

## Attachment 6B: Response to Public Comments

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## Summary of Public Comments and Response

A total of three public comments were received during the 60 day public notification of intent to collect data using the BRFSS. The first comment was from the Truth Initiative. The comment focuses on the inclusion of new questions on tobacco use to include asking respondents about the use of flavors in hookah use, e-cigarette use and cigars. The comment also requests that the current e-cigarette module be made into a core component of the BRFSS questionnaire. The comment in its entirety will be forwarded to the Office of Smoking and Health (OSH) which sponsors all tobacco use questions on the BRFSS for their review. The OSH is currently requesting a vote by the state health departments to include e-cigarette use in the core for the 2019 version of the questionnaire. Therefore this portion of the recommendation by the Truth Initiative will be considered by the states in the Spring of 2018 as part of the questionnaire development process (as described in Attachment 12).

The second comment was from the Academy of Nutrition and Dietetics. This comment focused on the length of the survey, some concerns about validity and reliability and the use of rotating core and optional module questions. The suggestions of the comment were to reduce the length of the questionnaire to 15-20 questions which are standard across states, and eliminate the optional modules. The suggestions also included removing questions that were redundant with national surveys. The suggestions to remove the state specificity of the questionnaire is contrary to the purpose of the BRFSS, which has as its mission to provide state-level data that can be tailored to the needs of each state. The response also directs the Academy to the literature on reliability and validity of the BRFSS, which is an ongoing activity within the Population Health Surveillance Branch. The suggestions provided by the Academy of Nutrition and Dietetics will be forwarded to the CDC programs which sponsor questions on nutrition and physical activity.

The third comment was provided by the Williams Institute of the UCLA School of Law. This comment focused on the need for continued information related to sexual orientation and gender identity (SOGI) which has been provided as an optional module on the BRFSS since 2014. The authors expressed a preference for the SOGI questions to be moved to the core questionnaire. The response focused on the process by which questions are adopted for the core, and the need to maintain flexibility for the states in the determination of their questionnaires.

# Letter from the Truth Initiative

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The Honorable Tom Miller,  
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December 11, 2017

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Robin Koval, Ex-Officio  
CEO and President  
Truth Initiative

Dear Mr. Richardson:

Truth Initiative welcomes the opportunity to submit comment regarding the Behavioral Risk Factor Surveillance System (BRFSS). Truth Initiative greatly values data from BRFSS as it is the only survey to assess state-specific prevalence estimates of current use of cigarettes, smokeless tobacco, and electronic cigarette among U.S. adults.

Truth Initiative is committed to creating a generation of Americans for whom tobacco use is a thing of the past. We believe each individual has the right to live in a world free from tobacco dependence, tobacco-related death and disease, and the devastating dollar cost to individuals and society. Truth Initiative's proven-effective and nationally recognized public education programs include truth®, the national youth smoking prevention campaign that has been cited as contributing to significant declines in youth smoking; EX®, an innovative smoking cessation program; and research initiatives exploring the causes, consequences and approaches to reducing tobacco use. Truth Initiative also develops programs to address the health effects of tobacco use – with a focus on priority populations disproportionately affected by the toll of tobacco – through alliances, youth activism, training and technical assistance. Located in Washington, DC, the organization was created as a result of the November 1998 Master Settlement Agreement (MSA) between attorneys general from 46 states

U.S. territories and the tobacco industry.

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Truth Initiative encourages CDC to add questions in its tobacco use core section about other tobacco products including cigars and hookah and to add questions about the use of flavored tobacco products.

Because BRFSS is the only national survey to assess state-specific prevalence estimates of current use of tobacco products among U.S. adults, it is important that **all** tobacco products be included in the survey, including hookah and cigars.

Flavors play a significant role in drawing youth and young adults to tobacco products. These products are commonly sold in bright, colorful packages and are often cheap and sold individually, making them even more appealing to these price-sensitive groups. Flavors are found in many tobacco products, including smokeless tobacco, cigars, hookah, and electronic nicotine delivery systems (ENDS). The flavors found in these products include: alcohol, candy and fruit flavors such as sour apple, cherry, grape, chocolate, strawberry margarita, appletini, pina colada, cotton candy, cinnamon roll, and menthol.<sup>1-5</sup> In 2014, an estimated 3.26 million middle and high school students in the U.S. used a flavored tobacco product in the preceding 30 days. 73.0% of high school students and 57.0% of middle school students who were currently using any tobacco product reported using flavored products.<sup>6</sup> Flavored tobacco product use is higher in younger adults than older adults. 72.7% of young adult current tobacco users reported flavored tobacco use, compared to adults aged 25-29 (63.3%), adults 30-34 (56.0%), adults 35-44 (44.1%), adults 45-64 (38.5%), and adults 65+ (28.6%).<sup>7</sup> Additionally, FDA announced in July 2017 that it intends to issue an ANPRM to seek public comment on the role that flavors (including menthol) in tobacco products play in attracting youth and may play in helping some smokers switch to potentially less harmful forms of nicotine delivery. Although the BRFSS is a survey of U.S. adults, having this information on adults at the state level could contribute to understanding whether adults use flavored tobacco products and if so, which of the tobacco products they use are flavored. BRFSS is ideally placed to collect such information.

Below, we have suggested questions to be added by tobacco product type:

#### Cigarettes

Truth Initiative suggests that a question be added regarding whether or not a respondent smokes menthol cigarettes. It is important to survey the prevalence of menthol cigarette use. In 2010, 8.2% (20.7 million) of those ages 12 or older in the U.S. smoked menthol cigarettes.<sup>8</sup> Studies show that menthol cigarettes are slowing the reductions in overall cigarette smoking prevalence. From 2000 to 2011, the decline in cigarette consumption was greater among non-menthol cigarettes (37% decline) than for menthol cigarettes (20% decline). Eighty-nine percent of the total decline in cigarette consumption is attributed to nonmenthol cigarettes.<sup>9</sup> The weight of the scientific evidence indicates that adult menthol smokers are less likely than non-menthol smokers to successfully quit smoking<sup>10-19</sup> despite increased quit intentions<sup>15</sup> and quit attempts.<sup>15,16,19</sup> Studies show significantly reduced cessation among African American<sup>10-12</sup> and Hispanic menthol smokers compared to non-menthol smokers.<sup>12</sup>

Because BRFSS is the only national survey to assess state-specific prevalence estimates of tobacco use among U.S. adults, it would be helpful to know the prevalence of menthol cigarettes among this population and would help us identify disparities. This would in turn be useful for policymakers to make policy determinations regarding menthol flavored tobacco products. Therefore, regarding cigarettes, we request the following question be added to the BRFSS:

*Are the cigarettes that you usually smoke menthol?*

Yes

No

Smokeless Tobacco

Truth Initiative recommends that a question be added regarding whether the smokeless tobacco products respondents are currently using are flavored. Data from the 2013-2014 National Adult Tobacco Survey shows that among U.S. adult smokeless tobacco users, 50.6% reported flavored use.<sup>20</sup> A study of internal tobacco industry documents found that smokeless tobacco product manufacturers added flavors to their products to attract new users, especially young males.<sup>21</sup>

As stated above, BRFSS is the only national survey to assess state-specific prevalence estimates of tobacco use among U.S. adults and thus having this information could contribute to understanding whether adults use flavored smokeless tobacco products. This information would be useful for policymakers to make policy determinations regarding flavored tobacco products.

*Is the chewing tobacco, snuff, or snus you usually use flavored to taste like menthol (mint), alcohol (wine, cognac), candy, fruit, chocolate, or any other flavors?*

Yes

No

E-Cigarettes

Truth Initiative recommends that the questions on e-cigarettes not be made into an optional module (Module 6 in the 2018 Questionnaire). The 2017 BRFSS Questionnaire asked about e-cigarette use as a Core Section (Section 10 in the 2017 Questionnaire). We recommend that the questions about e-cigarette use remain a Core Section. Since their introduction in the United States market, awareness, interest and use of electronic cigarettes (e-cigarettes) or Electronic Nicotine Delivery Systems (ENDS) has steadily grown. It is important to continue to gather information about the prevalence of these products.

Truth Initiative also recommends that a question be added regarding whether the e-cigarettes respondents are currently using are flavored. Data from the 2013-2014 National Adult Tobacco Survey shows that among U.S. adult e-cigarette users, 68.2% reported flavored use.<sup>20</sup> Evidence indicates that flavors are viewed as an attractive characteristic of ENDS,<sup>22</sup> and youth and adults cite flavors as a reason for e-cigarette use.<sup>23-25</sup>

Having state-specific electronic cigarette prevalence estimates of tobacco use among U.S. adults, would be helpful and would contribute to learning more about what kind of products adults use, and whether flavors play a role in that use. This would in turn be useful for policymakers to make policy determinations regarding flavored tobacco products.

*Is the e-cigarette or other electronic “vaping” product you usually use flavored to taste like menthol (mint), alcohol (wine, cognac), candy, fruit, chocolate, or any other flavors?*

Yes

No

Hookah

Truth Initiative recommends that questions be added about the current use of hookah and whether the products respondents are currently using are flavored. Data from the 2013-2014 National Adult Tobacco Survey shows that among U.S. adult hookah users, 82.3% reported flavored use.<sup>20</sup> A focus group study of young adult hookah smokers showed that participants found the fact that hookah comes in a wide variety of flavors appealing and liked that they could personalize their smoking experience by mixing and customizing flavors.<sup>26</sup> This compounds the fact that young adults perceive hookah to be less harmful and less addictive than cigarettes.<sup>27-30</sup>

Having hookah use prevalence about adults by state would help increase knowledge about use of this product among this population and would help identify disparities. This would in turn be useful for policymakers to make policy determinations regarding flavored tobacco products.

*Do you currently smoke tobacco in a hookah, waterpipe, or shisha every day, some days, or not at all?*

Every day

Some days

Not at all

*Is the tobacco in a hookah, waterpipe, or shisha you usually smoke flavored to taste like menthol (mint), alcohol (wine, cognac), candy, fruit, chocolate, or any other flavors?*

Yes

No

## Cigars

Truth Initiative recommends that questions be added about the current use of cigars and whether the products respondents are currently using are flavored. Because the users and the usage patterns appear to vary across the different types of cigars, Truth Initiative encourages CDC to ask questions in the BRFSS about typical large, traditional cigars, sometimes referred to as “stogies,” separately from the questions about little cigars or cigarillos. In July 2017, FDA announced that it intends to issue an ANPRM to solicit additional comments and scientific data related to the patterns of use and resulting public health impacts from premium cigars. Research suggests large cigar users and little cigar and cigarillo users have different demographic profiles and may have different patterns of multiple product use, with little cigars and cigarillos being more popular among young adults, African-Americans, individuals with lower education and those reporting current cigarette, marijuana and blunt use.<sup>31-33</sup> Furthermore, to improve the precision of prevalence estimates, we recommend that the CDC include brand-specific prompts, particularly of little cigar and cigarillo brands, for questions regarding current cigar use.

It would be helpful to know the prevalence of cigar, little cigar, and cigarillo use, and especially flavored cigar use, among U.S. adults and would help identify disparities. This information would be useful for policymakers to make policy determinations regarding flavored tobacco products.

*Do you currently smoke large, traditional cigars every day, some days, or not at all?*

Every day  
Some days  
Not at all

*INTERVIEWER NOTE: Large, traditional cigars do not include cigarillos and little cigars. Brand names of cigarillos and little cigars include Black and Mild, Swisher Sweets, Dutch Master, White Owl, or Phillies Blunts.*

*Do you currently smoke cigarillos or little cigars every day, some days, or not at all?*

Every day  
Some days  
Not at all

*INTERVIEWER NOTE: Cigarillos and little cigars do not include large, traditional cigars. Brand names of cigarillos and little cigars include Black and Mild, Swisher Sweets, Dutch Master, White Owl, or Phillies Blunts.*

As we have suggested for other tobacco products, CDC should include a question regarding the use of flavored cigars in the BRFSS. This is especially important for cigar products given the fact that flavored cigarettes, except for menthol, were banned by the Family Smoking Prevention and Tobacco Control Act. Furthermore, there is evidence that



some brands of flavored cigarettes simply changed their products to flavored cigars. Data from the 2013-2014 National Adult Tobacco Survey shows that among U.S. adult cigar smokers, 36.2% reported flavored use.<sup>20</sup>

*Is the cigarillo or little cigar you usually smoke flavored to taste like menthol (mint), alcohol (wine, cognac), candy, fruit, chocolate, or any other flavors?*

Yes

No

Truth Initiative appreciates CDC taking these comments into account as it develops the BRFSS for the period of 2018-2021. As we stated above, Truth Initiative greatly values data from BRFSS as it is the only survey to assess state-specific prevalence estimates of current use of cigarettes, smokeless tobacco, and electronic cigarette among U.S. adults. It is critical that we have the appropriate information about tobacco products in order to best determine how to protect the public health from the deadly effects of tobacco, especially as the breadth and variety of tobacco products continues to change. As stated above, we urge CDC to revise BRFSS to include questions regarding current use of other tobacco products such as cigars and hookah; include e-cigarette questions as a core module; and ask questions regarding whether respondents are using flavored tobacco products. Please do not hesitate to contact Maham Akbar, Public Policy Manager at [makbar@truthinitiative.org](mailto:makbar@truthinitiative.org) or 202-454-5932, should you need more information or have questions about this submission.

Sincerely,



M. David Dobbins  
Chief Operating Officer

## References

1. Aljarrah K, Ababneh ZQ, Al-Delaimy WK. Perceptions of hookah smoking harmfulness: predictors and characteristics among current hookah users. *Tobacco induced diseases*. 2009;5(1):16.
2. Cobb C, Ward KD, Maziak W, Shihadeh AL, Eissenberg T. Waterpipe tobacco smoking: an emerging health crisis in the United States. *Am J Health Behav*. 2010;34(3):275-285.
3. Smith-Simone S, Maziak W, Ward KD, Eissenberg T. Waterpipe tobacco smoking: knowledge, attitudes, beliefs, and behavior in two U.S. samples. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. 2008;10(2):393-398.
4. Good Times Tobacco. Other Products. 2017; <http://goodtimestobacco.com/other-products/>.
5. Prime Time Cigars. Prime Time Happy Hour Cocktail-Inspired Little Cigars. 2017.
6. Corey CG, Ambrose BK, Apelberg BJ, King BA. Flavored Tobacco Product Use Among Middle and High School Students--United States, 2014. *MMWR. Morbidity and mortality weekly report*. 2015;64(38):1066-1070.
7. Villanti AC, Johnson AL, Ambrose BK, et al. Flavored Tobacco Product Use in Youth and Adults: Findings From the First Wave of the PATH Study (2013-2014). *American journal of preventive medicine*. 2017.
8. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *The NSDUH Report: Recent Trends in Menthol Cigarette Use*. Rockville, MD November 18, 2011.
9. Delnevo CD, Villanti AC, Giovino GA. Trends in menthol and non-menthol cigarette consumption in the U.S.A.: 2000-2011. *Tobacco control*. 2014;23(e2):e154-155.
10. Tobacco Products Scientific Advisory Committee. *Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations*. Rockville, MD: Center for Tobacco Products, Food and Drug Administration;2011.
11. Stahre M, Okuyemi KS, Joseph AM, Fu SS. Racial/ethnic differences in menthol cigarette smoking, population quit ratios and utilization of evidence-based tobacco cessation treatments. *Addiction (Abingdon, England)*. 2010;105 Suppl 1:75-83.
12. Gundersen DA, Delnevo CD, Wackowski O. Exploring the relationship between race/ethnicity, menthol smoking, and cessation, in a nationally representative sample of adults. *Preventive medicine*. 2009;49(6):553-557.
13. Gandhi KK, Foulds J, Steinberg MB, Lu SE, Williams JM. Lower quit rates among African American and Latino menthol cigarette smokers at a tobacco treatment clinic. *International journal of clinical practice*. 2009;63(3):360-367.
14. Okuyemi KS, Faseru B, Sanderson Cox L, Bronars CA, Ahluwalia JS. Relationship between menthol cigarettes and smoking cessation among African American light smokers. *Addiction (Abingdon, England)*. 2007;102(12):1979-1986.
15. Trinidad DR, Perez-Stable EJ, Messer K, White MM, Pierce JP. Menthol cigarettes and smoking cessation among racial/ethnic groups in the United States. *Addiction (Abingdon, England)*. 2010;105 Suppl 1:84-94.

16. Levy DT, Blackman K, Tauras J, et al. Quit attempts and quit rates among menthol and nonmenthol smokers in the United States. *American journal of public health*. 2011;101(7):1241-1247.
17. Okuyemi KS, Ahluwalia JS, Ebersole-Robinson M, Catley D, Mayo MS, Resnicow K. Does menthol attenuate the effect of bupropion among African American smokers? *Addiction (Abingdon, England)*. 2003;98(10):1387-1393.
18. Delnevo CD, Gundersen DA, Hrywna M, Echeverria SE, Steinberg MB. Smoking-cessation prevalence among U.S. smokers of menthol versus non-menthol cigarettes. *American journal of preventive medicine*. 2011;41(4):357-365.
19. Pletcher MJ, Hulley BJ, Houston T, Kiefe CI, Benowitz N, Sidney S. Menthol cigarettes, smoking cessation, atherosclerosis, and pulmonary function: the Coronary Artery Risk Development in Young Adults (CARDIA) Study. *Archives of internal medicine*. 2006;166(17):1915-1922.
20. Bonhomme MG, Holder-Hayes E, Ambrose BK, et al. Flavoured non-cigarette tobacco product use among US adults: 2013-2014. *Tobacco control*. 2016;25(Suppl 2):ii4-ii13.
21. Kostygina G, Ling PM. Tobacco industry use of flavourings to promote smokeless tobacco products. *Tobacco control*. 2016;25(Suppl 2):ii40-ii49.
22. McDonald EA, Ling PM. One of several 'toys' for smoking: young adult experiences with electronic cigarettes in New York City. *Tobacco control*. 2015;24(6):588-593.
23. Rutten LJ, Blake KD, Agunwamba AA, et al. Use of E-Cigarettes Among Current Smokers: Associations Among Reasons for Use, Quit Intentions, and Current Tobacco Use. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. 2015;17(10):1228-1234.
24. Farsalinos KE, Romagna G, Voudris V. Factors associated with dual use of tobacco and electronic cigarettes: A case control study. *The International journal on drug policy*. 2015;26(6):595-600.
25. Kong G, Morean ME, Cavallo DA, Camenga DR, Krishnan-Sarin S. Reasons for Electronic Cigarette Experimentation and Discontinuation Among Adolescents and Young Adults. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. 2015;17(7):847-854.
26. Castaneda G, Barnett TE, Soule EK, Young ME. Hookah smoking behavior initiation in the context of Millennials. *Public health*. 2016;137:124-130.
27. Akl EA, Gaddam S, Gunukula SK, Honeine R, Jaoude PA, Irani J. The effects of waterpipe tobacco smoking on health outcomes: a systematic review. *Int J Epidemiol*. 2010;39(3):834-857.
28. Primack BA, Sidani J, Agarwal AA, Shadel WG, Donny EC, Eissenberg TE. Prevalence of and associations with waterpipe tobacco smoking among U.S. university students. *Ann Behav Med*. 2008;36(1):81-86.
29. Sutfin EL, McCoy TP, Reboussin BA, Wagoner KG, Spangler J, Wolfson M. Prevalence and correlates of waterpipe tobacco smoking by college students in North Carolina. *Drug and alcohol dependence*. 2011;115(1-2):131-136.
30. Heinz AJ, Giedgowd GE, Crane NA, et al. A comprehensive examination of hookah smoking in college students: use patterns and contexts, social norms and attitudes,

harm perception, psychological correlates and co-occurring substance use. *Addictive behaviors*. 2013;38(11):2751-2760.

31. Cullen J, Mowery P, Delnevo C, et al. Seven-year patterns in US cigar use epidemiology among young adults aged 18-25 years: a focus on race/ethnicity and brand. *American journal of public health*. 2011;101(10):1955-1962.
32. Borawski EA, Brooks A, Colabianchi N, et al. Adult use of cigars, little cigars, and cigarillos in Cuyahoga County, Ohio: a cross-sectional study. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. 2010;12(6):669-673.
33. Richardson A, Rath J, Ganz O, Xiao H, Vallone D. Primary and dual users of little cigars/cigarillos and large cigars: demographic and tobacco use profiles. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. 2013;15(10):1729-1736.

## Response to the Truth Initiative

December 18, 2017

Mr. M David Dobbins  
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Dear Mr. Dobbins:

Thank you for your public comment on the intent to collect data using the Behavioral Risk Factor Surveillance System (BRFSS: OMB Control Number 0920-1061). We value your input and strive to collect information that is useful for public health policy making at the local, state and national level. As you know addition of questions to the BRFSS is a process which takes into account the needs of state health departments, CDC programs and other federal agencies and non-profit organizations. There are many more requests for inclusion of questions than there is capacity for all requests. Your comment provides requests for new questions as well as a request to move a current optional set of questions to the require core component

Your comment in its entirety will be forwarded to the CDC Office of Smoking and Health (OSH) which sponsors all tobacco use questions on the BRFSS for their review and consideration. The OSH is currently requesting a vote by the state health departments to include e-cigarette use in the core for the 2019 version of the questionnaire. Therefore this portion of the recommendation by the Truth Initiative will be considered by the states in the spring of 2018 as part of the questionnaire development process (as described in Attachment 12).

Sincerely,

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## Letter from the Academy of Nutrition and Dietetics

December 14, 2017

Leroy A. Richardson  
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Re: Information Collection: Behavioral Risk Factor Surveillance System (BRFSS) —Revision (Docket No. CDC-2017-0077)

Dear Mr. Richardson,

The Academy of Nutrition and Dietetics (the “Academy”) appreciates the opportunity to submit comments to the Centers for Disease Control and Prevention (CDC) at the United States Department of Health and Human Services (HHS) related to its October 16, 2017 information collection, “Behavioral Risk Factor Surveillance System (BRFSS) —Revision.” Representing more than 100,000 registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutritionists, the Academy is the largest association of food and nutrition professionals in the United States, and is committed to supporting long-term research documenting changes in Americans’ dietary habits over time and how these habits may vary between regions, states and populations. The Academy supports the Behavioral Risk Factor Surveillance System (BRFSS) project and emphasizes its particular support for the focus on analyzing a consistent set of variables over time and the ability to provide state and local policymakers the precise data required to guide various health-related interventions and related services tailored for local needs.

### A. Significance of BRFSS in Research

The BRFSS has been used to describe the relationship of demographics to consumer use to menu nutrition labeling and has served as the source for secondary research into health disparities and their relationship to fruit and vegetable intake . The BRFSS has also provided valuable context for the interpretation of nutritional epidemiology research in the areas of health disparities and progress towards national dietary intake goals in addition to contributing background information for the Academy’s position statement on obesity, reproduction, and pregnancy . Furthermore, the BRFSS survey instrument advances other research in the field by providing validated survey questions that have been used to efficiently develop new instruments for measuring the determinants of sugar-sweetened beverage intake among low-income children , the validity of dietary intake assessments , and the financial costs of dietary modification for the treatment of type 1 diabetes .

Such research demonstrates the practical utility of the data this program provides for the advancement of public health and nutrition science. Importantly, the state-level and sub-state-level estimates provided by the BRFSS support research and policy for local needs which presently cannot be met by other data sources. For example, the recent addition of the 500 Cities project provides estimates at the census tract level for many parameters relative to the 500 largest cities in the US; these data are not otherwise available. In contrast, other data sources, such as the National Health and Nutrition Examination Survey, are summarized at the national level . Besides the uniqueness of the available

geographic estimates, the BRFSS also provides the unique ability to trend over time, as many of the core, and rotating core, items have been gathered over many years. It is therefore vital that the CDC continue its support of both of these programs for the proper and effective performance of the functions of the agency.

## B. Survey Enhancement

We offer the following general suggestions to improve the quality and utility of the survey:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility. The information collected in the BRFSS not only has practical utility but the information is of the highest importance since it allows state and sub-state estimates for topics (behavioral risks, health-seeking behaviors and interaction with the health care system, chronic disease, and injuries) that are otherwise not available. The proposed health data collection areas are relevant for state tracking of health trends, but we respectfully suggest that the survey could be shortened in length to decrease the burden of administration.

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used. The agency's estimate of the time burden are accurate. However, a phone survey that takes 20 – 30 minutes to administer may be too long for most busy young adults today and the accuracy of the answers given to the questions may be compromised due to respondents simply wanting to conclude the lengthy survey.

3. Comment to enhance the quality, utility, and clarity of the information to be collected. The agency correctly allows input from states to enhance the quality, utility, and clarity of the information to be collected. For example, Texas gathers input from statewide stakeholders on data quality improvement that are then discussed with the CDC and other states. Texas has successfully modified items working together with national partners. The optional modules allow states and local communities the opportunity to tailor the survey to meet state and local needs while still producing information according to a standard that then can be aggregated nationally and grouped by state. States also have the ability to oversample to enhance the quality, utility, and clarity of the information to be collected. However, data quality, utility, and clarity can also be enhanced by standardizing all questions so that all states ask the same questions every year, eliminating all optional modules and questions, and significantly reducing the number of questions to a bare minimum. Eliminating duplicative questions asked on other national surveys could be beneficial; states can obtain these data from these other national surveys. Field testing the bare minimum questions regionally across the nation, rather than in just one state, could also be helpful.

4. Comment to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses. States have had the ability to offer the most appropriate collection techniques, whether through the web or mail or the current landline and cellphone surveys. States have the ability to minimize the burden every year by balancing the amount of optional modules and state-added questions with the need for timely, useful, and local health-related survey items.

However, significantly reducing the number of questions (perhaps a maximum of 15-20 questions) has the potential to further reduce the respondent burden. Also, administering the survey electronically by sending a survey link through text messaging could also potentially reduce respondent burden, as well as cost.

5. Comment to help assess information collection costs.

Based on information from Texas, conducting BRFSS at the local level costs \$76.00-\$78.00 per survey. Costs could be potentially reduced more by eliminating all phone interviewers and administering the survey electronically via a survey link through text messaging. As noted above, significantly reducing the number of questions could also reduce administrative burden and cost.

D. Conclusion

The Academy appreciates the opportunity to comment on the proposed information collection for the “Behavioral Risk Factor Surveillance System (BRFSS) —Revision” docket. Please contact either Jeanne Blankenship at 312-899-1730 or by email at [jblankenship@eatright.org](mailto:jblankenship@eatright.org) or Mark Rifkin at 202-775-8277 ext. 6011 or by email at [mrifkin@eatright.org](mailto:mrifkin@eatright.org) with any questions or requests for additional information. Sincerely,

Jeanne Blankenship, MS, RDN  
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Academy of Nutrition and Dietetics

Mark E. Rifkin, MS, RD, LDN  
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## Response to the Academy of Nutrition and Dietetics

December 18, 2017

Ms. Jeanne Blankenship and Mr. Mark Rifkin  
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Chicago, Ill. 60606-6995

Dear Ms. Blankenship and Mr. Rifkin,

Thank you for your interest in the Behavioral Risk Factor Surveillance System (BRFSS) and your recent comment on the content and administration of the survey questionnaire. We are appreciative of your use of the BRFSS data to improve public health through the use of nutrition information collected by the survey. It should be noted that the BRFSS is not a national survey, but a system of state surveys which are purposely tailored to meet the needs of individual states. Sun exposure, for example, is a more serious health concern in some states than in others. Therefore we believe the flexibility of the optional modules is an asset. We are very careful only to ask questions which are essential on the core. Using the rotating (odd/even year) core also permits a larger number of standard core questions. Asking the same questions each year to all of the respondents would lengthen the survey rather than shorten it.

We share your concerns about survey length. To shorten the survey while allowing state health department to collect information that is specifically salient to their population, we permit states to split the questionnaire into up to three versions. Using split versions, states are able to collect information in the shortest time period possible. We are vigilant about the intrusion of a lengthy survey on our respondents and work to meet their schedules in the administration of each telephone interview.

We conduct annual validity and reliability checks on all of our data, including comparisons with other estimates, test/retest procedures and pilot testing. A list of publications on our reliability and validity can be found on our website at [https://www.cdc.gov/brfss/publications/data\\_qvr.htm](https://www.cdc.gov/brfss/publications/data_qvr.htm). We make use of the fact that national estimates from other survey are derived from similar or identical questions in order to test validity over time.

Unfortunately it is not feasible to send text messages to potential respondents, as the Telephone Consumer Protection Act (see <https://transition.fcc.gov/cgb/policy/TCPA-Rules.pdf>) precludes this activity without prior consent of the respondent. Moreover it is not possible to send text messages to landline phone numbers which are a portion of the BRFSS sample. We are committed to administering the survey in the most cost effective manner and do conduct pilots on address-based samples and directing potential respondents to the web using a mailed invitation letter. However, to date these methods are not as cost effective as our current method and result in lower response rates. We will continue to explore methods for reaching respondents, including younger adult respondents, who may have nontraditional personal communication patterns.

We will forward your input to the CDC programs which sponsor the nutrition and physical activity questions for their review. Thank you again for your interest in the content and administration of the BRFSS.

Sincerely,

Carol Pierannunzi  
Senior Survey Methodologist  
Centers for Disease Control and Prevention

## Letter from the Williams Institute, UCLA School of Law

December 15, 2017

Leroy A. Richardson  
Information Collection Review Office  
Centers for Disease Control and Prevention  
1600 Clifton Road NE., MS-D74  
Atlanta, GA 30329  
Submitted via Regulations.gov

RE: Proposed Data Collection Submitted for Public Comment and Recommendations  
(82 Fed. Reg. 48087, 48088, 48089) (Docket No. CDC-2017-0077).

We are grateful for the opportunity to provide recommendations on the Centers for Diseases Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) Survey. As scholars at The Williams Institute, an academic research center at the UCLA School of Law dedicated to conducting rigorous and independent research on sexual orientation and gender identity, we are writing to express our support for the sustained inclusion of the sexual orientation and gender identity (SOGI) items in the BRFSS. The Williams Institute has long analyzed governmental data, including the BRFSS, and worked with federal agencies to improve data collection on the U.S. population. We have also produced widely-cited best practices for the collection of sexual orientation and gender identity information on population-based surveys.

The BRFSS is a vital source of population-based information about adult demographic and socioeconomic characteristics, health behavior, and health status that informs both federal and state health priorities. Due to the size of the BRFSS, the probability sampling approach, and the lack of consistent inclusion of SOGI measures across the US health surveillance system and other federal population monitoring systems, analyses of BRFSS data have filled critical voids in knowledge about sexual minority and transgender adults. Over the last 10 years, 50 or so published, peer-reviewed BRFSS papers have provided information about LGBT adults, including over 40 publications that included sexual minorities and eight that featured transgender adults. Nearly half of these papers were published after CDC first supplied the SOGI optional module in 2014.

BRFSS analyses have produced information about the health of LGBT adults across a broad array of issues including physical and mental health, violence victimization, and disability, as well as among LGBT subgroups (veterans, cancer survivors, rural residents ). The BRFSS has also provided a unique source of information about the prevalence of socioeconomic (e.g., education, employment, income) and behavioral determinants of chronic disease such as smoking, drinking, diet, activity, and screening (e.g., HIV, colorectal, and pap testing) which is necessary to inform prevention and intervention efforts. Additionally, BRFSS data have been utilized to examine the relationship between public policies and health insurance coverage and self-reported health.

Moreover, given the significant value of data gathered through these optional items, we recommend the following changes to current protocol:

1) We recommend that SOGI questions should be added to the core survey so that it is asked of residents of all 50 states. Currently, the module is optional—in 2016, only half of the states included SOGI items on their BRFSS surveys.

2) We recommend testing an alternative to the item “Are you male or female?”, which could easily be confused as a measure of current sex, legal sex, sex assigned at birth, and/or gender identity, with a more precise measure of sex assigned at birth. Precise information about sex assigned at birth is needed to correctly triage respondents to sex-linked skip patterns in the BRFSS, as well as to understand the responses of transgender respondents who select gender nonconforming as their follow-up response to the question, “Do you consider yourself to be transgender?.”

The item informed by the GenIUSS national working group, tested by the California Health Interview Survey (CHIS) and Gallup for use on interviewer-administered surveys, and shown below, is a promising option.

On your original birth certificate, was your sex assigned as female or male? (only one answer allowed)

- Female
- Male

In summary, your efforts to sustain support for SOGI data collection in the BRFSS, to expand these data across all states by making SOGI items part of the core survey, and to further improve the quality of these data by testing alternatives to the current measure of sex, will support the federal government in fulfilling its commitment to monitor, promote, and protect the public health and to reduce health disparities based on sexual orientation and gender identity. We thank you for your commitment to population health.

Sincerely,

Kerith Jane Conron, ScD, MPH  
Blachford-Cooper Research Director and Distinguished Scholar

Amira Hasenbush, JD, MPH  
Jim Kepner Law and Policy Fellow

Jody L. Herman, PhD  
Scholar of Public Policy

M. V. Lee Badgett, PhD  
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Ilan H. Meyer, PhD  
Williams Distinguished Senior Scholar of Public Policy

Bianca D. M. Wilson, PhD  
Rabbi Barbara Zacky Senior Scholar of Public Policy

Andrew Flores, PhD  
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Akiesha Anderson, JD  
Daniel H. Renberg Law Fellow

Soon Kyu Choi, MPP  
Policy Analyst

Taylor N.T. Brown, MPP  
Policy Analyst

## Response to the Williams Institute, UCLA School of Law

December 18, 2017

Review Committee on BRFSS  
The Williams Institute  
UCLA School of Law  
Box 951476  
Los Angeles, California

Dear Members of the Review Committee:

Thank you for your interest in the content of the Behavioral Risk Factor Surveillance System (BRFSS) and your recent comments on suggested changes to the questionnaire. We appreciate your use of the data related to Sexual Orientation and Gender Identity (SOGI) which has been included in the questionnaire as an optional module since 2014. The BRFSS is a partnership of the state health departments in all states, Washington DC and several territories, CDC programs and other federal agencies which develop and fund the questions appearing on the core and optional modules.

As you know each of the states has different priorities which determine whether it will adopt an optional module. These include specific health needs and funding provided for the administration of the module. The SOGI module has been adopted by an increasing number of states each year since its adoption. In 2017 over half of the states are including the SOGI module. The CDC can provide information on the use of data collected in modules, but the nature of the BRFSS partnership and the process for including questions requires that the modules be sponsored and supported for inclusion on the core. Currently the SOGI module is not being proposed for the core for upcoming surveys. We will provide your feedback to the CDC programs which use the SOGI data and which could potentially sponsor the questions for the core in the future. Please refer to Attachment 12 to review the process by which questions are included in the core.

Thank you again for your insight and support of the BRFSS.

Sincerely,

Carol Pierannunzi  
Senior Survey Methodologist  
Centers for Disease Control and Prevention