



RI APCD Data Application

The Rhode Island Department of Health (RIDOH) may release data from HealthFacts RI, Rhode Island's All-Payer Claims Database (RI APCD), to a person or organization engaged in improving, evaluating, or otherwise measuring health care provided to members. The Requestor/Project Lead shall complete this RI APCD Data Application before a scoping meeting to gain more information on the project requirements.

Refer to the RIDOH HealthFacts RI webpage (www.health.ri.gov/data/healthfactsri) for information about the publication submission and review process.

Send any questions to DOH.HealthFactsRI@health.ri.gov

**Indicates section that will not be posted publicly*

Project Overview

Date	January 14 th , 2026
Project/Study Title	Transforming the Evidence Base on Estimating Prevalence of Opioid Use Disorder and Expanded Access to Interventions to Prevent Drug Related Deaths: An International Data Linkage Study (TRANSFORM)
Organization Name	Brown University School of Public Health
Organization Type	<input checked="" type="checkbox"/> Academic Researcher <input type="checkbox"/> Government Agency <input type="checkbox"/> Data Submitter to RI APCD <input type="checkbox"/> Other (_____)
Project Lead Name	Brandon DL Marshall
Project Lead Title	Professor of Epidemiology
Other Project personnel who will have access to APCD data	Alexandria Macmadu - Assistant Professor of Epidemiology Yu (Seashore) Li - Senior Biostatistician

Section 1: Project Personnel*

Project Contact (Main Point of Contact)	
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
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Co-Investigators: List all co-investigators, including those from other agencies and/or institutions. Co-investigators include any individuals with access to the data OR who meaningfully contribute to the project.

Name	Degree(s)/Qualifications	Project Role	Agency/Dept.	Email:
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[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
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Section 2: Project Timeline

Project Timeline: Describe the project timeline and any critical dates or milestones to achieve project goals.	
Project Start Date:	08/15/2024
Project End Date:	05/31/2029
Request Needed By:	06/30/2026
Other Deadlines or Milestone Date(s):	N/A

Funding: Is there a current or planned source of funding?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Funding Source:	NIH: R01-DA059822	
Funding Deadline:	N/A	

Section 3: Project Methodology



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Please provide a detailed description of each of the following project components (include additional information where identified below as needed).

Project Methodology: Describe methodology, project design, and plan for analysis.	
Project Purpose	<p>The United States (US) is in the midst of an accelerating opioid epidemic and overdose crisis, with multiple “waves” of overdose driven by prescription opioids, shifts to heroin use, and more recently, illicitly manufactured fentanyl and stimulant-opioid combination deaths.</p> <p>Estimates of the prevalence of opioid use disorder (OUD) are critical for measuring drug-related harms, developing strategies to prevent harms, and ensuring adequate treatment coverage. Many approaches to prevalence estimation are limited, particularly household surveys which underestimate OUD prevalence. In addition, while opioid agonist treatments (OAT; i.e., methadone or buprenorphine) are effective medicines for OUD, reducing overdose and all-cause mortality, they are under-utilized, and it is likely that intervening on specific features of OAT provision (e.g., increasing screening, treatment initiation, and retention) could improve health outcomes. However, the extent to which intervening at various points along the OAT care continuum could reduce population mortality is not well understood.</p> <p>This study will undertake a first of its kind multi-jurisdictional analysis using data linkages in the US (Rhode Island and Wisconsin), Australia (New South Wales), and the United Kingdom (UK; Scotland), to transform the evidence base on the prevalence of opioid use disorder and the impact of opioid agonist treatments as a strategy to prevent opioid-related harm. This world-first study will transform the evidence-base for OUD care, provide robust estimates of OUD prevalence, and offer key insights regarding how to enhance the benefits of OAT provision, thereby informing governments, service providers, researchers, and people with lived experience across the globe.</p> <p>Code and training documentation will be freely available on an online, open access repository, accelerating future research by sharing a robust analytical framework. This will enhance capacity and accelerate the pace of other US jurisdictions to use linked administrative data to better implement strategies to reduce opioid-related harm.</p>
Research questions (if applicable)	N/A
Why is the data you are requesting necessary to accomplish the project’s purpose?	<p>The requested data is necessary to accomplish this study’s purpose as databases linked at the individual-level have great power to inform prevalence estimates, examine rare outcomes, and explore subgroup and context specific variations of OAT. To date, there has been relatively limited use of administrative data linkages in US OUD and OAT research, in part reflecting challenges and concerns about ethics and feasibility, yet many of these challenges equally exist – and have been managed – in other</p>

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	<p>countries. The fragmented and particularly complex US healthcare system presents additional complications, but there are examples of US jurisdictions that have managed to overcome these, including those in this study.</p> <p>Our project will leverage the strong data linkage capacity of four jurisdictions across three countries and is underpinned by the assumption that there is considerable scope to apply data linkage to increase US-specific evidence on OUD prevalence and the impacts of OAT.</p>
<p>Sample or population of interest:</p>	<p>The population of interest includes Rhode Islanders who are members of the APCD and have evidence of an opioid overdose or diagnosis of OUD. Based on prior research, we estimate that the data set will include a cohort size of approximately 28,000 individuals. Consistent with this earlier work (see citation below), we expect that the demographic distribution of this updated cohort will be (approximately) as follows:</p> <ul style="list-style-type: none"> ● 74% white; 26% non-white ● 57% male; 43% female ● Age 18-29 (11%); 30-39 (29%); 40-59 (47%); ≥60 (13%)
<p>Comparison group: (if applicable)</p>	<p>N/A</p>
<p>Design:</p>	<p>The Transform study has been designed with three aims:</p> <ul style="list-style-type: none"> ● Aim 1: Generate robust OUD prevalence estimates, illustrating potential application in other jurisdictions. ● Aim 2: Examine the impact of OAT on overdose and all-cause mortality in different OAT populations, treatment systems, and jurisdictions. ● Aim 3: Determine the population-level impact of existing and expanded access of OAT provision on fatal overdose and all-cause mortality among people with OUD in select jurisdictions.
<p>Any Definitions or Methodology Required to Fulfill this Request:</p>	<p><i>(e.g., CPT Codes, CPT Modifiers, ICD 9/10, Lines of Business, Program Indicators)</i></p> <p>People in the RI APCD who had a healthcare encounter for an: (1) opioid overdose, (2) diagnosis of OUD, or (3) any receipt of OAT between July 1, 2013 and Dec 31, 2024.</p> <p>Variable definitions and relevant ICD and revenue codes to define the cohort are provided below:</p> <p>1) Opioid overdose</p> <p>Revenue codes: 0450-0459</p> <p>IDC-9 codes: 96500, 96501, 96502, 96509, 9701, E8500, E851, E852, E9351, E9352, E940, 9670, 9671, 9672, 9673, 9674, 9675, 9676, 9677, 9678, 9679, 9778, 9779, 9690, 9691, 9692, 9693, 9694, 9695, 9696, 9697, 9698, 9699</p>



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ICD-10 codes: t4040, t4028, t509, t406, t400x1a, t401x1a, t402x1a, t403x1a, t404x1a, t405x1a, t40601a, t40691a, t407x1a, t408x1a, t40901a, t40991a

2) OUD

ICD-9 codes: F11181, 30472, 30471, 30551, 30470, 30553, 30400, 30550, 30473, 30402, 30403, 30552, 30401

ICD-10 codes: F1119, F11288, F1194, F11259, F11251, F11120, F11129, F11988, F11122, F11920, F11151, F11182, F11222, F1111, F11250, F11951, F1199, F11229, F11950, F1114, F11150, F1193, F1124, F11188, F1129, F11929, F1110, F11281, F11959, F1121, F11221, F11921, F11982, F11220, F1123, F11282, F11121, F11159, F1120, F1190, F11922, F11981

3a) Methadone

ICD code: H0020

3b) Buprenorphine

National Drug Codes (NCD): 00054017613, 00490005130, 23490927009, 50383029493, 54868570700, 59385002160, 63629409201, 59385002660, 63629712604, 00054017713, 00490005160, 35356000407, 50383092493, 54868570701, 59385002360, 63874108403, 60846097003, 63629712605, 00054018813, 00490005190, 35356000430, 50383093093, 54868570702, 59385002460, 63874108503, 60846097103, 63629712606, 00054018913, 12496120201, 35356055530, 52959030430, 54868570703, 59385002560, 63874117303, 62175045232, 63629712607, 00093537856, 12496120203, 35356055630, 52959074930, 54868570704, 59385002760, 63874117403, 62175045832, 63629712608, 00093537956, 12496120401, 42291017430, 53217013830, 54868575000, 60429058630, 65162041503, 62756045964, 63629727001, 00093572056, 12496120403, 42291017530, 53217024630, 55045378403, 60429058633, 65162041603, 62756046064, 63629727002, 00093572156, 12496120801, 43063018407, 54123011430, 55700014730, 60429058730, 66336001530, 62756096964, 64725093003, 00228315303, 12496120803, 43063018430, 54123090730, 55700018430, 60429058733, 66336001630, 62756096983, 64725093004, 00228315403, 12496121201, 43063066706, 54123091430, 55700030230, 62756045983, 68071138003, 62756097064, 64725192403, 00228315473, 12496121203, 43063075306, 54123092930, 55700030330, 62756046083, 68071151003, 62756097083, 64725192404, 00228315503, 12496127802, 49999039507, 54123095730, 55887031204, 63481016160, 68258299103, 63629409202, 65162041509, 00228315573, 12496128302, 49999039515, 54123098630, 55887031215, 63481020760, 68258299903, 63629507401, 65162041609, 00228315603, 12496130602, 49999039530, 54569549600, 58284010014, 63481034860, 68308020230, 63629712501, 71335035301, 00378092393, 12496131002, 49999063830, 54569573900, 59385001201, 63481051960, 68308020830, 63629712502, 71335035302, 00378092493, 16590066605, 49999063930, 54569573901, 59385001230, 63481068560, 00228315567, 63629712503, 71335035303, 00406192303, 16590066630, 50268014411, 54569573902, 59385001401, 63481082060, 00406192309, 63629712504, 71335035304, 00406192403, 16590066705, 50268014415, 54569639900, 59385001430, 63481095260, 00406192409, 63629712505, 71335035305, 00490005100, 16590066730, 50268014511, 54569640800, 59385001601, 63629403401, 00406800503, 63629712506, 71335035306, 23490927006, 16590066790,

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	<p>50268014515, 54569657800, 59385001630, 63629403402, 00406802003, 63629712507, 71335035307, 50090157100, 23490927003, 50383028793, 42858050203, 42858050103, 63629403403, 12496010001, 63629712601, 76519117000, 12496030002, 12496030005, 63629712603, 76519117002, 59385002260, 59385002601, 12496030001, 63629712602, 76519117001, 76519117003, 76519117004, 58284020801, 58284021601, 58284022401, 58284023201, 58284026401, 58284029601, 58284022801</p> <p>Note: Upon DUA approval, the buprenorphine codes listed above will be expanded/updated to include additional generic transmucosal buprenorphine/naloxone films from newer manufacturers (e.g., Aveva).</p> <p>Additionally, as indicated under the RI APCD Data Dictionary pharmacy tab, we will also request additional information regarding methadone and buprenorphine prescriptions, such as quantity dispensed and days' supply, to allow us to capture and characterize periods of treatment engagement vs. disengagement.</p>
<p>Data analysis plan: <i>(specify statistical techniques)</i></p>	<p>The analytic methodology for each study aim is as follows:</p> <ul style="list-style-type: none"> ● Aim 1: A Bayesian statistical modeling approach will estimate OUD prevalence in multiple jurisdictions. This relies on a comprehensive cohort of OAT records linked to drug related event data, both to estimate opioid overdose and other drug related harm rates in people out of OAT, and the number of drug related events in the population that were not observed in the cohort. Incorporation of multiple drug related harm events and other information allows checking of the consistency and coherence of prevalence estimates. ● Aim 2: Cox proportional hazards and generalized estimating equations/mixed models will be used to calculate-adjusted all cause and drug-related mortality rates and hazard ratios to characterize the impact of OAT across treatment setting, demographics, comorbidities, injecting behavior and incarceration history for cross- country comparisons and for use in statistical (Aim 1) and population (Aim 3) modeling. ● Aim 3: A dynamic model of OUD, incarceration, OAT, and mortality will be parameterized by and calibrated to data in each jurisdiction. It will estimate how many deaths are averted by current OAT programs – and evaluate the potential impact of expanded OAT access on mortality among people with OUD
<p>Please provide shell tables that summarize your anticipated aggregated results. A table shell, also known as a dummy table, is titled and fully labeled but contains no data.</p>	<p>Expected outcomes by Aim:</p> <ul style="list-style-type: none"> ● Aim 1: Estimates of prevalence of OUD by age, gender, geography and other characteristics. We will conduct a comparison of prevalence estimates and age/gender distribution between jurisdictions for use in Aim 3. Estimates of coverage of OAT for each jurisdiction. Finally, we will publish an online tutorial demonstrating the method, statistical code, and anonymized datasets for use by others.



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<p>newsletters, program evaluation reports, etc.)</p>	<p>Primary study results, as well as other study results that involve RIDOH data, will be shared with the appropriate RIDOH subject matter experts, including Dr. Ben Hallowell, Jennifer Koziol, and Macy Daly.</p> <p>Results that involve vital records data, will be shared with the appropriate Vital Records subject matter experts, including Sarah Bowman and Blake Ducharme</p>
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Section 4: Data Request

There are three types of APCD Data Requests: Standard, Cohort, and Custom. A Standard Request is a pre-built researcher-friendly set of claims-line level data tables with individual member details that may be used for statistical and other complex analyses. Standard extracts are large files, and users will need a robust database infrastructure (e.g., SQL Service, Oracle, with 1–2 TB storage) in which analytic files can be prepared for use with statistical software, such as SAS or R. Standard extracts are delivered to users as flat text files via SFTP with PGP encryption.

The Standard Request offers two levels of detail: Core and Extended. Both levels contain member-level demographic information, claim line details (medical or pharmacy), and provider details. The Core contains member 3-digit zip codes and service year. The Extended includes member city, 5-digit zip codes, and service date.

Available years of data can be seen here: [APCD Snapshot - Rhode Island State APCD | Tableau Public](#) (See Data Availability Tab)

For details on available project licenses and to determine which data and value-added elements are available in each extract, visit the RIDOH HealthFacts RI webpage (www.health.ri.gov/data/healthfactsri)

Medicare FFS data can only be released to projects directed and funded (partially okay) by the State of Rhode Island.

Standard Request	
Data Requested	<ul style="list-style-type: none"> <input type="checkbox"/> Core Extract Medical Claims <input type="checkbox"/> Core Extract Pharmacy Claims <input type="checkbox"/> Extended Extract Medical Claims <input type="checkbox"/> Extended Extract Pharmacy Claims <input type="checkbox"/> Medicare Fee-for-Service** <input type="checkbox"/> Submitter Table <input type="checkbox"/> Provider Table <input type="checkbox"/> Dental Table <input type="checkbox"/> Alternative Payment Model Table <input type="checkbox"/> CurrentCare Race and Ethnicity Table



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If you are requesting the Extended Extract, please justify why the service date and 5-digit zip codes are required for the project.	
Years of Data requested	
Type of license requested	<input type="checkbox"/> Single-use, single agency <input type="checkbox"/> Multi-use, single agency <input type="checkbox"/> Multi-use, multi-agency <input type="checkbox"/> This is a single project under a multi-use license
If requesting a multi-project license, how many projects do you anticipate?	
Will you need new years of data as they become available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide a detailed description of your team's experience working with APCDs or other claims data sources.	

Custom Request offers the flexibility to request a subset of the database, a data report, or a data dashboard created by a state APCD developer to meet your project's needs.

Custom Request	
Type of Data requested	<input type="checkbox"/> Aggregate data (e.g., counts, percentages, sums, etc.) <input checked="" type="checkbox"/> Individual claims data
Please indicate the years of data requested and how often the data is requested to be updated.	<input checked="" type="checkbox"/> One time request <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Ad hoc
Please specify the data elements requested and describe in detail why the data elements are necessary for this project.	<p>We request data elements from the following extract tables:</p> <ul style="list-style-type: none"> Eligibility Medical Pharmacy Medical claim header Inpatient stay summary Medical crosswalk Aprdrg_output <p>Extract tables summary: The requested data elements are necessary to identify the study population, characterize insurance coverage and healthcare utilization over time, construct clinically</p>

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meaningful episodes of care, and examine patterns of inpatient, outpatient, and pharmacy service use relevant to the study aims. Elements have been selected to enable longitudinal linkage across claims files while adhering to principles of data minimization.

Within each extract table, we request the following **specific data elements**:

Eligibility:

Eligibility Record ID
 Internal Member ID
 Coverage Class
 Member Coverage Start Date
 Member Coverage End Date
 Member Gender Code
 Member Age (90+ Aggregate)
 Dual-Eligibility Code ID
 Dual-Eligibility Code
 Third-Party Liability Code ID
 Third-Party Liability Code
 Member City
 Member State
 Member ZIP Code
 Out-of-State Flag
 Duplicate Flag – TPA/PBM
 Duplicate Flag – Medicaid/Medicare Managed Care
 Duplicate Flag – Medicare Part D

Summary: Eligibility variables are required to define the analytic cohort, establish periods of continuous enrollment, and characterize insurance coverage and payer type over time. Member demographic fields (age category, gender, geography at the city/state/ZIP level) are necessary for descriptive analyses and stratification while maintaining privacy protections. Dual eligibility and third-party liability indicators are required to identify overlapping coverage and payer responsibility. Duplicate flags are used solely for data quality checks and exclusion of duplicative records.

Medical:

Medical Claim Service-Line Record ID
 Internal Member ID
 Submitter Claim Control Number (Encrypted)
 Member Gender Code
 Date of Service (From)
 Date of Service (Through)
 Admission Date
 Discharge Date



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	<p>Type of Bill ID Place of Service Code Revenue Code Procedure Code Procedure Modifier Code (1) Procedure Modifier Code (2) Procedure Modifier Code (3) Procedure Modifier Code (4) Diagnosis Code – Primary Diagnosis Code – Other 1 Diagnosis Code – Other 2 Diagnosis Code – Other 3 Diagnosis Code – Other 4 Diagnosis Code – Other 5 Diagnosis Code – Other 6 ICD Procedure Code – 1 ICD Procedure Code – 2 ICD Procedure Code – 3 Discharge Status Code Admission Type Code Member City Member State Member ZIP Code Claim Type ID Type of Setting ID Place of Setting ID Denied Claim Flag Emergency Room Flag Duplicate Flag – TPA/PBM Duplicate Flag – Medicaid/Medicare Managed Care</p> <p>Summary: Medical service-line elements are required to measure outpatient and inpatient-associated utilization, identify clinical services delivered, and characterize diagnoses and procedures at the encounter level. Dates of service, admission and discharge dates, and claim type indicators allow construction of episodes of care and temporal sequencing of events. Diagnosis and procedure codes (including modifiers and revenue codes) are necessary to classify services, identify conditions of interest, and distinguish care settings. Place and type of setting variables support analyses by site of care. Emergency room and denial flags are used to distinguish emergent from non-emergent utilization and to assess data completeness. Geographic fields are used only for contextual analyses and linkage consistency checks. Duplicate flags support internal data validation.</p> <p>Pharmacy: Pharmacy Claim Record ID</p>
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Internal Member ID
Member Gender Code
Member Age (90+ Aggregate)
Date Prescription Filled
National Drug Code
Drug Name
Claim Status Code ID
Claim Status Code
Quantity Dispensed
Days' Supply
Thirty-Day Equivalency
New Prescription or Refill
Generic Drug Indicator Code
Compound Drug Indicator Code
Member City
Member State
Member ZIP Code
Denied Claim Flag
Duplicate Flag – TPA/PBM
Duplicate Flag – Medicaid/Medicare Managed Care
Duplicate Flag – Medicare Part D

Summary: Pharmacy elements are required to identify prescription medication use, characterize dispensing patterns, and calculate standardized measures of medication exposure (e.g., days' supply and thirty-day equivalency). National Drug Codes and drug names enable classification of medications relevant to the study aims. Claim status and denial indicators are used to distinguish filled versus rejected claims. Demographic and geographic variables support stratified analyses and consistency checks, while duplicate flags are used exclusively for data quality purposes.

Medical claim header:

Medical Claim Header Record ID
Internal Member ID
Insurance Type / Product Code ID
Insurance Type / Product Code
Member Age (90+ Aggregate)
Date of Service (From)
Date of Service (Through)
ICD Diagnosis Code
ICD Version Indicator
Claim Header Status Code
Denied Claim Header Flag
Claim Type ID
Type of Setting ID
Place of Setting ID



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	<p>Type of Bill Code Emergency Room Flag Operating Room Flag</p> <p>Summary: Medical claim header elements are required to contextualize service-line claims, characterize payer and product type, and identify high-level claim attributes such as setting, bill type, and claim status. Header-level diagnosis codes and version indicators support validation and consistency checks across files. Emergency room and operating room flags enable identification of care intensity and acuity.</p> <p>Inpatient stay summary: Inpatient Discharge Record ID Internal Member ID Place of Setting ID Date of Service (From) Date of Service (Through) Admission Date Discharge Date Discharge Status Code Length of Stay Member Gender Code Member Age (90+ Aggregate) ICD Diagnosis Code – Admitting ICD Diagnosis Code – Primary ICD Diagnosis Code – 1 (through 30) ICD Procedure Code – 1 (through 30) icd_version_ind</p> <p>Summary: Inpatient stay summary elements are required to identify hospitalizations, characterize admission and discharge details, and measure length of stay. Diagnosis and procedure code fields (including multiple secondary diagnoses and procedures) are necessary to describe clinical complexity and inpatient care patterns. Version indicators ensure correct interpretation of diagnosis coding systems. These elements support construction of hospitalization-level analytic records without reliance on direct identifiers.</p> <p>Medical crosswalk: Medical Claim Service-Line Record ID Inpatient Discharge Record ID Medical Claim Header Record ID</p> <p>Summary: Crosswalk variables are required to link service-line medical claims, claim headers, and inpatient stay summaries. These identifiers are used exclusively for internal file linkage and</p>
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	<p>de-duplication and are not used for direct identification of individuals.</p> <p>Aprdrg_output: Inpatient Discharge Record ID Internal Member ID ICD Version Indicator Length of Stay Discharge Days After Admission Grouper Type & Version Diagnosis-Related Group Code Major Diagnostic Category DRG Label ID DRG Error Return Code Severity of Illness Index</p> <p>Summary: These elements are required to classify inpatient stays by diagnosis-related group, severity of illness, and major diagnostic category. These standardized clinical groupers enable risk stratification, adjustment for illness severity, and comparison of inpatient utilization patterns across populations and time periods. Length-of-stay-related fields may be used to support severity-adjusted analyses.</p> <p>Data Minimization: All requested elements are necessary to achieve the study objectives. No direct identifiers are requested. Identifiers included are limited to those required for longitudinal linkage, episode construction, and data quality assurance.</p>
<p>If requesting aggregate data, how should the data be stratified (e.g., by gender, age group, county, etc.)?</p>	<p>N/A</p>
<p>Are custom analytics required? (e.g., applying attribution methodologies, calculating quality metrics, applying custom groupers, etc.)</p>	<p>Custom analytics are not required</p>

Please include shell tables that summarize your Custom Request’s anticipated results, data specifications, explanations of methodology, and/or report templates that may be used to develop the custom extract here:

Cohort Request



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Does this request track a specific population (i.e., an evaluation cohort)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If tracking a specific population, please specify the number of individuals included in the cohort.	We anticipate the cohort will consist of approximately 28,000 Rhode Islanders who are in the APCD and who have evidence of an opioid overdose or diagnosis of OUD between July 1, 2013 and December 31, 2024
If a cohort is required, please explain why tracking this specific population is necessary for the study.	A cohort approach is required to answer the research questions laid out in the specific aims above. Specifically, we have to create a cohort in order to examine key outcomes—including drug overdose deaths from linked RI Vital Records data—over time.
If a cohort is required, please list any researcher-supplied fields (a Maximum of 20) requested to be matched to the APCD. No variables can be matched, including Personal Identifiers or Protected Health Information.	Information derived from overdose death decedents will be transmitted to the APCD team by RI Vital Records. A third-party Lock Box vendor will link these records to the cohort to determine which study participants died of a drug overdose during the study period.

By submitting this Application and signing the RI APCD Data Use Agreement, the requestor attests that they understand the following requirements:

1. No RI APCD user shall attempt to identify an individual member using RI APCD data or data outputs derived from RI APCD data.
2. RI APCD data shall not be linked with any other data source or information from another data source that could re-identify a member or patient.
3. Cohort request specifications must follow the Researcher File Layout detailed in the RI Researcher Extract Request Specifications document and may include no more than 20 researcher-supplied data fields.
4. Researcher-supplied data fields may not include Personal Health Information (PHI) or information enabling the researcher to re-identify.
5. If multiple Cohort IDs are required for research, no fewer than 11 members may be assigned to a single Cohort ID.

Section 5: Data Linkages

If this project requests linkage to another data source (e.g., Census data), the applicant must justify why this linkage is necessary.	
Will RI-APCD data be linked to another data source?	X Yes



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	<input type="checkbox"/> No
<p>If yes, will the data be linked to patient-level data, individual provider-level data, facility-level data, or aggregate-level data? (Check all that apply.)</p>	<p><input checked="" type="checkbox"/> Individual patient data</p> <p><input type="checkbox"/> Individual provider data</p> <p><input type="checkbox"/> Facility level data</p> <p><input type="checkbox"/> Aggregate level data</p>
<p>If yes, provide a justification for each linkage indicated above and the steps you will take to prevent the identification of individual members.</p>	<p>APCD data will be linked to death certificates provided by the office of Vital Records at RIDOH. Linkage to Vital Records is necessary to analyze mortality in aims two and three. Upon execution of necessary data use agreement, the Vital Records team will send PII for linkage to APCD via a third party lockbox service (PCC).</p> <p>First name, last name, date of birth, date of death, and social security number will be used to create the linkage.</p> <p>The third party Lockbox Services Vendor (PCC) will be responsible for linking death certificate data to information from the state's APCD. PCC will match the demographic data and assign a Lockbox ID. PCC will then send the Lockbox ID and corresponding records to Onpoint. Onpoint matches the Lockbox ID to the Unique Member ID within the APCD. Onpoint will then send the de-identified linked dataset to APCD for final report creation. An anonymized, row-level dataset (stripped all off identifiers) will then be sent from the APCD team to Brown University via SFTP. Once the linkage has been conducted, all identifiable information will be destroyed by the third party vendor.</p> <p>No individually-identifiable data or other PII is to be sent directly to the Brown University team.</p>