# 2007 Interview Record FAQs

1. **Why did CDC revise the Interview Record (IR)?**
The data currently available have not been adequate to describe characteristics of the existing and emerging STD epidemics (e.g., increases of syphilis cases in MSM, use of internet and drugs such as methamphetamine and Viagra) that are critical to prevention interventions. Additionally, different forms have been used for STD and HIV program purposes, which has made data collection and management cumbersome in some areas and not allowed for enhanced HIV program use. The standardized collection of these data points should help health departments and CDC to better understand and address STD occurrence.

2. **How does the enhanced Interview Record differ from the old IR?**
The old IR system uses two forms (interview and intelligence) and does not allow for enhanced HIV program use. The new form accounts for a) the interview and intelligence forms and enhanced HIV program information, b) less duplication of effort in areas (e.g., interviewing co-infected patients), c) 10 standardized, up-to-date risk variables (instead of 13 variables on old form), d) new standardized variables on Internet and other places where persons are meeting/having sex with partners, e) extensive space for DIS and supervisory notes.

3. **How will using this form benefit our STD program?**
The Interview Record will benefit local STD Programs in many ways. For the individual DIS and supervisor, many questions concerning patient lifestyle, places to meet partners, and previous STD and HIV testing will now be recorded on the IR, instead of in the case write-up. This information will be routinely collected for every individual interviewed so that better and more consistent patient assessment and risk reduction counseling can occur. The IR allows for enhanced HIV program use so that no duplication of effort will occur in areas that are interviewing patients who are co-infected with both syphilis and HIV. In addition, the IR combines the old interview record and intelligence sheet and provides extensive space for DIS and supervisory notes all in one form.

Programmatically, the IR provides a greater opportunity to conduct enhanced analysis of data, an activity that is critical to detecting changes in morbidity, identifying potential outbreaks and evaluating intervention and prevention efforts in communities or project areas.

4. **How long will it take to complete this form?**
Although initial use of the pilot IR increased the time to complete post-interview paperwork, time difference decreased as familiarity with the form increased. The enhanced IR may decrease the time required to write narratives.

5. **How do we access the new IR?**
The IR will be available to the STD Program Manager (or his/her designee) through a secure website. The form will be downloadable, so the Program Manager will have continual access and therefore, not have to wait for forms to arrive by mail.

6. **Why do we need to record the patient's primary language on the form?**
Information documenting the patient's primary language may be used to ensure that language or cultural barriers are recognized by the DIS and addressed during the interview and follow-up activities. This information is for local use and is not intended to be reported to CDC with case surveillance information.

7. **Why are there so many questions about transgender, e.g. self and partners?**
Until now, there has been no standardized way to assess the burden of STDs in the transgender population. Information documenting a person's gender can be used by case management and disease intervention staff to ensure that gender- and culturally-appropriate prevention information and referrals are offered to persons regardless of their gender. Documentation of this information should be guided by local or state practice, but is supported by the enhanced IR.

8. **The old form had a control number. Why doesn't the new form have a control number?**
The IR control number found on the previous IR form was generated during the printing of the multipart IR forms and was intended to allow linkage of the different pages from the same multi-part form. Some project areas also used this control number for other purposes as they managed their STD program information. Since the Division of STD Prevention (DSTDP) will not be printing the enhanced IR (see FAQ #5), IR control numbers will not be provided. Project areas should define how they used the previous IR control number and devise a process to ensure that the function for the IR control number is accounted for when using the enhanced IR and that physical or electronic data linkage is accurate**.**

9. **Why isn't the new IR available as a triplicate, printed form? What do we do since the form is no longer a triplicate form?**
With the U.S. public health system's transition to standards-based, electronic information interchange in the *National Electronic Diseases Surveillance System/Public Health Information Network (NEDSS/PHIN)* environment, DSTDP is promoting the collection and use of electronically-maintained information rather than information collected and maintained via specific hard-copy forms. However, DSTDP will continue to play a role in the collaborative development of and training in the use of standardized data collection forms for use by local and state STD prevention programs. The enhanced IR represents a standardized data collection form that describes the type and content of information that DSTDP recommends as having value for local or state prevention program decision-making during the interview, partner notification, and case management processes. DSTDP does not intend that all of the information collected via the enhanced IR be reported to CDC as part of surveillance or performance measures reporting. The enhanced IR form template will be provided to STD prevention programs for their use and adaptation (see #5). Therefore, DSTDP does not intend to constrain local or state use of the enhanced IR by mandating use of a specific data collection form or physical format. If project areas have used the different parts of the multipart form for different purposes (e.g. control copy, reporting copy), areas will need to produce as many copies of the enhanced IR as needed and label them appropriately to support their information

management needs. In collaboration with our local and state partners, DSTDP is defining the data elements that should be reported electronically from states to CDC for notifiable STDs. DSTDP will seek Office of Management and Budget (OMB) approval for those specific data elements (regardless of the data collection method or medium) rather than approval for the enhanced IR which is mainly for local and state prevention program use.

10. **Can we still use the old form?**
It is expected that all project areas will begin using the enhanced IR by the end of December 2007, because the new form has 12 new variables that must be reported to CDC. If the project area elects to continue to use the old form after that date, the new variables will still have to be collected and submitted to CDC.

11. **Can we modify the form for use with chlamydia and gonorrhea interviews?**
The IR can be adapted for use with chlamydia, gonorrhea, or any other STD interview.

12. **Will STD*MIS be updated to work with the new interview record?**
Yes, STD*MIS is currently undergoing a significant upgrade so that it can be used in conjunction with the enhanced interview record.

13. **When will the updated STD*MIS be available for use?**
The upgrade to STD*MIS is scheduled for completion in late summer, 2007.

14. **Will the new interview record affect morbidity data reported to CDC?**
Yes, the current morbidity report to CDC will be expanded to include some data elements that are represented on the new interview record and are not currently being reported. Once the content of the new morbidity report has been finalized, it will be published so that project areas can adapt their collection and reporting systems to accommodate the new content. STD*MIS will be updated to support the reporting of the new content as well.

15. **What variables will be expected to be sent to CDC?**
While the information content of the future STD morbidity report to CDC is not finalized, at this time, DSTDP recommends reporting the following variables (as defined on the IR) as part of the morbidity report.

- item 32, “had sex with an anonymous partner” within past 12 months
- item 32, “had sex while intoxicated and/or high on drugs” within past 12 months
- item 32, “exchanged drugs/money for sex” within past 12 months
- item 33, specific drugs used within past 12 months
- item 34, “been incarcerated” within past 12 months
- item 35, “quantitative result” titer of first positive non-treponemal test related to the current diagnosis being interviewed for (draws from four possible lines)
- item 39, “anatomic site” of lesion(s)
- item 38, HIV status (i.e., “qualitative result”), which draws from three possible lines
- item 40, “previous STD history”
- item 45, “places met partners” within past 12 months (up to five possible on form)

- item 46, “places had sex” within past 12 months (up to five possible on form)
- item 47, total number of sex partners in past 12 months (draws from female, male, and transgender partner codings)

16. **What is the format/record lay-out of the extended list of variables to be sent to CDC?**
DSTDP plans to finalize the information content of the future STD morbidity report to CDC in summer 2007. Since DSTDP is requesting that project areas begin reporting additional risk factor information in STD case reports to CDC effective January 1, 2008, the current "National Electronic Telecommunications system for Surveillance (NETSS) CDC Implementation Plan for STD Surveillance Data" (http://www.cdc.gov/std/std-mis/STD-MIS-Doc.htm under Miscellaneous Files) will be updated in the fall of 2007 following finalization of the STD morbidity record content.

17. **What type of feedback will project areas receive on the data that are submitted?**
The information content represented by the enhanced IR should be considered information best used for local and state STD prevention purposes (e.g., case management, partner notification, referrals) rather than information reported to CDC. Project areas will continue to receive reports detailing data completeness and timeliness for the critical data elements reported to CDC as part of notifiable STD surveillance and performance measures monitoring. Project areas should implement data quality assurance procedures to ensure the most accurate and complete data.

18. **Will CDC provide training and/or technical assistance for project area staff during implementation and afterwards?**
CDC will host two webinars to introduce programs to the new form and answer program questions and concerns. The following resources will be available to programs on the CDC DSTDP website:

- A PowerPoint presentation with step-by-step instructions on using the new form
- Frequently Asked Questions (FAQs)
- Practice case using the new IR
- IR instructions
- IR

You may also contact your STD program consultant to request technical assistance.

19. **When is it expected that the project areas will use the form?**
Project areas can begin using the IR, at their discretion, anytime after the webinar. However, all project areas must begin reporting the new variables to CDC on January 1, 2008. If the project area elects to stay with the old form, remember that 1) the new variables will still have to be collected and reported to CDC beginning January 1, 2008 and 2) production of the old forms will cease and they will not be available from CDC.

20. **Whom should I contact if I have further questions about the Interview Record?**
Please contact your STD program consultant.