provider identity include or providers are potentially identifiable)  **(please specify)** Click here to enter text.

**19. How will consumer/provider confidentiality be protected?** Click here to enter text.

**20. How will data security be ensured?** Click here to enter text.

**21. How long will the data be kept?** Click here to enter text.

**22. When will it be destroyed?** Click here to enter text.

**FOR OFFICIAL USE ONLY:**

**Review**

Behavioral Health Administration, Director, Applied Research and Evaluation

Date Reviewed: Click here to enter text.

Signature: Click here to enter text.

***Decision***

Approved as presented

Approved with revisions  (please specify) Click here to enter text.

Approved with conditions  (please specify) Click here to enter text.

Disapproved

Medicaid Care Programs Administration

Date Reviewed: Click here to enter text.

Signature: Click here to enter text.

***Decision***

Approved as presented

Approved with revisions  (please specify) Click here to enter text.

Approved with conditions  (please specify) Click here to enter text.

Disapproved Click here to enter text.