Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

TRANSCEND: Transgender Status-neutral Community-to-clinic Models to End the HIV Epidemic

**Attachment 3c**

**EHR Data Variables**

Public reporting burden of this collection of information is estimated to average 8 hours per response from each recipient data manager, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

**Data to be extracted from the Electronic Health Record**

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| --- | --- | --- | --- | --- |
| **Number** | **Data element** | **Source** | **Description** | **Required/Optional to Report with CDC** |
| **A** | **Lab Testing Data from Clinic** | This module will be applied to all relevant tests for HIV and other sexually transmitted infections. | | |
| A1 | Date of test | EHR | Date | Required |
| A2 | Name of test | EHR | Text | Required |
| A3 | Procedure code | EHR | CPT/HCPCS/ICD-10-PCS | Required |
| A4 | Test code | EHR | LOINC code/Quest code | Required |
| A5 | Test result code | EHR | LOINC code | Required |
| A6 | Type of test (in-house test) | EHR | Text, customized by clinics  Ex (Point-of-care antigen/antibody) | Required |
| A7 | Test result code (in-house) | EHR | LOINC code/Any standard results | Required |
| A8 | Test result, numeric | EHR | Number | Required |
| A9 | Test result unit, for numeric result | EHR | Unit of result | Required |
| A10 | Test result, text | EHR | Any result recorded in text format | Required |
| A11 | Test result interpretation | EHR | Text | Optional |
| **B** | **Prescription (Rx) Data from Clinic** | This module will be applied to all prescriptions relevant for HIV prevention or treatment, STI treatment, gender-affirming hormone therapy. | | |
| B1 | Date of Rx | EHR | Date | Required |
| B2 | NDC code of Rx | EHR | 11 digit code | Required |
| B3 | Number of prescribed units of medicine | EHR | Number | Required |
| B4 | Unit of medicine | EHR | Bottle/Box/Vial/ml/gram, ect | Required |
| B5 | Days of supply prescribed | EHR | Number | Required |
| B6 | Diagnosis associated with Rx | EHR | ICD-10 | Required |
| B7 | Reason for Rx | EHR | Free text | Optional |
| B8 | Prescriber NPI | EHR | Number | Optional |
| **C** | **Clinical Visit** | This module will be applied to all encounters for general clinic services. | | |
| C1 | Date of encounter | EHR | Date | Required |
| C2 | Reason for visit | EHR | Text | Required |
| C3 | Diagnosis code for encounter | EHR | ICD-10 CM | Required |
| C4 | Procedure code for encounter | EHR | CPT/HCPCS/ICD-10-PCS | Required |
| C5 | Procedure extension code | EHR |  | Required |
| C6 | Clinical notes | EHR | Any additional notes | Optional |
| C7 | Referral for Clinical Services | EHR | Referral code or free text | Required |
| C8 | Referral Reason | EHR | Free text | Required |

**Data to be collected from client intake forms, clinic EHR, CBO, other sources**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Number** | **Variables Category and Name** | **Source** | **Categories** | **Required/Optional to Report to CDC** |
| **D** | **Demographic and Behavioral Information** |  | | |
| D1 | Unique ID | Client Intake Form | Numeric free text | Required |
| D2 | Year of birth | Client Intake Form | Numeric free text | Required |
| D3 | Date intake form completed | Client Intake Form | Date | Required |
| D4 | Race | Client Intake Form | American Indian/Alaska Native  Asian  Black or African American  Native Hawaiian/Pacific Islander  White  Unknown/not answered | Required |
| D5 | Ethnicity | Client Intake Form | Hispanic or Latino/a  Not Hispanic or Latino/a  Unknown/not answered | Required |
| D6 | Gender Identity | Client Intake Form | Male  Female  Transgender male  Transgender female  Non-binary/ genderqueer  Another gender identity  Unknown/not answered | Required |
| D7 | Sex assigned at birth | Client Intake Form | Male  Female  Unknown/not answered | Required |
| D8 | Sex in the past 6 months | Client Intake Form | Yes  No  Not answered | Required |
| D9 | Type of sex in the past 6 months | Client Intake Form | (check all that apply)  Receptive anal sex  Insertive anal sex  Receptive vaginal sex  Insertive vaginal sex  Receptive oral sex  Insertive oral sex  Not answered | Required |
| D10 | Used condoms in the past 6 months | Client Intake Form | Always  Sometimes  Never  Not answered | Required |
| D11 | Number of sex partners in the past 6 months | Client Intake Form | Numeric | Required |
| D12 | Sex with a person with HIV in past 6 months | Client Intake Form | Yes  No  Unknown | Required |
| D13 | Injection drug use behavior in the past 6 months | Client Intake Form | Yes  No  Not answered | Required |
| D14 | If yes to injection drug use in the past 6 months, shared any injection equipment? | Client Intake Form | Yes  No  Not answered | Required |
| D15 | Substance use in the past 6 months | Client Intake Form | (check all that apply)  Alcohol  Marijuana  Methamphetamine  Cocaine  Opioids  Other  Not answered | Required |
| D16 | Current use of hormone therapy | Client Intake Form | Yes  No | Required |
| D17 | If yes to hormone therapy, shared needle or syringe? | Client Intake Form | Yes  No  N/A | Optional |
| D18 | If no, interested in using hormone therapy? | Client Intake Form | Yes  No | Required |
| **E** | **Intake Information** |  | | |
| E1 | Initial intake in TRANSCEND at CBO | Client Intake Form | Yes  No | Required |
| E2 | If yes, name of CBO | Client Intake Form | Text | Required |
| E3 | New client at CBO | Client Intake Form | Yes  No | Required |
| E4 | Initial intake in TRANSCEND at clinic | Client Intake Form | Yes  No | Required |
| E5 | If yes, name of clinic | Client Intake Form | Care Resource  Callen Lorde  St. Johns  Whitman Walker Health  Other | Required |
| E6 | New client at clinic | Client Intake Form | Yes  No | Required |
| E7 | Reason for intake visit | Client Intake Form | Establish primary care  HIV testing  STI testing  HIV PrEP  HIV PEP  HIV treatment  Gender-affirming hormone therapy  Other gender-affirming care  Support services  Mental or behavioral health care  Substance use treatment  Other | Required |
| E8 | Interest in services | Client Intake Form | Housing  Insurance  Transportation  Employment  Legal  Food  Other | Optional |
| E9 | Interest in navigation | Client Intake Form | Yes  No | Required |
| E10 | Referred to clinic at intake visit | Client Intake Form | Yes  No | Required |
| E11 | Referral from | Client Intake Form | Free text | Optional |
| E12 | HIV test in last 6 months | Client Intake Form | Yes  No | Required |
| E13 | Result of most recent HIV test | Client Intake Form | Positive  Negative  Unknown  Not answered | Required |
| **F** | **Referral and Service Use Information** |  | | |
| F1 | Date received service at CBO (repeating if multiple) | Clinic/CBO database | Date | Required |
| F2 | Referred to clinic | Clinic/CBO database | Yes  No | Required |
| F3 | Date referred to clinic | Clinic/CBO database | date | Required |
| F4 | Referred to CBO | Clinic/CBO database | Yes  No | Optional |
| F5 | Date referred to CBO | Clinic/CBO database | Date | Optional |
| F6 | If referred to CBO, which CBO | Clinic/CBO database | Text | Optional |
| F7 | If referred to CBO, for what service | Clinic/CBO database | Text | Optional |
| F8 | Linked to CBO | Clinic/CBO database | Yes  No | Optional |
| **G** | **HIV Testing Information from CBO or Community Outreach** |  | | |
| G1 | Date of HIV test | Clinic/CBO database | Date | Required |
| G2 | Type of HIV test | Clinic/CBO database | Lab-based antigen/antibody  Point-of-care antigen/antibody  Point-of-care antibody  RNA testing | Required |
| G3 | Result of HIV test | Clinic/CBO database | Positive/reactive  Negative  Indeterminate  Invalid  No result | Required |
| G4 | If positive, new diagnosis | Clinic/CBO database | Yes, new diagnoses  No | Optional |
| G5 | Referred to clinic for treatment after positive HIV test | Clinic/CBO database | Yes  No | Required |
| G6 | Date referred for treatment after positive HIV test | Clinic/CBO database | date | Required |
| G7 | Referred to clinic for PrEP after negative HIV test | Clinic/CBO database | Yes  No | Required |
| G8 | Date referred to clinic for PrEP after negative HIV test | Clinic/CBO database | Date | Required |
| **H** | **Navigation** |  | | |
| H1 | Offered navigation for clinic referral | Clinic/CBO database | Yes  No | Required  \*if navigation services available |
| H2 | Used navigation for clinic referral | Clinic/CBO database | Yes  No | Required  \*if navigation services available |