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| **DHIN Evergreen Logo** | **DELAWARE HEALTH CARE CLAIMS DATABASE**  **Data Use Agreement** |

Data Use Agreement #: [To be entered by DHIN]

Effective Date: [Date that the last party signs]

End Date: [To be entered by DHIN - project completion date]

Requesting Organization: [Insert name of Principal Investigator or Institution]

Address: [Insert Address]

[Insert Address]

Data Provider: The Delaware Health Information Network (DHIN)

Address: 107 Wolf Creek Blvd., Suite 2

Dover, DE 19901

Purpose: This Agreement addresses the terms and conditions under which DHIN will release and the Requesting Organization may obtain, use, and disclose Health Care Claims Database data specified in this Agreement.

Project: This Agreement pertains to the project entitled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as described in the HCCD Data Access Application #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ approved by the HCCD Committee and incorporated into this Agreement as Attachment 1. Any other projects or uses require separate applications and approvals.

Attachments: Attachment 1: Approved HCCD Data Access Application

Attachment 2: Fee Schedule

HCCD Data Requested: This Agreement pertains to the following files, in accordance with the specifications, as requested and approved in Attachment 1.

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| **Type of File** | **Years** |
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**Data Use Agreement and Obligations of Parties**: (Requesting Organization must initial each line)

1. **HCCD Data Use and Protection**

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| 1. \_\_\_\_\_\_\_ | I will use HCCD Data only for the purposes identified in Attachment 1. |
| 1. \_\_\_\_\_\_\_ | I will ensure that access to HCCD Data is provided only to the authorized individuals listed in Attachment 1, including employees, agents, and/or approved subcontractors. |
| 1. \_\_\_\_\_\_\_ | I and my colleagues, associates, agents, or subcontractors involved in this research will comply with all current laws and regulations, whether or not specifically referenced in this Agreement, regarding patient privacy, data security, and the privacy and security of protected health information. |
| 1. \_\_\_\_\_\_\_ | I will obtain and maintain an agreement with each agent or contractor who has or will have access to the HCCD Data which binds them to the same terms and restrictions as this Agreement. |
| 1. \_\_\_\_\_\_\_ | I will not attempt to re-identify the individuals included in a de-identified or limited data set, either now or in the future, should publicly available data sets and tools make that possible, nor will I make any attempt to contact individuals. |
| 1. \_\_\_\_\_\_\_ | I understand that DHIN may charge me a reasonable cost-based fee for preparing and transmitting the requested HCCD Data, and this may include costs associated with aggregating, storing, extracting, de-identifying, and transmitting the Data Set, to include associated labor costs. This fee and payment terms shall be agreed upon before any data is transferred. |

1. HCCD Data Disclosure

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| 1. \_\_\_\_\_\_\_ | I understand that any HCCD data shared publicly or disclosed to anyone other than an authorized user listed in Attachment 1 shall adhere to the following re-disclosure requirements: adhere to CMS cell size suppression requirements for CMS Research Identifiable Files; exclude any Reporting Entity-specific Pricing Information that includes post-adjudicated claims data. |

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| 1. \_\_\_\_\_\_\_ | I will share or disclose the HCCD Data only in the manner approved in Attachment 1, and will not permit my colleagues, associates, agents, employees, or contractors to use or disclose the HCCD Data in any manner other than what has been approved in Attachment 1. |
| 1. \_\_\_\_\_\_\_ | I will use appropriate safeguards to prevent the sharing or disclosure of the HCCD Data other than as permitted under Attachment 1. |

1. Reporting and Mitigating Unauthorized Uses or Disclosures of HCCD Data

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| 1. \_\_\_\_\_\_\_ | I will notify DHIN within five (5) days of becoming aware of any use or disclosure of the HCCD Data in violation of this Agreement. The notification will include the date of the incident; any harmful effects that may or have been caused by the unauthorized use or disclosure; details about the most likely causes of the incident and how it occurred; and a description of the HCCD data accessed, used, or disclosed. |
| 1. \_\_\_\_\_\_\_ | In the event that DHIN has reasonable belief that a Requesting Organization has made an unauthorized use or disclosure of the HCCD Data, DHIN may, at its sole discretion, require the Requesting Organization to investigate and report to DHIN any circumstances regarding any alleged or actual unauthorized use or disclosure; promptly resolve any issues or problems identified by the investigation; submit a corrective action plan outlining the steps that the Requesting Organization will take to prevent future unauthorized use or disclosure; return or destroy the HCCD Data received from DHIN under this Agreement. |

1. Termination

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| 1. \_\_\_\_\_\_\_ | I understand that DHIN may terminate this Agreement upon five (5) days written notice in the event of breach of any provision of this Agreement and such breach is not cured within such five (5) day period. |
| 1. \_\_\_\_\_\_\_ | Upon termination of this Agreement, either because the research is concluded or by termination for breach or other just cause, I will return or destroy all HCCD Data and retain no copies of such information unless retention is required for the research project records. If return or destruction of HCCD Data is not feasible, I will comply with the terms of this Agreement that are applicable to PHI for as long as the PHI is retained. |

1. Data Ownership

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| 1. \_\_\_\_\_\_\_ | I understand and acknowledge that all data provided to me by DHIN under this Agreement is and shall remain the sole property of DHIN. I will not sell or transfer the HCCD Data or any portion thereof, whether identifiable or de-identified, to any other party without the express written consent of DHIN. |

1. Indemnification

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| 1. \_\_\_\_\_\_\_ | I will indemnify and hold DHIN and its affiliated Covered Entities harmless from and against any actual or threatened legal or administrative action, claim, liability, penalty, fine, litigation, or other loss, expense or damage, including without limitation any reasonable attorneys’ fees and costs that DHIN may incur directly or indirectly resulting from my actions or omissions or those of any of my agents or subcontractors, including failure to perform my obligations under this Agreement. |

The persons signing below have the right and authority to execute this Agreement and no further approvals are necessary to create a binding agreement

**ACCEPTED AND AGREED:**

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| **Requesting Organization (Data Recipient)**  Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Data Provider**  Name: Delaware Health Information Network  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |