OMB CHANGE REQUEST PACKAGE
TO A GENERIC CLEARANCE:
State and Local Area Integrated Telephone Survey
OMB # 0920-0406

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Supporting Statement
Proposed 2011 National Survey of Children's Health

This submission to the Office of Management and Budget (OMB) by the State and Local Area Integrated Telephone Survey program (SLAITS) (OMB control number generic 0920-0406) requests approval to implement the 2011 National Survey of Children's Health (NSCH). The NSCH is a major source of information on the health and well-being of the civilian, non-institutionalized population of children aged 0 to 17 years at the time of the interview, their families, and communities in the United States (US).

Section A: Justification
1. Circumstances making the collection of information necessary

Background

The NSCH is conducted by the SLAITS mechanism of the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC) with contractor assistance. This is the third survey iteration, and like its predecessors in 2003 and 2007, it is funded by the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). To economize and reduce overall burden on the public, this SLAITS module will use the sampling frame of the Centers for Disease Control and Prevention's (CDC) National Immunization Survey (NIS), which is exempt from OMB Paperwork Reduction Act (PRA) review under legislative authority[1]. The NIS assesses universal vaccination coverage in two target groups of children: primarily for young children aged 9 to 35 months, and secondarily for older youth aged 13 to 17 years.

This survey will provide representative estimates of the physical, mental, and emotional health and well-being of children aged 0 to 17 years for the nation, each of the 50 states and the District of Columbia (DC). Absolutely no children will be interviewed during the course of data collection; the respondent will be the parent or guardian who knows about the health and health care of the sampled child.

The NSCH screens for households that contain at least one resident child 0 to 17 years of age at the time of the interview (Attachment 1). In households with more than one child, one will be randomly selected for the detailed survey. In households that contain at least one NIS age-eligible child, the NIS interview is conducted first, followed by the NSCH. In NIS-ineligible households, the respondent will segue to the full NSCH detailed interview. The data collection contractor has integrated the NSCH and NIS instruments such that the NSCH interview will launch upon completion of the NIS interview or after determining the household is NIS-ineligible.

The NSCH provides analysts, researchers, and public health officials timely, high quality, and comparable data to assess the health, well-being, and unmet needs of children and their families, to plan and evaluate programs, and develop policy related to Title V of the Social Security Act

[1] Specifically, the National Childhood Vaccination Injury Act of 1986 (PL 99-660), Title III, Part A, Section 311, #7 established data collection systems to monitor immunization and Part B, Section 321 waives the PRA for all activities under the Act.

(SSA). Under Title V, the Federal MCHB provides block grants to states to improve the health of children and their families. The NSCH has proven to be of immense value not only to its federal sponsor, but also to state-level maternal and child health (MCH) programs. It serves a critical monitoring role in that it provides uniform comparable data at the national and state levels, which are used to assess progress toward achieving performance goals for key health indicators and 2020 program objectives, and evaluate performance of public health programs. Specifically, NSCH data are commonly used to monitor and evaluate program and health outcomes. First, these data provide contextual information on the overall health and well-being of the general population of US children and their families as a background against which MCHB program goals and performance measures are formulated and evaluated. Second, national NSCH estimates are used as benchmarks against which individual state monitoring efforts are compared. The NSCH instrument (Attachment 2) again focuses on the physical, emotional, and mental health and well-being of children, their families, and communities. The length of the 2011 interview will not be increased beyond that of the 2007 interview; if questions have been proposed to be added in 2011, an equal number of questions have been deleted.

Several new questions have been included in the proposed survey instrument to assess two broad topics of great interest to MCHB: (1) provision of home visitation programs and services for mothers, infants, and young children, and (2) the child and family life course perspective. Funds from the Affordable Care Act of 2010 (ACA) (Public Law 111-148) will be used to establish maternal, infant, and early childhood home visitation programs through MCHB and the Administration for Children and Families (ACF). Under Section 2951 of the ACA, Title V will be amended to "assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to these children and families through home visiting programs" [2]. For the HRSA Funding Opportunity Announcement number HRSA-10-275, "home visiting" is defined as "an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crimes or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports"[3]. The proposed NSCH questions will assess selected components of this implementation effort, particularly at the state-level; these questions will not attempt to track full implementation due to the breadth of the scope of this effort. In a second area of great interest to MCHB, a few questions will be added to assess a life-course development perspective, to "..highlight the importance of positive interventions at sensitive developmental periods and address social and environmental determinants critical in improving outcomes and reducing disparities. Ideally, such interventions

[2] Source: Information download (purpose guidance), HRSA-10-275_Final[1].doc, page 1; available at the website for Funding Opportunity Announcement Number HRSA-10-275, accessed at https://grants.hrsa.gov on July 6, 2010. For more information visit the archived webcast and view presentation slides of "Maternal, Infant, and Early Childhood Home Visiting Program" from June 17, 2010, available at http://webcast.hrsa.gov/postevents/archivedWebcastDetailNewInterface.asp?aeid=525 (accessed July 6, 2010).
[3] Ibid, HRSA-10-275 document, page 7.

begin before birth and extend throughout the life course and across multiple generations"[4]. Two recognized life course experts and practicing pediatricians, Drs. Paula Braveman and Neal Halfon, were actively involved to evaluate proposed life course questions.

Interviews for the 2011 survey will be conducted in English, Spanish, and four Asian languages: Cantonese, Mandarin, Vietnamese, and Korean using translated questionnaires. Target sample sizes for each state and DC are set at 1,700 completed detailed child-level interviews. Select respondents will be asked to confirm or offer contact information from a subsample of up to 6,000 households for a possible followback survey. We have experience with this procedure, which was approved and implemented in the 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). We have followback survey experience with three SLAITS modules: the Survey of Adult Transition and Health, the National Survey of Adoptive Parents, and the National Survey of Adoptive Parents of Children with Special Health Care Needs.

Law and regulation that authorizes this data collection:
NCHS is authorized to collect data under Section 306 of the Public Health Service Act (42 USC 242k). Text from this section of the code was submitted in the three-year generic clearance package and is not included in this request.

Privacy Impact Assessment

Overview of the data collection system:
The respondent will be an adult parent or guardian who lives in the household and is knowledgeable about the health and health care of the sampled child. Data will be collected with the Random-Digit-Dial (RDD) telephone methodology over household landline telephones or the respondent's cellular telephone, by trained interviewers using a state-of-the-art Computer Assisted Telephone Interviewing (CATI) program in two centralized telephone centers. Both telephone center sites will use identical data collection and training methods. The automatic dialer is based in one site and issues telephone calls to the next available interviewer regardless of location, which is invisible to respondents. Randomly generated sampled telephone numbers will be dialed with either the autodialer or by hand for cellular telephone sample to comply with the Telephone Consumer Protection Act (TCPA). Once a call is placed, the recipient's Caller ID unit usually registers the contractor's name unless local companies truncate or change the display, an operation they control. To address current needs and the overall decline in survey participation, it may be necessary during the course of this data collection to expand and/or combine sampling frames to include mail and internet options.

The contractor will conduct all sample management and data collection, and maintain NSCH data and sampled case information until the project ends. Confidential data will be maintained by NCHS on a server equipped with firewalls and access limited to two key people. Through its website, NCHS will release one public use file (PUF) that does not contain identifiable

[4] Source: Information download (purpose guidance), HRSA-10-275_Final[1].doc, page 5; available at the website for Funding Opportunity Announcement Number HRSA-10-275, accessed at https://grants.hrsa.gov on July 6, 2010. Detailed information on the life course perspective in maternal and child health can be found at http://mchb.hrsa.gov/lifecourseresources.htm (accessed July 2, 2010). Additionally, an excellent peer-reviewed overview article on the life-course perspective is: Braveman P, Barclay C. Health disparities beginning in childhood: a life-course perspective. *Pediatrics* 2009;124:S163-S175

information. Following review by an internal nondisclosure committee, the public use file will be available for use indefinitely at no charge.

Items of information to be collected:
Questions primarily focus on the sampled child, while some ask about his/her family's characteristics. Topics listed below are included in the 2011 survey, as in past iterations:

- demographic and socioeconomic characteristics
- child's health and functional status
- health insurance coverage
- health care access and utilization
- medical home
- family functioning
- parental health
- neighborhood and community characteristics, and
- two age-specific sections: early childhood (0 to 5 years); middle childhood and adolescence (6 to 17 years of age).

Information in Identifiable Form
A minimal amount of information in identifiable form (IIF) is collected by the data collection contractor. This process was generically described in the earlier package. To reiterate, this is not a new procedure. Although the majority of data collected are not considered personally identifiable, some fit the definition of IIF and are listed below. All of these items have been routinely approved and collected in the past. We may explore data linkage in this survey iteration using zip code information, but this information would not be released in the PUF. The only data that will be released to the public or become part of the public use files below is age in months or years for the sampled child, which may be perturbed if necessary to maintain confidentiality. None of the other IIF data will be released to the public or become part of public-use files.

The IIF are collected by the contractor, and once separated from interview data, the file is transmitted to the CDC using a secure data network. These data are not accessible to anyone other than the NCHS Project Director and the project's computer scientist.

IIF categories:

- name or initials of the respondent
- first name or initials of the sampled child
- another telephone number where the respondent can be reached if the sampled telephone number is not working for any reason;
- additional telephone number type (e.g., cellular, landline, or work number)
- mailing address with zip code obtained through a telephone and address matching procedure (or directly from some respondents)
- zip code collected directly from the respondent (for verification)
- state name of the state the respondent lives in (for verification)
- date of birth for children in the household (for NIS-eligible households only)
- age in months or years for children in the household (for NIS-ineligible households only)

These IIF are collected for several reasons.

- Telephone numbers are linked to addresses whenever possible so that an introductory letter (Attachment 3) can be sent to the households prior to being called for an interview. The phone number and address are on a Record of Calls file which is separate from the interview file, and is never released to the public. Also, monetary remuneration is sent via first class mail. The address information is either confirmed from the earlier matching activity or obtained from households if the only known information is the telephone number.
- The child's first name or initials are collected to identify the person to whom the questions refer. To reduce the respondent's cognitive burden and make questionnaire administration less awkward (e.g., by not having to repeatedly ask about the "X-year old child", the child's first name or initials may be substituted in the computerized interviewing system.
- Variables for date of birth and child's age are collected to determine household eligibility, and eligibility for certain age-specific questions (such as questions about adolescents which are not relevant for infants). The date of birth is not released on the public use file. Again, the child's age may be perturbed if necessary.

Identification of website(s) and website content directed at children under 13 years of age: There is no web-based data collection. The NIS advance letter used for SLAITS modules states "For more information, turn this letter over or go to the study's web site: http://www.cdc.gov/nis". SLAITS hosts a website located at www.cdc.gov/nchs/slaits.htm. Absolutely no content and information on these websites or subpages is directed at children under the age of thirteen years.

2. Purpose and use of information collection

The purposes of the NSCH are to provide (1) national and state-level data on a timely basis on the health and well-being of children, their families, and their communities; (2) a source for detailed uniform comparable information on topics and covariates; (3) data for Congressionally mandated reports, such as *Health U.S.*, health disparities, and to evaluate the Children's Health Insurance Program (CHIP) to support reauthorization; (4) to support Federal efforts such as monitoring progress toward *Healthy People 2010* and *Healthy People 2020* goals and objectives; and (5) extensive use at the state-level to plan and evaluate related programs and policies. NSCH data will also be used to monitor implementation of systems of services for children, and serve as performance measures for state Title V programs and block grant applications. NSCH results have been used extensively at the state level, and by health-related non-profit advocacy groups and health researchers. These data are of great practical utility particularly to the Federal and state governments.

A major strength of these data is its ability to display health characteristics by selected demographic and socioeconomic characteristics of the general US child population and their families at national and state-levels, contingent upon robust subgroup sample sizes. These uses are generally in the areas of program planning and evaluation, public health education and health promotion, and epidemiological research.
Privacy Impact Assessment Information

The survey will provide key, up-to-date, uniform, comparable, and comprehensive data, which can be analyzed at various geographic levels, and that are not available in toto from any other source. Only the NSCH contains enough sample to generate representative estimates for many indicators, particularly at the subnational level. No other data source offers this capacity.

The NSCH will collect, on a confidential basis, data needed to recontact respondents for additional information and for participation in potential followback surveys, and possibly to match respondents to administrative records. The ability to track respondents and match to other records greatly expands the usefulness of these data at very low cost.

Only those NCHS employees and our full research partners who must use the personal information for a specific purpose can access and use such data. Everyone else who uses NSCH data can do so only after all identifiable information is removed.

The collection of information in identifiable form requires strong measures to ensure that private information is not disclosed in a breach of confidentiality. All NCHS employees as well as all contract staff receive appropriate training and sign a "Nondisclosure Statement." Staffs of collaborating agencies are also required to sign this statement and outside agencies are required to enter into a more formal agreement with NCHS. The transmission and storage of confidential data are protected through procedures such as encryption and carefully restricted access. See A10 for more details.

3. Use of improved information technology and burden reduction

The survey will be conducted using a Computer Assisted Telephone Interviewing (CATI) program in centralized telephone centers, which reduces the time required to collect, transfer, process, and release data. The CATI system also tracks all landline and cellular call outcomes and date, time of day, and length of each call, in addition to detailed notes maintained by the interviewers. It also ensures that skip patterns are followed properly. Teletype machine (TTY) administration is available to interview deaf respondents. Use of the CATI system typically reduces the average duration of interviews, compared to a paper questionnaire with identical content, thus reducing the respondent's burden. To address current needs and the overall decline in survey participation, it may be necessary during the course of this data collection to expand and/or combine sampling frames to include mail and internet options.

4. Efforts to identify duplication and use of similar information

This is also the only population-based general children's health survey within the Federal government designed specifically to produce state and national estimates that address key MCHB objectives and the HRSA and MCHB strategic plans. Although other Federal and non-Federal surveys such as the Medical Expenditures Panel Survey (MEPS, OMB# 0935-0118) and CDC's Behavioral Risk Factor Surveillance System (BRFSS) collect limited health data on children, they do not focus entirely on the health and well-being of the child, family, and community, and do not collect extensive data on MCHB-prioritized topics for analysis at the state level. To the extent that there is some overlap in content of this module with other surveys,

it is because it is necessary to insure that the full range of relevant variables are included for complex analyses of data for the NSCH sample.

We used various formal and informal methods to determine the existence of duplicate data collections, such as literature and data base searches, attending national and state meetings, and consulting with Federal agencies, researchers and staff at relevant private organizations, and individual researchers. The names and organizations of the most directly involved individuals who are members of the 2011 NSCH Technical Expert Panel (TEP) are listed in Attachment 4. Consultation included not only issues of design and content but also knowledge of existing surveys or data, and took place in face-to-face meetings, telephone conferences, and electronic mail.

Numerous end-users submitted comments after being contacted by either SLAITS staff or under the auspices of inquires sent by the Child and Adolescent Health Measurement Initiative (CAHMI) and the Society for Pediatric and Perinatal Epidemiologic Research. End-users were also consulted in agencies and offices in the Federal government which use NSCH data for policy planning and evaluation, such as staff within three MCHB divisions: the Division of Child, Adolescent, and Family Health; the Division for Services for Children with Special Health Care Needs; and the Office of Data and Program Development.

5. Impact on small businesses or other small entities

No small businesses will be involved in this data collection. This is a household population-based survey.

6. Consequences of collecting the information less frequently

Data for the NSCH are collected periodically, at an interval appropriate to monitor improvements in health, programs, and access to medical care (approximately every four years depending on MCHB funding). Many data items are used to track Federal and state-level Title V objectives and outcomes. The periodic design also makes it possible to aggregate data over periods of time to include enough cases to study rare events and small subgroups. Reducing the frequency of data collection would undermine these desirable features.

Respondents are asked to respond to the NSCH only once. Selected households will be asked for contact information for a possible follow up survey.

There are no legal obstacles to reduce the burden.

7. Special circumstances related to the guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

8. Comments in response to the Federal Register notice and efforts to consult outside the agency

A. Federal Register Notice:
Per the terms of our most recent clearance, SLAITS is not required to publish a separate Federal Register (FR) notice for the proposed NSCH because this topic was specifically listed in the three-year generic clearance FR notice.

B. Consultation with persons outside the agency:
Senior managers from MCHB guide the format and content decisions in collaboration with NCHS and contractor staff. Subject-matter experts in child health, Title V, survey methodologists, federal and state MCH program directors, and individuals representing federal partner agencies were convened as a 2011 NSCH Technical Expert Panel (TEP) meeting on April 23, 2010. The TEP members offered expert guidance on availability of similar data, reporting format and data elements, methodology, instrument construction, clarity and completeness of content, and analysis plans. Questionnaire modifications reflect the informed decisions of this group in consultation with a much wider audience. A subset of technical experts can be consulted for methodological, programming, sampling, weighting, or post-stratification issues when necessary.

Additionally, in 2008 the National Center for Health Statistics Board of Scientific Counselors Review Committee released a final evaluation of the overall SLAITS program, not just the NSCH module, which emphasized the program's efficiency, effectiveness, value, flexibility, and uniqueness.

We plan to update the Department of Health and Human Services (DHHS) Data Council periodically on our activities. Selected experts who have been consulted extensively and are knowledgeable about the NSCH and SLAITS mechanism are listed below and in Attachment 4.

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Other public contacts & opportunities for public comment:
SLAITS staff members often receive formal and informal input at conferences and through email about the utility of various items and subjects in previous survey iterations.

The SLAITS informational website (www.cdc.gov/nchs/slaits.htm) offers module-specific subpages, which are available at all times as an option for data users and interested parties to elect to be kept up to date on NSCH activities and product releases. Survey participants are also provided multiple ways to contact NCHS about this module. Calls about the survey are made periodically to the NCHS Research Ethics Review Board, CDC-Info, and the SLAITS Project Director, and occasional letters and e-mail are sent to NCHS project staff. The SLAITS website provides convenient ways for respondents and data users to contact SLAITS staff.

Senior managers at MCHB have systematically requested input from their user communities such as state health departments, state-level MCH and Title V program directors, and similar entities. Suggestions are given careful consideration during the planning process to ensure maximum data utility.

9. Explanation of Any Payment or Gift to Respondents

Like all telephone surveys, there has been a consistent need to improve the interview completion and screener completion rates for SLAITS modules. Our experience has repeatedly demonstrated that of all survey modifications, incentive use has the most dramatic effect on improving response rates. NCHS wishes to continue its use of monetary incentives in the NSCH to combat unit non-response.

A monetary incentive experiment was conducted in the 2009-2010 NS-CSHCN, which included a "no incentive" control group. Overall, this experimental effort found[5]:

- small increases in response rates were achieved with the use of promised incentives, while prepaid incentives yielded larger response rate increases;
- using prepaid and promised incentives together yielded further increases relative to those achieved by using prepaid incentives alone;
- a promised incentive offered after the first refusal increased response rates over offering a larger incentive only after the second refusal; and
- the monetary value of the prepaid incentive mattered, as the $5 prepaid incentive outperformed a $1 coin.

[5]Foster EB, Frasier AM, Morrison HM, O'Connor KS, Blumberg SJ. All things incentive: Exploring the best combination of incentive conditions. Paper presented at the 65th annual research conference of the American Association of Public Opinion Research, May 14, 2010, Chicago, IL.

MCHB ultimately chose to implement the lowest cost incentive option in the 2009 – 2010 survey (e.g., implemented only after the second refusal, upon which cases with valid mailing addresses were mailed a $1 bill with a $10 offer using regular first class postage to complete the interview; cases with no mailing addresses were offered $11 upon contact with a potential respondent). For respondents with valid address information, a thank you letter containing either $10 or $11 was sent via first class postage. When compared to the no incentive control group, this option paid for itself in terms of special needs interview completion (but not for screener completion), reduced nonresponse bias particularly among African-American sampled children, boosted the screener completion rate by 1.22 percentage points with 459 additional screener completes, and boosted the special needs interview yield rate by 0.70 percentage points with 263 additional special needs interview completes.

Since gaining cooperation has become even more difficult over time, we have demonstrated a need to offer incentives. Building on our prior experimentation, with the start of interviewing in calendar Quarter 1 (Q1) 2011, we propose to use the incentive model outlined in the paragraph above that was demonstrated in the 2009-2010 survey to best balance response rates, cost-efficiency, and overall survey quality. This protocol is triggered by the number of respondent refusals, and note that the count of refusals is added across both the NIS and NSCH. As a case moves from the NIS to the NSCH, it carries with it the number of refusals (if any) that it had in the NIS.

Although all interviewers are trained in refusal aversion, the contractor trains especially adept interviewers to be refusal converters in its CATI center. The refusal converters not only have a prior track record for success in gaining cooperation by recognizing explicit and implicit respondent concerns, but also receive additional training regarding ways to handle situations in a non-coercive manner. These refusal converters call households that refused participation during the initial contact to address respondents' concerns. At any time during the call process, if a "hard" or definitive hostile refusal is given, the case is immediately finalized. SLAITS cases that refuse participation twice with a "soft" refusal (including their NIS call history) are automatically deactivated and receive a "cooling off" period of at least 10 days prior to any subsequent calls. These cases have never said "no I will not participate" but instead typically indicate they don't have time, or it is not a good time and to call back. These "soft refusal" cases are given an opportunity for a final refusal, regardless of the refusal characteristics. Upon this refusal, the case is finalized.

10. Assurance of confidentiality provided to respondents

This information in its entirety was included in the approved generic clearance package; to reduce reader burden, it is not repeated here.

Per a new request by the NCHS Confidentiality Officer and OMB liasion, the cover page of the survey will display the following information:

> All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and

will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

11. Justification for sensitive questions

No sensitive questions are included in the NSCH instrument. The potential sensitivity of questions was an evaluation criterion to determine survey content. The multipurpose nature of this survey makes it necessary to exclude topics so sensitive that they may interfere with participation

However, if a respondent thinks a topic is sensitive in nature even if NCHS and MCHB staff members do not, in the informed consent procedure all sample persons are advised of the voluntary nature of their participation. Sample persons are informed that they can choose not to answer any individual questions and may stop the interview at any time. Additionally, all questions and procedures are reviewed by the NCHS Research ERB for issues of sensitivity as discussed in the full generic approval package.

12. Estimates of annualized burden hours and costs

A. Respondent Burden

The NSCH involves a short screener as many people in the population must be contacted to identify the subgroup we wish to survey. Based on sample size projections and prior module-specific survey work, NCHS requests 47,607 burden hours annually for the NSCH. Just over 515,000 households will be screened for an average of 1 minute each, or 8,592 burden hours. Once one or more resident children ages 0 to 17 years are identified, adult respondents in almost 87,000 households will complete the detailed interview for an average of 27 minutes, or 39,015 burden hours.

Table 1 on the next page indicates the annualized total burden hour estimate for this module estimated for a 1 minute screening procedure (Attachment 1) and a 27 minute interview (Attachment 2), for a total of 28 minutes for households that contain at least one child aged 0 to 17 years. The interview will be much shorter for households that do not contain children. We are currently approved for up to 55,190 burden hours; thus, we do not request an increase in the number of burden hours or respondents.

Table 1. Annualized burden hours.

Type of respondent	Form	Number of respondents	Number of responses per respondent	Average Burden per Response (in hours)	Response burden
Resident adult parent or guardian who knows about the child's health & health care	Household screener	515,506	1	1/60	8,592
Resident adult parent or guardian who knows about the child's health & health care	Household survey	86,700	1	27/60	39,015
				TOTAL	47,607

Not all questions apply to each sampled child, and the questionnaire instrument automatically skips over questions that do not apply, based on earlier information given by the respondent. Thus, no respondent is ever asked all questions in the questionnaire.

B. Annualized Cost to Respondents

As of July 6, 2010, the latest publicly available data (May 2009) are from the Occupational Employment Statistics Survey (OES), a mail survey that measures occupational employment for wage and salary workers in non-farm establishments in the US. The OES collects data from over 1.2 million business establishments through six semiannual panels over a three year period. It is sponsored by the Department of Labor, Bureau of Labor Statistics, and uses the OMB-required occupational classification system (the Standard Occupational System (SOC)).

The mean hourly wage rate in May 2009 was $20.90/hour across all occupations. At an average wage rate of $20.90/hour and an average burden of 5.5 minutes for respondents (including those who screen out of the survey), the average cost per respondent listed in Table 2 is $1.93, for a total average estimated cost of $994,927 per year. This estimated cost does not represent an out-of-pocket expense, but rather a monetary value attributed to the time spent to screen for and/or complete the interview. Since the NSCH is a population-based survey, it is not possible to break out the respondent cost by major occupational groups.

Table 2. Costs to respondents.

Number of respondents	Frequency of response	Average estimated cost per respondent	Total average estimated cost per year

515,506	1	$1.93	$994,927

13. Estimates of other total annual cost burden to respondents or recordkeepers

No capital or maintenance costs are involved.

14. Annualized cost to the Federal government

An estimate of the average annual cost to the government for a SLAITS module depends on the size of the survey (for example, the desired number of completed interviews), the length and complexity of the interview, characteristics of the target population, and prevalence of the key health characteristic of interest. Costs for SLAITS modules are paid through either a contractual or Interagency Agreement (IAA) mechanism.

We estimate the typical annual cost of a general child health survey for parents or guardians of youth ages 0 to 17 years of age that can produce state and national estimates, such as the NSCH, at approximately $6 million per module for this one year survey as summarized below.

Survey support from NCHS staff	less than $1 million dollars
Additional CDC-related costs	less than $500,000
Data collection	~ $3 million
Other costs	~$1.5 million

The Interagency Agreement (IAA) with MCHB includes all costs for contractor and Federal staff salaries; survey planning, design, and development; training; field pretesting; coding; data collection, weighting and preliminary estimation; printing of survey materials; file release, possible incentives used to address non-response; and staff observation (travel and per diem).

15. Explanation for program changes or adjustments

No change.

16. Plans for tabulation and publication and project time schedule

Analyses of the 2011 NSCH data will be performed at the person, household, and family levels, beginning with initial baseline descriptive analyses. Baseline measures will be compared among states and the nation, and to previous survey results. We will perform trend analyses based on previously published work from the 2003 and 2007 surveys. We anticipate the 2011 data will be released approximately 6 to 9 months following the end of data collection.

Proposed timeline:

NCHS Questionnaire Design Research Laboratory (QDRL) testing activities	October, November 2010
Questionnaire revisions due to contractor	December 2010
Revisions to programming, testing, training materials, production-level recruitment & training	Winter 2010
Production start	mid-January 2011 (pending OMB approval)
Data collection ends	December 2011
Public Use File released	August 2012

17. Reason(s) display of OMB expiration date is inappropriate

N/A. Not requesting exemption.

18. Exceptions of certification for Paperwork Reduction Act submissions

There are no exceptions to the certification.

Section B.

Collection of Information Employing Statistical Methods

1. Respondent Universe and Sampling Methods

The target population for the State and Local Area Integrated Telephone Survey (SLAITS) 2011 National Survey of Children's Health (NSCH) is children 0 to 17 years of age at the time of the interview. The universe from which the sample is drawn is all households. The respondent for all questions will be the resident parent or guardian over the age of 18 years who knows about the health and health care of the sampled child. Absolutely no children under age 18 years will be interviewed. In households with one or more age-eligible children, one child will be randomly sampled as the subject for a detailed interview.

SLAITS uses the National Immunization Survey (NIS) sampling frame, the size of which provides an economical opportunity to survey other populations in addition to the population that eventually screens into the NIS itself. For the 2011 NSCH, the NIS sampling frame will be used to identify and complete 1,700 detailed interviews in households with children in each of 50 states and the District of Columbia (DC). For more information on the NIS or NIS sampling methods, please refer to the website of the NIS sponsor, CDC's National Center for Immunization and Respiratory Diseases (NCIRD) www.cdc.gov/vaccines, or NCIRD's webpage entitled 'Statistics and Surveillance: Immunization Coverage in the US' at http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis.

Sample design. A sample of telephone numbers (presumably of households) will be randomly generated and drawn for the NSCH. There may be a need to develop a small independent sample of telephone numbers for SLAITS called "augmentation sample" to meet target sample sizes, which is developed in the same fashion as the regular sample. The only difference is that this sample is not screened for the NIS prior to administration of the relevant SLAITS module, and would not receive the NIS advance letter.

We expect the design effects for the 2011 NSCH to be comparable to those of previous SLAITS studies.

Oversampling subpopulations. There will be no oversampling to identify adequate numbers of households or children with a particular characteristic.

Estimation procedures. All data will be weighted to national and state control total estimates to produce population-based estimates of totals, means, and proportions. A sampling weight will be calculated for each completed interview case. We anticipate the 2011 survey weighting strategy will mirror procedures used in other recent and relevant SLAITS modules.

We anticipate that one weight will be produced, a child-level interview weight, for the single public use data file (PUF) to be released. Numerous non-response adjustments will be applied to the base sampling weight to reflect the probability of selection of the household's telephone number, and account for households that have multiple landline or cellular telephone numbers,

unknown household status, unknown household eligibility, non-telephone households, and eligible households who do not complete the age screener.

The child-level interview weight will be adjusted to account for households that contain multiple children, and for sampled children who do not complete a detailed interview. Final post-stratification calculations will be made at the person-level through marginal adjustments to compensate for any imbalance in the age, sex, and race/ethnicity groupings in the sample. State-level population estimates by age, sex, and race/ethnicity published by the U.S. Bureau of the Census will be used as population control totals for this adjustment. Data from CDC's National Health Interview Survey (NHIS, OMB number 0920-0214) will also be used to assess whether additional adjustments are necessary for the characteristics of households without fixed telephone lines (i.e., cellular phone only households, or cellular phone mostly households). The standard error for key estimates will be calculated using a Taylor linearization approach with SUDAAN software to accommodate the complex sample design and calculate accurate standard errors.

Additional technical details of sample design and survey execution can be found in the design and operation reports for past NSCH iterations. Documentation for the 2003 and 2007 NSCH modules is available at www.cdc.gov/nchs/slaits.htm under the module-specific webpage, and the webpage entitled "Publications and selected presentations using SLAITS data" under "Design and Operations Reports".

Degree of Accuracy. For the NSCH, the primary analytic variable determines the sample size. To determine the sample size necessary for reasonable levels of precision, the baseline prevalence of a key statistic is estimated.

NSCH sample:
Assuming the estimate is for a 50% statistic for the NSCH, the sample percentages for an estimate for the District of Columbia will have a margin of error of plus or minus 2.38 percent based on a sample size of 1,700. For a 50% statistic, a national NSCH estimate will have a margin of error of plus or minus 0.33 percent at the 95% confidence interval based on a sample size of 86,700. The power to detect differences in a given child characteristic between subgroups or states depends on the size of the samples being compared.

2. Procedures for the collection of information

In consultation with NCHS, the data collection contractor draws the sample, designs and conducts interviewer and supervisor trainings, plans the interview operations, and implements and monitors the survey interview procedures. The contractor also develops the data files, draft documentation, and preliminary and final sampling weights.

SLAITS staff members provide specifications for sample design, specific questionnaire content, detailed interview instructions, and procedures to measure quality control; monitor interviews through direct observation; and maintain continuous communication with the data collection contractor.

The SLAITS 2011 NSCH questionnaire will immediately follow administration of the NIS interview or screener in eligible households, as the two surveys will be seamlessly integrated in the Computer Assisted Telephone Interviewing (CATI) data collection program. Certain household and demographic questions are identical in both surveys, and the CATI system is programmed so these questions are not repeated to reduce respondent burden. The respondent will be the parent or guardian who lives in the household and is knowledgeable about the health and health care of the sampled child. The questionnaire sections cover the child's health and functional status, their health insurance coverage, access to and use of health care, medical home, family functioning, parental health, neighborhood and community characteristics, demographics, and two age-specific sections (early childhood ages 0 to 5 years, and middle childhood and adolescence ages 6 to 17 years).

Data collection, entry, and file preparation.
Data collection is scheduled to start on January 6, 2011 (pending OMB approval) and continue through December 2011. The NIS advance letter will be sent to sample households for which the randomly-generated telephone numbers can be matched to valid addresses.

After data collection, editing and weighting are completed, the 2011 NSCH release will include one child interview-level data file with all information necessary for analysis. It will contain appropriate demographic information on the focal child, respondent, and household, as well as substantive health and health-related data. Final sampling weights will be assigned to each child-level observation to permit users to generate national and state estimates. The methodology will be described thoroughly in a survey design and operations report that will be released simultaneously (if possible) with the data file release.

3. Methods to maximize response rates and deal with nonresponse

This information in its entirety was included in the approved generic clearance package; to reduce reader burden, it is not repeated here.

4. Tests of procedures or methods to be undertaken

The NCHS Questionnaire Design Research Laboratory (QDRL) is scheduled to test a list of approximately 25 proposed "new" or revised questions for the final version of the 2011 instrument in October and November 2010. Any question additions will be balanced with an equal number of deletions to maintain the average amount of time to complete an interview. Proposed questions include a few new questions such as those on life course variables, and to assess the impact of health care reform. Revised questions will also be tested, such as the concept of parent's "limiting" versus "monitoring" the sampled child's screen and media use, and physical activity questions to integrate the latest physical activity guidelines for children and adults (e.g., the 2008 Physical Activity Guidelines for Americans issued by the Department of Health and Human Services).

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The following person was consulted on the statistical aspects of the design and data collection for SLAITS:

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The following person is responsible for the collection and analysis of SLAITS data:

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Additional experts and consultants knowledgeable about the SLAITS mechanism and/or specific modules are listed in Attachment 4.

List of attachments to this Supporting Statement (Parts A & B)

1. Screener: 2011 National Survey of Children's Health (NSCH)
2. Survey: 2011 NSCH instrument
3. Letters (NIS, augmentation, refusal conversion, thank you)
4. Technical Expert Panel, 2011 NSCH, and roster of expert staff and consultants involved in SLAITS mechanism or module-level planning