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

Data to be extracted from the Electronic Health Record

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	Required

			Not answered	
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	Text	Required

		Intake Form		
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	Required

			Not answered	
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