

**Teen and Parent Surveys of Health (TAPS)**

0920-new

**Supporting Statement – Section A**

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# Table of Contents

<b>SECTION A - JUSTIFICATION</b> .....	4
<b>A.1. Circumstances Making the Collection of Information Necessary</b> .....	5
<b>A.2. Purpose and Use of the Information Collection</b> .....	6
<b>A.3. Use of Improved Information Technology and Burden Reduction</b> .....	10
<b>A.4. Efforts to Identify Duplication and Use of Similar Information</b> .....	11
<b>A.5. Impact on Small Business or Other Small Entities</b> .....	12
<b>A.6. Consequences of Collecting the Information Less Frequently</b> .....	12
<b>A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5</b> .....	12
<b>A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency</b> 12	
<b>A.9. Explanation of Any Payment or Gift to Respondents</b> .....	13
<b>A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents</b> .....	15
<b>A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions</b> .....	16
<b>A.12. Estimates of Annualized Burden Hours and Costs</b> .....	18
<b>A.13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers</b> .....	21
<b>A.14. Annualized Cost to the Government</b> .....	21
<b>A.15. Explanation for Program Changes or Adjustments</b> .....	21
<b>A.16. Plans for Tabulation and Publication and Project Time Schedule</b> .....	22
<b>A.17. Reason(s) Display of OMB Expiration Date is Inappropriate</b> .....	23
<b>A.18. Exceptions to Certification for Paperwork Reduction Act Submissions</b> .....	23

## **LIST OF ATTACHMENTS**

1. Public Health Service Act (PHSA) 42 U.S.C
2. 60-Day Federal Register Notice
- 2a. 60-Day Federal Register Notice Comments
3. Teen Survey Screenshots
4. Parent/Caregiver Survey Screenshots
5. Privacy Impact Assessment (PIA)
6. Consent Form parent
7. Consent Form teen
8. NORC IRB Approval Letter
9. NORC IRB Amendment Approval Letter
10. Adolescent Survey
11. Parent/Caregiver Survey
12. Technical Overview of the AmeriSpeak Panel NORC's Probability-Based Research Panel
13. Phone Script
14. Sample SMS Prompts
15. Teen Survey Recruitment Email
16. Parent Survey Recruitment Email
17. Teen Survey Invitation Letter
18. Teen Survey Reminder Letter
19. Teen Survey Final Reminder Letter
20. Parent Survey Invitation Letter
21. Parent Survey Reminder Letter

**Goal of the study:** To collect data from a national sample of adolescents ages 15 to 19 years and a subsample of matched parents/guardians to (1) describe the prevalence of key factors that protect young people's health (including family and school-level protective factors), health education experiences, health service use, and health behaviors and experiences and (2) examine associations between these factors and adolescent mental health, sexual and reproductive health, and substance use outcomes.

**Intended use of the resulting data:** Data will be used to inform the CDC's Division of Adolescent and School Health's (DASH) key school-based programmatic strategies of improving family- and school-level protective factors, bolstering health education, and increasing adolescent access to quality health services. Collecting primary data provides the opportunity to examine untested associations of these strategies with mental health, sexual health, and substance use outcomes. Additionally, this survey research complements and extends DASH's ongoing surveillance efforts.

**Methods to be used to collect:** Using the AmeriSpeak existing online survey panels, a one-time, cross-sectional national sample of 15-19 year-old young people and a subset of matched parents/caregivers will be selected, invited, and consented and/or assented to participate in a web-based survey. Respondents will complete the self-administered web survey on their computer, phone, or tablet.

**The subpopulation to be studied:** A national sample of adolescents ages 15 to 19 years will be generated. Additionally, the project will survey a matched parent/primary caregiver for the sub-sample of respondents ages 15-17 years of age.

**How data will be analyzed:** Appropriate statistical analyses of quantitative survey data will be used, including, but not limited to, frequencies, chi-squares, and logistic regressions.

**Impact of Covid-19 on this collection:** This collection is not affected by the Covid-19 pandemic. The recruitment and subsequent collection activities are impacted by masks and or social distancing requirements as this is an online survey.

## **SECTION A - JUSTIFICATION**

### **A.1. Circumstances Making the Collection of Information Necessary**

The Centers for Disease Control and Prevention (CDC) requests a 2-year approval for a new information collection entitled, “Teen and Parent Surveys (TAPS)” for the one-time collection of quantitative information from a national sample of 15- to 19-year-olds and a subset of their parents/caregivers.

This project will gather information on protective factors (e.g. communication with parents, school connectedness), health education experiences, health service use, adolescent behavior, and mental health, sexual health, and other health outcomes, allowing CDC’s Division of Adolescent and School Health’s (DASH) to inform key school-based programmatic strategies of improving family- and school-level protective factors, bolstering health education, and increasing adolescent access to quality health services.

#### **Background**

Documenting health-related risk behaviors and experiences and health outcomes of young people through routine surveillance is a critical component of DASH’s prevention efforts. Another component of DASH’s efforts to improve adolescent health is observational research to inform its school-based programmatic strategies. This type of research serves to inform priority settings and sub-populations for intervention as well as specific intervention strategies. To the extent possible, DASH uses secondary data sources for such research (e.g., National Survey of Family Growth, National Longitudinal Study of Adolescent to Adult Health), but has identified a need to collect primary data from a national sample of adolescents to complement what is already known through existing surveys. Of particular importance are factors that protect adolescents from harm and promote positive health and well-being. Specifically, there is interest in three areas that are the current focus of DASH’s school-based HIV/STD prevention approach: family- and school-level protective factors, health education, and health services. DASH’s funding to local education agencies supports work in these areas given their known impact on relevant health behaviors and outcomes. Protective factors such as parent-adolescent communication, parental monitoring, and school connectedness are associated with reductions in adolescent sexual behaviors and STD diagnosis in adulthood.<sup>1-5</sup> Sexual health education programs and preventive services (e.g., STD testing) are similarly associated with reductions in adolescent sexual risk behaviors and adverse outcomes.<sup>6-10</sup> Moreover, family and school-level protective factors have benefits across other health outcomes of interest to DASH, including mental health, substance use, and violence,<sup>11-13</sup> and health education and services can be tailored to address these outcomes, either individually or as part of a comprehensive, integrated approach to adolescent health.

Although evidence suggests these factors are valuable to promote as part of primary prevention efforts, there are some gaps in what is known. For example, there is limited recent national data on the prevalence of family- and school-level protective factors, and associations with health information- and health care-seeking have not been well-studied.

Collecting primary data also provides the opportunity to examine untested associations with sexual behavior outcomes, including those not typically measured in national surveillance systems. Likewise, associations with mental health, substance use and violence can be explored, considering indicators not included in existing surveillance systems. Including additional constructs and operationalizations as part of survey research would complement and extend DASH's surveillance efforts.

CDC is authorized to collect the data described in this request by Section 301 of the Public Health Service Act (42 USC 241). A copy of this enabling legislation is provided in **Attachment 1**. In addition to this legislation, there are several national initiatives and programs that this information collection would serve to support, including but not limited to:

- *Healthy People 2030*, which provides national health objectives and outlines a comprehensive plan for health promotion and disease prevention in the United States. Of the Healthy People 2030 objectives, many objectives align specifically with topics and evaluation questions generated from TAPS data, including many related to increasing protective factors like connections to parents or trusted adults, increased screening and treatment of mental health issues for adolescents, and reducing HIV infection, other STD, and pregnancy among adolescents.<sup>14</sup>
- *Ending the HIV Epidemic (EHE)*, an initiative to end the HIV epidemic in the United States within 10 years. This initiative will prioritize 57 geographic focus areas for first year efforts, and 20 of these overlap with communities in which CDC/DASH currently funds education agencies, offering opportunities for alignment between CDC/DASH efforts and the national EHE initiative.<sup>15</sup>
- The National Prevention Strategy (NPS) calls for “medically accurate, developmentally appropriate, and evidence-based sexual health education.” The NPS encourages the involvement of parents in educating their children about sexual health, the provision of sexual and reproductive health services, and the reduction of intimate partner violence.<sup>16</sup>

## **A.2. Purpose and Use of the Information Collection**

These data will allow DASH to refine existing strategies for funded school district partners to improve the

quality of their programs and services to prevent HIV, other STDs, and pregnancy among adolescents as well as improve mental health, sexual health and other adolescent health outcomes (e.g. substance use, violence victimization). Data will be used to inform DASH's key school-based programmatic strategies of improving family- and school-level protective factors, bolstering health education, and increasing adolescent access to quality health services. This observational research complements and extends DASH's ongoing surveillance efforts through the Youth Risk Behavioral Surveillances System (YRBSS) (OMB # 0920-0493 exp. 11/30/2023), which provides key national estimates of adolescent health risk behaviors and health outcomes, by providing a deeper dive into individual, family, and school factors that positively associate with adolescent behaviors and health outcomes.

Collecting this observational data provides the opportunity to examine untested associations of protective factors, health education experiences, and health service use (immediate outcomes of DASH strategies) with mental health, sexual health, and substance use outcomes.

#### Overview of the data collection procedures

This one-time data collection will be conducted via a contract with NORC (no acronym, NORC is company name) and its national online panel survey, AmeriSpeaks. This national data collection is intended to provide key correlational associations between DASH strategies and adolescent health outcomes. Using the AmeriSpeak panel, a representative sample of adolescents and parents/caregivers for minor adolescents will be selected and invited to participate in a web survey. For minor adolescents, parents/caregivers will consent for their adolescent to participate before they are invited to complete the survey. Respondents will complete the self-administered web survey on their computer, phone, or tablet.

#### Items of information to be collected

In addition to the information that will be collected as part of this survey (see Table 1 below), NORC collects PII from AmeriSpeaks panel members during registration into the online panel in connection with the receipt and redemption of rewards and incentives. These data include including name, address, telephone numbers and email addresses. This information is not collected as part of this survey data collection and existing PII that AmeriSpeaks panel members have will not be shared with CDC.

Table 1: Items of Information to be Collected for this data collection

**Teen Survey**

<b>Sections</b>	<b>Description</b>
Section A: Background	Demographic data, using categorical responses, will be used to describe the living arrangements, information on the adult/caregiver responsible for the teen, grade, and gender identity, attraction and expression.
Section B. Individual Protective Factors	Questions will be used to learn more about participant’s self-regulation, problem-solving, school-related self-efficacy, and future orientation.
Section C. Family Protective Factors	Questions about family/parent connectedness, parental expectations, parental monitoring, parent-adolescent communication will be used to understand the dynamics of the teen and parent relationship in order to identify ways to improve DASH parent engagement strategies.
Section D. Peer and School Protective Factors	Questions about participants’ social support, school connectedness will help evaluate any positive associations with individual level behaviors and health outcomes in order to identify potential peer and teacher/counselor intervention strategies.
Section E. Neighborhood/Community Protective Factors	Questions in this section focus on connections to neighbors and organizations in an adolescent’s immediate community in order to identify any positive associations between these agents and individual behaviors and health outcomes. Again, this is intended to identify appropriate intervention agents and strategies.
Section F: Mental Health	This section contains questions about the stress, anxiety, and depression. Mental health is one of the key outcomes of interest for this study.
Section G. Adverse Childhood Events	Questions on adverse childhood events are included in NAHS to assess how DASH’s school-based strategies may help ameliorate the impact of ACES.



<b>Sections</b>	<b>Description</b>
Section H. Experience with Racism	Questions will be used to gain a deeper understanding of participant's level of discrimination they face in their community.
Section I. Health Education	Questions in this section focus on where sources and satisfaction with information about mental health, sexual and reproductive health, and school-based health education.
Section J. Health Services	This section includes questions on participant experiences and communication with health providers, health service use, receipt of quality adolescent health care, and their satisfaction with the healthcare received.
Section K. Sexual Health	Questions focus on sexual activity and sexual health and are intended to be used as health outcomes in analyses.
Section L. Substance Use	Section focused on substance use and frequency.

## Parent Survey

Sections	Description
Section A. Family Protective Factors	Questions about family/parent connectedness, parental expectations, parental monitoring, parent-adolescent communication will be used to understand the dynamics of the teen and parent relationship.
Section B: Mental Health	This section contains questions about the stress, anxiety, and depression. Mental health is one of the key outcomes of interest for this study.
Section C. Adverse Childhood Events	Questions on adverse childhood events are included in NAHS to assess how DASH's school-based strategies may help ameliorate the impact of ACES.
Section D. Health Education	Questions in this section focus on where sources and satisfaction with information about mental health, sexual and reproductive health, and school-based health education.
Section E. Health Services	This section includes questions on participant experiences with health providers and their satisfaction with the healthcare they have received.
Section F. Sexual Health	Questions focus on perceived sexual activity and sexual health of adolescents, adolescent/parent communication about sexual health topics, and other parenting practices associated with positive adolescent sexual health outcomes.
Section G. Substance Use	Section focused on perceived adolescent substance use.

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

We will use industry standard information technology for survey data collection in order to reduce respondent burden. The survey will be programmed using the Voxco system, a computer-aided interviewing system, in order to provide respondents the opportunity to participate in the study online or

by telephone with a professional NORC telephone interviewer. NORC's Voxco survey software system supports both Computer Assisted Telephone Interviewing (CATI) and Computer Assisted Web Interviewing (CAWI) modes, providing an integrated sample management and data collection platform. This mode of questionnaire administration will include skip logic patterns to reduce overall respondent burden and minimize user errors such as missing data. Use of a web survey will also reduce the time needed to complete the questionnaire. Transfer of data collected electronically will eliminate the need for data entry.

To reduce respondent burden, AmeriSpeak enables respondents to use their personal smartphones, tablets, computer, or laptop. For respondents using a mobile device, NORC's Voxco system will render an optimized presentation of the questions for smartphone and tablet screens. The Voxco system produces fully responsive, 508-compliant web pages that can be viewed through most modern browsers (including Internet Explorer, Chrome, Firefox, and Safari). Each questionnaire will be programmed to create visual consistency across questions, examine potential user proficiency and technology limitations, and accommodate multiple technology platforms. Questionnaires are formatted to maximize readability, including appropriate question spacing, pixilation, font type and size, and properly programmed branching patterns. Questionnaire formatting considerations also include the use of color, diagrams, and pictures to enhance respondent comprehension. Screenshots of the formatted questionnaire can be found in **Attachments 3 and 4**.

For all participants regardless of mode, the survey technology includes tailored skip patterns and text fills, which allow respondents to move through the questions more easily and minimizes respondent burden. To reduce respondent burden, respondents can complete the survey online at any time that is convenient to the respondents. Lastly by recruiting from the pre-selected AmeriSpeak Panel, potential participants have already been recruited to receive survey invites as part of the panel, and costs and respondent burden associated with locating and contacting activities are kept to a minimum.

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

Based on a division- and federal-wide review, CDC has determined that the planned data collection efforts do not duplicate any other current or previous data collection efforts related to protective factors, health education experiences, or health service use and mental health or sexual health. An ongoing and updated environmental scan and literature review revealed no known projects with a similarly focused data collection effort. Colleagues from other CDC Divisions including the Division of STD Prevention, the Division of Reproductive Health, and Division of Violence Prevention were consulted to consolidate research questions across areas of interest and to review data collection tools. Additionally, external

experts in the fields of health education, adolescent health, and mental and sexual health service research were regularly consulted throughout project and instrument development to ensure the content was relevant and there were not similar efforts already in place.

#### **A.5. Impact on Small Business or Other Small Entities**

This data collection effort does not involve any small businesses or other small entities.

#### **A.6. Consequences of Collecting the Information Less Frequently**

Although there is a well-documented research on adolescent risk behaviors, there is a gap in the existing knowledge base on the protective factors that may ameliorate negative adolescent experiences and health. There is limited recent national data on the prevalence of family- and school-level protective factors, and associations with health information- and health care-seeking have not been well-studied. In general, data about health education, whether school-based or via other channels, including social media, is sparse, and key dimensions such as acceptability and quality are additional detail about the nuances of adolescent-parent-provider interactions, such as adolescent comfort and truthfulness disclosing sensitive behaviors and parents' reactions to time alone between an adolescent and provider.

Collecting a large-scale comprehensive survey describing the role of protective factors, health education, and health service use provides the opportunity to examine untested associations with mental health and sexual behavior outcomes. Therefore, if data are not collected, an opportunity to assess the needs of this population and inform future public health efforts will have been missed. Only key questions and topics are included in the survey in order to respect respondent burden, by keeping the survey administration time as short as possible.

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

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5.

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

A. Federal Register Notice

In accordance with 5 CFR 1320.8(d), 2021 a 60-day notice for public comment was published in the *Federal Register* Friday, July 2, 2021, Vol. 86, No. 125, page 35294 (**Attachments 2**). No public comments were received.

**B. Efforts to Consult Outside the Agency**

Subject matter experts (SMEs) were consulted to get feedback on the survey domains and constructs. They also provided review and feedback of the adolescent and parent/caregiver questionnaires. NORC staff involved in the statistical aspects of the project are listed in the Supporting Statement Part B OMB document. Titles and contact information for all SMEs consulted are listed in the Table 2 below:

**Table 2. List of Consulted Subject Matter Experts (SMEs)**

<b>Name</b>	<b>Affiliation</b>	<b>Email Address</b>	<b>Type of input</b>
Alida Bouris	University of Chicago School of Social Service Administration	abouris@uchicago.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on protective constructs and inclusivity for sexual and gender minority youth.
Kevin Haggerty	Director, Social Development Research Group, University of Washington School of Social Work	haggerty@uw.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on protective constructs.
Philip Leaf	Director, Center for Adolescent Health, Johns Hopkins Bloomberg School of Public Health	pleaf1@jhu.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on mental health and substance use items.
Annie-Laurie McRee	University of Minnesota Department of Pediatrics	almcree@umn.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on health services, sexual health, and parent-child communication.
Chris Markham	Interim Chair, Health Promotion and Behavioral Sciences, University of Texas School of Public Health	christine.markham@uth.tmc.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on protective constructs.
John Santelli	Population and Family Health and Pediatrics,	js2637@columbia.edu	Provide specialized subject matter expertise in the development of

	Columbia Mailman School of Public Health		survey instruments with a specific focus on sexual health and healthy schools.
Renee Sieving	Director, Center for Adolescent Nursing, University of Minnesota School of Nursing  Director, Healthy Youth Development - Prevention Research Center	sievi001@umn.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on protective constructs, dyad surveys, and sexual health.
Eric Walsh-Buhi	Department Chair, Applied Health Science, Indiana University Bloomington School of Public Health	erwals@iu.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on sexual health and communication.
Marc Zimmerman	Director, Prevention Research Center, University of Michigan School of Public Health	marcz@umich.edu	Provide specialized subject matter expertise in the development of survey instruments with a specific focus on protective constructs.

### **A.9. Explanation of Any Payment or Gift to Respondents**

Participants in the Teen and Parent Surveys of Health (TAPS) will be offered an incentive with \$20 cash value. AmeriSpeak panel members will receive this incentive as survey choice “points” to redeem for prizes which are commonly provided to survey panel respondents who complete online surveys. Respondents redeem these points for cash, Amazon gift codes, virtual Mastercard currency, or physical goods via the AmeriSpeak Panel member web portal or by calling the AmeriSpeak support toll-free telephone number. The points are funded by CDC, and delivered via the online panel provider to respondents who complete the survey. Respondents who are not yet AmeriSpeak panel members will receive a \$20 gift card in lieu of points.

Points will be offered to keep participants engaged and motivated in order to obtain maximum survey participation. Providing points to panelists is positively associated with response rates and helps to build trust.<sup>17,18</sup> For TAPS, points having \$20 cash value will be awarded to the age 18-19 adult respondents, and \$20 in points will also be awarded to both respondents in the parent and the teen pairs completing the survey (\$40 in total). Non-responders invited to participate in the study will also receive a non-contingent payment in the form of a \$2 bill included in a USPS mailed letter for boosting cooperation. If the non-

continent incentive is needed to boost response, we will follow up with known parents or teens who have not responded to survey invites via mail, including a letter and a \$2 bill to encourage response. This would be limited to parents who have not yet initiated the survey, or teens (either dyad-teens or non-dyads) who have not yet responded.

We anticipate sending non-contingent incentives to 75% of the invited sample. Of that 75%, we plan for 40% of the non-contingent incentives to be mailed to parents and 60% to teens. We will only send incentives to those parents who have a known eligible teen member in the home.

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

The CDC NCHHSTP Privacy and Confidentiality Review Officer has assessed this package for applicability of 5 U.S.C. § 552a, and has determined that the Privacy Act does not apply to the information collection. The Privacy Office has determined that PII not being collected. Therefore, a signed PIA is not required for this submission (**Attachment 5-** Privacy Impact Assessment). CDC is contracting with NORC to collect and analyze the survey data. NORC already maintains PII, such as name, address, telephone numbers, and email address as part of their maintenance of the AmeriSpeak online panel. This PII was collected in order to contact individuals for participation and reimbursement and is maintained according to privacy regulations. CDC will not receive nor have access to AmeriSpeak panel members' PII. The TAPS questionnaires do not collect additional PII.

To maintain the confidentiality of the participants, any data files shared with CDC will be stripped of any PII. At the conclusion of the study, the final datasets will be delivered to CDC in de-identified format. Additionally, data files will be delivered using a secure file transfer protocol (SFTP) site. When reporting data from this study, only aggregate data will be used to report study results.

Key safeguards have been put in place to assure respondents that their responses will be treated in a secure and private manner. Prior to the start of the survey, the prospective respondent will be shown a landing page with informed consent text (**Attachments 6 and 7**). The informed consent language is written in simple language (grade 7.5 Flesch-Kinkaid reading level). In addition to the landing page, a Frequently Asked Questions (FAQs) link will be provided at the bottom of each survey page. Consent includes a brief description of the study and contains the following key points:

- Purpose of the study
- Study procedures
- Question topics

- Estimated time required to participate
- Disclosure of incentive
- Potential risks and benefits
- Statement that participation is voluntary
- Telephone numbers of persons they may contact with further questions
- Authority for the data collection

For minor participants ages 15-17 years old, parental consent will be collected prior to their being invited to participate in the survey. Consent will include a brief description of the study and contain the key points listed above. Minors will also be required to assent to participate before initiating the survey. Every AmeriSpeak panelist is provided a Privacy Statement, which outlines the information that will be collected and how the information will be used. Because each panel member is asked to provide key demographic data such as age, gender, race/ethnicity, state of residence, household income, and more, the Privacy Statement also tells panel members how they can verify the accuracy of their PII and how they can request that the information be deleted or updated.

The AmeriSpeak Privacy Statement includes the following:

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

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

### **IRB Approval**



NORC submitted the initial study protocol for IRB approval to conduct cognitive interviews; the cognitive interview protocol was approved in 2020 (**Attachment 8**). An amendment for the main data collection effort was submitted in January 2021; the main data collection was approved by NORC's IRB (**Attachment 9**).

### **Sensitive Questions**

The adolescent survey can be found in **Attachment 10** and the parent survey is in **Attachment 11**. The proposed data collection includes sensitive information related to the respondent's mental health, sexual history, and substance use. Sensitive information is required in order to describe and understand the relationship between protective factors such as parent-adolescent communication, parental monitoring, and school connectedness, and adolescent sexual behaviors. We will ask respondents to provide a summary of their sexual history and risk reduction behaviors (such as condom use) to allow us to conduct this sort of analysis. Further, health education programs are similarly associated with reductions in high-risk sexual behavior. Knowing what sort of methods the adolescent is using for STI and pregnancy prevention will allow us to understand what features of health education and other protective factors at the family, school, and neighborhood level help to reduce risk. In general, data about health education, whether school-based or via other channels, including social media, is sparse, and key dimensions such as acceptability and quality are not routinely assessed.

DASH also seeks to address health risk behaviors and experiences that co-occur with sexual risk and independently contribute to substantial morbidity and mortality among young people, including mental health issues and substance use. We will ask if adolescent sample members have used illicit substances, and to what degree, to facilitate this analysis. In terms of mental health, most ten-year trends for mental health and suicide-related indicators are concerning, and in 2017, nearly one-fifth (17.2%) of high school students had seriously considered attempting suicide in the prior year. We want to understand what factors protect adolescents from harm, including family- and school-level protective factors, health education, and health services, as DASH funds work in these areas. Collecting data on mental health and substance use allows us to explore these associations.

In addition, questions concerning education may be viewed as sensitive by a portion of respondents. Other demographic data, such as race/ethnicity, are already collected as part of the AmeriSpeak panel. The sensitivity of the data to be collected necessitates privacy protection.

To minimize psychological distress, participants will be informed that they may skip over any questions that they do not want to answer and that they may stop participating at any time. The project will be

covered by a Certificate of Confidentiality to further safeguard participant privacy as it relates to sensitive personal information such as questions about genetic testing. Participants will be given the toll-free telephone number and email address of the AmeriSpeak Support Team as well as the NORC IRB to answer questions pertaining to the study or their rights as a research volunteer.

#### **A.12. Estimates of Annualized Burden Hours and Costs**

NORC expects to contact 129,762 households to screen and interview 1,500 adolescents and 2,093 parents/caregivers for TAPS. The table below shows the breakdown of cases by respondent type. The original AmeriSpeak sample was established previously and additional information on the sampling and recruitment can be found in **Attachment 12**. For these purposes, it has been screened for a 15-17 year old living in the household to identify a sampling frame for participation. Outreach and contacting materials are included as **Attachments 13-21**. After establishing contact and re-confirming eligibility at the beginning of the interview, we expect 98% of households to be eligible for a parent and teen interview, and 82% of the eligible households to complete the parent survey. For the new ABS sample, we expect 6% of the addresses to be an eligible household and 65% of eligible households to complete the parent survey. Participants will initially be contacted via advance postcard or letter through the mail and will ask about their interest in participating in a new survey about adolescent health.

#### **Exhibit A.12.A Estimated Teen and Parent Survey Completes**

	<b>Current AmeriSpeak Sample</b>	<b>New ABS Sample</b>	<b>Total Completes</b>
<b>15-17 year olds / Dyads</b>			
Initial postcard to AmeriSpeak/ Initial Letter to ABS	3,597	59,797	
Reminder letter w/\$2 incentive	1,439	53,817	
Screen for 15-17 year old in the household	1,417	3,588	
Complete Parent Interview w/\$20 incentive	1,163	1,471	2,093
Consent to interview teen	698	956	
Teen invitation letter w/\$2 incentive		956	
Teen reminder letter w/\$2 incentive/Reminder Calls	628	860	
Teen complete w/\$20 incentive	422	478	900
<b>18-19 year olds</b>	<b>Current AmeriSpeak Sample</b>	<b>New ABS Sample</b>	<b>Total Completes</b>

Initial postcard to AmeriSpeak/ Initial Letter to ABS	368	66,000	
Screen for 18-19 year old	NA	2,640	
18-19 reminder letter w/\$2 incentive/Reminder Calls	298	2,376	
18-19 complete w/\$20 incentive	72	528	600

The estimate of burden for the instruments is based on cognitive interviews with nine respondents. A variety of instruments and platforms will be used to collect information from respondents. The annual burden hours requested (1,378) are based on the number of completed responses we expect to collect over the requested period for this clearance. The survey, which will only be administered once, is estimated at no longer than 20 minutes per respondent.

#### Exhibit A.12.A Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs)	Total Burden (in hrs)
Parents/Caregivers of 15-17 year olds	Adult/Caregiver Survey Att 11	2,634	1	20/60	878
Adolescent 15-17 year olds	Adolescent Survey Att 10	900	1	20/60	300
Adolescent 18-19 year olds	Adolescent Survey Att 10	600	1	20/60	200
Totals					1,378

#### A.12.B Estimated Annualized Costs

The annualized wages are based on data from the United States Department of Labor, Bureau of Labor Statistics (2019) ([https://www.bls.gov/oes/current/naics4\\_611100.htm](https://www.bls.gov/oes/current/naics4_611100.htm) ) for state, local, and private industry earning and assumes an average hourly wage rate for respondents who work an estimated 40-hour work week and usual hourly earnings of \$25.72.<sup>1</sup>

Type of	Form Name	No. of	Total	Hourly	Total Cost
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<sup>1</sup> [https://www.bls.gov/oes/current/oes\\_nat.htm#00-0000](https://www.bls.gov/oes/current/oes_nat.htm#00-0000)

<b>Respondents</b>		<b>Respondents</b>	<b>Burden (in hrs.)</b>	<b>Wage Rate</b>	
Parents/Caregivers of 15-17 year olds	Adult/Caregiver Survey	2,634	878	\$25.72	\$22,812.16
Adolescent 15-17 year olds	Adolescent Survey	900	300	\$25.72	\$7,716.00
Adolescent 18-19 year olds	Adolescent Survey	600	200	\$25.72	\$5,144.00

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

There will be no direct costs to the respondents other than their time to complete the survey.

### **A.14. Annualized Cost to the Government**

Total estimated cost to the government is \$580,687 based on the estimated participation of two, CDC health scientists at 4% time (GS-14) who are responsible for the project design, obtaining approvals, providing project oversight, and analysis and dissemination of the results. The CDC scientists will provide remote technical assistance to local area implementing data collection. Costs are estimated based on GS14, step 9 salaries for Atlanta area federal employees. Contractor costs \$569,175 are estimated for survey development, recruitment, and survey administration. With the expected period of performance, the annual cost to the federal government from contractor and other expenses is estimated to be approximately

Table 6. Estimated Annualized Cost to the Government

<b>Expense Type</b>	<b>Expense Explanation</b>	<b>Annual Costs (dollars)</b>
<b><i>Direct Cost to the Federal Government</i></b>		
CDC employee oversight of contractor for project	CDC non-supervisory employee (GS-14, step 9) labor costs for 2 employees at 4% time	\$11,512
<b>Subtotal, Direct Costs to the Government per year</b>		<b>\$11,512</b>
<b><i>Contractor and Other Expenses</i></b>		
Assistance with data collection, processing, and preliminary analysis	Labor and other direct costs for survey development, recruitment, and administration	\$569,175
<b>Subtotal, Contract and Other Expenses per year</b>		<b>\$580,687</b>

### **A.15. Explanation for Program Changes or Adjustments**

This is a new information collection request (ICR).

### **A.16. Plans for Tabulation and Publication and Project Time Schedule**

#### Project Time Schedule

Table 7 presents the estimated timeline for conducting data collection following receipt of OMB clearance. Information will be collected over approximately a 6-month time period and will not exceed the approved expiration date.

Table 7: Estimated schedule for survey recruitment, administration, data analysis, and publication.

<b>Activity</b>	<b>Time Schedule</b>
Survey recruitment and administration	1 month after OMB approval
Data delivery and documentation	7 months after OMB approval
Data Analysis	7-13 months after OMB approval
Publication	13 months onward after OMB approval

Survey findings will inform comprehensive adolescent health planning efforts and inform the CDC’s Division of Adolescent and School Health’s (DASH) key school-based programmatic strategies of improving family- and school-level protective factors, bolstering health education, and increasing adolescent access to quality health services. Findings will be used to: 1) describe the prevalence of key factors that protect young people’s health (including family and school-level protective factors), health education experiences, health service use, and health behaviors and experiences, and (2) examine associations between these factors and adolescent mental health, sexual and reproductive health, and substance use outcomes which will aid DASH in developing and refining programmatic strategies to improve adolescent health. Additionally, findings will be disseminated through presentations and/or posters at meetings and publications in peer-reviewed journals. All abstracts, poster presentations, and manuscripts will undergo CDC clearance review prior to submission to conferences or journals. In addition to standard peer-reviewed publications and conference presentation, reports of results for the public will be developed and posted on the CDC website. These brief results synopses for the lay public will focus on the aims of this study and the gaps and issues identified. These descriptions will focus heavily on data visualizations to ease interpretation of results and will be developed with health literacy and numeracy needs of the public in mind. These results briefs will also be shared with partner organizations in adolescent health for dissemination and use in decision-making and priority setting. Additional briefs may be developed based on feedback from partner organizations or based on interesting results.

Specific questions will be based on the specific aims of the study as well as identification of gaps in the literature identified by previous CDC work and input from adolescent health experts. Namely we will look at the relationships between protective factors and sexual and mental health outcomes. For each manuscript, we first will use descriptive statistics to summarize the

characteristics of the study sample and examine the distribution of individual variables. For scales that were drawn from the literature and are being used as they were originally designed, scale scores will be calculated as described by the instruments' developers. Means and standard deviations will be calculated for the scale items and where possible, compared to scores reported in the literature. We will conduct a series of analyses employing descriptive statistics (means, medians, t-tests, and chi-square tests), linear and logistic regression, and other multivariate techniques to address the questions outlined below.

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

The display of the OMB expiration date is not inappropriate. We are not requesting an exemption.

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

No certification exemption is being sought. These activities comply with the requirements in 5 CFR 1320.9.

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