

HUMAN BEHAVIOR IN FIRE STUDY

Supporting Statement for OMB Review

Part A

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Human Behavior in Fire Study

A. Justification

A.1. Circumstances Making the Collection of Information Necessary

Many lives are lost each year due to fires. In 2003, more than 402,000 residential fires in the United States claimed the lives of 3,145 people and injured another 14,075 (Karter, 2004). Most victims of fire die from smoke inhalation or toxic gases and not from burns (Hall, 2001).

Approximately half of residential fire deaths occur in homes without smoke alarms (Ahrens, 2001). In 2003, residential fires accounted for more than \$6.1 billion in direct property damage (Karter, 2004).

Several epidemiologic studies have examined risk factors for fire deaths and injuries (Warda, 1999). Non-modifiable risk factors include young age, old age, male gender, non-white race, low income, disability, and late night/early morning occurrences. Modifiable risk factors include place of residence, type of residence, smoking, and alcohol use. Knowledge, attitudes, and beliefs of risks for fires also have been assessed in national surveys. For example, the National Fire Escape Survey (NFPA, 2004) found that fewer than one in ten surveyed thought that their smoke alarm going off meant that there was a fire or that they had to get out, two-thirds have a fire escape plan (but of those only one-third have practiced it), and almost 90% think that they have 30 minutes or less before a fire in their home becomes life-threatening.

Bryan (2002) presented six steps in the process for people's behaviors or response to a fire. These steps include recognition, validation, definition, evaluation, commitment, and reassessment. The steps divide the response of individuals to fire in terms of their actions in response to initial fire cues, (typically ambiguous) that include detection of abnormal conditions being present, confirmation that their perceptions of the changed environment are correct, and identification that the changes are due to a fire. These three steps can occur nearly simultaneously when the individual is close to the fire and sees the flaming or smoldering object. Otherwise, the steps may take place over an extended period of time as the individual seeks to confirm that something abnormal is occurring and perhaps seeks to identify the nature and source of the abnormality. Once aware of the presence of a fire, people evaluate possible courses of action and select a "best" course according to their assessment. They monitor the situation to ascertain whether the selected course of action is still appropriate after some time has expired. Brennan (1998) notes that delays in evacuation caused by delays in recognizing cues or investigating may result in people being injured in fires.

Four notable studies conducted in the 1970's and 1980's attempted to develop an understanding of people's response to fire incidents in residences: Wood, U.K. (1972); Bryan, U.S. (1977); Keating and Loftus, U.S. (1984); and Canter, U.K., (1985). Two of these studies included fires exclusively in residences (Keating & Loftus; Canter), while the Wood and Bryan studies included all incidents reported to the study team during a multi-year time period, though a large majority consisted of fires in residences. Each of the studies was conducted using the post-fire interview technique where building occupants were asked a series of questions. Researchers sought to survey all building occupants who reacted to the fire to develop basic information

about patterns of behavior in response to fires. Principal findings from these studies were that smelling smoke was a frequent means of becoming aware of the fire, a common first action after becoming aware of the fire was to notify others, males were more likely to engage in fire fighting behavior than females, and many individuals re-entered the building after evacuation.

Much research has been done in understanding environmental and non-behavioral risk factors for injuries related to residential fires. Behavioral research, as mentioned above describes responses of individuals who have previously been involved in a fire, but the information is limited because it does not assess whether those behaviors are associated with an injury. In order to develop behavior-based interventions to prevent the occurrence of residential fire-related injuries, it is necessary to better understand which response behaviors increase (or decrease) risk during a fire.

This data collection addresses one priority in the CDC's Injury Research Agenda for Prevention of Injuries at Home and in the Community. That priority is to identify modifiable behavioral responses to residential fires that can inform the development of intervention and prevention strategies.

Authority for CDC to collect this data is granted by Section 301 of the Public Health Services Act (42 U.S.C. 241) (Appendix 1). This act gives federal health agencies, such as CDC, broad authority to do many public health activities, including this type of research.

A.2. Purpose and Use of Information Collection

The purpose of this study is to examine the relationship between individuals' behavior in response to a residential fire and the occurrence of a fire-related injury. The findings from this study will provide information about risk and protective factors associated with injuries in residential fires among our study population that are amenable to intervention and prevention strategies. Risky behaviors that are associated with residential fire-related injuries could be targeted for intervention through either environment modification or educational approaches. Protective behaviors could be encouraged through similar strategies.

A.3. Use of Improved Information Technology and Burden Reduction

Partner fire departments have been made aware of the study's inclusion and exclusion criteria through personal contact and email updates, and have agreed to complete fire incident reports for appropriate cases. Please refer to sections A10 and B1 for more details about the fire department recruitment and responsibilities. If a fire incident meets the criteria for the study, fire department personnel will be asked to submit the incident report to the Battelle Centers for Public Health Research and Evaluation (Battelle) either by fax or email. Fire departments will not be asked to fill out any forms that they do not normally use after their response to a residential fire. Fire departments will be sent a weekly email as a reminder and will receive weekly updates on the progress of the study. Every effort will be made to impose as small a burden as possible on fire departments. Fire departments will not invest time other than faxing or emailing the fire incident information to Battelle. Fire departments are considered CDC's community partners for this project, and therefore not considered to be "public" from the perspective of the Paperwork Reduction Act.

Trained Battelle interviewers will then conduct a brief, computer-assisted telephone interview (CATI) (Appendix 2) to screen out incidents that do not meet the study's inclusion criteria and to screen out individuals who do not want to participate.

The face-to-face interview data will be collected using the Computer Assisted Personal Interview (CAPI) process. This sophisticated system can handle complex questionnaires and incorporate the type of information handling required by the Behavioral Sequence Interview Technique (BSIT; Keating & Loftus, 1984) that will be used in this study. The survey instrument (Appendix 3) will be installed onto laptop computers using Blaise® software (Netherlands' Central Bureau of Statistics for Windows). Blaise® is a computer-assisted interviewing (CAI) system and survey processing tool for the Windows® operating system. In addition, it includes the capability to review and edit data, customize screen layouts, and include multimedia applications, if needed. The pre-programmed interview will have skip patterns so that the study subject need only answer in-depth questions that are appropriate for the type of fire the respondent encountered and to ensure that questions answered in the narrative section of the interview will not be asked again in the semi-structured part of the survey. In addition to these data, an audio recording will be made of the study participants' recounting of the sequence of events that occurred after fire recognition. The audio recording is handled through the Blaise® software, with a built-in microphone.

Use of the CATI for screening and the CAPI for conducting the face-to-face interview captures the data more accurately and will reduce the burden to the respondent since it normally reduces the amount of time necessary to complete a screening interview.

A.4. Efforts to Identify Duplication and Use of Similar Information

A review of the scientific literature reveals several notable studies conducted in the 1970's and 1980's to attempt to develop an understanding of people's response to fire incidents in residences: Wood (1972), Bryan (1977), Keating and Loftus (1984), Bryan and Milke (1981), and Canter (1985). However, most of the fire incidents included in these studies occurred in long-term health care facilities rather than residences and none examined the relationship between behaviors and the occurrence of injury. Additionally, the literature review revealed substantial gaps in the public health knowledge base concerning the knowledge, attitudes, beliefs and behaviors that most strongly influence risks for injuries in residential fires. The present study will provide a detailed examination of the elements that affect the behavior of people in fires and how their behaviors were associated with being injured.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses or other small entities will be impacted by this study.

A.6. Consequences of Collecting the Information Less Frequently

Study participants will be contacted twice for (1) a brief CATI telephone interview for screening and recruitment and (2) a face-to-face interview. Members of the project's Technical Advisory

Group (TAG), (see Table A-1 below), a national group of experts in fire and behavior, recommended that the main data collection for this study occur in a face-to-face interview. They felt that collecting behavior information in a telephone interview would result in data of poorer quality; therefore, surveyors were advised not to conduct the full interview at the time of the brief CATI telephone call. There are no legal obstacles to reduce the burden.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This study complies fully with the guidelines of 5 CFR 1320.5. No exceptions to the guidelines are required.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

- A. CDC published a 60-Day notice soliciting public comment on the proposed information collection in the Federal Register on March 28, 2005, Volume 70, No. 58, p. 15626. A copy is attached (Appendix 4). There were several requests to review the data collection guidance. This information was provided for each request. After reviewing the data collection guidance, there were no additional comments.
- B. A Technical Advisory Group (TAG) has been formed, composed of experts throughout the country in fire prevention, engineering, and human behavior (Table A -1). Since 2003, the TAG group has provided (and will provide through the end of the study) technical assistance, consultation, and recommendations in the following four areas:
 - a. Technical guidance in designing and planning the study, especially in the areas of fire science, human behavior in fires, data sources and data quality, fire department and fire marshal operations, policies, and practices.
 - b. Contacts and assistance in networking in the fire service and fire protection communities to identify and recruit jurisdictions to participate in the study.
 - c. Identification of study limitations.
 - d. Interpretation of study findings.

Table A -1: Members on Technical Advisory Group (TAG) for the Human Behavior in Fire Study

Name and Title	Phone	Agency	Email
<i>Gerry N. Bassett</i> Program Chair, Education	(301) 447-1094	United States Fire Administration Department of Homeland Security Building J, Room 212 16825 South Seton Avenue Emmitsburg, MD 21727	Gerry.bassett@dhs.gov
<i>Rita Fahy, PhD</i> Manager of Fire Databases and Systems	(617) 984-7469	National Fire Protection Association1 Batterymarch Park Quincy MA 02169 USA	Rfahy@nfpa.org
<i>Guylene Proulx, PhD</i> Senior Researcher	(613) 993-9634	Fire Risk Management Program, National Research Council Canada	Guylene.proulx@nrc.gc.ca

		Building M-59, 1200 Montreal Road Ottawa, Ontario K1A 0R6 Canada	
<i>Michael Greene, PhD</i> Mathematical Statistician	(301) 504-7335	U. S. Consumer Product Safety Commission Division of Hazard Analysis Directorate for Epidemiology 4330 East West Highway, Bethesda, MD 20814	MGreene@cpsc.gov
<i>Daniel O’Conner, P.E.</i> Vice President	(410) 272-8340	Schirmer Engineering Corporation Suite 200 707 Lake Cook Road Deerfield, IL 60015	Dan_oconnor@ Schirmereng.com
<i>Jane Edwards</i> Program Manager/Legislature Coordinator	(410) 653- 8976	Maryland Office of the State Fire Marshall 1201 Reistertwon Road Pikesville, MD 21208	jwedwards@mdsp.org

A.9. Explanation of Any Payment or Gift to Respondents

Since response rates are always a concern in conducting a survey, we propose to pay respondents \$25 for their participation in this survey. There is consistent evidence that monetary remuneration significantly increases response rates in most surveys, and experts on survey methods such as Dillman (1978) and Sudman (1985) recommend their use. Studies have clearly shown that even a nominal gratuity increases response rates by 10-20%, and that the amount of the incentive is positively correlated with response rate (Hopkins and Gillickson, 1992).

Kasprzyk et al (2001) used a \$25.00 incentive for physicians responding to a 25 minute survey. Surveys, with three follow-up mailings, were sent to a national probability sample of 311 physicians. Overall, 156 physicians returned completed surveys (56% overall response rate). Significant effects for incentive level ($F = 28.2$, $df = 2$, $p < .01$) existed.

A.10. Assurance of Confidentiality Provided to Respondents

The CDC Privacy Act Officer has reviewed this application and has determined that the Privacy Act is applicable. The appropriate system of records is 09-20-0136, “Epidemiologic Studies and Surveillance of Disease Problems.”

This project will be collecting personally identifying information. Multiple procedures will be undertaken to safeguard the privacy of participant information. Dr. Milke will recruit fire departments to participate in the study. Dr. Milke and his project affiliated research assistants will recruit fire departments through state and local fire protection associations, internet searches, referrals from fire prevention colleagues of the University of Maryland, Department of Fire Protection Engineering, and internet searches. Please refer to Section B2 for more details. Once the project begins, participating fire departments will notify Battelle about any residential fires in their area by sending fire incident reports, which contain the potential participants’ names, addresses, and telephone numbers (see Appendix 5 for an example of a fire incident report). Reports with identifying information are not publicly available and are being sent to Battelle in

the context of this study. Each local fire department may have different procedures to send these reports. The Battelle study manager will work with them individually to determine the most efficient way to receive the incident report, through either fax or email. Some departments have indicated that they are most comfortable faxing the contact information to Battelle. Fire incident reports faxed to Battelle will be sent directly to a Battelle project-specific email address using a fax server account. Only assigned Battelle staff will have access to the email exchange mailbox.. Other fire departments have indicated that they prefer communicating information by email. These emails will be only accessible by program staff and stored in password protected systems.

Interview data, also stored by Battelle, will contain a participant ID and will not have any personal identifiers associated with it. The interview data will be stored separately from the tracking data, which will have respondents' names, addresses, and phone numbers. The encryption of the participant ID will prevent any linkage between the interview data and the tracking data during the transfer process. Only the Battelle staff will have access to the data file that includes the link between participant ID and name, and all staff members will sign a confidentiality agreement.

To further ensure privacy and protect the data, unless otherwise compelled by law, a number of additional safeguarding procedures will be implemented:

- Participants will sign a consent form (Appendix 6) to participate in this study. They will be informed about the purpose of the data collection and that the information they provide will be treated in a confidential manner.
- All data will be stored electronically on password protected computers that will be in locked offices. Only study personnel will have access to these data. All identifying information will remain with the study contractor and will not be forwarded to CDC.
- The tracking data and interview data and will be stored separately and will not be linkable, as described above; therefore, interview data will not contain identifiable variables.
- All identifying information will be destroyed (shredding hard copies of any completed forms) or de-identified prior to the closure of the IRB protocol and/or within one year of the final report/publication. The de-identification process involves determining which data variable are identifiable in nature (such as the participant's name, address, and phone number), then removing this information from databases to be kept.
- CDC plans to report and publish the study findings in de-identified, aggregate form. De-identified data will be stored indefinitely for future analyses.

This project has been reviewed by three Institutional Review Boards. The CDC IRB approved the original protocol and amendments #1 and #2 on 11/3/2005, amendment #3 on 11/14/2005, amendment #4, on 2/1/2006, and amendment #5 on 8/25/2006 (Appendix 7). The study was approved by the Battelle Centers for Public Health Research and Evaluation IRB on 9/15/2005 and 9/7/2006 and by the University of Maryland IRB on 8/18/2005 and 7/21/2006. (These IRB approvals can be found in Appendix 8).

The Principal Investigator has applied for a Certificate of Confidentiality (301[d]) which is being processed by CDC. The Certificate of Confidentiality will provide the highest level of protection currently available to the sensitive information being requested. The current versions of the

consent-related materials (e.g., the consent document and the Screener Call Script) use language that is protective of privacy, but does not guarantee confidentiality. After the Certificate of Confidentiality is obtained, the Principal Investigator will revise and strengthen the language in the consent document and the Screener Call Script.

A.11. Justification for Sensitive Questions

The set of questions in the semi-structured part of the survey relating to mental and physical health are of a sensitive nature. Specifically, these are numbers J1-5 and J15-16 of the questionnaire (see Appendix 3). These items assess 1) on how many occasions the participant used tobacco, alcohol, marijuana, or other illegal drugs during the two weeks before the fire, 2) smoking and alcohol use within the few hours before the fire, 3) the number of drinks and number of hours that the participant consumed alcohol before the fire, 4) their estimation of their mental health before the fire, and 5) the number of days poor mental health kept them from doing their normal activities before the fire.

Without confidentiality protection, information regarding the participant's drug and alcohol use and/or mental health history could potentially be used against them in civil, criminal, administrative, or legal proceedings. For this reason, participants may be hesitant to answer these questions honestly. A lack of honesty on these questions would compromise study findings, so a Certificate of Confidentiality will help to assure the study participants that the information they provide will be protected from disclosure.

Interviewer training will include handling sensitive situations. We have scheduled 40 hours of training time for each interviewer. This includes training for screeners, tracers, phone interviewers and people who conduct face-to-face interviews.

A.12. Estimates of Annualized Burden Hours and Costs

The estimated three year total respondent burden includes: 1) a brief telephone screening interview which will be conducted with potential cases and controls received from the fire departments and 2) interviews which will be conducted with 650 cases of persons who were injured in a residential fire and 650 controls of persons involved in similar residential fires who were not injured. Of these 1,300 people, 300 persons (150 cases and 150 controls) will be conducted in homes that have elderly and homes with children occupants. These populations were chosen because they represent at-risk populations for residential fires. The estimated annualized response burden hours is presented in Table A-2.

Approximately 1,625 persons (approximately 543 people a year for three years) will be contacted and screened by trained Battelle interviewers to make sure they meet the study requirements. We anticipate 1,300 of the 1,625 screened persons will be eligible and willing to participate (approximately 434 people a year for three years). This screening process will involve a 15 minute, computer-assisted telephone interview (CATI). Therefore, the annualized burden hours for this group will be 109 hours.

We anticipate that 325 of the 1,625 persons (approximately 109 people each year for three years) will be screened, but will either be ineligible or refuse to participate. Their computer-assisted telephone interview (CATI) will take approximately 5 minutes. Therefore, the annualized burden hours for this group will be 9 hours.

The protocol requires the 1,300 respondents (approximately 434 a year for three years) to participate in an hour long face-to-face, computer-assisted personal interview (CAPI) conducted by trained interviewers. The total annualized burden in hours to these respondents is 552.

Table A-2: Estimated Annualized Response Burden Hours

Respondents	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden (Hours)
Adults – Screened and are Eligible	434	1	15/60	109
Adults – Screened but are Ineligible or Refused	109	1	5/60	9
Adults – Cases and Controls	434	1	1	434
TOTAL				552

- A. The persons screened as possible cases and controls will be from all occupations across the United States. The average hourly wage for all occupations is \$17.75, according to the Bureau of Labor Statistics Data, US Department of Labor for the year 2003 (www.bls.gov). Based on this wage, the total respondent cost for the participants who are screened and eligible to participate is \$1,934.75. The total respondent cost for the participants who are screened and are not eligible or refused to participate is \$159.75. The total respondent cost for the cases and controls participating in the one hour interview is \$7,703.50. Therefore the total respondent cost for this study is \$9,798.00.

Table A-3: Annualized Cost to Respondents

Type of Respondents	Total Burden Hours	Hourly Wage Rate	Respondent Cost
Adults – Screened and Eligible	109	\$17.75	\$1,934.75
Adults – Screened and Ineligible or Refused	9	\$17.75	\$159.75
Adults – Cases and	434	\$17.75	\$7,703.50

Controls			
Total			\$9,798.00

A.13. Estimate of Other Total Annual Cost Burden to Respondents or Record keepers

This data collection does not include any other annual cost to respondents, nor to any record keepers. No capital or startup costs will be incurred.

A.14. Annualized Cost to the Government

Although the costs are annualized over four years, data collection for the study will be completed in three years. The external (contractor) costs to the federal government for conducting the research for which OMB clearance is required will be approximately \$422,017 annually. Costs for contract labor hours include planning and design, development of OMB, IRB and study protocols, recruitment, training of interviewers, travel to conduct interviews, data collection, data preparation, data analysis, and report writing. The government costs include personnel costs for federal staff involved in the oversight, study design, OMB and IRB review, travel to study sites, and data collection, which include approximately 10 percent of a GS-13 scientist. Combined with contractor costs, this yields a total annual cost of \$430,717. The overall cost of this research to the Federal Government is presented below in Table A-4.

Table A-4: Estimated Annualized Cost to the Government

	Year 1 (\$)	Year 2 (\$)	Year 3 (\$)	Year 4 (\$)	Average Annual (\$)
Labor:					
CDC personnel for oversight, travel time, data collection and analysis and project oversight.	8,500	8,700	8,700	8,900	8,700
Contract labor for planning and design, OMB, IRB, and other protocol development, recruitment, training, travel time, data collection, data preparation, data analysis, and report writing	96,125	323,684	323,684	148,201	222,923
Other direct costs:					
Travel	4,398	47,217	47,217	4,398	25,808
Mailings		284	284		142
Incentives		17,614	17,614		8,807
Communications		31,205	31,205		15,603
Subcontractor	88,508	42,332	42,332	90,519	65,923
TAG consultants honoraria	6,250	1,562	1,562	3,125	3,125
Miscellaneous (G&A, Fees)	32,736	104,013	104,013	77,986	79,687
Total estimated contract costs	228,017	567,911	567,911	324,229	422,017
Total estimated government costs	236,517	576,611	576,611	333,129	430,717

A.15. Explanation for Program Changes or Adjustments

This is a new data collection.

A.16. Plans for Tabulation and Publication and Project Time Schedule

A.16.1. Plans for Tabulation

The main objective of this study is to identify specific residential fire and fire-related behavioral factors that are amenable to intervention and prevention. The following behaviors have been identified as being important in previous studies of fires: leave building, fight fire, contact fire department, activate alarm system, notify others, get family, get others, investigate, prepare for further action, get dressed, get others to call fire department, self-protective action, get personal property, re-enter building, panic, and no action.

The analysis plan for this study involves both descriptive and analytic steps. The outcome of interest is the occurrence of injury (case status). First, frequency distributions of all fire characteristics obtained from in-depth interviews will be prepared for both cases and controls. Similarly, frequency distributions of all personal characteristics will be prepared for both cases

and controls. Chi-square tests will be used to examine univariate relationships between case status and both the fire characteristics and the personal characteristics. Univariate associations significant at the 0.10 alpha level will be included in the regression model described below.

Second, multivariable logistic regression analyses will be used to assess which combination of fire and personal characteristics are associated with injury in residential fires. Displayed below are examples of the planned output tables from the analyses:

Step 1: Univariate Analysis

	CASES (n, %)	CONTROLS (n, %)	p
Fire Characteristics*			
Personal Characteristics**			

*Fire characteristic categories: fire ignition, building structure, individuals present, injuries sustained (cases only), past fire training and home evacuation training, past fire experience, and mental and physical health.

** Personal characteristic categories: behaviors and demographics (e.g., occupation)

Step 2: Multivariable Logistic Regression Analysis

	Odds Ratio	95% CI
Model 1		
Personal characteristics*		
Model 2		
*Personal and Fire** characteristics		

* Personal characteristic categories: behaviors and demographics (e.g., occupation, education)

**Fire characteristic categories: fire ignition, building structure, individuals present, injuries sustained (cases only), past fire training and home evacuation training, past fire experience, and mental and physical health.

As mentioned previously, of the 1,300 participant interviews over the 3 year study, 300 (150 cases and 150 controls) will be conducted among homes that have either children or elderly occupants present at the time of the fire incident. Children under age five and adults ages 65 and older are at increased risk of fire-related injuries and death. For this reason, we will conduct additional analyses focusing on these subgroups. Separate hypotheses and confidence intervals will be constructed to identify and examine any meaningful subgroup differences in behavioral responses to fire incidents. The results of these analyses will assist us in developing environmental modifications and educational programs targeted toward these populations.

A.16.2.Plans for Publication

Findings will be disseminated across a number of different formats. First, findings will be shared with other scientists and public health workers through presentations at scientific meetings and publication in peer review journals. Second, findings will be shared with the general public through the National Center for Injury Prevention and Control (NCIPC) website (www.cdc.gov/ncipc) and various forms of print media coverage.

A.16.3.Timeline

Data collection will take approximately 36 months. This includes receiving Fire Incident Reports from fire departments, abstracting related information, screening potential cases and controls, setting up interviews and conducting face-to-face interviews. We will begin receiving Fire Incident Reports two months after OMB approval is obtained. The project time schedule is shown in Table A-5.

Table A-5: Project Time Schedule

Activity	Time schedule
Fire Departments Recruited	1-2 months after OMB approval
Fire Incident Reports received from Fire Departments	2-3 months after OMB approval
Train interviewers	3 months after OMB approval
Conduct pilot interviews	3-6 months after OMB approval
Telephone screening interviews with potential cases and controls conducted, interview date set	6-12 months after OMB approval
Confirmation of interview date letters sent to cases and controls	12-15 months after OMB approval
Begin field work: Computer-assisted personal interviews	12-36 months after OMB approval
Close data collection	36 months after OMB approval
Data entry, coding, cleaning	36 months after OMB approval
Preliminary descriptive analysis	32-36 months after OMB approval
Complete analysis, deliver tabulations	32-36 months after OMB approval
Final Report	36-38 months after OMB approval
Presentation at meetings and Publication in Peer Review Journals	48 months after OMB approval

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

CDC, NCIPC is not seeking an exemption from displaying the expiration date of OMB approval.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

CDC, NCIPC is not requesting any exceptions from OMB Form 83-I, the Paperwork Reduction Act.