

Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS)

OMB Control No. 0920-1204, Exp. Date 11/30/2020

**Supporting Statement
Revision**

Part A: Justification

August 6, 2020

**Xiaoting Qin
Centers for Disease Control and Prevention
National Center for Environmental Health
Environmental Hazards and Health Effects
Asthma and Community Health Branch
4770 Buford Highway F- 60
Atlanta, GA 30341
Xqin@cdc.gov
770-488-0797**

Supporting Statement Part A

Table of Contents

A. Justification.....4

A.1 Circumstances Making the Collection of Information Necessary.....4

A.2 Purpose and Use of the Information Collection.....8

A.3 Use of Improved Information Technology and Burden Reduction.....10

A.4 Efforts to Identify Duplication and Use of Similar Information.....11

A.5 Impact on Small Businesses or Other Small Entities.....12

A.6 Consequences of Collecting the Information Less Frequently.....12

A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....12

A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....12

A.9 Explanation of Any Payment or Gift to Respondents.....14

A.10 Protection of the Privacy and Confidentiality of Information Provided by Respondents.....14

A.11 Institutional Review Board (IRB) and Justification for Sensitive Questions.....18

A.12 Estimates of Annualized Burden Hours and Costs.....19

A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers.....22

A.14 Annualized Cost to Federal Government.....22

A.15 Explanation for Program Changes or Adjustments.....22

A.17 Reason(s) Display of OMB Expiration Date is Inappropriate.....30

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions.....31

References.....29

Supporting Statement Part A

Goal: The Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS) will produce state or jurisdiction level data about asthma. The goal of this information collection is to add in-depth data about those with asthma (e.g., symptoms, environmental factors, medication use etc.) and their experiences (e.g., activity limitation, health system use, self-management education, etc.) to the BRFSS (OMB Control OMB No. 0920-1061, expiration date 03/31/2021).

Intended use of the resulting data: CDC's National Asthma Control Program (NACP) uses BRFSS ACBS data to plan for and evaluate public health programs at the state or jurisdiction level. Information collected will be used by asthma control programs located in state or jurisdiction health departments and at the federal level to improve tracking the disease, and for planning and evaluating interventions to reduce the disease burden. For most state or jurisdiction, ACBS data are the only source of asthma related health information that is targeted to state or jurisdiction asthma prevention and intervention and needs.

Methods to be used to collect data: Data will be collected through a follow-up survey approximately two days after the BRFSS survey is administered.

The subpopulation to be studied: Adult respondents (18 years and older) from BRFSS who report ever being diagnosed with asthma. Parents or guardians of children (less than 18 years), if a state includes them in BRFSS and if the randomly selected child has ever been diagnosed with asthma, then the parent or guardian will serve as the proxy respondent for the child. If both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS.

Supporting Statement Part A

A. Justification

A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is requesting a three-year Paperwork Reduction Act (PRA) clearance to conduct information collection under the “Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS) (OMB Control No. 0920-1204, expiration date 11/30/2020). CDC is seeking PRA clearance to continue to collect state or jurisdiction level asthma data for next three-year cycle. CDC’s authority to collect information for this purpose is provided by the Public Health Service Act Section 301 [241] (**Attachment 1**). Asthma indicators are vital to the health of populations, and poor asthma control results in adverse health outcomes and burden on the health care system. Asthma is the third highest cause of asthma hospitalizations among children and costs the US \$56 billion in medical costs, lost school and working days, and early deaths annually.

Asthma data need to be available at the state or jurisdictions level to track the burden of the disease, monitor adherence to asthma guidelines, direct and evaluate interventions undertaken by asthma control programs located in state or jurisdictions health departments. State or jurisdictions health departments have the primary role of targeting resources to reduce the burden of asthma. To make asthma data available to them, the CDC National Asthma Control Program (NACP) saw the need to develop the ACBS at a state or jurisdictions level to provide more detailed asthma data for disease tracking and interventions. The NACP plays a critical role in addressing the health risk of persons with asthma. The program funds state or jurisdictions health department, territorial, and the District of Columbia (collectively called “states” or “jurisdictions” in this document) programs through the BRFSS (CDC-RFA- DP15-1513). The BRFSS request for applications (RFA) funds a state-based telephone survey coordinated by the CDC with data collection occurring concurrently in each of the 50 states, Washington DC, Guam, Puerto Rico and the US Virgin Islands.

The ACBS is an ongoing data collection administered for the NACP by CDC’s National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) through their BRFSS cooperative agreement with state health departments under CDC-RFA DP15-1513 (BRFSS,

Supporting Statement Part A

OMB Control No. 0920-1061, expiration date 03/31/2021). The ACBS is an in-depth asthma survey that contains questions such as medication use, symptoms, health care use, and disease management. The respondent will be either an adult (BRFSS respondent) or child (chosen using the Random Child Selection and Childhood Asthma Prevalence module) who has ever had asthma. The ACBS sample includes all cases meeting the qualification criteria in BRFSS. The ACBS will only conduct one call-back interview per household.

Since 2015, states must collect data through cell phone and landline. The list of states participating in ACBS is provided in **Attachment 3**. The information provided reflects the number of states that participated in 2020 and the most recent year of ACBS data released in 2016.

CDC, in collaboration with the BRFSS recipients, provides standard guidelines for ACBS data collection, which all recipients are encouraged to adopt (**Attachment 4**). State BRFSS coordinators are responsible for administering the ACBS in their respective states or jurisdictions. All participating entities use the same ACBS screeners, consent forms, and questionnaires each calendar year (**Attachments 5a–5f**).

State BRFSS coordinators submit ACBS datasets using a data submission layout (**Attachment 5g–5h**) to the CDC BRFSS unit for cleaning and weighting, and they are returned to the state of origin for its use. The NACP receives the clean and public available dataset. The BRFSS unit provides technical assistance to states on methodological issues such as sample selection, data quality, weighting, and the interpretation of findings. Weighted ACBS data, documentation, analysis guidance, and asthma prevalence tables are made broadly available through the BRFSS Web site at <http://www.cdc.gov/brfss/acbs/index.htm>. The ACBS methods are described in more detail in **Supporting Statement Part B**.

Past Three-Year Accomplishments and Summary of Proposed ACBS Revisions

Supporting Statement Part A

In response to the 2017 Terms of Clearance,¹ the ACBS nonresponse bias and impact on prevalence estimation are being analyzed and reported starting with the 2015 dataset. Two response tracking tables have been added to the annual data quality report released with the public use dataset for adult and child participants

(https://www.cdc.gov/brfss/acbs/2016/pdf/sdq_report_acbs_16-508.pdf). The first table reports unweighted and weighted demographic distribution percentages for each participated state based on BRFSS-eligible asthma respondents, non-responding to the ACBS, and ACBS final completes. The second table reports estimated current asthma percentage among individuals who have ever been diagnosed with asthma. These two tables will help communicate the potential impact of nonresponse bias on the ACBS published dataset.. Annual ACBS risk factors prevalence tables will include a footnote with a hyperlink to the nonresponse report, to more clearly communicate the caveats of state-to-state comparisons

(https://www.cdc.gov/brfss/acbs/2016/prevalence_tables/table1_LLCP.html)

Based on feedback from ACBS working groups, the NACP proposes to revise the ACBS protocol to improve response (**Attachment 16**). The protocol revisions include three significant changes:

- to recommend the ACBS interview be done within two days of the BRFSS interview, instead of two weeks based on a NACP project that evaluated the lag day impact on ACBS response rates. The NACP published findings in 2019 that showed the highest ACBS response rate resulted if callback was within two days after the BRFSS interview [4]
- if both the randomly selected child and adult responding to the BRFSS have a diagnosis of asthma, to increase the child proportion from 50% up to 75% to 100% in order to maximize the child sample size; and

¹ Terms of Clearance: Approved consistent with ACBS staff commitment to collaborate with BRFSS staff to more transparently present a) joint response rates from BRFSS and ACBS and b) potential non-response bias. Tables of prevalence estimates and risk factors disseminated by CDC (either through its web page or publications) should more clearly communicate the caveats of state-to-state comparisons. Over the next three years, ACBS staff should work to streamline the instrument to reduce unnecessary burden and ensure that the question wording is synchronized with more recent studies (Issue Date 11/06/2017).

Supporting Statement Part A

- to drop the option of identifying the Most Knowledgeable Person for child respondents in the ACBS, and to move it to the BRFSS state-added questions section.

Also, in response to the 2017 Terms of Clearance,¹ the NACP undertook efforts to streamline the ACBS, reduce unnecessary burden, and ensure that the question wording is synchronized with more recent studies. The questionnaires were re-evaluated by ACBS questionnaire working groups and the ACBS recipients. Question changes and additions to the 2021 ACBS questionnaire (**Attachments 5e–5f**) are further discussed in **Section A.15**. In summary, the NACP proposes to:

- add one new question about the coordination of asthma care for 2021;
- add eight new asthma medications to the list in the Medications Section of both the child and adult questionnaires;
- remove the Comorbid Conditions Section from the adult questionnaire, as the questions are similar to the BRFSS questions; and
- remove the Complementary and Alternative Therapies Section from both questionnaires due to the low item response.

Revisions in Time Burden Requested

Although no revisions to the number of responses per respondent or the average time burden per response are requested, the NACP proposes the following changes to the burden estimation from 2017 to 2021:

- Increase the total number of responses from 61,204 to 68,846 responses (+7,642 responses); and
- Increase the annual time burden requested from 6,029 to 6,615 hours (+586 hours), based on the changes to the number of responses.

See further discussion and details on the requested revisions to burden estimation in **Section A.15**.

Supporting Statement Part A

The 60-day Federal Register Notice was published on 06/02/2020 (**Attachment 2**); and is further discussed in **Section A8**.

A.2 Purpose and Use of the Information Collection

CDC's NCCDPHP Division of Population Health administers the BRFSS parent survey, which provides the foundation for the ACBS administration and data collection. The BRFSS questionnaire data (**Attachment 7**) and the ACBS questionnaire data (**Attachments 5e-5f**) are combined for the final ACBS analysis file to link demographics, behavioral, and risk factor data with the asthma-specific data on the ACBS at the state level. Data linking is done by a sequence number (person ID) that is scrambled on the public file.

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

- The ACBS data will be used to report asthma prevalence by state. See the 2016 prevalence tables for specific details (https://www.cdc.gov/brfss/acbs/2016_tables_LLCP.html). State health department websites as well as a CDC website will be used as platforms to report ACBS data.
- The ACBS data will inform a variety of data resources, programs and organizations which use the data for asthma surveillance. These include but are not limited to National Institute for Occupational Safety and Health analysis and reporting of work-related asthma and calculating the Congressional Justification Measures of Asthma Control.
- CDC disseminates a publicly available annual ACBS dataset at the BRFSS website (see the website at www.cdc.gov/brfss/ACBS). This dataset is frequently used by public health officials in government at the national, state, and local level as well as researchers at university and non-profit organizations. Information will be used for program evaluation and reporting related to health status, risk factors, health care system use, medication use, and various indicators of asthma such as asthma attacks, prevention behaviors, and asthma control levels. Data will be appropriate for trend analyses, tests of

Supporting Statement Part A

differences among (demographic) subpopulations, multivariate analyses of health outcomes, and other statistical processes.

- The ACBS data may be used to draw comparisons from data taken from identical and/or similar questions on other surveys using other modes, thereby creating a means for validation and comparisons across population samples.
- Data collection based on state-level sampling also permits the analyses of data at the local level when sample sizes within county or MSAs are large enough for statistical interpretation. The ability to identify state and sub-state differences optimizes program interventions designed by state health departments.

Additionally, the ACBS questionnaires (**Attachments 5e–5f**) include information about the health and experiences of people with asthma on their age at first diagnosis (incidence), asthma attack prevention measures, medication use, treatment modalities, severity level, and demographic information. Key questionnaire features of the information collection help to address critical questions surrounding the health and experiences of persons with asthma, such as:

- What health, socioeconomic, and environmental risk factors exist for asthma?
- How well are asthma attacks and episodes, as well as symptoms, controlled through medications and preventive measures?
- Are asthma medications taken on a regular basis to prevent asthma symptoms or used more often as a bronchial dilator during attacks?
- What modes of care are most often utilized by persons with asthma– urgent or emergent care, hospital care, or primary care?
- Are persons with asthma educated regarding signs and symptoms of asthma and do they understand what to do when having an asthma attack?
- Have persons with asthma received a written asthma management plan from their health care provider?

Supporting Statement Part A

Consequences of not collecting the ACBS data are below:

- ACBS data are used to calculate and derive the NACP Congressional Justification Performance Measure which cannot be produced if ACBS information collection is not done.
- State level adult and child asthma prevalence data will not exist.
- Data for the proposed Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities indicators will not be produced.
- State level incidence rates cannot be produced.
- State level intervention planning and monitoring of asthma severity, control, and management and education as indicated in the expert panel three report will not be conducted.

A.3 Use of Improved Information Technology and Burden Reduction

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

Interviewers will use Computer Assisted Telephone Interview (CATI) software to enter data directly into a database. Use of CATI software promotes efficiency in two ways: skip patterns can be programmed to route respondents only to questions that they are eligible to answer, and real-time quality control checks can be used to eliminate some errors which may have been caused by manual data entry procedures. As we have been informed by BRFSS operation team, future changes to the BRFSS methods may include the elimination of landline phone numbers in the sample. This is prompted by the low percentage (approximately 4%) of US residents without cell phones, the deterioration of the accuracy of landline samples, and the streamlining of methods which would result from a single sample of phone numbers.

Supporting Statement Part A

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

Beyond asthma prevalence estimates, for most states, the ACBS provides the only sources of adult and child asthma program and case management data at the state level. Data on these topics are available at the national level through other CDC surveys (see below), but do not include sufficient sample size to determine whether there are measurable changes/trends in health risk behaviors at lower geographic levels.

The National Center for Health Statistics surveys collect data on asthma prevalence, asthma-related deaths (mortality), and several indicators of asthma-related illness (morbidity), such as hospitalizations and emergency department visits (the National Hospital Care Survey [formerly the National Hospital Discharge Survey, OMB Control No. 0920-0212, expiration date 03/31/2022], the National Hospital Ambulatory Medical Care Survey [NHAMCS, OMB Control 0920-0212, expiration date 04/30/2022], the National Ambulatory Medical Care Survey [NAMCS]), OMB Control No 0920-0278, expiration date 06/30/2021]; national surveys such as the National Health Interview Survey [NHIS, OMB Control No. 0920-0214, expiration date 12/31/2020], the National Health and Nutrition Examination Survey [NHANES; OMB Control No 0920-0950, expiration date 11/30/2021]), among others offer data for prevalence estimates at the national level. These data provide a good basis for analyzing national trends, establishing national goals, and assessing progress toward those goals, but not all can be analyzed by states and they do not have detailed data needed at the state level. ACBS differs in that it samples at state levels, and produces direct, not modeled, estimates for all states and some local geographic jurisdictions. It also provides a state level public use dataset on a broad range of asthma related topics, many of which are not included in national surveys.

Elsewhere, state prevalence may be modeled by other data collections. The NHIS has been used to model prevalence estimates at the state level. However, they do not provide sufficient data from which direct state estimates can be derived. Moreover, in most instances state level data modeled from national surveys use national level control totals for weighting, while the ACBS uses state control totals for all post-data collection raking weights. National surveys use modeled estimates to obtain state and local prevalence estimates, however, these modeled estimates

Supporting Statement Part A

cannot be used to evaluate interventions that public health programs at the state and local level may have implemented.

A.5 Impact on Small Businesses or Other Small Entities

There will be no impact on small businesses.

A.6 Consequences of Collecting the Information Less Frequently

ACBS data are collected on a monthly basis throughout the year. All BRFSS asthma eligible and ABCS respondents are asked to respond once during the yearly data collection cycle; however, state BRFSS coordinators submit de-identified data files to CDC on a monthly or quarterly basis for cleaning and weighting. The CDC BRFSS ACBS operation team returns clean, weighted data files to the state of origin for its use yearly. This frequency of monthly or quarterly reporting is necessary because the BRFSS ACBS operation team performs routine data processing tasks on an ongoing basis to track the response rate and ensure the data collection follow the protocol. Collecting this data less frequently would result in missing the timeline to correct any deviations from standard data collection procedures which may lead to low data quality.

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

There are no special circumstances and this request fully complies with 5 CFR 1320.5.

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

- A. A 60-day Federal Register Notice was published in the *Federal Register* on 06/02/2020, Vol. 85, No. 106, pp. 33670 (**Attachment 2**). CDC received two comments. One was

Supporting Statement Part A

anonymous and non-substantive. One was a request to increase the timeliness of the NACP data releases and did not require changes to the information collection request. CDC replied with a standard response (**Attachment 2a**).

B. The CDC BRFSS ACBS operation team is constantly seeking outside suggestions from other agencies for various topics, including data collection quality control, clarity of survey instruction, strategies to improve response rate, dataset uploading and downloading, and data public release elements. The ACBS operation team has a regular monthly conference meeting with outside agencies, including different states' BRFSS coordinators, ACBS data collectors, and asthma epidemiologists who are listed in Table 8.1 below. The ACBS operation team hosts an ACBS panel section during a yearly BRFSS conference to discuss and resolve issues related to ACBS operations. Our questionnaire and protocol modifications are based on their suggestions.

Table 8.1. 2020 ACBS External Consultations

Name	Title	Affiliation	Phone	Email
Judy Bass, MAS	BRFSS Program Manager	Arizona Department of Health Services	602-542-1125	Judy.Bass@azdhs.gov
Sandy Kwong, M.P.H.	Research Scientist Supervisor	California Cancer Registry	916-731-2532	sandy.kwong@cdph.ca.gov
Celeste Jorge, MPH	BRFSS Coordinator	Connecticut Department of Public Health	860-509-7695	Celeste.Jorge@ct.gov
Leah L. Atwell, MPH	BRFSS Coordinator	Florida Department of Health	850-245-4444 ext 2445	Leah.Atwell@flhealth.gov
Rana Bayakly, MPH	Chief Epidemiologist	Georgia Department of Public Health	404-657-2617	Rana.Bayakly@dph.ga.gov
Archana Pant	BRFSS Coordinator	Hawaii State Department of Health	808-586-8051	archana.pant@doh.hawaii.gov
Roland K. Lucht, MBA	BRFSS Coordinator	Illinois Department of Public Health	217-557-5283	roland.lucht@illinois.gov
Kristy Thacker	BRFSS Coordinator	Indiana State Department of Health	317-447-4520	kthacker2@isdh.in.gov
Joyce Mbugua	BRFSS Coordinator	Iowa Department Public Health	515-725-2540	Joyce.Mbugua@idph.iowa.gov
Lance Sweeney	BRFSS Advanced Epidemiologist	Kansas Department of Health & Environment	785-368-7355	Lance.Sweeney@ks.gov
Maria McKenna	BRFSS Coordinator	Massachusetts Department of Public Health	617-624-5643	maria.mckenna@state.ma.us
Allison Murad	BRFSS Coordinator	Michigan Department of Community Health	517-335-8144	MuradA@michigan.gov
Nagi Salem, PhD	BRFSS Coordinator	Minnesota Department of Health	651-201-5996	Nagi.salem@health.state.mn.us
Katie Long	BRFSS Coordinator	Missouri Department of Health and Senior	573-526-6660	Katie.Long@health.mo.gov

Supporting Statement Part A

		Services		
Hallie Koeppen, MPH	BRFSS Coordinator/Epidemiologist	Montana Department of Public Health and Human Services	406-444-2973	Hallie.Koeppen@mt.gov
Kim Lim, Ph.D. MPH	BRFSS Coordinator	Division of Public Health Services	603-271-4671	kim.c.lim@dhhs.state.nh.us
Kenneth J. O'Dowd, Ph.D., M.S.	BRFSS Coordinator	NJ Dept. of Health and Senior Services	609-984-6703	Kenneth.ODowd@doh.nj.gov
Ian Brissette, Ph.D	BRFSS Coordinator	New York State Department of Health	518-473-0673	ian.brissette@health.ny.gov
Justina Slesman	BRFSS Coordinator	Ohio Department of Health	614-466-7774	justina.slesman@odh.ohio.gov
Renee K. Boyd	BRFSS Coordinator	Oregon Health Division	971-673-1145	renee.k.boyd@state.or.us
Ruby A. Serrano-Rodriguez, MS,DrPH(c)	BRFSS Coordinator /Epidemiologist	Puerto Rico Department of Health	787-274-7828	raserrano@salud.pr.gov
Tara Cooper, MPH	BRFSS Coordinator	Rhode Island Department of Health	401-222-7628	tara.cooper@health.ri.gov
Rebecca Wood, MSHP	BRFSS Coordinator	Texas Department of State Health Services	512-776-6579	rebecca.wood@dshs.state.tx.us
Lynne M. MacLeod, M.Stat.	BRFSS Coordinator	Utah Department of Health	801-538-9466	lmacleod@utah.gov
Mallory Staskus	BRFSS Coordinator	Vermont Department of Health	802-651-1516	Mallory.Staskus@vermont.gov
Anne Ziege, Ph.D.	BRFSS Coordinator	Wisconsin Department of Health and Family Services	608-267-9821	anne.ziege@wisconsin.gov

A.9 Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents

A.10 Protection of the Privacy and Confidentiality of Information Provided by

Respondents

The ACBS is implemented as a follow-up survey through the NCCDPHP BRFSS Program. As administered, the ACBS uses the same privacy protections as outlined in the BRFSS protocol (**Attachment 6**) and as summarized in the BRFSS Supporting Statement A Section A.10 (OMB Control No. 0920-1061, expiration date 03/31/2021) (**Attachment 6a**). The NCCDPHP BRFSS Program has determined that the Privacy Act does not apply to their data collection procedures. States are responsible for developing and maintaining procedures to ensure respondents' privacy,

Supporting Statement Part A

assure and document the quality of the interviewing process, and supervise and monitor trained interviewers.

Overview of the BRFSS and the ACBS Data Collection System

Random digit dialing (RDD) telephone samples will be delivered to the states on a monthly or quarterly schedule. Information collection will be implemented by state health departments or their designees. States will administer the core/rotating/emerging core questions without change. Field operations are managed by state health departments and/or their contractors following The Data Collectors' Protocol provided by the BRFSS (**Attachment 4, 6**). States submit data to CDC BRFSS operation team for final cleaning, weighting, the production of analysis datasets, and other technical assistance as needed. Computer-assisted telephone interviewing (CATI) programming is provided by the CDC to states to convert the BRFSS questionnaire into a CATI interface from which interviewers will read and record answers to each question. States may opt to use their own CATI programming software. States run edit checking programs (CDC-provided) against the data and submit to the CDC on a monthly/quarterly basis. CDC then conducts additional data quality processes and summarizes the data in YTD reports provided to the states. At the end of each calendar year, data are finalized and weighted.

Respondents for ACBS are the subset of BRFSS adults, 18 years and older, in participating states who report ever being diagnosed with asthma. Some states include children, below 18 years of age, who are randomly selected subjects in the BRFSS household. In participating states, parents or guardians serve as ACBS proxy respondents for their children ever diagnosed with asthma. Children do not respond directly to the ACBS questionnaire. If both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in a flowchart (**Attachment 9**).

The datasets provided to the states at the end of the year include a large number of variables on calling attempts, final calling outcomes, questionnaire item responses and calculated variables. A subset of the dataset provided to the states is published on the BRFSS website for public use (<http://www.cdc.gov/brfss/acbs/index.htm>). BRFSS ACBS operation team is responsible for data processing and intermediate dataset storage security, The NACP at the Asthma and Community Health Branch only receives a deidentified public use dataset.

Supporting Statement Part A

Items of Information to be Collected in ACBS

The ACBS questionnaire (**Attachment 5e-5f**) includes information on medication use, symptoms, health care use, and disease management, and environmental risk factor. The basic demographic information was transferred from BRFSS dataset. Other than phone numbers, which are part of the original sample files sent to the states, no information in individually identifiable form (IIF) will be collected from respondents during the telephone interviews. When states gained the ACBS consent in BRFSS, first names were asked to ensure that the ACBS interview is conducted with the same individual. The ACBS operation team uses the HHS Safe Harbor guidelines (<https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>) to determine suppression of variables from public use information. Researchers who request access to information not provided in the public use dataset may use the Research Data Center (RDC) hosting agreement with the BRFSS and Asthma and Community Health Branch. States must develop and maintain procedures to ensure respondents' privacy, assure and document the quality of the interviewing process, and supervise and monitor trained interviewers. The CDC provides states with guidelines for training interviewers and standard procedures for monitoring a minimum of 10% of all interviews. ACBS data storage and confidentiality of responses followed the BRFSS protocol (**Attachment 6, 6a**).

IIF (e.g., first name, initials) is collected (**Attachments 5a–5d**) by the states during field operations as part of routine collection for the purposes of call back and to ensure completion of the interview with the respondents. The final ACBS datasets delivered to CDC will not contain the participant's initials or name.

How Information Will Be Shared and For What Purpose

Since state health departments and/or their designees are the data collectors for the ACBS, information will originate with the states. States may determine whether and how their data will be released to third parties. The CDC maintains an upload website by which data are submitted monthly/quarterly. CDC does not transmit data from one state to any other, with the exception of cell phone interviews of persons who have an area code from one state, but who actually live in another state. Telephone numbers are not linked to respondents. Files containing RDD telephone samples are kept separately from files which include responses to questionnaire items. CDC

Supporting Statement Part A

receives only de-identified records. Sample files contain sequence numbers which are provided by the sampling vendor and used by data collectors (the states or their designees) to determine calling outcomes for each phone number. The CDC does not receive full phone numbers in the sample file. Sample files received by the CDC and states which have contracted data collection include only area code and prefixes of phone numbers which are associated with sequence numbers. States which have internal data collection systems and contracted data collectors have sole access to both sequence numbers and full phone numbers during the data collection process. States keep responses to the BRFSS questionnaire separately from sample files. After data collection, sequence numbers are recoded to prevent subsequent links of sample files and responses to questions by any person or organization involved in data collection. State level data sets are owned by individual states. A subset of state data sets is provided for public use. Public use data sets have been stripped of a number of variables which provide locational information on the respondents including zip codes, and county identifiers for counties with adult populations of less than 10,000, occupational information, uncategorized ages of respondents, and detailed race. CDC may provide data with locational information for internal users to produce small area estimates of health indicators.

Impact of the Proposed Collection on Respondents' Privacy

ACBS sample files from BRFSS asthma eligible respondents, include phone numbers only. Since sample files are separate from datasets, no phone numbers are included in the datasets. No dates of birth, last names, or email address are obtained. Information that details race/ethnicity, occupation and small geographic residence (such as county or zip code) is transferred from BRFSS and suppressed in the public use dataset based on BRFSS protocol. In order to determine which variables to suppress, the BRFSS ACBS uses the HHS Safe Harbor guidelines (<https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>).

How Individuals Are Informed That Providing Information Is Voluntary or Mandatory

Individuals participating in the ACBS are informed that they do not have to participate and that they may refuse to answer any question (**Attachment 5a-5f**).

Supporting Statement Part A

Opportunities to Consent

Verbal consent for recontact and follow-up is obtained during the initial BRFSS contact and screening process (see **Attachment 5a-5d**). Verbal consent for participating in the ACBS is obtained during the follow-up call. The introductory script and informed consent, including the voluntary nature of the survey, precede the survey questions (see **Attachment 5e-5f**).

How Information Will Be Secured

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

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

The ACBS information collection has been reviewed by the NCEH/ATSDR Human Subjects Contact. This CDC collection has been classified as a non-research public health surveillance activity undertaken by a public health authority as defined in 45 CFR 46. Thus, IRB review is not required (**Attachment 8a**).

The BRFSS Program classifies its activity as exempt research as approved by the CDC Human Research Protection Office (**Attachment 8b**) Some state IRBs require that BRFSS respondents be specifically asked if their BRFSS responses could be linked to their ACBS responses. Other state IRBs do not. If consent is denied, the ACBS is not conducted and there will be no record in the file. The state-specific consent scripts are maintained by each participating state. Individuals participating in the ACBS are informed that they do not have to participate and that they may refuse to answer any question during the consent/permission process and before survey administration. See **Attachments 5e-5f** for CDC suggested consent templates.

Supporting Statement Part A

The BRFSS includes standard demographic questions (such as race and income category) which may be considered sensitive (**Attachment 6**). This information is included in the ACBS final dataset. There are no questions of sensitive nature on the ACBS (**Attachments 5e-5f**).

A.12 Estimates of Annualized Burden Hours and Costs

The estimated burden to respondents is summarized in Table A12-1 below. Within the selected BRFSS household, ACBS respondents are adults 18 years or older with an asthma diagnosis or parents or guardians of a randomly selected child, below 18 years, with an asthma diagnosis. Children do not respond directly to the ACBS; parents or guardians provide proxy responses for children. Respondent burden is estimated separately for each step. The number of interviews varies from state to state, based on the population size, lifetime asthma prevalence, and response rate of each state. For states conducting both landline and cellphone samples, approximately 50 percent of interviews are currently conducted on landlines and 50 percent on cell phones. The burden calculation was computed based on the states that implemented both landline and cellphone samples in 2016 because this will be the data collection mode for all participating states starting in 2021. The estimated number of recipients will remain as approved in 2017 (n=40), in case program funding increases above the current 32 recipients. Since the cooperation rate (based on AAPOR cooperation rate #2 – **Attachment 12**) in 2016 was 54.6 percent for landline respondents and 53.1 percent for cellphone respondents, it is estimated that 20,376 landline respondents and 20,557 cell phone respondents will complete the consent screening questions. The estimated burden per screening response is one minute for adults, and one minute for children. The ACBS screener documents are provided in **Attachments 5a–5d**.

Respondents who are eligible for the ACBS and agree to participate will be contacted again within two days to complete the ACBS questionnaire (**Attachments 5e–5f**). We estimate that total of 26,953 respondents screened on both landline and cell phones will participate in the ACBS data collection (23,166 adults and 3,787 children).

For the ACBS, states administer one questionnaire for adult respondents and a similar questionnaire for the randomly selected child in the household. Again, if both the BRFSS adult

Supporting Statement Part A

respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in **Attachment 9**.

We estimate the average burden for the ACBS survey at 10 minutes per response. The burden hour estimates reflect the landline and cell phone data collection method that will be used starting 2021.

Additionally, the burden table accounts for reporting burden incurred by the states for the monthly or the quarterly data submission to CDC. For the purpose of this information collection, monthly data submission is assumed for the time burden and the average burden for the ACBS data reporting is estimated at three hours per response (or 180 minutes). Therefore, based on the annualized percentage of adult and child ACBS surveys (86% and 14%, respectively), we estimate that 155 minutes will be spent reporting adult, and 25 minutes will be spent reporting child, ACBS data back to the CDC per month.

The total time burden requested is **6,615** hours.

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

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs.)	Total Burden Hours
BRFSS Adults	ACBS Landline Screener – Adult	17,800	1	1/60	297
	ACBS Cell Phone Screener – Adult	16,733	1	1/60	279
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	2,576	1	1/60	43
	ACBS Cell Phone Screener – Child	3,824	1	1/60	64
ACBS Adults	ACBS Adult Consent and Questionnaire	23,166	1	10/60	3,861
ACBS Parents or Guardians of Children	ACBS Child Consent and Questionnaire	3,787	1	10/60	631
State BRFSS Coordinators	ACBS Adult Data Submission Layout	40	12	155/60	1,240
	ACBS Child Data	40	12	25/60	200

Supporting Statement Part A

	Submission Layout				
Total					6,615

Annualized burden costs are summarized in the table below. Hourly rates were taken from the Bureau of Labor Statistics May 2019 National Industry-Specific Occupational Employment and Wage Estimates (available at https://www.bls.gov/oes/current/oes_nat.htm#00-0000).

Occupation Code	Occupation Title	Mean Hourly Wage
00-0000	All Occupations	\$25.72
11-9111	Medical and Health Services Managers	\$55.37

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

Type of Information Collection	Form Name	Number of Respondents	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
BRFSS Adults	ACBS Landline Screener - Adult	17,800	297	\$25.72	\$7,630.27
	ACBS Cell Phone Screener - Adult	16,733	279	\$25.72	\$7,172.88
BRFSS Parents or Guardians of Children	ACBS Landline Screener - Child	2,576	43	\$25.72	\$1,104.25
	ACBS Cell Phone Screener - Child	3,824	64	\$25.72	\$1,639.22
ACBS Adults	ACBS Adult Consent and Questionnaire	23,166	3,861	\$25.72	\$99,304.92
ACBS Parents or Guardians of Children	ACBS Child Consent and Questionnaire	3,787	631	\$25.72	\$16,233.61
State BRFSS Coordinators	ACBS Adult Data Submission Layout	40	1,240	\$55.37	\$68,658.80
	ACBS Child Data Submission Layout	40	200	\$55.37	\$11,074.00
Total			6,615		\$205,187.67

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

There are no maintenance or capital costs to respondents.

Supporting Statement Part A

A.14 Annualized Cost to Federal Government

Costs that are presented below include data collection, weighting, and sampling as well as data distribution (i.e., websites and production of data sets). These are based on the 2016 funds provided to states for data collection as well as internal BRFSS costs.

Table 14.1. Annualized Cost to the Federal Government

Funds provided to 32 ACBS recipient states and Puerto Rico	\$900,000
Funds provided to BRFSS (administration and data processing)	\$600,000
Survey planning and documenting for Federal Employees	\$200,000
Total	\$1,700,000

A.15 Explanation for Program Changes or Adjustments

Proposed ACBS Protocol Changes

Survey protocol (**Attachment 16**) and questionnaire revisions (**Attachment 5e-5f**) have been made to the ACBS child survey in identifying eligible asthma children based on BRFSS random child section module and childhood asthma prevalence module. The most knowledgeable adult answers the child survey and can be a parent or guardian or a different person pointed by a parent or guardian as a most knowledge adult to conduct the child ACBS interview. Prior to 2019, the protocol had two scripts provided to states, in which the state could choose to identify the most knowledgeable person at the end of BRFSS survey or at the beginning of the child ACBS interview. By comparing response rates of the two scripts, identifying the most knowledge person at the beginning of the ACBS had a lower response rate (around 5%) compared to identifying the s/he at the end of the BRFSS. Therefore, a new protocol proposes that states identify the most knowledge person at the time of the BRFSS survey and record it in the state-added questions section, and not in the public release dataset. The Introduction of the Child asthma questionnaire is revised to drop the option of identifying the MKP at the ACBS interview and to keep Appendix A where MKP is identified during the BRFSS (**Attachment 16**).

Supporting Statement Part A

A proposal has been made to revise the ACBS protocol to improve the response rate (**Attachment 4 and Attachment 16**). Lag days are the number of days between BRFSS interview completion date and the ACBS interview date when the final disposition code was assigned. Lag days have a significant impact on the ACBS response rate. A research paper published in 2019, determined that the highest ACBS response rate resulted if callback was within two days after the BRFSS interview [4]. Based on that assessment, the 2021 ACBS protocol changes the interview to be done within two days, instead of within two weeks, of the BRFSS interview.

In order for a state to include children in the ACBS, it must have the Random Child Selection and Childhood Asthma Prevalence modules in the BRFSS. If a randomly selected child for the BRFSS has a diagnosis of asthma, then he/she is eligible for the ACBS. If both the randomly selected child and adult responding to the BRFSS have a diagnosis of asthma, then one is eligible for the ACBS. Proposed protocol revisions to improve response rates include increasing the child proportion from 50% (in 2017) up to 75% or 100% to increase the child sample size.

Proposed Questionnaire Changes

Question changes and additions to the 2021 ACBS questionnaire (**Attachments 5e-5f**) are based on the feedback from ACBS working groups. Changes to existing questions and additions of new questions to the 2021 child and adult ACBS questionnaires are included in Table. A15.1 and A15.2. A proposed total of 7 questions will be deleted from the questionnaire. These 7 questions only applied to those who currently have asthma (65% of the respondents). The addition of one new question and 8 new medications were such that the estimated time burden for the interview will remain unchanged from that of the 2017 questionnaire (10 minutes per response).

Studies have found that care coordination for asthma care can improve asthma control and self-reported asthma-management knowledge and confidence, and eventually lead to reduced asthma-related emergency department visits, hospitalizations, and health care costs [1,2,3]. There are currently no population-based studies in the U.S. that estimate prevalence of care coordination for asthma care, on a national or state level. One asthma care coordination question that was adopted and modified was Question D7 from the CDC's National Center for Health Statistics (NCHS) National Survey of Children's Health. The modifications included inserting "asthma" to

Supporting Statement Part A

the question and adding an optional follow-up question. On the 2021 ACBS a question on coordination of care was added (Tables A15.1 and A15.2).

A set of new medications list was added to Section 8 “Medication Name List” for both adult and child questionnaires to reflect the most current medication use for asthma treatment.

The Adult Section 11 of “Comorbid Conditions” strongly overlapped with BRFSS main survey questions, therefore, the entire section was removed from the 2021 questionnaire.

Section 12 of “Complementary and Alternative Therapy” was removed from both adult and child questionnaires since the use of alternative methods to control asthma is not an essential measure for asthma control.

Table A15.1. Changes in ACBS Adult Questions (ACBS Attachment 5e)

We propose the following modified (M) and new (N) questions for the 2021 ACBS compared with the original (O) 2017 ACBS Adult Questionnaire (OMB Control OMB No. 0920-1204, expiration date 11/30/2020).

STATUS	CHANGE	JUSTIFICATION OR SOURCES
SECTION 1 - INTRODUCTION		
M	Add if conducting the survey via a cellphone, read: “Is this a safe time to talk with you now or are you driving?”	Recommended safety precaution
SECTION 2 - INFORMED CONSENT		
O	No Changes	N/A
SECTION 3 - RECENT HISTORY		
O	No Changes	N/A
SECTION 4 - HISTORY OF ASTHMA (<i>Symptoms & Episodes in the Past Year</i>)		
M	Delete Question 4.8: “Compared with other episodes or attacks, was this most recent attack shorter, longer, or about the same?”	This is not a clear indicator for asthma symptoms.
SECTION 5 - HEALTHCARE UTILIZATION		
N	Add Question 5.10: During the past 12 months, does anyone help you arrange or coordinate your <i>asthma</i> care among the different doctors or services that you use? (READ IF NECESSARY: By “arrange or	Adopt and modify NCHS Question D7 from the NCHS survey by inserting “asthma” and adding the optional follow-on question. Base question source: NCHS’ National Survey of Children’s Health:

Supporting Statement Part A

	<p>coordinate,” I mean: Is there anyone who helps you make sure that you get all the health care and services you needs, that health care providers share information, and that these services fit together and are paid for in a way that works for you?)</p> <p>(1) YES (2) NO (7) DON'T KNOW (9) REFUSED</p>	<p>https://www.census.gov/content/dam/Census/programs-surveys/nsch/tech-documentation/questionnaires/2019/NSCH-T1.pdf</p> <p>The primary purpose of adding this question is to provide more detailed state-level information regarding the prevalence of care coordination for asthma care among adults in state-level and nationwide. Asthma affects about 25 million Americans and about 40% of Americans with asthma do not have control of their disease. Studies have found that care coordination for asthma care can improve asthma control, and reduce asthma-related emergency department visits, hospitalizations, health care costs, and missed school or work days. Yet, there are no population-based studies in the U.S. that estimate prevalence of care coordination for asthma care, nationally or state-level.</p>
SECTION 6 - KNOWLEDGE OF ASTHMA/MANAGEMENT PLAN		
<input type="radio"/>	No Changes	N/A
SECTION 7 - MODIFICATIONS TO ENVIRONMENT		
<input type="radio"/>	No Changes	N/A
SECTION 8 - MEDICATIONS		
M	<p>Questions 8.9 and 8.27: Add new asthma medications in name serious list.</p> <ul style="list-style-type: none"> • Q8.9: add 7 new inhalers to the ACBS inhaler list and a new type of medication group • Q8.27: Add one new Nebulizer to the nebulizer list • No changes to the ACBS Pill or Syrup List 	<p>Update the asthma medication lists to capture the most up-to-date information regarding asthma treatment in clinical practice, which is consistent with current asthma treatment guidelines.</p>
SECTION 9 - COST OF CARE		
<input type="radio"/>	No Changes	N/A
SECTION 10 - WORK-RELATED ASTHMA		
<input type="radio"/>	No Changes	N/A
SECTION 11 - COMORBID CONDITIONS		

Supporting Statement Part A

M	Delete entire Section 11.	Reducing burden and unnecessary duplication. "Comorbid Conditions" questions are already included in the BRFSS.
SECTION 12 - COMPLEMENTARY AND ALTERNATIVE THERAPY		
M	Delete entire Section 12.	Reducing burden. Participant use of alternative methods to control asthma is not an essential measure for asthma control.
End of Questions		

Table A15.2. Changes of ACBS Child Questions (ACBS Attachment 5f)

We propose the following modified (M) and new (N) questions for the 2021 ACBS compared with the original (O) 2017 ACBS Child Questionnaire (OMB Control OMB No. 0920-1204, expiration date 11/30/2020).

STATUS	CHANGE	JUSTIFICATION OR SOURCES
SECTION 1 - INTRODUCTION		
M	Drop the Appendix B option "Identifying the Most Knowledgeable Person/Parent (MKP)" at the ACBS interview. <i>For states identifying the Most Knowledgeable Person/Parent (MKP) at the BRFSS interview use language in Appendix A.</i> Add if conducting the survey via a cellphone, read: "Is this a safe time to talk with you now or are you driving?"	Previously, Appendix A and Appendix B options allowed states to ask for the MKP during either the BRFSS or the ACBS interview, respectively. For 2021, all BRFSS states will implement Appendix A "Identifying the Most Knowledgeable Person/Parent (MKP)" during the BRFSS interview. Recommended safety precaution
SECTION 2 - INFORMED CONSENT		
O	No Changes	N/A
SECTION 3 - RECENT HISTORY		
O	No Changes	N/A
SECTION 4 - HISTORY OF ASTHMA (SYMPTOMS AND EPISODES IN THE PAST YEAR)		
M	Delete Question 4.8: "Compared with other episodes or attacks, was this most recent attack shorter, longer, or about the same?"	This is not a clear indicator for asthma symptoms.
SECTION 5 - HEALTH CARE UTILIZATION		
N	Add Question 5.14: During the past 12 months, does anyone help you arrange	Adopt and modify NCHS Question D7 from the NCHS survey by inserting

Supporting Statement Part A

	<p>or coordinate {child’s name}’s asthma care among the different doctors or services that [he/she] uses?,</p> <p>(READ IF NECESSARY: By “arrange or coordinate,” I mean: Is there anyone who helps you make sure that {child’s name} gets all the health care and services [he/she] needs, that health care providers share information, and that these services fit together and are paid for in a way that works for you?)</p> <p>(1) YES (2) NO (7) DON'T KNOW (9) REFUSED</p>	<p>“asthma” and adding the optional follow-on question.</p> <p>Base question source: NCHS’ National Survey of Children’s Health: https://www.census.gov/content/dam/Census/programs-surveys/nsch/tech-documentation/questionnaires/2019/NSCH-T1.pdf</p> <p>The primary purpose of adding this question is to provide more detailed state-level information regarding the prevalence of care coordination for asthma care among children in state-level and nationwide. Asthma affects about 25 million Americans and costs over \$80 billion annually; about 40% of Americans with asthma do not have control of their disease, leading to emergency department visits, hospitalizations, and missed school or work days. Studies have found that care coordination for asthma care can improve asthma control, increase appropriate medication use, and reduce asthma-related emergency department visits, hospitalizations, hospital readmissions, health care costs, and missed school or work days. Yet, there are no population-based studies in the U.S. that estimate prevalence of care coordination for asthma care, nationally or state-level.</p>
SECTION 6 - KNOWLEDGE OF ASTHMA/MANAGEMENT PLAN		
O	No Changes	N/A
SECTION 7 - MODIFICATIONS TO ENVIRONMENT		
O	No Changes	N/A
SECTION 8 - MEDICATIONS		
M	<p>Questions 8.9 and 8.25: Add new asthma medications in name serious list.</p> <ul style="list-style-type: none"> • Q8.9: add 7 new inhalers to the ACBS inhaler list and a new type of 	<p>Update the asthma medication lists to capture the most up-to-date information regarding asthma treatment in clinical practice, which is consistent with current</p>

Supporting Statement Part A

	medication group • Q8.25: Add one new Nebulizer to the nebulizer list • No changes to the ACBS Pill or Syrup list	asthma treatment guidelines.
SECTION 9 – COST OF CARE		
O	No Changes	N/A
SECTION 10 – SCHOOL-RELATED ASTHMA		
O	No Changes	N/A
SECTION 11 – COMPLEMENTARY AND ALTERNATIVE THERAPY		
M	Delete entire Section 11.	Reducing burden. Participant use of alternative methods to control asthma is not an essential measure for asthma control.
SECTION 12 – ADDITIONAL CHILD DEMOGRAPHICS		
M	Change section title: SECTION 11	Move the section number up to “11”
End of questions		

Revisions in Time Burden Requested

Although no revisions to the number of responses per respondent or the average time burden per response are requested, the NACP proposes the following changes to the burden estimation from 2017 to 2021:

- Increase the total number of responses from 61,204 to 68,846 responses (+7,642 responses) due to:
 - a proposed increase of 4,050 BRFSS consent screenings, from 36,883 to 40,933 respondents adjusted based on data from the states that implemented both landline and cellphone samples for adults and children in 2016; and
 - a proposed increase of 3,112 ACBS respondents, from 23,841 to 26,953 respondents adjusted based on data from the states that implemented both landline and cellphone samples for adults and children in 2016.
 - no change to the number of state BRFSS coordinators (n=40). In 2017, we submitted a combined response and time burden estimate for adult and child

Supporting Statement Part A

ACBS results in a single row in the burden estimate (n=480 responses; n=1,440 hours) . For 2021, we have more accurately split the reporting for adult and child ACBS results into two rows in the burden table; therefore, this doubled the number of responses but did not affect the time burden requested (n=960 responses; n=1,440 hours). The time burden for adult and child ACBS reporting is based on the proportion of adult vs. child ACBS questionnaires per year (86.1% vs. 13.9%, respectively).

- Based on the above changes to the number of responses and respondents, we propose an increase in the annual time burden from 6,029 to 6,615 hours (+586 hours).

Table A15.3. Net Change in Annualized Number of Responses and Time Burden in 2021 Relative to 2017

No revisions to the number of responses per respondent or the average time burden per response are requested. Changes to the estimated number of respondents and resulting burden hours are reflected below.

Type of Respondents	Form Name	ICR Year	No. of Responses	Total Burden Hours	Net Change in Responses and Burden Hours, 2021
BRFSS Adults	ACBS Landline Screener – Adult	2017	21,424	357	-3,624 resp -60 hours
		2021	17,800	297	
	ACBS Cell Phone Screener – Adult	2017	8,976	150	+7,757 resp +129 hours
		2021	16,733	279	
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	2017	4,245	71	-1,669 resp -28 hours
		2021	2,576	43	
	ACBS Cell Phone Screener – Child	2017	2,238	37	+1,586 resp +27 hours
		2021	3,824	64	
ACBS Adults	ACBS Adult Consent and Survey	2017	19,954	3,326	+3,212 resp +535 hours
		2021	23,166	3,861	
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey	2017	3,887	648	-100 resp -17 hours
		2021	3,787	631	
State BRFSS	ACBS Data	2017	480	1,440	±480 resp

Supporting Statement Part A

Coordinators	Submission Layout	2021	960	(1,240+200 =) 1,440	±0 hours
Total Net Change in Responses and Burden Hours, 2021					+7,642 resp +586 hours

Table A.15.3 shows how the number of respondents by respondent type and form is estimated to change. The burden calculation for screening BRFSS adults and BRFSS parents/guardians was computed based on the states that implemented both landline and cellphone samples in 2016 because this will be the data collection mode for all participating states starting in 2021. Therefore, there will be a marked shift toward cellphone screening in 2021 for both BRFSS adults and BRFSS parents/guardians of children, relative to the burden estimates in 2017.

In 2021, there will be an estimated increase in the distribution of BRFSS and ACBS adults and their time burden ([+4,133 respondents and +69 hours] vs. [+3,212 respondents and +535 hours], respectively). On the other hand, there will be an estimated decrease in the distribution of BRFSS and ACBS parents/guardians responding for their children ([-83 respondents and -1 hour] vs. [-100 respondents and -17 hours], respectively).

Table A.15.3 shows how the net increase of 7,642 responses and 586 burden hours were derived,

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

The expiration date of OMB approval will be displayed.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

References

1. Kelly, R & Stoll, Shelley & Bryant-Stephens, Tyra & Janevic, Mary & Lara, Marielena & Ohadike, Yvonne & Persky, Victoria & Ramos-Valencia, Gilberto & Uyeda, Kimberly & Malveaux, Floyd. (2015). The Influence of Setting on Care Coordination for Childhood Asthma. Health promotion practice. 16. 10.1177/1524839915598499

Supporting Statement Part A

2. Mary R. Janevic, Alan P. Baptist, Tyra Bryant-Stephens, Marielena Lara, Victoria Persky, Gilberto Ramos-Valencia, Kimberly Uyeda, Rebecca Hazan, Ashley Garrity & Floyd J. Malveaux (2017) Effects of pediatric asthma care coordination in underserved communities on parent perceptions of care and asthma-management confidence, *Journal of Asthma*, 54:5, 514-519, DOI: 10.1080/02770903.2016.1242136
3. Isik, E, Isik, IS. (2019) Asthma care coordination in schools by school nurses: An integrative literature review. *Public Health Nurs.*; 36: 498– 506.
<https://doi.org/10.1111/phn.12610>
4. Qin X, Bailey CM, Zahran HS. Comparison response patterns on landline and cell phone in a call back survey: effects of demographic characteristics and lag days. *Survey Methods Insights Field*. 2019; 2019:10.13094/SMIF-2019-00019. doi:10.13094/SMIF-2019-00019