# *SUPPORTING STATEMENT: PART A*

**Test Predictability of Falls Screening Tools**

**OMB# 0920-XXXX**

**Date: March 6, 2018**

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Table of Content

## S

**Summary Table....4**

**Justification....5**

**A1. Circumstances Making the Collection of Information Necessary....5**

**A2. Purpose and Use of Information....6**

**A3. Use of Improved Information Technology and Burden Reduction....7**

**A4. Efforts to Identify Duplication and Use of Similar Information....7**

**A5. Impact on Small Businesses or Other Small Entities....8**

**A6. Consequences of Collecting the Information Less Frequently....8**

**A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5....9**

**A8. Comments in Response to the Federal Register Notice/Consultation....9**

**A8.a. Federal Register Notice....9**

**A8.b. Efforts to Consult Outside the Agency....9**

**A9. Explanation of Any Payment or Gift to Respondents....9**

**A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents....10**

**A11. Institutional Review Board (IRB) and Justification for Sensitive Questions....11**

**IRB Approval....11**

**A12. Estimates of Annualized Hour and Cost Burden....12**

**A13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers....15**

**A14. Annualized Cost to the Federal Government....15**

**A15. Explanation for Program Changes or Adjustments....16**

**A16. Plans for Tabulation and Publication and Project Time Schedule....16**

**A17. Reason(s) Display of OMB Expiration Date is Inappropriate....17**

**A18. Exceptions to Certification for Paperwork Reduction Act Submissions....17**

**Attachments**

A-1. Public Health Service Act (PHSA) 42 U.S.C.
A-2. AmeriSpeak Technical Overview
A-3. 60-Day Federal Register Notice
A-4. Public Comment
A-5. Privacy Impact Assessment (PIA)
A-6. Documentation for AmeriSpeak Panel for IRBs
A-7. AmeriSpeak Standard Profile Variables with Values
A-8. AmeriSpeak Privacy Statement
A-9. IRB Protocol
A-10. IRB Approval Letter
A-11. Research Determination
B-1. Sample Prenotification Postcard
B-2. Sample Prenotification Email
B-3. Falls Diary
B-4. Cover Letter for Monthly Survey & Diary – Mail Version
B-5. Cover Letter for Monthly Survey & Diary – Email Version
B-6. Proxy Survey Protocol
B-7. Baseline Survey – Web Mode
B-8. Baseline Survey – Telephone Mode
B-9. Monthly Update Survey – Web Mode
B-10. Monthly Update Survey – Telephone Mode
B-11. Final Survey – Web Mode
B-12. Final Survey – Telephone Mode
B-13. Proxy Survey – Web Mode
B-14. Proxy Survey – Telephone Mode

# Summary Table

| **Goal of the study:** |
|---|
| Although screening tools exist for the identification of risk factors for older adult falls exist, they have never been tested to determine how well they predict future falls. Therefore, the overall purpose of the *Test Predictability of Falls Screening Tools* project is to collect new data in order to compile a parsimonious set of questions that predict falls and medically treated falls, rather than identify risk factors for falls, for community dwelling, adults 65 and older. In this effort, the study will: 1) test the ability of existing falls screening tools[1] to predict falls and falls requiring medical attention in the subsequent year; 2) assess how well questions predict falls for specific groups (e.g., gender, race, disability status); and 3) assess how responses to questions change over time. |
| **Intended use of the resulting data:** |
| The intended use of the resulting data is to evaluate current screening tools and potentially design a new tool for health care practitioners for predicting falls in community-dwelling adults 65 and older. The analysis will consider individual questions and groupings of questions that predict falls for multiple subgroups (e.g., gender, race, disability status) of adults 65 and older. Selected study findings may be published in peer-reviewed journals and presented in oral and poster presentations. |
| **Methods of data collection:** |
| Data will be collected using the AmeriSpeak Panel generated by NORC at the University of Chicago. Study data will be collected by internet or phone interviews, depending on respondents' preferred modes of recruitment and participation. Interviews will consist of a baseline survey beginning immediately after OMB approval, 11 brief monthly update surveys for the 11 months after initial survey, and a final survey (similar in content to the baseline survey) 12 months after initial survey. |
| **Population being studied:** |
| The study population is a longitudinal sample of approximately 1,900 adults 65 and older. |
| **How the data will be analyzed:** |
| At baseline, *exploratory factor analysis* and *confirmatory factor analysis* will be used to demonstrate which survey items have the greatest likelihood of predicting future falls. To narrow down the larger list of survey items, *item response theory* will be used. *Descriptive* data analysis techniques will be used at every data collection time point in order to clean the data and to look for trends and outliers. *Univariate* and *multivariate* data analysis (primarily logistic regression) techniques will be used at 6 and 12 months after initial survey in order to determine which survey questions are related to fall status with statistical significance and to identify which survey questions have the greatest likelihood of predicting fall status while considering whether separate tools are necessary for key subgroups at high risk for falls, such as women and persons with prior history of falls. |

[1] Fall screening tools were selected by CDC and identified through an environmental scan. These include, but are not limited to, the following:

1) Stay Independent Checklist: https://www.cdc.gov/steadi/pdf/stay_independent_brochure-a.pdf
2) American Geriatric Society (AGS) Fall Prevention Guidelines and Recommended Questions: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations
3) Falls Risk for Older People – Community Setting (FROP-Com): http://www.nari.net.au/files/files/documents/frop-com-screen-dec09.pdf

# Justification

## A1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is seeking OMB approval to conduct a new information collection for a project entitled, "Test Predictability of Falls Screening Tools," over a period of two years (2017-2019) as allowed under Section 301 of the Public Health Service Act (42U.S.C. 241) [280-1a] (Att. A-1).

Falls are the leading cause of fatal and nonfatal injuries among adults aged 65 and older in the US and represent a significant burden to the healthcare system. Research demonstrates that clinical interventions can reduce the number of risk factors for falls, and the American and British Geriatrics Societies (AGS/BGS) have developed a clinical practice guideline to reduce the number of risk factors for falls among their older adult patients.[2] Based on these guidelines, the Centers for Disease Control and Prevention (CDC) developed a falls prevention initiative called Stopping Elderly Accidents, Deaths, and Injuries (STEADI). STEADI includes a suite of materials (available at www.cdc.gov/STEADI) that help health care practitioners to implement these clinical guidelines.

The first step in clinical falls prevention is for health care practitioners to administer a fall risk screening. The screening identifies whether adults 65 and older are at "increased risk" for a fall based on the total number of risk factors for falls identified. Additional assessments and follow-up medical care (e.g., medication review, vitamin D supplements, vision testing, and physical therapy) are then given to those with more risk factors for falls. The initial screening step is critical because it identifies who will receive the assessments and follow-up care, which has the potential to place a large burden on health care practitioners and the health care system. Given the demands on health care practitioners, among them to reduce health care costs, it is important to have a tool that can quickly and reliably predict falls and medically treated falls in adults 65 and older and thus need this additional care. The tool must also be able to exclude those who are unlikely to fall or to benefit from additional care. While medical organizations such as the American Geriatrics Society recommend that adults 65 and older be screened annually for risk factors for falls, and although there are a number of tools used to screen older adults for risk factors for falls, there is currently no standard for these screeners across care settings.[3] This is in part due to the length and resulting time burden of existing screeners for fall risk factors as well as because many of these existing tools have never been tested to determine how well they predict future falls. Thus, research is needed to test the ability of existing screening tools and questions to predict falls in the subsequent year. Those results can be used to develop a parsimonious standardized tool that can

[2] AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons – Summary of Recommendations. (2016). American Geriatrics Society & British Geriatrics Society. Available at: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/prevention_of_falls_summary_of_recommendations

[3] Scott, V., Votova, K., Scanlan, A., & Close, J. (2007). Multifactorial and functional mobility assessment tools for fall risk among older adults in community, home-support, long-term and acute care settings. Age and Ageing, 36(2), 130-139. doi:10.1093/ageing/afl165

be used by health care practitioners to predict falls and medically treated falls in older adults. Such a tool would increase the chances that older adults likely to fall within the subsequent year will be correctly identified in clinical settings, and their modifiable risk factors for falls addressed.[4]

A tool for predicting falls and medically treated falls in older adults that addresses these limitations would be designed to aid in the formation of prevention strategies related to falls among community dwelling adults 65 and older. Medically treated falls represent a costly and avoidable public health concern. Furthermore, such data will help to guide and evaluate progress in reducing the public health burden of falls in adults 65 and older.

## A2. Purpose and Use of Information

CDC currently recommends that health care practitioners use the Stay Independent brochure checklist, a 12-question patient risk factors for falls self-assessment, or a smaller subset of the Stay Independent Checklist known as CDC's 3 Key Questions, to identify patients' risk factors for falls.[5] While the Stay Independent Checklist has been validated by a clinical evaluation (i.e., patient self-reports match clinical evaluation), it has not been validated in terms of its ability to predict future falls. Currently, health care practices use a variety of falls screening questions but there is no gold standard recommendation. More data are needed to determine an ideal set of questions for predicting falls and medically treated fall in community dwelling older adults. The overall purpose of the *Test Predictability of Falls Screening Tools* project is to collect new data in order to compile a parsimonious set of questions that would be clinically useful for quickly predicting falls and medically treated falls within the subsequent year for community dwelling adults 65 and older. The eventual goal of this research is to develop a set of questions that can be recommended for use by CDC as the standard for predicting falls and medically treated falls in community dwelling adults 65 and older in clinical settings.

The data collection and analyses for this research effort will be conducted by NORC at the University of Chicago (NORC) under contract for CDC.[6] NORC conducted an environmental scan to identify screeners and/or questions in addition to the Stay Independent Checklist that are currently used in clinical practice to identify risk factors for falls. These questions will be asked to a sample of community dwelling adults 65 and older recruited by NORC, who will then be followed with surveys repeated monthly over the following year to determine whether and how often they fall. The study pool should be powered to adequately detect falls and fall injuries. To accomplish this NORC will oversample those aged 85 and older if needed.

Study participants who experience a fall will be asked to complete a falls diary to help with recall, which is further described in section A12. These new data, which are not available from any other data source, will be used to examine the predictability (sensitivity and specificity) of various sets of screening

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[4] Chang, J.T., Morton, S.C., Rubenstein, L.Z., Mojica, W.A., Maglione, M., Suttorp, M.J., Shekelle, P.G. (2004). Interventions for the prevention of falls in older adults: Systematic review and meta-analysis of randomised clinical trials. The BMJ, 328(680). doi:10.1136/bmj.328.7441.680

[5] CDC Stay Independent Brochure. (2015). Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available at: http://www.cdc.gov/steadi/pdf/stay_independent_brochure-a.pdf

[6] CDC Contract Number: HHSD2002013M53955B. Fixed-price contract. Deliverables include but are not limited to: approved IRB, OMB, and FISMA packages, bi-weekly conference calls, quarterly and annual reports, predictability manuscript, de-identified data set, year-to-year screening report, recommendations for changes to STEADI screening tools.

questions on the occurrence of falls, including medically treated falls. These data will be used to address the following research objectives:

1) Test the ability of existing screeners and/or questions in addition to the Stay Independent Checklist that are currently used in clinical practice to identify risk factors for falls to predict falls in the subsequent year;
2) Assess how well questions predict falls of different severity (not resulting in injury, resulting in injury) within different time periods (6 months, 12 months), and for specific groups (gender, race, age group); and to
3) Assess how responses to the screening questions change over time.

When a parsimonious set of questions is identified CDC will conduct follow-up testing to ensure usability among health care providers.

## A3. Use of Improved Information Technology and Burden Reduction

We will use advanced technology to collect and process data to reduce respondent burden and make data processing and reporting more timely and efficient. All participants will be given the choice of completing each survey online via the web or by telephone with a telephone interviewer. NORC's AmeriSpeak survey software system supports both Computer Assisted Telephone Interviewing (CATI) and web modes, providing an integrated sample management and data collection platform. The NORC AmeriSpeak survey software system also provides opportunities to participate in a web-mode using smartphones; for these panelists, the web-based system renders an optimized presentation of the questions. For all participants regardless of mode, the AmeriSpeak survey technology includes tailored skip patterns and text fills, which allows respondents to move through the questions more easily and minimizes respondent burden. Lastly, by using the pre-selected AmeriSpeak Panel for a longitudinal study, costs and respondent burden associated with locating and contacting activities are kept to a minimum.

## A4. Efforts to Identify Duplication and Use of Similar Information

No effort to collect similar data is being conducted within the agency. Additionally, no efforts outside the agency have been made to collect these data.

Notably, there are other federal data sources that collect information on falls among community-dwelling older adults, including the Behavioral Risk Factor Surveillance System (BRFSS), the Medicare Current Beneficiary Survey (MCBS), Medicare claims data, and the Healthcare Cost and Utilization Project (HCUP). CDC is currently analyzing these data sources to report on trends in falls, the relationship between medication use and subsequent falls, and differences in falls across states. However, none of these sources collect screeners for fall risk factors from older adults (e.g., the Stay Independent Checklist) being tested by this particular data collection effort, so they are unable to meet the needs of the *Test Predictability of Falls Screening Tools* project.

These data are important because they represent the first federal effort to test the predictability of screeners for fall risk factors. CDC is in regular contact with other federal agencies that have an interest in preventing older adult falls (e.g., Administration for Community Living [ACL], Centers for Medicare

and Medicaid Services [CMS], National Institutes of Health [NIH]). These agencies will be interested in the findings from this project, as they are engaged in complementary but not redundant efforts (see above), and we plan to share results during our partnership calls. There also may be opportunities for future collaboration in the implementation and testing of the parsimonious tool for predicting falls and medically treated falls in older adults that could be developed as a result of this data collection effort.

## A5. Impact on Small Businesses or Other Small Entities

There is no anticipated involvement of small businesses related to this project.

## A6. Consequences of Collecting the Information Less Frequently

This is a one-time data collection effort that seeks to establish a new diagnostic tool for use in medical settings. This data collection is necessary because despite widespread belief in the importance of clinical fall prevention, there is currently no prospective federal data collection effort which tests the predictability (i.e., usefulness) of existing screeners for fall risk factors. This information is critical to CDC's efforts to make fall prevention a routine in medical settings, which requires giving health care practitioners the tools they need to assess the likelihood that their patients' will fall in the subsequent year.

Data collection for this project includes a baseline survey, 11 monthly update surveys to collect information on falls since the previous survey, and a final survey. Each is a critical aspect of data collection in order to determine if a fall occurs and, if so, whether the baseline tool predicts the fall, and finally, whether there is a change in predictive ability of the screening questions between the baseline and final surveys. The collection of monthly data will increase the accuracy of incidence estimates for falls in adults 65 and older. Less frequent data collection (e.g., collecting information quarterly instead of monthly) would increase the likelihood of missing fall-related events due to recall bias, and thus limit the insights to be gathered from the project. Recall is a particular issue with this and other fall-related studies, because 1) the focus is on adults 65 and older, who may be prone to forgetfulness due to cognitive decline, and 2) falls that do not result in injury are important to the *Test Predictability of Falls Screening Tools* project, but may not be particularly salient for the adults 65 and older and thus difficult to remember over longer periods of time. For these reasons, monthly data collection is the standard for falls research,[7,8] and it is critical that we use monthly data collection in this project.

Frequent data collection will also reduce attrition of the sample that could result from less frequent contact with participants.

Analysis of the longitudinal survey data will also allow the NORC team to answer questions about the predictive capabilities of individual survey items and groupings of survey items. Collecting longitudinal data over a two-year period will allow NORC to capture changes over time and report on those changes.

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[7] Sanders, K.M., Stuart, A.L., Scott, D., Kotowicz, M.A., & Nicholson, G.C. (2015). Validity of 12-Month Falls Recall in Community-Dwelling Older Women Participating in a Clinical Trial. International Journal of Endocrinology, 2015, 210527. http://doi.org/10.1155/2015/210527

[8] Garcia, P. A., Dias, J. M. D., Silva, S. L. A., & Dias, R. C. (2015). Prospective monitoring and self-report of previous falls among older women at high risk of falls and fractures: a study of comparison and agreement. Brazilian Journal of Physical Therapy, 19(3), 218–226. http://doi.org/10.1590/bjpt-rbf.2014.0095

# A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The request fully complies with the regulation 5 CFR 1320.5.

# A8. Comments in Response to the Federal Register Notice/Consultation

## A8.a. Federal Register Notice

A 60-day Federal Register Notice for the *Test Predictability of Falls Screening Tools* project was published in the *Federal* Register on December 29, 2016, vol. 81 no. 250, pp. 96000-96001. (Att. A-3). CDC received one anonymous public comment (Att. A-4)

## A8.b. Efforts to Consult Outside the Agency

CDC engaged NORC to assist in compiling the screeners and/or questions in addition to the Stay Independent Checklist that are currently used in clinical practice to identify fall risk factors and in the development of the methodology for this project. NORC is experienced in managing and conducting projects of this nature and provides expertise on issues including the availability of data, frequency of collection, clarity of instructions, record keeping, data privacy, disclosure of data, reporting format, and necessary data elements.

Subject Matter Experts (SMEs) were consulted during the environmental scan to get feedback on the validated falls screening tools identified and their usefulness for web or phone surveys with community-dwelling adults 65 and older. NORC staff involved in the statistical aspects of the project are listed in section B5 of the Supporting Statement Part B OMB document. Titles and contact information for all SMEs consulted are listed in the Table 1 below:

**Table 1.** List of Consulted Subject Matter Experts (SMEs)

| Name | Affiliation | Email Address |
|---|---|---|
| William Dale | Associate Professor of Medicine and Chief, Section of Geriatrics & Palliative Medicine at University of Chicago; Director, SOCARE Clinic | wdale@medicine.bsd.uchicago.edu |
| Bernard Dugoni | Senior Research Methodologist II, Statistics and Methodology, NORC at the University of Chicago | dugoni-bernard@norc.org |
| David Reuben | NIH-PCORI STRIDE Study; David Geffen School of Medicine at the University of California, Los Angeles | dreuben@mednet.ucla.edu |
| Lindy Clemson | University of Sydney, Australia ARC Centre of Excellence in Population Ageing Research, Sydney & Canberra, Australia | lindy.clemson@sydney.edu.au |
| Yasuko Ishimoto | Center for Southeast Asian Studies, Kyoto University | yasu325ap@gmail.com |

## A9. Explanation of Any Payment or Gift to Respondents

Participants in the *Test Predictability of Falls Screening Tools* project are registered with AmeriSpeak, and per the AmeriSpeak model, rather than being offered cash remuneration, will be offered survey choice "points" to redeem for prizes which are commonly provided to survey panel respondents who complete online surveys. The points are funded by CDC, and delivered via the online panel provider to respondents who complete the survey.

The *Test Predictability of Falls Screening Tools* project is a longitudinal survey utilizing the AmeriSpeak panel involving repeated surveying, with the same or similar questions, of the same individuals monthly for a year. Therefore, points will be provided to help keep participants engaged and motivated in order to obtain maximum retention of panelists and survey participation. Providing points to panelists is positively associated with response rates and helps to build trust.[9,10] For the *Test Predictability of Falls Screening Tools* project, points worth $5, $2, and $10 will be awarded to panelists for completing the baseline survey, each monthly update survey (or a proxy survey), and the final survey, respectively. Panelists who complete all 11 monthly update surveys will receive bonus points worth $10. Therefore, the greatest total amount of points a panelist will be able to receive for participation will be worth $47 (which averages to $3.62 per completed survey).

In the *Test Predictability of Falls Screening Tools* project, loss to follow-up will be particularly detrimental because the value of the responses to the baseline survey depend on the update surveys, which collect the actual falls behavior (i.e., do the baseline questions predict future falls). Furthermore, the repetitive nature of the data collection effort places an extra burden on the respondent. Therefore, points to help encourage high levels of participation are extremely beneficial to the project, which would otherwise be expected to experience high attrition, and have been proven to be effective in other such surveys. [11,12,13]

## A10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does apply. The applicable System of Records Notice (SORN) is 0920-0136 Epidemiologic Studies and Surveillance of Disease Problems. Published in the Federal Register on December 31, 1992. Volume 57, Number 252, Page 62812-62813. The Privacy Impact Assessment (PIA) is attached and is part of the process to obtain an ATO under FISMA (Att. A-6). All procedures have been developed, in accordance with Federal, State, and local guidelines, to ensure that the rights and privacy of respondents are protected. No personal identifiers (e.g., full name, address or phone number, social security number, etc.) will be collected or maintained. Surveys done through the online AmeriSpeak panel will use secondary data from already-established records systems to link respondent responses over time. Additional information about the

[9] Thompson, W. (1985). Utility of paying respondents: evidence from the Residential Energy Consumption Surveys. Paper presented at the annual conference of the American Association for Public Opinion Research, May 1985.
[10] Dillman D.A., Smyth J.D., & Christian, L.M. (2014). Internet, phone, mail, and mixed-mode surveys: The tailored design method (Fourth Edition). John Wiley & Sons, Inc.
[11] Jackle A. & Lynn P. (2008). Respondent Incentives in a Multi-Mode Panel Survey: Cumulative Effects on Non-Response and Bias. *Survey Methodology*. 34(1):105-117.
[12] Laurie H. & Lynn P. (2009). The Use of Respondent Incentives on Longitudinal Surveys. *Methodology of Longitudinal Surveys*. 205-233.
[13] Chatfield M.D., Brayne C.E., & Matthews F.E. (2005). A Systematic Literature Review of Attrition between Waves in Longitudinal Studies in the Elderly Shows a Consistent Pattern of Dropout between Differing Studies. *Journal of Clinical Epidemiology*. 58:13-19.

procedures NORC employs to maintain the security of sensitive data for its clients can be found in the Documentation for NORC's AmeriSpeak Panel for Institutional Review Boards included (Att. A-7).

Every AmeriSpeak panelist is provided a Privacy Statement, which outlines the information that will be collected and how the information will be used. Because each panel member is asked to provide key demographic data such as age, gender, race/ethnicity, state of residence, household income, and more (see Att. A-8 for AmeriSpeak standard profile variables), the Privacy Statement also tells panel members how they can verify the accuracy of their PII and how they can request that the information be deleted or updated. Social security numbers of respondents are not being collected, so language specific to this request will not be incorporated into any of the materials used for the *Test Predictability of Falls Screening Tools* project.

The AmeriSpeak Privacy Statement (see Att. A-9) includes the following:

- A promise to treat all AmeriSpeak panelists and their information with respect.
- The assurance that participation in any AmeriSpeak study is completely voluntary and that panel members may choose not to answer any questions that they do not wish to answer. Furthermore, panel members may withdraw their participation in AmeriSpeak at any time.
- AmeriSpeak will never try to sell the panel member anything or ask for donations.
- AmeriSpeak will not share the personally identifying information with any clients unless panel members have given explicit permission to do so. Only survey responses will be shared with clients.
- Personal information will never be shared with telemarketers or others who would try to sell panel members anything.
- AmeriSpeak has established security measures to protect the security and confidentiality of its panel members.
- Panel members control their personal information and have the right to view their personal information or ask AmeriSpeak to delete it.

## A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

## IRB Approval

CDC has received IRB approval through local IRB to collect data from study participants. The IRB protocol and Approval Letter can be found in Attachments A-10 and A-11.

## Sensitive Questions

In general, the surveys designed for this data collection effort do not contain sensitive questions about topics such as sexual behavior or drug use. However, for some individuals, health information is considered sensitive. *Test Predictability of Falls Screening Tools* project participants will be asked about current medications and medical history because these factors are risk factors for falls. The AmeriSpeak Support Team email address, support@AmeriSpeak.org, and telephone number, 888-326-9424, are available for respondents to contact if they need help or have questions about the project. Phone interviewers are also trained in handling respondent concerns. NORC's experience with the Medicare

Current Beneficiary Survey (MCBS)[14] and National Social Life, Health, and Aging Project (NHSAP)[15] has given the organization extensive experience in fielding a comprehensive health survey to adults 65 and older.

## A12. Estimates of Annualized Hour and Cost Burden

Of the 2,925 AmeriSpeak panelists expected to be contacted, about 1,900 are estimated to agree to participate in the *Test Predictability of Falls Screening Tools* project, since historically about 65% of AmeriSpeak panelists 65 and older agree to participate in a study. Participants will initially be contacted via advance postcard through the mail (for those who prefer telephone administration) or through the internet (for those who prefer web administration). Since participants have already consented to participate in the AmeriSpeak Panel, the postcard will ask about their interest in participating in a new survey designed to understand factors that predict falls. An example of the pre-notification postcard and email can be found in Attachments B-1 and B-2.

The project consists of a baseline and final survey, each of which is expected to take approximately 20 minutes online and 30 minutes over the phone, as well as 11 monthly update surveys that are expected to take 10 minutes each online and 15 minutes each over the phone. We expect about 60% or 1,140 participants to respond via web-based survey (the shorter mode option) and about 40% or 760 participants to respond via phone survey (the longer mode option). Approximately 20% of participants will attrite prior to the final interview, resulting in a final estimate about 1,520 participants completing the final interviews. However, we are using the full 1,900 participants to estimate burden.

Because approximately 29% of older adults report a fall over a period of a year, we expect 551 participants to complete a falls diary, which is expected to take about 5 minutes for each fall. We expect each faller to average 2 falls per year. A template for the falls diary is included in Attachment B-3. A sample cover letter that will accompany the mailing of the diary is included in Attachment B-4, with the corresponding email in Attachment B-5.

Furthermore, we expect about 10% of all respondents to require a proxy to respond on their behalf to a monthly survey in the event that the panelist does not complete a survey within the survey period, placing the number of proxy respondents at 190. Proxies will respond for up to 4 months, at which time the observations will be censored. (See Attachment B-6 for the protocol for conducting proxy surveys.) Again, we expect about 60% or 114 of proxy respondents to use the web mode, taking about 3 minutes, and about 40% or 76 of proxy respondents to use the phone mode, taking about 5 minutes.

Due to the AmeriSpeak piloting or "soft launch" process (further described in section B4 of the Supporting Statement Part B), rolling admissions, tracking down proxy respondents, and rolling completions, data collection for the *Test Predictability of Falls Screening Tools* project is expected to take two years to complete. Therefore, the number of respondents for each component discussed above is split in half to calculate the *annualized* burden (Table 2 and Table 3). The estimated annual burden in hours is shown in Table 2 below.

**Table 2.** Estimated Annualized Burden in Hours

[14] NORC at the University of Chicago: The Medicare Current Beneficiary Survey (MCBS). Available at: http://www.norc.org/research/projects/pages/the-medicare-current-beneficiary-survey-.aspx

[15] NORC at the University of Chicago; National Social Life, Health, and Aging Project (NSHAP). Available at: http://www.norc.org/Research/Projects/Pages/national-social-life-health-and-aging-project.aspx

| Type of Respondents | Instrument Name | Number of Respondents | Number of Responses per Respondent | Average Burden per Response (hours) | Total Burden (hours) |
|---|---|---|---|---|---|
| Contacted AmeriSpeak Panelists | Initial Postcard and Email[16] (Att. B-1, B-2) | 1,463 | 1 | 2/60 | 49 |
| Participating AmeriSpeak Panelists | Baseline Survey Web Mode (Att. B-7) | 570 | 1 | 20/60 | 190 |
| | Baseline Survey Phone Mode (Att. B-8) | 380 | 1 | 30/60 | 190 |
| | Monthly Update Survey (months 1-11) Web Mode (Att. B-9) | 570 | 11 | 10/60 | 1,045 |
| | Monthly Update Survey (months 1-11) Phone Mode (Att. B-10) | 380 | 11 | 15/60 | 1,045 |
| | Final Survey Web Mode (month 12) (Att. B-11) | 570 | 1 | 20/60 | 190 |
| | Final Survey Phone Mode (month 12) (Att. B-12) | 380 | 1 | 30/60 | 190 |
| | Falls Diary (Att. B-3) | 276[17] | 2 | 5/60 | 46 |
| Proxy Respondents | Proxy Survey Web Mode (Att. B-13) | 57 | 4 | 3/60 | 12 |
| | Proxy Survey Phone Mode (Att. B-14) | 38 | 4 | 5/60 | 13 |
| | | | | Total Hours | 2,970 |

**Annual Burden Cost**

The estimated annualized burden costs are presented in Table 3. This time cost to respondents is computed in terms of an average hourly wage in 2015, according to the Social Security Administration, of $22.35.[18] The estimated annual burden in costs is shown in Table 3 below.

[16] Please see prenotification postcard in Attachment B-1.

[17] Calculated based on 29% of older adults reporting a fall over one year, as noted in the following sources: Bergen, G., Stevens, M.R., Burns, E.R. (2016). Fall and Fall Injuries Among Adults Aged ≥ 65 Years – United States, 2014. *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/mmwr/volumes/65/wr/mm6537a2.htm?s_cid=mm6537a2_e
Centers for Disease Control and Prevention. "Important Facts about Falls." (2016). Available at: http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

[18] Estimates are based on those provided by the Social Security Administration's National Average Wage Index, available at: https://www.ssa.gov/oact/cola/AWI.html

**Table 3.** Estimated Annualized Burden in Costs

| Type of Respondents | Instrument Name | Number of Respondents | Number of Responses per Respondent | Total Burden (hours)[19] | Average Hourly Wage Rate (dollars)[20] | Total Respondent Cost |
|---|---|---|---|---|---|---|
| Contacted AmeriSpeak Panelists | Initial Postcard and Email [21] (Att. B-1, B-2) | 1,463 | 1 | 49 | $22.35 | $1,095.15 |
| Participating AmeriSpeak Panelists | Baseline Survey Web Mode (Att. B-7) | 570 | 1 | 190 | $22.35 | $4,246.50 |
| | Baseline Survey Phone Mode (Att. B-8) | 380 | 1 | 190 | $22.35 | $4,246.50 |
| | Monthly Update Survey (months 1-11) Web Mode (Att. B-9) | 570 | 11 | 1,045 | $22.35 | $23,355.75 |
| | Monthly Update Survey (months 1-11) Phone Mode (Att. B-10) | 380 | 11 | 1,045 | $22.35 | $23,355.75 |
| | Final Survey Web Mode (month 12) (Att. B-11) | 570 | 1 | 190 | $22.35 | $4,246.50 |
| | Final Survey Phone Mode (month 12) (Att. B-12) | 380 | 1 | 190 | $22.35 | $4,246.50 |
| | Falls Diary (Att. B-3) | 276[22] | 2 | 46 | $22.35 | $1,023.10 |
| Proxy Respondents[23] | Proxy Survey Web Mode (Att. B-13) | 57 | 4 | 12 | $22.35 | $268.20 |
| | Proxy Survey Phone Mode (Att. B-14) | 38 | 4 | 13 | $22.35 | $290.55 |
| | | | | | Total Costs | $66,379.50 |

## A13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

The requested data collection does not impose a financial burden on respondents, nor will respondents incur any expense other than the time spent completing the surveys. Therefore, there are no additional respondent costs associated with start-up or capital investments. There are also no operational,

[19] Rounded to nearest whole number.

[20] Estimates are based on those provided by the Social Security Administration's National Average Wage Index, available at: https://www.ssa.gov/oact/cola/AWI.html

[21] Please see prenotification postcard in Attachment B-1.

[22] Calculated based on 29% of older adults reporting a fall over one year, as noted in the following sources: Bergen, G., Stevens, M.R., Burns, E.R. (2016). Fall and Fall Injuries Among Adults Aged ≥ 65 Years – United States, 2014. *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/mmwr/volumes/65/wr/mm6537a2.htm?s_cid=mm6537a2_e
Centers for Disease Control and Prevention. "Important Facts about Falls." (2016). Available at: http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

[23]

maintenance, or equipment respondent costs associated with continued participation in the assessment.

## A14. Annualized Cost to the Federal Government

Data collection and data delivery costs for conducting the *Test Predictability of Falls Screening Tools* project are included in the contract between NORC at the University of Chicago and the CDC under contract number HHSD2002013M53955B. The total estimate cost for the *Test Predictability of Falls Screening Tools* project for year one is $417,048.00 and for year two is $186,586.00. In addition, the cost for CDC professional staff to oversee and direct the research is $6,282.85 for 5% time for a GS-13 Step 1 and 5% of time for a GS-11 Step 1.

**Contractual Costs**

This is a contracted data collection. CDC has contracted with AIR to collect this data. The total cost of the contract over three years is $746,482 (Table 4).

**Table 4. Contractual Costs**

| | Base Year | Option Year 1 | Option Year 2 | Total |
|---|---|---|---|---|
| Personnel Costs | $108,235 | $356,064 | $162,955 | $627,255 |
| Other Direct Costs | $27,388 | $37,952 | $28,863 | $94,202 |
| Respondent Fees | $0 | $67,640 | $6,000 | $73,640 |
| G&A + Fee | $4,738 | $6,566 | $4,993 | $16,297 |
| Volume Discount | ($11,229) | ($37,458) | ($16,225) | ($64,912) |
| Total | $129,132 | $430,764 | $186,586 | $746,482 |

**Federal Employee Costs**

NCIPC has assigned a Public Health Advisor (PHA), a Health Scientist and a Senior Health Scientist to assist with and oversee this data collection. A CDC PHA (GS-11), health scientist (GS-12), and senior health scientist (O-4) devote 10% of their FTE for an estimated cost of $17,500 per year for 3 years (for a total of $52,500) (Table 5).

**Table 5. Federal Employee Costs**

| Year | Budget |
|---|---|
| Year 1 | $22,500 |
| Year 2 | $22,500 |
| Year 3 | $22,500 |
| **TOTAL** | **$67,500** |

Total project cost to the Federal Government is **$813,982**

## A15. Explanation for Program Changes or Adjustments

There are no changes in burden. This is a new project.

## A16. Plans for Tabulation and Publication and Project Time Schedule

Table 6 shows plans for tabulation and publication.

**Table 6.** Project Timeline Overview

| Activity | Schedule |
|---|---|
| Conduct Baseline Survey | Beginning immediately after OMB approval |
| Clean Data | Beginning immediately after Baseline Survey data collection is complete |
| Conduct Psychometric Analysis of Baseline Survey | Beginning immediately after Baseline Survey data are clean |
| Conduct Follow Up Surveys | Follow-up Surveys will be available to respondents for 1 month |
| Deliver Midpoint De-identified Data | Immediately after 6-month Follow-up Survey data collection is complete and data are clean |
| Midpoint Data Analysis | Beginning immediately after 6-month Follow Up Survey data collection is complete and the data are clean |
| Conduct Final Survey | Beginning immediately after 11-month Follow-up Survey data collection is complete |
| Final Data Analysis | Immediately after Final Survey data collection is complete and data are clean |
| Deliver Final De-identified Data | Immediately after Final Survey data collection is complete and data are clean |
| Write Reports/Manuscripts | Within 2 years from start of data collection |
| Publish for Peer Review | Within 2 years from start of data collection |

Data collection will begin immediately after OMB approval and will continue for approximately 2 years. After completion of the 6 Month Follow Up Survey, the CDC will obtain a midpoint de-identified data set with documentation including a data dictionary and a description of the cleaning processes used for the data. After completion of the Final Survey, CDC will obtain a second and final de-identified data set including a data dictionary and a description of the cleaning processes used for the data.

Within 2 years from the beginning of data collection, a report will be developed to explore differences in answers from the baseline to final surveys. The analysis will begin with paired t-tests of differences between individual items and between groupings of items. Results showing significant differences

between overall scores will be investigated to understand whether certain groups of individuals score differently and which key factors are related to those differences. Recommendations for  a set of questions or tool to be used to predict falls and medically treated falls based on the overall findings and analysis for key subgroups will be developed.

A final manuscript summarizing key findings from the *Test Predictability of Falls Screening Tools* project will be developed within 2 years from the beginning of data collection as well. The analysis will consider individual questions and groupings of questionsthat predict falls and medically treated fallsfor multiple subgroups of adults 65 and older, and will consider the implications of these findings for clinical practice . De-identified data will be provided to the CDC and resultingtools and manuscript will be shared widely. Finally, two years after the beginning of data collection, the results of the project will be reported in peer-reviewed journal articles and conference presentations for dissemination to researchers, states, and the public.

## A17. Reason(s) Display of OMB Expiration Date is Inappropriate

OMB expiration dates will be displayed on all materials.

## A18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement identified in item 19 “Certification for Paperwork Reduction Act Submissions,” of OMB Form 83-I.