

Supporting Statement B

Revision Request for Clearance

**NATIONAL HEALTH INTERVIEW SURVEY**

OMB No. 0920-0214

(Expiration Date 12/31/2020)

Contact Information:

Stephen Blumberg

Division of Health Interview Statistics  
National Center for Health Statistics/CDC  
3311 Toledo Road  
Hyattsville, MD 20782  
301.458.4107 (voice)  
301.458.4035 (fax)  
[swb5@cdc.gov](mailto:swb5@cdc.gov)

September 25, 2020

## Table of Contents

1. Respondent Universe and Sampling Methods.....	3
2. Procedures for the collection of Information.....	3
3. Methods to Maximize Response Rates and Deal with Nonresponse.....	4
4. Test of Procedures or Methods to be Undertaken.....	6
5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data.....	6

### List of Attachments

Attachment 1	Legislative Mandates (Excerpts)
Attachment 2a	60-Day Federal Register Notice
Attachment 2b	Public Comments to the 60-Day Federal Register Notice
Attachment 2c	Program Response to the Public Comments to the 60-Day Federal Register Notice
Attachment 2d	Program Response to the Public Comments to the 30-Day Federal Register Notice
Attachment 3a	NHIS Survey Content Justification
Attachment 3b	NHIS Snapshot 3 Year-Cycle Questionnaire Content and Periodicity
Attachment 3c	NHIS Annual and Rotating Core 2021, 2022, 2023 - Sample Adult
Attachment 3d	NHIS Annual and Rotating Core 2021, 2022, 2023 - Sample Child
Attachment 3e	NHIS Sponsored Content Repeated Annually 2021, 2022, 2023
Attachment 3f	NHIS Questionnaire Redesign Consultations
Attachment 4a	2020 Q3 NHIS 2020 Q3 COVID-19 Items - Content Summary
Attachment 4b	2020 Q3 NHIS 2020 Q3 COVID-19 Items - Concepts Measured, Duplication, and Proposed Uses of the Data
Attachment 4c	NHIS 2020 Q3 Emergency COVID-19 Items - OMB Approval
Attachment 4d	2020 Q3 NHIS 2020 Q3 COVID-19 Items - Preliminary analyses
Attachment 4e	2020 Q3 NHIS 2020 Q3 COVID-19 Items - RANDS Evaluation
Attachment 5a	2021 NHIS Proposed New Content - Content Summary
Attachment 5b	2021 NHIS Proposed New Content - Concepts Measured, Duplication, and Proposed Uses of Data
Attachment 6	NHIS Methodological projects
Attachment 7a	2021-2022 Adolescent Follow-back Survey (AFS) - Content Summary and Field Dates
Attachment 7b	2021-2022 Adolescent Follow-back Survey (AFS) - Concepts Measured, Duplication, and Proposed Uses of Data
Attachment 8	Precision Tables - Sample Adult, Sample Child, Sample Adolescents
Attachment 9a	2021 NHIS Household Roster Questionnaire
Attachment 9b	2021 NHIS Sample Adult Questionnaire
Attachment 9c	2021 NHIS Sample Child Questionnaire
Attachment 9d	2021 NHIS Reinterview Questionnaire
Attachment 9e	2021-2022 Adolescent Follow-back Survey (AFS) - Adolescent Questionnaire
Attachment 10a	2021 NHIS Advance Letter
Attachment 10b	2021 NHIS Brochure
Attachment 10c	2021 NHIS Supplemental Mailings
Attachment 10d	2021 NHIS Thank You Letter
Attachment 11	NHIS Human Subjects Clearance
Attachment 12a	2022, 2023 NHIS Potential Sponsored Content - Summary
Attachment 12b	Healthy People 2030 Objectives Slated for NHIS

## **B. Collection of Information Employing Statistical Methods**

### **1. Respondent Universe and Sampling Methods**

The NHIS is a cross-sectional household interview survey. The respondent universe is the civilian, noninstitutionalized population of the US. Approximately every ten years, the NHIS sampling plan is revised following the decennial census of the population. From 2006-2015, the sampling plan was based on the 2000 decennial census. In 2016, a new sampling plan was implemented to keep the sample current with population distribution changes over the decade.

The 2016 NHIS sample design is structured with a nationally focused design as its core and contains large reserve samples that can be used to increase the overall sample size or achieve state or minority estimation objectives. The sample design considers demographic shifts in the U.S. civilian, noninstitutionalized population, and allows for additions and contractions in the sample size to reflect funding availability and to meet estimation goals. The annual base sample for the 2016 design includes approximately 58,800 addresses. With the questionnaire redesign in 2019 and the 2019 response rates, the base sample is expected to yield approximately 28,800 sample adult and 8,400 sample child completed interviews in 30,000 households annually. In general, the sample is allocated proportionally to state populations to maximize the precision of national-level estimates. However, a small portion of the sample in the most populous states is shifted to increase sample in the 10 least populous states, enabling slightly more precise state-level estimates of key variables to be produced for these states when pooling multiple years of data. This flexibility reflects the increasing demand for state-level health outcomes.

While the sampling frame for the NHIS had traditionally used field listing by the Census Bureau, in order to contain costs, the frame used from 2016 onward employs a commercial list that covers addresses within all 50 states and the District of Columbia. Supplementary field listing is undertaken to improve coverage in rural areas with poorly defined addresses and in high density areas with addresses that are too general (such as drop boxes for apartment buildings).

The sample design implemented in 2016 has not been found to affect estimates generated using NHIS data compared to previous years. To monitor the design's performance, NHIS analysts perform monthly checks as part of routine data quality reviews. In addition to comparing the unweighted and weighted frequencies, the input and output specifications are reviewed, and the flowcharts are compared to the skip instructions and universes for each question. If a difference is found, steps are taken to determine whether the change is legitimate or whether there is a factor other than the programming of the questionnaire such as the location or context of the question in the questionnaire. If a difference persists, the paradata are reviewed to determine whether there are changes in the mean or median time spent on that question, whether interviewers had a high rate of backing up to return to that question, and whether other questions in that battery were similarly affected. Persistent differences are examined to determine whether there is any other interviewer effect, such as differences between newly hired and experienced interviewers or newly added primary sampling units compared to continuing primary sampling units. In addition, national estimates on the key set of indicators that are released in a quarterly report as part of the Early Release program are monitored by NHIS analysts.

Two future follow-up studies are being planned for the NHIS. The specifics for the design and implementation of these two follow-up studies are currently under development and dependent on funding. The first is a pilot study that follows up with adolescents age 12-17 in the 2021 and 2022 NHIS by web, phone, or mail to

ask them questions about topics that were already included in the NHIS and some new content specifically for the follow-back. The annual NHIS selects on sample child from each household that includes children age 17 or under. Approximately 4,500 NHIS sample children age 12-17 years will be invited to participate in the adolescent follow-back survey beginning around July of 2021 and continuing through December of 2022. We expect 3,600 of these adolescent children age 12-17 to complete the adolescent follow-back survey.

The second follow-up study involves re-contacting NHIS sample adults to participate in a health exam. A pilot study will be conducted in cooperation with staff from another NCHS survey — the National Health and Nutrition Examination Survey — in 2021 to determine the feasibility of including this follow-up health exam in the 2022 and 2023 NHIS. This pilot study is also part of the CDC Public Health Data Modernization Initiative. The pilot study would potentially inform an upcoming redesign of NHANES. The NHANES sample design is highly clustered, and declining response rates are affecting the sample yield. Stable annual estimates are not possible from the current NHANES design, especially for population subgroups. On the other hand, the NHIS sample design has less clustering and yields a large sample size. If the pilot study is successful and a sufficient percentage of NHIS adult respondents provide biological specimens (including venous blood and urine) and physical measurements (including height, weight, and blood pressure) following the survey interview, the NHIS may be able to supplement NHANES data collection with annual national prevalence estimates for overweight, obesity, hypertension, diabetes, kidney disease, Hepatitis C virus infection, and other key measures. The follow-up health exam would potentially begin in January of 2022 pending a successful pilot study in 2021. Approximately 18,750 sample adults would be invited to participate in a health exam in 2022 and 2023 if the pilot study is successful. The goal is to complete approximately 15,000 health exams with NHIS sample adults in each of those years.

## **2. Procedures for the Collection of Information**

The U.S. Bureau of the Census is responsible for drawing the final sample and for performing the necessary field procedures related to data collection and initial processing. Specifications for the field operations are provided by the Division of Health Interview Statistics (DHIS) staff at NCHS.

DHIS staff provide to the Census Bureau specifications for the sample design, specific content of the questionnaire, detailed instructions for the administration of the interview, and procedures to carry out quality control measures, such as reinterview and paradata analysis. The Census Bureau, in addition to drawing the sample, performs supervisor and interviewer training and conducts the field operations. These operations include first contacting all households via an advance letter (Attachment 10a), followed by a personal visit. The roughly 900 trained interviewers working on the NHIS are directed by survey supervisors in the six U.S. Census Bureau Regional Offices. Interviewers (also referred to as Field Representatives or FRs) receive initial and/or annual refresher training in common interviewing procedures, the concepts and procedures unique to the NHIS, and survey content changes. In some cases, contact via telephone is also used under certain circumstances: telephone interviews may be attempted when efforts to make personal contact have not been successful, when the respondent requests a telephone interview, when part of the interview needs to be completed and it is not possible to schedule another personal visit, or when road conditions or travel distances would make it difficult to schedule a personal visit.

Since the onset of the coronavirus pandemic in March of 2020, the Census Bureau has made allowances for interviewers to conduct interviews over the telephone in keeping with efforts to control the spread of COVID-19. Interviewers may conduct personal visits as local conditions and considerations for interviewer and respondent safety allow.

DHIS staff monitor the field activities through observation and communication with Census during all phases of data collection and through the analysis of paradata (such as audit trails, contact history, and item timing). Frequent status meetings are held to assess progress toward data collection goals.

The 2019 survey redesign provided an opportunity to evaluate weighting processes that had been in place since 1997. Based on that evaluation, the 2019 weighting process was updated to include person-level weighting classes based on response propensity and calibration based on more detailed demographic data. Starting from 2019, data are weighted to produce national estimates using the following components: the reciprocal of the probability of selection; household- and person-level nonresponse adjustments based on the inverse of the median response propensity within the propensity quintile, and raking adjustments to the U.S. population by age, sex, race-ethnicity, education, Census Division and MSA.

Standard errors may be calculated using a Taylor linearization approach as applied in SUDAAN variance software. (See: Research Triangle Institute. SUDAAN Language Manual; Release 11.0. Research Triangle Park, NC: Research Triangle Institute. 2012.)

A small sample of respondents is reinterviewed by the Census Bureau to ensure that interviewers are not submitting falsified information. NHIS reinterviews are conducted primarily by telephone, by staff at one of the Census Bureau's centralized call centers. The reinterview is very brief and verifies that the original interview was completed. Typically, the NHIS reinterview is conducted within two to three weeks of the main survey with the same respondent who originally participated in the NHIS. The reinterview questionnaire is shown in Attachment 9d.

Additional technical details on routine survey execution can be found in the National Center for Health Statistics (2018) Survey Description Document available at [ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/NHIS/2018/srvydesc.pdf](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2018/srvydesc.pdf).

A sample of adult respondents that is not part of the sample set aside for MEPS (OMB# 0935-0118, expires 12/31/2020) may be selected to participate in follow-back surveys and special methodological projects. For instance, in 2021, NHIS respondents may be included as participants in methodological projects and cognitive testing that will inform the development of new rotating and supplemental content using web and/or mail survey tools. Additional details about these methodological activities are provided in Attachment 6.

### **3. Methods to Maximize Response Rates and Deal with Nonresponse**

As 2020 NHIS data collection is still underway, the latest year of available data is from the 2019 survey. In 2019, the household response rate was 61.1 percent. The sample adult response rate was 59.1 percent. The sample child response rate was 59.1 percent.

These are the first response rates available for the redesigned version of the NHIS that started in 2019. The NHIS, like most surveys, has witnessed steadily declining response rates. Reasons for declining response rates are unclear but may include increased survey length, general mistrust of the government, growing time constraints, improvements in privacy screening technology for telephones, and other reasons.

To provide respondents with advance notification of the interview in an attempt to maximize response rates, an advance letter is sent to all sampled addresses prior to the interviewer's arrival (Attachment 10a). The letter legitimizes and justifies the survey, increasing the probability that the respondent will cooperate. It references the authorizing legislation of the survey, a statement of confidentiality and an explanation of how

the data will be used, as well as the voluntary nature of the survey and other elements for informed consent. The letter further explains the purpose of and need for the survey and tells the respondent that there is some chance that they may be contacted more than once. If at the time of the initial contact the interviewer is told that the letter was not received, another letter is provided prior to the interview and time is allowed for the person to read it before proceeding. Additional written materials have been developed in recent years to supplement the advance letter, most recently the new informational brochure that was launched in 2016 to visually brand the survey and engage respondents in fulfilling the important mission of the NHIS (Attachment 10b). In addition, targeted interviewer training modules on improving respondent cooperation (such as gaining cooperation, accessing respondents through gatekeepers, and averting refusals) are presented at initial training for new interviewers and at least once a year during their annual refresher training.

If the time of contact is inconvenient for a respondent, interviewers offer to schedule an appointment for a more convenient time. If the respondent declines the interview with one interviewer, the field work supervisor often reassigns the case to an interviewer with more experience at converting reluctant respondents. Although face-to-face interviews are preferred, interviewers are allowed to substitute telephone interviews if attempts to get a face-to-face interview are not successful.

To explore the utility of employing monetary incentives in the NHIS, an incentive experiment was conducted in the summer of 2015. Fielded from May through July in the states included in three Census Regional Offices (New York, Philadelphia, and Denver), the experiment was designed to assess the impact of respondent incentives on response rates, survey costs, and data quality. Preliminary results from this experiment indicated, however, that offering incentives across the board to all respondents has limited potential to improve survey outcomes, and that incentives may be better suited for application in a targeted manner when they are deemed to be beneficial to the study design. Further evaluation of the use and impact of incentives could be part of future NHIS data collection years. An incentive of \$5 in cash will be provided to adolescents who complete the 16 minute adolescent follow-back survey as a token of appreciation, which reflects a similar rate seen in other adolescent surveys (e.g. the National Survey on Drug Use and Health offers \$30 for an hour-long interview). An additional non-conditional \$5 cash token of appreciation will be provided to adolescents who have not completed the survey after the first few weeks of the study period. The NHIS plans to include a \$75 incentive for NHIS sample adults who participate in a follow-up health exam. This amount is consistent with other studies that collect biomeasures such as the National Health and Nutrition Examination Survey.

In the third quarter of 2016, an adaptive design experiment (OMB # 0920-0214, approved 6/9/2016;) was carried out to test the impact of adaptive case prioritization on sample representativeness and nonresponse bias, while maintaining survey costs and minimizing any possible negative effect on the overall response rate. Initial analysis suggests that the last two criteria were met: cost neutrality and no reductions in response rates. However, the primary goal of the experiment, reduction of nonresponse bias, does not appear to have been met. Although R-indicator values indicated greater sample representativeness in the treatment group, compared to the control group, for the first month of the experiment, corresponding values for the last two months indicated either no differences or less sample representativeness in the treatment group. In addition, and using past nonresponse bias analyses as a guide, comparisons of key health estimates between the treatment and control groups provided no evidence that the treatment estimates represented an improvement (i.e., reduction of nonresponse bias) compared to the control estimates. In sum, initial results were not indicative of an overall improvement in data quality due to the adaptive design protocol. Therefore, the decision was made for 2017 to return to data collection procedures in place prior to the experiment. Pending further evaluation of the results, a revised case prioritization protocol may be tested and/or implemented during 2021 NHIS data collection. Case prioritization would affect only interviewer activities

and would neither affect nor alter public burden from conducting the NHIS.

#### **4. Tests of Procedures or Methods to be Undertaken**

For 2021-2023, a series of small-scale projects is planned to evaluate and inform future content for the questionnaire, building on and extending the findings from prior follow-back surveys and methodological experiments described in Supporting Statement A and Attachment 6. These projects will serve to inform the development of new rotating and supplemental content, by testing new and updated questionnaire items, evaluating the impact of different response options on response frequencies, and measuring respondents' comprehension of health care-related terms and concepts.

Other developmental work related to the NHIS questionnaire is conducted by the NCHS Center for Questionnaire Design and Evaluation Research (CQDER) under their clearance (OMB No. 0920-0222, expires 07/31/20).

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

The following person was consulted in the statistical aspects of the design and collection of the NHIS:

Van L. Parsons, Ph.D.  
Collaborating Center for Statistical Research and Survey Design  
Division of Research Methodology  
National Center for Health Statistics  
(301)458-4421  
VParsons@cdc.gov

The following person is responsible for collection of the data:

Lindsay M. Howden, Ph.D.  
Survey Director, National Health Interview Survey  
Demographic Surveys Division  
U.S. Bureau of the Census  
Suitland, MD  
(301)763-6780  
[lindsay.m.howden@census.gov](mailto:lindsay.m.howden@census.gov)

The following person is responsible for analysis of the NHIS data:

Anjel Vahratian, Ph.D.  
Associate Director for Science  
Division of Health Interview Statistics  
National Center for Health Statistics  
(301)458-4436  
[avahratian@cdc.gov](mailto:avahratian@cdc.gov)