

Behavioral Risk Factor Surveillance System (BRFSS)

Existing Collection In Use Without an OMB Control Number

Supporting Statement

Part A: Justification

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Contents

A.	Justification.....	4
1.	Circumstances Making the Collection of Information Necessary.....	4
2.	Purpose and Use of Information Collection.....	9
3.	Use of Improved Information Technology and Burden Reduction.....	9
4.	Efforts to Identify Duplication and Use of Similar Information.....	10
5.	Impact on Small Businesses or Other Small Entities.....	11
6.	Consequences of Collecting the Information Less Frequently.....	11
7.	Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....	11
8.	Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....	11
9.	Explanation of any Payment/Gift to Respondents.....	11
10.	Assurance of Confidentiality Provided to Respondents.....	11
11.	Justification for Sensitive Questions.....	12
12.	Estimates of Annualized Burden Hours and Costs.....	12
13.	Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers.....	13
14.	Annualized Cost to Federal Government.....	14
15.	Explanation for Program Changes or Adjustments.....	14
16.	Plans for Tabulation and Publication and Project Time Schedule.....	14
17.	Reason(s) Display of OMB Expiration Date is Inappropriate.....	15
18.	Exceptions to Certification for Paperwork Reduction Act Submissions.....	16

Attachments

1. Authorizing Legislation: Public Health Service Act

2. List of BRFSS Awardees

- 3a-2015. Summary of All Core Sections
- 3b-2015. Reference Set of Approved Questions, by Core Section

- 4a-2015. Summary of Approved Optional Modules
- 4b-2015. Reference Set of Approved Questions, by Optional Module

- 5a-2015. Sample 2015 BRFSS Questionnaire
- 5b-2015. Summary of Optional Modules, by State

- 6a. Federal Register Notice
- 6b. Summary of public comments

- 7a-2015. U.S. Adult Population and Estimated BRFSS Sample Size By Jurisdiction
- 7b-2015. Sampling Geostrata by State
- 7c-2015. 2013 BRFSS Weighting Documentation
- 7d-2015. 2013 BRFSS Overview

- 8a-2015. Landline interview screener
- 8b-2015. Cell phone interview screener

- 9-2015. BRFSS Data Collectors by State

- 10a-2015. Disposition Table With Callback Rules
- 10b-2015 Understanding Coding for Technological/ Telecommunication Barriers

- 11-2015. Summary Data Quality Report for 2013

- 12-2015. BRFSS Questionnaire Development Process

Overview

CDC seeks OMB approval to collect information through the Behavioral Risk Factor Surveillance System (BRFSS) for three years. The BRFSS is a system of customized telephone surveys conducted by U.S. states, territories, and the District of Columbia to produce state- or jurisdiction-level data about health-related risk behaviors, chronic health conditions, use of preventive services, and emerging health issues. Each year, an independent sample of adults ≥ 18 years of age is drawn for each participating state or jurisdiction and the survey instrument is adapted to the needs of each state or jurisdiction. Information collection is conducted in a continuous, three-part telephone interview: screening, participation in the common BRFSS core, and participation in optional modules that states may use to customize survey content for their specific needs. Information collection is conducted primarily to support state and local health departments, which plan and evaluate public health programs at the state or sub-state level. Information collected through the BRFSS is also used by the federal government and other entities.

A. *Justification*

1. Circumstances Making the Collection of Information Necessary

Scientific research clearly shows that personal health behaviors play a major role in premature morbidity and mortality. Patterns of behavior that affect health or predict adverse effects on health are called behavioral risk factors. For example: lack of physical activity is a behavioral risk factor for obesity, type 2 diabetes, cardiovascular disease, and other diseases and conditions; and alcohol consumption (including binge drinking) is a behavioral risk factor for injury, unplanned or unprotected sexual behavior, and a contributor to numerous chronic conditions. Risk behaviors are thus key targets for prevention. Timely and accurate information about risk behaviors is needed to plan, initiate, support, and evaluate public health programs designed to prevent, control, or mitigate disease and disability.

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) was established at the Centers for Disease Control and Prevention (CDC) to provide coordinated leadership and support for prevention and control programs specifically related to chronic diseases or conditions. NCCDPHP works with partners from multiple sectors of society to create and disseminate expertise, information, and tools that reduce the burden of disease on the American public, and to identify populations that are most in need of strategies to promote physical and mental health and prevent disease. Key partners within CDC include the National Center for Immunization and Respiratory Diseases (NCIRD), the National Center for Environmental Health (NCEH), the National Institute of Occupational Safety and Health (NIOSH), the National Center for Injury Prevention and Control (NCIPC), the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), the Office of Public

Health Preparedness and Response (OPHPR), and the National Center for Health Statistics (NCHS). Surveillance efforts that quantify disease and risk factors, and identify opportunities for prevention, are central to CDC's planning and evaluation efforts. CDC's authority to collect information for this purpose is provided by the Public Health Service Act (**Attachment 1**).

Although national estimates of health risk behaviors among U.S. adult populations are periodically obtained, and are useful for establishing national goals and assessing progress toward those goals, national estimates alone are insufficient for some public health purposes. Due to the geographic, cultural, demographic and economic diversity of the U.S., the methods used to produce national estimates provide only limited insight into regional, or state-specific variability in health status and health-related behaviors. State and local health agencies are focal points for public health program planning and implementation. National data may not be applicable to the conditions found in any given state, or detailed enough to assist federal, state, and local health agencies determine the most effective allocation of public health resources. As a result, state- or jurisdiction-specific surveys are needed to monitor state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality.

In 1984, CDC and 15 states collaboratively initiated behavioral risk factor surveys designed to address the states' information and public health needs. Since that time, CDC has provided technical assistance and funding to an increasing number of states and territories, and survey content and methods have become increasingly sophisticated. The surveys are now known as the Behavioral Risk Factor Surveillance System (BRFSS), managed by NCCDPHP's Division of Population Health (DPH). Under the current BRFSS cooperative agreement program, CDC provides funding and technical assistance to 57 awardees including 50 states, the District of Columbia, and six territories (collectively referred to as "states" in this document). A list of current awardees is provided in **Attachment 2**. The primary purpose of the BRFSS is to provide the information that these awardees need in order to plan and evaluate public health programs at the state and sub-state level.

BRFSS information collection is conducted annually. The CDC and BRFSS awardees produce a new set of state-specific BRFSS questionnaires each calendar year (i.e., 2015 BRFSS series, 2016 BRFSS series, etc.). Information is collected through telephone interviews except in a limited number of jurisdictions with low telephone coverage, where interviews are conducted in-person. The methods for selecting respondents and determining questionnaire content reflect the system's origins. An independent sample of adult, non-institutionalized respondents is drawn for each state and is based on the state's parameters for state-level or sub-state analysis. The questionnaire is based on modular design principles allowing rapid customization of content. Each state's annual questionnaire includes a common core that is administered by all states, and standardized optional modules that may be fielded at the states' discretion. Data sets are submitted to CDC for cleaning and weighting, and returned to the state of origin for its use. In keeping with its historical role in promulgating standards that strengthen data quality and

comparability, CDC, in collaboration with the states, provides standard protocols for BRFSS data collection which all states are encouraged to adopt. The BRFSS collaboration of CDC and the states also develops and validates questions for both the core component(s) and the optional modules, and provides technical assistance to states on methodological issues such as sample selection, data quality, weighting, and the interpretation of findings. Weighted subsets of BRFSS data are made broadly available through the BRFSS Web site along with guidance on statistically appropriate uses of the data.

The interactive partnership between CDC and BRFSS awardees results in the collection of surveillance information that is adaptive to both state and national needs, and uniform where states have common interests. Over time the BRFSS has developed into an important source of information for federal agencies and the public as well as state and local health departments. Therefore, although the BRFSS remains primarily a state-based data collection system, in consultation with OMB, and in recognition of the BRFSS as a unique and influential source of public health information developed with federal assistance, CDC is seeking OMB approval for BRFSS annual surveys, beginning with the 2015 cycle of data collection.

CDC expects that the BRFSS will continue to reflect its essential character and purpose, which is to provide statistically representative, state-level behavioral risk factor data useful for state-level public health program planning and evaluation. Substantial flexibility in questionnaire content will be retained as a key feature responding to the needs of each BRFSS awardee. The OMB approval process is expected to result in improved guidance on uses of data generated under the auspices of the BRFSS. CDC anticipates that the initial clearance request will require amendments reflecting the dynamic nature of the BRFSS partnership, regularly scheduled annual updates, and the adaptability of BRFSS infrastructure to a wide variety of subject matters and national and state-specific needs for information. Amendments will be processed in consultation with OMB, subject matter experts at CDC and other federal agencies, and BRFSS awardees.

CDC and states frequently collaborate on methodological studies to strengthen data collection procedures and the utility of the information collected. The current request for OMB approval does not encompass methodological studies such as cognitive testing of questions, pilot tests, or other protocol enhancements or callback surveys (conducted to collect detailed information on a single health topic, such as asthma). CDC plans to submit one or more additional information collection requests to OMB that will establish the clearance mechanism(s) needed to support new areas of interest, quality improvement, and innovation.

The focus of this submission is on annual data collection conducted as part of the BRFSS core survey and approved optional modules that are adopted by states. These data comprise information that is used by the states to plan health policies. In addition, a subset of these data for all states and territories are publicly available for use by researchers and public health officials on the BRFSS website at www.cdc.gov/brfss.

2. Purpose and Use of Information Collection

The BRFSS data will be used for a number of purposes by a diverse set of users. The primary uses of the data are listed below:

- BRFSS data will be used by states to identify specific program needs and track health status over time.
- States will use BRFSS data to help them establish and track state and local health objectives, plan health programs, implement disease prevention and health promotion activities, and monitor trends.
- BRFSS data will be used to compare state-level behavioral health risk and health status information taken from persons residing within all U.S. states, D.C., the U.S. Virgin Islands, Guam, and Puerto Rico.
- A publicly available annual BRFSS dataset will be used by public health officials in government at the national, state and local level as well as researchers at university and non-profit organizations. Information will be used for program evaluation, research and reporting related to health status, chronic disease indicators and health risk and risk preventive behaviors. Data will be appropriate for trend analyses, tests of differences among (demographic) subpopulations, multivariate analyses of health outcomes and other statistical processes.
- BRFSS data will be used to create web-based tools to illustrate differences in health status and behaviors by state. State health department websites as well as a CDC website will be used as platforms to illustrate differences using mapping and charting software.
- BRFSS data will inform a variety of data resources, programs and organizations which use the data as a basis for smaller area estimation. These include but are not limited to the Health Indicators Warehouse, County Health Indicators, the Robert Wood Johnson Foundation, and HealthyPeople 2020.
- BRFSS data may be used to draw comparisons from data taken from identical and/or similar questions on other surveys using other modes thereby creating a means for validation and comparisons across population samples.

Data collection based on state-level sampling also permits the analyses of data at the local level when sample sizes within county or MSAs are large enough for statistical interpretation. The ability to identify state and sub-state differences optimizes program interventions designed by state health departments.

3. Use of Improved Information Technology and Burden Reduction

The BRFSS data will be collected using list-assisted random digit dialing (RDD) landline and cell phone telephone samples. Given the need for state-level samples that are large enough for statistical analyses, telephone surveys offer a cost effective method of data collection. In addition

to their cost advantages, telephone surveys are especially desirable at the state and local level, where the necessary expertise and resources for conducting area probability sampling for in-person household interviews are available in many state health departments. Interviewers will use Computer Assisted Telephone Interview (CATI) software to enter data directly into a database. Use of CATI software promotes efficiency in two ways: skip patterns can be programmed to route respondents only to questions that they are eligible to answer, and real-time quality control checks can be used to eliminate some errors which may have been caused by manual data entry procedures.

4. Efforts to Identify Duplication and Use of Similar Information

For most states and territories, the BRFSS provides the only sources of data amenable to state and local level health and health risk indicators. Extant data on these topics are available at the national level, but do not include sufficient sample size to determine whether there are measureable changes/trends in health risk behaviors at lower geographic levels. National surveys such as the National Health Interview Survey (NHIS, OMB No. 0920-0214, exp. 12/31/2016), the National Tobacco Survey (OMB No. 0920-0828, exp. 7/31/2015), the National Health and Nutrition Examination Survey (NHANES; OMB No. 0920-0950, exp. 11/30/2016), among others offer data for prevalence estimates at the national level. The BRFSS differs in that it samples at (sub) state levels, and produces direct, not modeled, estimates for state and local geographic jurisdictions.

In some cases, state prevalence may be modeled by other data collection. The National Adult Tobacco Survey and the National Health Interview Survey have both been used to model prevalence estimates at the state level. However they do not provide sufficient data from which direct state estimates can be derived nor do they allow for local area estimation. Moreover, in most instances state level data modeled from national surveys use national level control totals for weighting, while the BRFSS uses (sub)state control totals for all post-data collection raking weights. National surveys use modeled estimates to obtain state and local prevalence estimates, however, these modeled estimates can not be used to evaluate interventions that public health at the state and local level may have implemented. Many states use BRFSS data to evaluate their public health interventions.

Data from the BRFSS are also unique and necessary in that they provide a means by which states can tailor data collection to their unique needs. Optional modules which are important in one state may not be as salient in others. For example, the excess sun exposure optional module may be more critical in coastal states than in other jurisdictions. The addition of state-added questions is also a means by which specifically targeted information critical to a particular state may be obtained, using the infrastructure of the BRFSS.

5. Impact on Small Businesses or Other Small Entities

There will be no impact on small business.

6. Consequences of Collecting the Information Less Frequently

Trend analyses created from annual data would be interrupted by less frequent data collection. The BRFSS minimizes the number of questions included in the annual survey by including a rotating core (in even and odd numbered years) for a select number of indicators which have more detailed response sets.

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

There are no special circumstances.

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

A 60-day Notice was published in the Federal Register on September 15, 2014, Volume 79, Number 178, pages 54983-54984 (see **Attachment 6a**). Two public comments were received (see **Attachment 6b**). One comment was an expression of opinion that was acknowledged by CDC. The additional substantive comment suggested changes in the questions regarding tobacco use including the number of cigarettes per day and the use of electronic cigarettes (vaporizers). Inclusion of questions on the use of electronic cigarettes has been discussed by the BRFSS as part of the emerging issues section of the core in the near future. Often questions which are used in the emerging core are adopted for continuous use, based on their contributions to understanding public health issues and behaviors. All questions in the tobacco use section will continue to be monitored for effective population surveillance in consultation with subject matter experts. Changes to questions on the BRFSS are carefully reviewed so as to maintain the ability of researchers to produce trends based on multiple years of reports from standard questions. In addition, increasing the number of questions on the BRFSS is always carefully considered, as length of telephone surveys has been associated with negative effects on respondent participation in all or portions of the survey. In-person interviews, such as those mentioned in the comment, are less likely to experience problems associated with longer questionnaires.

9. Explanation of any Payment/Gift to Respondents

Not applicable.

10. Privacy Impact Assessment Information

Overview of the Data Collection System

Random digit dialing (RDD) telephone samples will be delivered to the states on a monthly or quarterly schedule. Information collection will be implemented by state health departments or their designees. States will administer the core/rotating/emerging core questions without change. States will determine which of the optional modules will be included in their jurisdictions and whether the state will split the sample to allow for the inclusion of a large number of optional modules. Field operations are managed by state health departments and/or their contractors following guidelines provided by the BRFSS (see Attachment 10a). States submit data to CDC for final cleaning, weighting, the production of analysis datasets, and other technical assistance as needed. Computer-assisted telephone interviewing (CATI) programming is provided by the CDC to states to convert the BRFSS questionnaire into a CATI interface from which interviewers will read and record answers to each question. States may opt to use their own CATI programming software. States run edit checking programs against the data and submit to the CDC on a monthly/quarterly basis. CDC then conducts additional data quality processes and summarizes the data in YTD reports provided to the states. At the end of each calendar year, data are finalized and weighted.

The datasets provided to the states at the end of the year include a large number of variables on calling attempts, final calling outcomes, questionnaire item responses and calculated variables. A subset of the data set provided to the states is published on the BRFSS website for public use.

Items of Information to be Collected

The BRFSS core questionnaire (see **Attachment 3a** and **Attachment 3b**) includes information on health status, health risk and risk preventive behaviors, as well as basic demographic information. Optional modules which are selected by individual states, based on their information needs, must also be implemented as written without changes in wording. Optional modules cover a range of health topics (see **Attachment 4b**). Other than phone numbers, which are part of the original sample files sent to the states, no information in identifiable form (IIF) will be collected from respondents during the telephone interviews. On occasions when states make appointments to call selected respondents back after portions of the survey have been completed, first names may be given to ensure that the remainder of the interview is conducted with the same individual. States must develop and maintain procedures to ensure respondents' privacy, assure and document the quality of the interviewing process, and supervise and monitor trained interviewers.

How Information Will Be Shared and For What Purpose

Since state health departments and/or their designees are the data collectors for the BRFSS, information will originate with the states. States may determine whether and how their data will be released to third parties. The CDC maintains an upload website by which data are submitted monthly/quarterly. CDC does not transmit data from one state to any other, with the exception of cell phone interviews of persons who have an area code from one state, but who actually live in another state. Telephone numbers are not linked to respondents. Files containing RDD telephone samples are kept separately from files which include responses to questionnaire items. CDC receives only de-identified records. Sample files contain sequence numbers which are provided by the sampling vendor and used by data collectors (the states or their designees) to determine calling outcomes for each phone number. The CDC does not receive full phone numbers in the sample file. Sample files received by the CDC and states which have contracted data collection include only area code and prefixes of phone numbers which are associated with sequence numbers. States which have internal data collection systems and contracted data collectors have sole access to both sequence numbers and full phone numbers during the data collection process. States keep responses to the BRFSS questionnaire separately from sample files. After data collection, sequence numbers are recoded to prevent subsequent links of sample files and responses to questions by any person or organization involved in data collection. State level data sets are owned by individual states. A subset of state data sets is provided for public use. Public use data sets have been stripped of a number of variables which provide locational information on the respondents (including zip codes, and county identifiers for counties with adult populations of less than 10,000), occupational information, uncategorized ages of respondents, and detailed race. CDC may provide data with locational information for internal users to produce small area estimates of health indicators.

Impact of the Proposed Collection on Respondents' Privacy

BRFSS sample files include phone numbers, and some addresses. Addresses are only available for telephone numbers in the landline sample where the sample contractor has been able to match phone numbers and addresses. These addresses are used by some states to send advance letters to households in the landline sample. No address matching is done for cell phone numbers. If a state does not send advance letters, addresses are not included in the sample files.

Approximately 40 states use advance letters, with about 60% of the landline sample having a matching address.

Since sample files are separate from datasets, no phone numbers or addresses are included in the datasets. No dates of birth, last names, or email address are obtained. Information that details race/ethnicity, occupation and small geographic residence (such as county or zip code) is suppressed in the public use dataset.

How Individuals Are Informed That Providing Information Is Voluntary Or Mandatory

Individuals participating in the BRFSS are informed that they do not have to participate and that they may refuse to answer any question.

Opportunities to Consent

Verbal consent is obtained during the initial contact and screening process (see **Attachment 8a** and **Attachment 8b**). The introductory script, including the voluntary nature of the survey, precedes the survey questions.

How Information Will Be Secured

Access to state data sets will be limited to the states themselves and CDC contractors and staff who conduct weighting and data cleaning procedures. Security measures include: 1) Physical controls: CDC facilities are secure, ID accessed buildings. Data will not be stored in hard copy formats; and 2) Technical controls: All electronic data are stored on secured servers protected with firewalls and passwords. All employees are trained on data security measures by taking appropriate HHS courses online. All data collection and records management practices and systems adhere to HHS and CDC IT policies and procedures.

Privacy Act Determination

The Privacy Act does not apply. The BRFSS data will be collected using list-assisted random digit dialing (RDD) landline and cellular telephone samples. No IIF will be collected, filed or retrieved by the name of the individual or other unique respondent identifier such as social security number.

11. Justification for Sensitive Questions

The BRFSS includes standard demographic questions (such as race and income category) which may be considered sensitive. In addition, some questions regarding preventive behaviors, such as HIV testing, may be considered sensitive. Participating states have used these standardized questions on state behavioral risk surveys for many years. Sensitive questions are necessary to identify changes in behaviors and/or self-assessments of health status when aggregated to local or state levels. In order to assess changes in health risk behaviors, it is necessary to ask questions of a sensitive nature. This sensitive information would be pertinent to determine state needs for health programs and services.

12. Estimates of Annualized Burden Hours and Costs

Respondents are adults ≥ 18 years of age. Information collection is conducted in a continuous, three-part telephone interview: screening, participation in the common BRFSS core, and participation in optional modules. Respondent burden is estimated separately for each step.

Although the number of interviews varies from state to state--based on the needs, population size and diversity of each state--a minimum number of interviews is set by the state in the sampling process. The estimated population for each U.S. state or territory, and the estimated size of the BRFSS sample that will complete interviews, are provided in **Attachment 7**. Approximately 65% of interviews are currently conducted on landlines and 35% on cell phones. The screening questions for the two groups are slightly different and are presented in **Attachment 8a** (Screener for Landline Respondents) and **Attachment 8b** (Screener for Cell Phone Respondents). Since the cooperation rate (based on AAPOR cooperation rate #2) for all BRFSS in 2013 was 63% for landline respondents and 71% for cellphone respondents, it is estimated that 440,486 landline respondents and 223,334 cell phone respondents will complete the screening questions. The estimated burden per response is one minute.

After completing the screening interview, respondents who are eligible and agree to participate will proceed to the core section of the BRFSS questionnaire. Questions in the core are drawn from the approved reference set (**Appendix 3b**). Questions in the core may be edited from one year to the next but topics remain standard. Editing occurs as a result of an outdated question (for example questions on preventive testing which refer to testing which is no longer recommended) or due to a minor format change. Large scale question changes are rare in the core and would be reported to the OMB as part of the annual review of the questionnaire. The rotating (even/odd numbered year) core includes standard topics and questions which may also include editorial changes from one administration to the next. We estimate that 321,522 respondents screened on landline phones and 173,128 respondents screened on cell phones will participate in the core data collection (total of 494,650 respondents). The estimated burden per response for the core is 15 minutes.

Each state participating in the BRFSS may customize its survey by appending additional questions to the core survey. These questions will be drawn from the reference set of approved questions for optional modules (see **Attachment 4b**). A complete BRFSS questionnaire (sample) is provided in **Attachment 5a**. Each state will administer one or more state-specific versions of the instrument in English. Spanish language versions are also routinely administered. The CDC does not provide requirements for administration of the survey in a second language. A standard Spanish translation is provided to the states, which may or may not adopt it for use. States may opt to modify the translation in order to match Spanish dialects of their populations. For example, states with larger number of Cuban residents may have populations with different word usage than states larger proportions of Spanish speaking residents with other backgrounds.

States may translate the questionnaire into other languages as budgets permit, although this is rare and is not being done in 2015. The pre-call status of the landline sample alerts the states to the potential of a language barrier and in some cases bilingual interviewers are assigned to that segment of the sample. In other instances, states use a callback system of bilingual interviewers to return calls after interim dispositions indicate that the household or cell phone may have a language barrier. Differential weighting of surveys conducted in Spanish or other languages is not included in the post data collection methods, although race and Hispanic ethnicity are included in weighting margins.

A summary of optional modules fielded in 2014 was used as an initial estimate of burden for 2015 (see **Attachment 5b-2014**). A summary of optional modules is provided summary states plans for 2015 (**Attachment 5b-2015**). As **Attachment 5b-2014** illustrates, states may split their samples in order to include a wider range of topics in the questionnaire, without lengthening the time for each interview. The number of optional questions/modules varies from state to state and year to year, but states typically limit the total length of the BRFSS interview to no more than 30 minutes on average. We estimate an average burden across the states of 15 minutes for their choice of optional modules. The BRFSS experiences a very low drop off rate for respondents who complete the core but do not complete the optional modules. We estimate that 484,757 respondents will complete the optional modules, after completing the core questionnaire.

Table A.12-1. Estimated Annualized Burden to Respondents

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hr)	Total Burden (in hr)
U.S. General Population	Landline Screener	440,486	1	1/60	7,341
	Cell Phone Screener	223,334	1	1/60	3,722
Adults \geq 18 Years	BRFSS Core Survey	494,650	1	15/60	123,663
	BRFSS Optional Modules	484,757	1	15/60	121,189
Total					1643227 1643227

Annualized burden costs are summarized in the table below. These calculations assume the average hourly wage of \$24.54 for all jurisdictions included in the BRFSS. Hourly rates were taken from the most recent publically available Current Employment Statistics of the Bureau of Labor Statistics and are based upon the average hourly earnings for October 2012 from the

Current Employment Statistics survey conducted by the Bureau of labor Statistics (available at <http://data.bls.gov/cgi-bin/surveymost>).

Table A.12-2. Estimated Annualized Cost to Respondents

Type of Respondents	Form Name	Number of Respondents	Total Burden Hours	Average Hourly Wage Rate*	Total Cost Burden
U.S. General Population	Landline screener	440,486	7,341	\$24.54	\$180,148
	Cell phone screener	223,334	3,722	\$24.54	\$91,338
Adults \geq 18 Years	BRFSS Core Survey	494,650	123,663	\$24.54	\$3,034,690
	BRFSS Optional Modules	484,757	121,189	\$24.54	\$2,973,978
Total			255,915		\$6,280,154

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There are no maintenance or capital costs to respondents.

14. Annualized Cost to Federal Government

Costs that are presented below include data collection, weighting and sampling as well as data distribution (i.e. websites and production of data sets). These are based on the funds provided to states for data collection as well as internal BRFSS costs.

Annualized Estimated Cost to the Federal Government

Estimated funds provided to states	\$14,000,000
Estimated CDC BRFSS budget	\$3,500,000
Total	\$17,500,000

15. Explanation for Program Changes or Adjustments

Although the BRFSS has been conducting surveys for many years, this request is the first for OMB review due to the evolution of the BRFSS as an important data source for federal agencies. Initial burden estimates are based on data collection plans for 2015. CDC will use the Change

Request mechanism to provide annual updates on the content of the core survey; the modules available for use and modules selected for use by states; and estimated burden per response for the core BRFSS questionnaire and optional modules.

16. Plans for Tabulation and Publication and Project Time Schedule

Data collection for the 2015 BRFSS core questionnaire is scheduled to begin on January 1, 2015. Data will be submitted monthly to CDC for editing and cleaning. Quarterly data quality reports are provided to states by the CDC. Final data sets for the 2015 year will be received from the states by February 15, 2016. Editing, cleaning and weighting of the data will take place until July 2016. Final weighted data sets (see description below) will be returned to the states by September 1, 2016. Datasets and supporting technical documentation will be available for public use by October 2016.

A. 16 – 1 Project Time Schedule	
Activity	Approximate Time Schedule
Data collection	January 1 - December 31, 2015
Monthly data submission	February, 2015 - January 2016
Quarterly data quality reports	March, June, September, December 2015
Data cleaning and editing	March 2015 - July 2016
Weighting	January - July 2016
Final data sets to states	By September 1, 2016
Final public use datasets with supporting documentation	By October 2016

The CDC assists the states by weighting each state’s dataset annually. Once all data are received from the states, CDC staff members apply individual respondent weights to ensure that the persons interviewed most accurately reflect the population of each state. Weighting is completed in two steps: a design weight to correct for the probability of selection and a raking (iterative proportional fitting) weighting process to match the demographic characteristics of the respondent to those of the population.

Design weights are based on the number of phones and eligible respondents in each household for landline phone numbers for each of the geostrata defined in the states’ samples. Cell phone respondents are treated as single adult households in the design weights. The formulae for the design weights are:

Stratum weight ($_STRWT$) = (number of records in the strata)/(number of records selected)
 Design Weight = $_STRWT$ * (1/number of phones within the household) * (number of eligible adults within the household)

Raking weights are based on population totals obtained from a private vendor (Neilson), the National Health Interview Survey (NHIS), and the American Community Survey (ACS). The vendor provides updated, county-level estimates and race/ethnicity totals which are not available from the Census in a timely manner. The following variables are used in the raking process: age, race, Hispanic ethnicity, home ownership, sex, phone ownership, (sub)state region, marital status and education. While the same variables are used for weighting for each state, in some instances the categories are collapsed differently from one state to the next. For example, if the state has a very small number of Asian residents, then there might not be sufficient numbers of respondents to include Asian as a separate race category. In these cases, smaller groups may be collapsed into a single category. Once raking weights are assigned a final weight is provided for each respondent using the formula:

$$\text{Total Weight} = \text{Design weight} * \text{Raking weight}$$

Because states may ask optional modules to only portions of their samples (split samples) several sets of weights are calculated for each state. These weights are also provided to the public on the BRFSS website (at www.cdc.gov/brfss) with technical documentation on the appropriate use of each weight assignment.

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

As this collection is “in use without an OMB number,” CDC commits to displaying the OMB number and expiration date of OMB approval beginning as soon after approval as is practical. Specifically, it is anticipated that we can begin to display the number and expiration date beginning within a two month period after receipt of OMB approval.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.