CURE ID

CURE ID and EHR DATA Dictionary

Question #	EHR Variable Name	Included in EHR data	Question Text	CURE ID Clinician-Submitted Definition	CDRC EHR Definition	Type of Values	Example
1	**Disease**	Yes, Prepopulated	What disease did your patient have?	The name of the current disease of interest the patient is experiencing for which the treatment is being reported.	The name of the current disease of interest the patient is experiencing for which the treatment is being reported.	Controlled terminology, characters	COVID-19
2	**How Diagnosis**	Yes, prepopulated	How did you make the diagnosis?	The methods by which the clinician made the diagnosis of the infection.	From the EHR data, by default this patient was admitted under clinical suspicion of COVID-19 and had a positive PCR or other nucleic acid test for SARS-CoV-2 within 21 days of admission. This is used to select "Clinical assessment" and "PCR or other nucleic acid test" as the responses for how the diagnosis was made for all patients with data coming from EHRs.	Controlled terminology, characters	Clinical Assessment AND PCR or other nucleic acid test
3	**Why New Way**	Yes, prepopulated	What made your patient's infection difficult to treat?	The reason why the clinician chose to use a drug in a new way (repurposed the drug). This is used to select "Therapeutic options were	The reason why the clinician chose to use a drug in a new way (repurposed the drug). This is used to select "Therapeutic options were	Controlled terminology, characters	There is no standard/approved therapy for this disease

				inadequate" for all patients with data coming from the EHR.	inadequate" for all patients with data coming from the EHR.		
4	**Drug**	Yes	What drug(s) did you use to address this difficult to treat infection?	Each individual medication the clinician prescribed (or administered if patient was hospitalized) that were treating the patient's infection.	Each individual medication administered during hospitalization for this infection, as captured in the patient's EHR.	Controlled terminology, characters	Albendazole, Hydroxychloroqu-ine, IVIG, etc.
5	**Outcome (death in hospital)**	Yes	What was the patient's outcome?	Outcome of the patient's treatment for their infection, as assessed and reported by their clinician.	Outcome of the patient's treatment at Day 28 of hospitalization.	Controlled terminology, characters	Patient was cured/recovered
6a	**Adverse Events**	Yes, prepopulated	Did the patient experience any adverse events?	Whether or not the patient experienced any adverse events during treatment of their infection.	Whether or not the patient experienced any adverse events during treatment of their infection. This is used to select Unknown for all patients with records coming from the EHR as this information is not generally captured in structured variable form in the EHR.	Controlled terminology, characters	Unknown
6b	What Adverse Events	No, clinician	What adverse events did the patient experience during treatment?	Description of the adverse events, if experienced	N/A	Free text	elevated LFTs

7	**Pregnancy**	Yes, in future	Was the patient pregnant at the time of treatment?	Pregnancy status of the patient during initiation of treatment of their infection	Pregnancy status at the time of admission for the infection to the hospital	Controlled terminology, characters	Yes
8	**When Reminder**	Yes, prepopulated	When would you like to receive your reminder?	Whether and, if so, at what time at which the healthcare provider wishes to receive a reminder to update their case report	N/A	Controlled terminology, characters and numeric	2 weeks
9a	**Age**	Yes	Age	The patient's age represented as a range.	The patient's age group at date of admission to hospital for this infection	Controlled terminology, numeric and units	31-40 years
9b	**Sex**	Yes	Sex	The patient's documented sex at time of treatment	The patient's documented sex at time of treatment	Controlled terminology, characters	Female
9c	**Ethnicity**	Yes	Ethnicity	The patient's documented primary ethnicity at time of treatment	The patient's primary ethnicity as documented in the EHR	Controlled terminology, characters	Hispanic/Latino
9d	**Race**	Yes	Race	The patient's documented primary race at time of treatment	The patient's primary race as documented in the HER	Controlled terminology, characters	Asian
10a	Country contracted	No, clinician entered only	Country in which the patient was infected or treated? Country disease contracted in -	The country in which the patient's infection was (or was suspected) to have been contracted	N/A	Controlled terminology, characters	Nigeria
10b	**Country treated**	Yes	Country disease treated	The country where the infection was treated.	The country where the infection was treated.	Controlled terminology, characters	United States

			in -		Used to select USA or Unknown in cases coming from the EHR.		
11	**Year**	Yes	Patient began treatment with this regimen in... Patient began treatment in (year):	The year in which the treatment began	Year of admission for index COVID-19 hospitalization	numeric	2021
12a	**HIV**	Yes	Other conditions - Please select the patient's underlying conditions, as applicable. HIV	Whether the patient has known HIV infection at time of treatment.	Whether the patient has a history of HIV infection, defined by the presence of a positive HIV test in their laboratory assessments and/or the presence of ICD10 codes for HIV in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	Yes
12b	**Asthma**	Yes	Asthma	Whether the patient has a diagnosis of Asthma at time of treatment.	Whether the patient has a history of Asthma, defined by the presence of ICD-10 codes indicating Asthma in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	No

12c	COPD	Yes	COPD	Whether the patient has a diagnosis of COPD at time of treatment.	Whether the patient has a history of COPD, defined by the presence of ICD-10 codes indicating COPD in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	Yes
12d	Other Chronic Lung Disease	Yes	Other Chronic Lung Disease	Whether the patient has a diagnosis of any chronic lung disease besides asthma or COPD at time of treatment.	Whether the patient has a history of Chronic Lung Diseases other than Asthma and COPD, defined by the presence of ICD-10 codes for chronic lung diseases that are not asthma or COPD (as defined by their inclusion in the Elixhauser score component for chronic pulmonary disease) in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	No
12e	Diabetes Mellitus	Yes	Diabetes Mellitus	Whether the patient has a diagnosis of diabetes at time of treatment.	Whether the patient has a history of Diabetes, defined by either a Hemoglobin A(1)c ≥ 6.5 in their lab work and/or the presence of ICD-10 codes for Diabetes mellitus in	Yes/No	Yes

					the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization		
12f	**Hypertension**	Yes	Hypertension	Whether the patient has a diagnosis of hypertension at time of treatment.	Whether the patient has a history of Hypertension, defined by the presence of ICD-10 codes for Hypertension in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	No
12g	**Cardiovascular Disease**	Yes	Cardiovascular Disease	Whether the patient has a diagnosis of cardiovascular disease at time of treatment.	Whether the patient has a history of cardiovascular disease, defined by the presence of ICD-10 codes for cardiovascular disease in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	Yes
12h	**Chronic Renal Disease**	Yes, in future	Chronic Renal Disease	Whether the patient has a diagnosis of chronic renal disease at time of treatment.	Whether the patient has a history of chronic renal disease, defined by the presence of ICD-10 codes	Yes/No	No

					for chronic renal disease in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization		
12i	**Chronic Liver Disease**	Yes, in future	Chronic Liver Disease	Whether the patient has a diagnosis of chronic liver disease at time of treatment.	Whether the patient has a history of chronic liver disease, defined by the presence of ICD-10 codes for chronic liver disease in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	Yes
12j	**Other Immunodeficiency**	Yes, in future	Other Immunodeficiency	Whether the patient has a diagnosis of an immunodeficiency aside from HIV at time of treatment.	Whether the patient has a history of other immunodefiency, defined by the presence of ICD-10 codes for non-HIV immunodeficiencies (specify) in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	No
12k	**Immunosuppressant Drugs**	Yes, in	Immunosuppressant Drugs	Whether the patient is known to currently be taking	Whether the patient has a history of prescription	Yes/No	Yes

					immunosuppressant drugs at time of treatment.	of immunosuppressant drugs, defined by the presence of a list of immunosuppressant drugs (in problem list and diagnoses documented in the present admission) in the current hospitalization		
12l	**Cancer**	Yes	Cancer	Whether the patient has a diagnosis of cancer at the time of treatment.	Whether the patient has a history of cancer, defined by the presence of ICD-10 codes for cancer (specify) in the patient's EHR (in problem list and diagnoses documented in the present admission) at the date of hospitalization	Yes/No	No	
12m	Neurologic/Neurodevelopmental/Intellectual Disability	No, clinician entered only	Neurologic/Neurodevelopmental/Intellectual Disability	Whether the patient has a diagnosis of a neurologic, neurodevelopmental, or intellectual disability at the time of treatment.	N/A	Yes/No	Yes	
12n	**Smoker**	Yes, in future	Smoker	Whether the patient has reported to the clinician that they are an active smoker at time of treatment.	Whether the patient has a history of being a smoker, according to their EHR (in problem list and diagnoses documented in the present admission) at	Yes/No/Unknown	No	

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					the date of hospitalization		
12o	Unknown	No, clinician entered only	Unknown	Whether the clinician is unaware of whether the patient has any comorbidities and coinfections or not.	N/A	Yes/No	Yes
12p	Other relevant comorbidities or coinfections	No, clinician entered only	Other relevant co-morbidities and coinfections	Whether the clinician is aware of the patient having any other comorbidities or coinfections	N/A	free text, characters	Huntington's disease
13a	Site of Disease	No, clinician entered only	Describe the clinical presentation: Site(s) of disease -	Site of disease (e.g., physical location such as right ankle)	N/A	free text, characters	right ankle
13b	Clinical syndrome	No, clinician entered only	Clinical syndrome(s)	Clinical syndrome patient experienced as part of their hospitalization (e.g., pneumonia, sepsis)	N/A	free text, characters	sepsis
14	Unusual	No, clinician entered only	Did anything else make this case unusual? - (e.g., unusual clinical manifestations, abnormal findings, etc.)	Any additional details the clinician wants to be included in the case report that describes what they felt made the case unusual and therefore worth reporting	N/A	free text, characters	The patient was exposed to an armadillo.
15	**Organism**	Yes, prepopulated	What is the organism(s)	The causative organism of the disease.	The causative organism of the disease.	Controlled terminology, characters	SARS-CoV-2

			causing this infection?				
16	Resistant Drugs	No, clinician entered only	Was the organism resistant to any drugs?	Description of whether the organism was resistant to any drugs via susceptibility testing	N/A	Yes/No and then Controlled terminology, characters	Yes, Rifampicin
17	Sample	No, clinician entered only	What is the sample from which the organism was isolated?	The sample from which the organism was isolated for laboratory testing.	N/A	Controlled terminology, characters	Blood
18a	**Dose**	Yes, in future	What dosing regimen did you use for "drug name that the user entered in Q4"? (Repeated for each drug) Dose (e.g., 500 mg):	The dose of the drug administered to the patient in mg or other similar units (e.g., 500mg).	The dose of the drug administered to the patient in mg or other similar units (e.g., 500mg).	numeric and units	500 mg
18b	**Frequency**	Yes, in future	Frequency (e.g., BID):	The frequency with which the drug was administered to the patient, generally on a daily or weekly basis (e.g., BID, twice weekly).	The frequency with which the drug was administered to the patient, generally on a daily or weekly basis (e.g., BID, twice weekly).	free text	BID
18c	**Route**	Yes, in future	Route of administration (e.g., IV, IM):	The route of administration by which the drug was administered (e.g., oral, IV).	The route of administration by which the drug was administered (e.g., oral, IV).	free text	

18d	Duration	Yes, in future	Duration (e.g., 9 months):	The duration of treatment with the drug (e.g., 7 days).	The duration of treatment with the drug (e.g., 7 days).	numeric and units	
19	**How New Way**	Yes, prepopulated	How was the "drug name" used in a new way? (question should be asked for each drug)	The manner in which the drug was being used in a new way that differs from its labelled indication by FDA.	The manner in which the drug was being used in a new way that differs from its labelled indication by FDA.	Controlled terminology, characters	It was not used in a new way
20a	**Severity**	Yes, prepopulated	What was the treatment setting in which this drug was introduced? (question should be repeated for each drug)	The setting in which each treatment was administered or received by the patient. Used as a proxy for the severity of their condition and the level of care they required. Used to populate all patient's with EHRs as Inpatients.	The setting in which each treatment was administered or received by the patient. Used as a proxy for the severity of their condition and the level of care they required. Used to populate all patients with EHRs as Inpatients	Controlled terminology, characters	Inpatient
20b	Additional Details of Severity	No, clinician entered only	Additional details of setting or severity	Any additional details about the severity of the patient's illness or level of care where they received treatment.	N/A	free text, characters	The patient was admitted to the ICU and given IVIG.
21	Adverse Event Outcome	No, clinician entered only	You stated that an adverse event occurred. What was the outcome	The outcome associated with the adverse event that occurred.	N/A	Controlled terminology, characters	Death

			attributed to this adverse event?				
22	Surgery	No, clinician entered only	Did the patient require surgery as part of the treatment for this infection?	Whether the patient required surgery as part of the control of their infection, in addition to drug treatment.	N/A	Controlled terminology, characters	Yes
23	Previous Treatment	No, clinician entered only	What drug(s), if any, was the patient previously treated with for this infection?	Any previous drugs that the patient was administered as part of the treatment of their infection prior to the current therapy described in the case report	N/A	Controlled terminology, characters	Linezolid
24	**How Outcome Determined**	Yes, prepopulated	You stated that the "patient was (outcome that the user entered, e.g., cured/recovered)". How did you determine the outcome?	The method by which the treatment outcome was determined, as reported by the clinician.	The method by which the treatment outcome was determined. Used to populate Clinical assessment for all patients with EHRs.		
25	When Outcome Assessed	No, clinician entered only	When did you assess the outcome?	The time at which the treatment outcome was assessed	N/A	Controlled terminology, characters	After a period of follow-up
26a	**Gestational Age**	Yes, in future	You stated that the patient you	The gestational age of the infant in weeks at the	The gestational age of the infant in weeks at the	Controlled terminology, characters and numbers	40 weeks

			treated was pregnant. The following questions are related to the pregnancy. What was the gestational age at the time when treatment began (round to nearest week)?	time of hospitalization for the infection	time of hospitalization for the infection		
26b	**Pregnancy Outcome**	Yes, in future	Please specify the outcome of the pregnancy:	If pregnant during treatment of the infection, what the outcome of the birth was	If pregnant during treatment of the infection, what the outcome of the birth was	Controlled terminology, characters	Full term live birth
26c	**Gestational Age at Delivery**	Yes, in future	What was the gestational age at the time of delivery (round to nearest week)?	The gestational age of the infant in weeks at the time of birth	The gestational age of the infant in weeks at the time of birth	Controlled terminology, characters and numeric	36 weeks
27a	**Congenital Transmission**	Yes, in future	Please describe the following neonatal details. Was	Whether the neonate is infected with the same organism as the mother (congenital transmission)	Whether the neonate is infected with the same organism as the mother (congenital transmission)	Controlled terminology, characters	Yes

			the neonate/fetus diagnosed with [insert disease in question]?				
27b	**Neonatal Anomalies**	Yes, in future	Please describe the details of neonate/fetus anomalies/disabilities, if present:	Description of any congenital anomalies or defects experienced by the neonate	Description of any congenital anomalies or defects experienced by the neonate	free text	sensorineural hearing loss
27c	Additional Neonatal Outcomes	No, clinician entered only	Is there any additional information you would like to add concerning this neonatal/fetal outcome? (e.g. reason for termination of pregnancy)	Any other additional information about the neonate the clinician wants to add	N/A	Free text	pregnancy was terminated due to congenital anomalies
28	Relapse	No, clinician entered only	Did the patient experience a disease relapse?	Whether or not the patient experienced a relapse of their infection after successful	N/A		

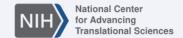|				completion of an initial or prior treatment course.			
29	Other important information	No, clinician entered only	Is there any important information about this case you would like to add?	A free text box enabling a healthcare provider to enter any other relevant information they feel is helpful for contextualizing the case.	N/A	Free text	Patient had a seizure on day 5
EHR Only Variables							
30	**BMI**	Yes	What was the patient's BMI at hospital admission? BMI:		The patient's body mass index, displayed as groups, and calculated based on variables for first height and weight documented according to the Formula: weight (kg) / [height (m)]2 OR Formula: weight (lb) / [height (in)]2 x 703 at the time of hospitalization?	numeric	30.0-34.9
31a	**Charlson Index**	Yes	Charlson Index Score:	N/A	Charlson Comorbidity Index predicts the ten-year mortality for a patient who may have a range of comorbid conditions as calculated at time of hospitalization.	numeric	10
31b	**Serum Creatinine**	Yes	Creatinine (serum):	N/A	First serum creatinine level collected during hospitalization, which is	numeric	0.71 mg/dL

					the level of creatinine in the blood.		
31c	**GFR**	Yes	GFR:	N/A	First glomerular filtration rate collected during hospitalization, which is equal to the total of the filtration rates of the functioning nephrons in the kidney.	numeric	20 mL/min/1.73m2
31d	**WBC**	Yes	WBC:	N/A	First white blood cell count collected during hospitalization, which measures the number of white cells in the patient's blood.	numeric	4000 WBCs/microliter
32	**Pulse Oximetry**	Yes	Pulse oximetry:	N/A	Lowest oxygen saturation during the patient's hospitalization as measured by pulse oximeter.	numeric (percent)	93%
33	**SpO2/FiO2**	Yes	SpO2/FiO2:	N/A	The SpO2/FiO2 ratio is shown as the ratio at the time of highest oxygen demand within the first 48 hours of hospitalization	numeric	300
34	**Oxygen Support Device**	Yes	What level of oxygen support was required?	N/A	The highest level of oxygen support device required at any point during the patient's hospitalization.	characters	Invasive Mechanical Ventilation

35	Hospitalization length	Yes	Length of Hospital Stay:	N/A	Hospital discharge date - Hospital admission date (in number of days as a whole number/calendar days)	numeric and units (days)	21 days
36	WHO Ordinal Scale Change	Yes	Change in WHO Ordinal Score from highest value on any day to value at death or discharge = # (range 3-10)	N/A	The WHO Ordinal scale represents a measure of disease severity and improvement, taking into account hospitalization, oxygen support requirements, and organ support required. Calculated for each day of the patient's hospitalization, then the highest value during the hospitalization (most severely ill state) is used as the first term, but which the value at either discharge or death is subtracted, to provide a delta of the change in value over the course of hospitalization.	numeric	6
NA	Date of Hospitalization	Yes	Included (as a shifted) date only for the purposes of	N/A	Only use for the purposes of assigning Day 0 as the relative first date of hospitalization ,	day and number	Day 0

			anchoring relative day of hospitalization (this data is not publicly displayed)		suggest getting which quarter or month the admission was in (if two hospitalizations, it's the first one) (suggest having an anchor date of Jan 1 or Mar 1 as anchor point) - consider having options for sites to pick whether they want to not provide any dates or provide months/quarters		
NA	**CURE ID Assigned identification**	Yes	a CURE ID assigned identification number (this data is not publicly displayed)	N/A	An identification number assigned by the CURE ID system for tracking purposes.	numeric	187095
NA	**Subject ID**	Yes	a subject identification number (this data is not publicly displayed)	N/A		numeric	123456

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Legend
Bolded variable names in Column B are Variables in initial EHR extraction and planned future EHR extraction.
Non-bolded variables are those that come from the clinician-submitted version of the case report and are not currently being extracted from the EHRs or are automatically pre-populated as they are the same for all entries from the EHRs at this time.