

Behavioral Risk Factor Surveillance System (BRFSS)

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Revision

Supporting Statement

Part A: Justification

Submitted by:

Division of Population Health
National Center for Chronic Disease Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia

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Contents

Attachments List.....3

A. Justification.....5

1. Circumstances Making the Collection of Information Necessary.....5

2. Purpose and Use of Information Collection.....25

3. Use of Improved Information Technology and Burden Reduction.....27

4. Efforts to Identify Duplication and Use of Similar Information.....28

5. Impact on Small Businesses or Other Small Entities.....28

6. Consequences of Collecting the Information Less Frequently.....29

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5.....29

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency.....29

9. Explanation of any Payment/Gift to Respondents.....29

10. Protection of the Privacy and Confidentiality of Information Provided by Respondents.....29

11. Institutional Review Board (IRB) and Justification for Sensitive Questions.....33

12. Estimates of Annualized Burden Hours and Costs.....33

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers.....38

14. Annualized Cost to Federal Government.....38

15. Explanation for Program Changes or Adjustments.....38

16. Plans for Tabulation and Publication and Project Time Schedule.....39

17. Reason(s) Display of OMB Expiration Date is Inappropriate.....41

18. Exceptions to Certification for Paperwork Reduction Act Submissions.....41

Attachments List

1. Authorizing Legislation: Public Health Service Act
2. List of BRFSS Awardees
3. Sections of the Core Questionnaire
4. Optional Modules by Topic
5. BRFSS Screening and Recruitment Scripts
6. 6a. Federal Register Notice/6b. Summary of Public Comments
7. BRFSS Weighting and Comparability Documentation
8. State Population Totals and BRFSS Sample Size
9. BRFSS Summary Data Quality Report 2019
10. BRFSS 2021 Data Collectors' Protocol
11. BRFSS Methods for Questions Adoption and Modification
12. Example of Field Test Questionnaire
13. 2021 BRFSS Questionnaire
14. BRFSS Crisis Protocol for Sensitive Questions
15. BRFSS Optional Modules by State 2019
16. Report on the 2020 BRFSS Core Questionnaire Resign

- Goal. To conduct Behavioral Risk Factor Surveillance System (BRFSS) surveys in collaboration with U.S. states, territories, and the District of Columbia. The surveys will produce state- or sub-state jurisdiction-level data about health-related risk behaviors, chronic health conditions, use of preventive services, and emerging health issues. CDC conducts an annual field test to prepare for the primary BRFSS information collection.
- How data will be used. CDC and BRFSS partners use BRFSS data to plan for and evaluate public health programs at the (sub) state level. For most states, BRFSS data is the only source of health information that is targeted to state and local public health needs. CDC also creates a national level dataset that is used by HHS to evaluate its progress toward Healthy People 2030 goals and other policy needs.
- Methods of collection. Each year, an independent sample of respondents is drawn for each participating state or jurisdiction. Information collection is conducted in a continuous, three-part telephone interview: screening, participation in the common BRFSS core, and participation in optional modules that states may use to customize survey content for their specific needs. Interviews are conducted on landline and mobile telephones. Participants may be offered the option to complete the survey online. A few US territories with low telephone coverage conduct in-person interviews. Each state or territory coordinates BRFSS administration within its jurisdiction.
- Respondent population. Adults \geq 18 years of age who live in private households or college housing.
- Analysis techniques. Each state or territory submits a de-identified dataset to CDC for cleaning, weighting, and compilation. Because sample size and survey content vary by state or territory, CDC provides guidance on statistically appropriate uses of BRFSS data and technical assistance, as needed, on survey content and administration.

A. *Justification*

1. *Circumstances Making the Collection of Information Necessary*

The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) was established at the Centers for Disease Control and Prevention (CDC) to provide coordinated leadership and support for prevention and control programs specifically related to chronic diseases or conditions. NCCDPHP works with partners from multiple sectors of society to create and disseminate expertise, information, and tools that reduce the burden of disease on the American public, and to identify populations that are most in need of strategies to promote physical and mental health and prevent disease. Key partners within CDC include the National Center for Immunization and Respiratory Diseases (NCIRD), the National Center for Environmental Health (NCEH), the National Institute of Occupational Safety and Health (NIOSH), the National Center for Injury Prevention and Control (NCIPC), the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), the Office of Public Health Preparedness and Response (OPHPR), and the National Center for Health Statistics (NCHS). Surveillance efforts that quantify disease and risk factors, and identify opportunities for prevention, are central to CDC's planning and evaluation efforts. CDC's authority to collect information for this purpose is provided by the Public Health Service Act (**Attachment 1**).

Scientific research has identified personal health behaviors that play a major role in premature morbidity and mortality. Patterns of behavior that affect health or predict adverse effects on health are called behavioral risk factors. For example: lack of physical activity is a behavioral risk factor for obesity, type 2 diabetes, cardiovascular disease, and other diseases and conditions; and alcohol consumption (including binge drinking) is a behavioral risk factor for injury, unplanned or unprotected sexual behavior, and a contributor to numerous chronic conditions. Patterns of risk behaviors are key targets for prevention. Timely and accurate information about risk behaviors is needed to plan, initiate, support, and evaluate public health programs designed to prevent, control, or mitigate disease and disability.

Due to the geographic, cultural, demographic, and economic diversity of the U.S., the methods used to produce national estimates provide only limited insight into regional, or state-specific variability in health status and health-related behaviors. State and local health agencies are focal points for public health program planning and implementation. Nationally representative datasets that do not have the

ability to be geographically disaggregated due to sample size limitations may not be informative about conditions found in any given state or sub-state region, or detailed enough to assist federal, state, and local health agencies inform effective allocation of public health resources. Surveys that sample at the state level are needed to monitor state-level prevalence of the major behavioral risks for premature morbidity and mortality.

In 1984, CDC and 15 states collaboratively initiated behavioral risk factor surveys designed to address the states' information and public health needs. Since that time, CDC has provided technical assistance and funding to an increasing number of states and territories, and survey content and methods have become increasingly sophisticated. The surveys are now known as the Behavioral Risk Factor Surveillance System (BRFSS), managed by NCCDPHP's Division of Population Health (DPH). Under the current BRFSS cooperative agreement program, CDC provides funding and technical assistance to 57 awardees including 50 states, the District of Columbia, and six territories (collectively referred to as "states" in this document). A list of current awardees is provided in **Attachment 2**. The primary purpose of the BRFSS is to provide the information that these awardees need in order to plan public health programs and track health outcomes at the state and sub-state level.

BRFSS information collection is conducted annually. The CDC and BRFSS awardees produce a new set of state specific BRFSS questionnaires each calendar year (i.e., 2022 BRFSS series, 2023 BRFSS series, etc.). Information has traditionally been collected through telephone interviews except in a limited number of jurisdictions (such as the territories of Palau, and the Federated States of Micronesia) with low telephone coverage, where interviews are conducted in-person. In 2022-2024, the Division of Population Health may offer participants options to complete surveys online to reduce overall burden on respondents and to allow for participation at the convenience of the participants. The methods for selecting respondents and determining questionnaire content reflect the system's origins. An independent sample of adult, non-institutionalized respondents is drawn for each state and is based on the state's parameters for state-level or sub-state analysis. The questionnaire is based on modular design principles allowing rapid customization of content. Each state's annual questionnaire includes a common core for even-numbered and odd-numbered years as well as limited content which is used in three-year cycles (see Attachment 3), and standardized optional modules (see Attachment 4) that may be fielded at the states' discretion. In addition to meeting standards of need for information during the process to adopt new questions (see Attachment 11) all new questions are cognitively tested and field

tested before inclusion.

1.1 Revisions to the BRFSS Questionnaire for 2022-2024

In Table 1 below, information is provided on changes since the OMB approval of the 2019-2021 BRFSS in each of the core sections. Any core section which is administered in rotating years may be offered as an optional module in years when it does not appear on the core questionnaire.

Table 1. 2022-2024 BRFSS Core Section Changes and Core Question Periodicity

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
General Health	Would you say that in general your health is—Excellent/Very good/Good/Fair/Poor?	Annual	None
Healthy Days	Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	Annual	Allow interviewer to code 88 when respondent indicates that this never happens. This would prevent the requirement of having a number for a response.
	Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?		
	During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?		
Healthcare Access	What is the primary source of your health care coverage?	Annual	<p>Previous question on whether the respondent had insurance to be replaced by question on type of insurance with option to respond that there was no insurance.</p> <p>Replace wording with “What is the primary source of your health insurance”?</p> <p>The change will produce the same data with only one,</p>

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
			rather than two questions. Moreover, the phrase “health care coverage” is not clear to respondents, who often have to be told that the question refers to insurance.
	Do you have one person you think of as your personal doctor or health care provider?		There is a recommendation that the program revise this question to include professional practices rather than single doctors, which the respondent thinks of as their personal healthcare providers. New wording would be “Do you have one person or a group of doctors that you think of as your personal health care provider?”
	Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?		There is a recommendation that the wording of the question be changed, as respondents seem to have difficulty in hearing the last part of the question. The word “cost” is especially difficult for respondents to understand at the end of the sentence. New wording would be “Was there a time in the past 12 months when you needed to see a doctor but could not because you could not afford it?” States and data collectors report that respondents are confused as to whether to include groups of doctors as personal health care providers.
	About how long has it been since you last visited a doctor for a routine checkup?		None
Hypertension Awareness	Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?	Odd-year rotation	None

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	Are you currently taking medicine for your high blood pressure?		None
Cholesterol Awareness	Blood cholesterol is a fatty substance found in the blood. About how long has it been since you last had your blood cholesterol checked?	Odd-year rotation	Recommendation to remove the word “blood” as most respondents understand “cholesterol” but are confused by “blood cholesterol.” New wording will be “Cholesterol is a fatty substance found in the blood. About how long has it been since you last had your cholesterol checked?”
	Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?		Recommendation to remove word “blood” from question.
	Are you currently taking medicine prescribed by a doctor or other health professional for your blood cholesterol?		Recommendation to remove word “blood” from question.
Chronic Disease	(Ever told) you that you had a heart attack also called a myocardial infarction?	Annual	None
	(Ever told) (you had) angina or coronary heart disease?		None
	(Ever told) you had a stroke?		None
	(Ever told) (you had) asthma?		None
	Do you still have asthma?		None
	(Ever told) (you had) skin cancer?		None
	(Ever told) you had any other types of cancer?		None
	(Ever told) (you had) (chronic obstructive pulmonary disease) COPD, emphysema, or chronic bronchitis?		Minor change: interviewer will just say COPD with option of not saying “chronic obstructive pulmonary disease.”
	(Ever told) (you had) some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?		None
	(Ever told) (you had) a depressive disorder (including depression, major depression, dysthymia, or minor depression)?		None
(Ever told) (you had) some form of arthritis, rheumatoid arthritis, gout,	Moved back into Chronic Disease Section from Arthritis		

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	lupus, or fibromyalgia?		Section. This change is because of the recommendation to remove the burden of arthritis section back to a module
	Not including kidney stones, bladder infection or incontinence, were you ever told you have kidney disease?		None
	(Ever told) (you had) diabetes?		None
	If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"		
	How old were you when you were told you had diabetes?		None
Arthritis	Has a doctor or other health professional ever suggested physical activity or exercise to help your arthritis or joint symptoms?	Removed from core	Moved to Arthritis Burden Module.
Have you ever taken an educational course or class to teach you how to manage problems related to your arthritis or joint symptoms?			
Are you now limited in any way in any of your usual activities because of arthritis or joint symptoms?			
In the next question, we are referring to work for pay. Do arthritis or joint symptoms now affect whether you work, the type of work you do or the amount of work you do?			
Please think about the past 30 days, keeping in mind all of your joint pain or aching and whether or not you have taken medication. During the past 30 days, how bad was your joint pain on average on a scale of 0 to 10 where 0 is no pain and 10 is pain or aching as bad as it can be.			
Tobacco Use	Have you smoked at least 100 cigarettes in your entire life?	Annual	Minor
	Do you now smoke cigarettes every	Annual	None

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	day, some days, or not at all?		
	During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?	Removed from core	Moved from core to Tobacco Cessation Module.
	How long has it been since you last smoked a cigarette, even one or two puffs?		
	Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?	Annual	None
	Do you now use e-cigarettes or other electronic vaping products every day, some days or not at all?	Annual	Moved from module to core; minor changes in interviewer notes proposed as well. Since the prevalence of e-cigarette use is dynamic, it is recommended that this question appear in the core.
Alcohol Consumption	During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?	Annual	None
	One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?		None
	Considering all types of alcoholic beverages, how many times during the past 30 days did you have X [CATI X = 5 for men, X = 4 for women] or more drinks on an occasion?		None
	During the past 30 days, what is the largest number of drinks you had on any occasion?		None
Fruits and Vegetables	Not including juices, how often did you eat fruit?	Changed to 4-year rotation	
	Not including fruit-flavored drinks or fruit juices with added sugar, how often did you drink 100% fruit juice such as apple or orange juice?		

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	<p>How often did you eat a green leafy or lettuce salad, with or without other vegetables?</p> <p>How often did you eat any kind of fried potatoes, including French fries, home fries, or hash browns?</p> <p>How often did you eat any other kind of potatoes, or sweet potatoes, such as baked, boiled, mashed potatoes, or potato salad?</p> <p>Not including lettuce salads and potatoes, how often did you eat other vegetables?</p> <p>Not counting what you just told me about, during the past month, about how many times per day, week, or month did you eat OTHER vegetables? Examples of other vegetables include tomatoes, tomato juice or V-8 juice, corn, eggplant, peas, lettuce, cabbage, and white potatoes that are not fried such as baked or mashed potatoes.</p>		
Physical Activity	<p>During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?</p> <p>What type of physical activity or exercise did you spend the most time doing during the past month?</p> <p>How many times per week or per month did you take part in this activity during the past month?</p> <p>And when you took part in this activity, for how many minutes or hours did you usually keep at it?</p> <p>What other type of physical activity gave you the next most exercise during the past month?</p> <p>How many times per week or per month did you take part in this activity during the past month?</p> <p>And when you took part in this</p>	<p>Annual</p> <p>Changed to 4-year rotation</p>	<p>Decrease the number of responses in the response sets to allow question to fit onto CATI screen.</p>

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	<p>activity, for how many minutes or hours did you usually keep at it?</p> <p>During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Count activities using your own body weight like yoga, sit-ups, or push-ups and those using weight machines, free weights, or elastic bands.</p>		
Drinking and Driving and Seat Belt Use	<p>How often do you use seat belts when you drive or ride in a car? Would you say</p> <p>During the past 30 days, how many times have you driven when you've had perhaps too much to drink?</p>	Three-year rotation	
Immunization	<p>During the past 12 months, have you had either flu vaccine that was sprayed in your nose or flu shot injected into your arm?</p> <p>During what month and year did you receive your most recent flu vaccine that was sprayed in your nose or flu shot injected into your arm?</p> <p>At what kind of place did you get your last flu shot or vaccine?</p> <p>A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot also known as a pneumococcal vaccine?</p> <p>Have you ever had the shingles or zoster vaccine?</p> <p>Have you received a tetanus shot in the past 10 years?</p>	<p>Annual</p> <p>Three-year rotation (current)</p> <p>Annual</p> <p>Three-year rotation (current)</p> <p>Three-year rotation (current)</p>	<p>None</p> <p>None</p> <p>None</p> <p>None</p> <p>None</p>
HIV/AIDS	Have you ever been tested for HIV? Do not count tests you may have had	Annual	None

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	as part of a blood donation. Include testing fluid from your mouth.		
	Not including blood donations, in what month and year was your last HIV test?	Annual	None
	I am going to read you a list. When I am done, please tell me if any of the situations apply to you. You have injected any drug other than those prescribed for you in the past year. You have been treated for a sexually transmitted disease or STD in the past year. You have given or received money or drugs in exchange for sex in the past year. You had anal sex without a condom in the past year. You had four or more sex partners in the past year. Do any of these situations apply to you?	Even-year rotation	None
Sleep	On average, how many hours of sleep do you get in a 24-hour period?	Three-year rotation	
Oral Health	Including all types of dentists, such as orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists, how long has it been since you last visited a dentist or a dental clinic for any reason?	Even-year rotation	None
	Not including teeth lost for injury or orthodontics, how many of your permanent teeth have been removed because of tooth decay or gum disease?		None
Falls	In the past 12 months, how many times have you fallen?	Three-year rotation	
	How many of these falls caused an injury that limited your regular activities for at least a day or caused you to go to see a doctor?		None
Breast/Cervical Cancer	The next questions are about breast and cervical cancer. Have you ever had a mammogram?	Even-year rotation	None
	How long has it been since you had your last mammogram?		None

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	Have you ever had a Pap test?		None
	How long has it been since you had your last Pap test?		None
	An H.P.V. test is sometimes given with the Pap test for cervical cancer screening. Have you ever had an H.P.V. test?		None
	How long has it been since you had your last H.P.V. test?		None
	Have you had a hysterectomy?		None
Prostate Cancer Screening	Has a doctor, nurse, or other health professional ever talked with you about the advantages of the Prostate-Specific Antigen or P.S.A. test?	Even-year rotation	
	Has a doctor, nurse, or other health professional ever talked with you about the disadvantages of the P.S.A. test?		
	Has a doctor, nurse, or other health professional ever recommended that you have a P.S.A. test?		None
	Have you ever had a P.S.A. test?		None
	How long has it been since you had your last P.S.A. test?		None
	What was the main reason you had this P.S.A. test - was it ...?		None
Colorectal Cancer Screening	A colonoscopy checks the entire colon. You are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. Have you ever had a colonoscopy?	Even-year rotation	<p>Currently the section is long, but it is not likely that any single respondent will answer more than three questions.</p> <p>CATI skip patterns will be developed to ensure that the minimum required number of questions is asked of each respondent.</p>
	How long has it been since you had this test?		
	A sigmoidoscopy checks part of the colon and you are fully awake. Have you ever had a sigmoidoscopy?		
	How long has it been since you had this test?		
	Another test uses a special kit to		

Core Section	Question text	Periodicity	Changes recommended in questions/ coding/ programming
	<p>obtain a small amount of stool at home to determine whether the stool contains blood and returns the kit to the doctor or the lab. Have you ever had this test using a home kit?</p> <p>How long has it been since you had this test?</p> <p>Another test uses a special kit to obtain a small amount of stool at home to determine whether the stool contains blood and returns the kit to the doctor or the lab. Have you ever had this test using a home kit?</p> <p>How long has it been since you had this test?</p> <p>How long has it been since you had this test?</p> <p>Another test uses a special kit to obtain an entire bowel movement at home and returns the kit to a lab. Have you ever had this test?</p>		
	<p>How long has it been since you had this test?</p>		
	<p>For a virtual colonoscopy, your colon is filled with air and you are moved through a donut shaped X-ray machine as you lie on your back and then on your stomach. Have you ever had a virtual colonoscopy?</p>		
	<p>How long has it been since you had this test?</p>		

Since OMB review is conducted every three years, Attachment 4 includes all modules which may be used during 2022-2024. It is likely that many of these modules will not be used during that period but are provided for review so that they may be considered as states evaluate their health information needs. The number of optional modules available to states in any single year is dependent on state health departments' needs and funding. All of modules have been previously cognitively tested, but if reintroduced into the questionnaire after long periods when questions were not administered, additional cognitive tests may be conducted. If they are adopted for use in 2022-2024, their complete documentation will be provided in the change requests submitted by CDC for annual questionnaire approval.

Several modules included in Attachment 4 have not been previously reviewed. The BRFSS first came under PRA review in 2015. Several of these modules have been administered by the BRFSS prior to the 2015 review. These include General Preparedness, Heart Attack and Stroke, Reactions to Race, Social Context, Mental Health and Stigma, Health Literacy, Clinica Breast Exam, Sleep Disorder, Anxiety and Depression and Veteran's Health. The module on Other Tobacco Use is comprised of questions which previously appeared on the core with one new question on the use of heated tobacco products. The module on the knowledge and impact of the COVID pandemic is comprised of a subset of questions on this topic suggested by the National Institute of Health. The module may/may not be used in the future but is included for review. The Periodontal Disease module is comprised of new questions developed by the CDC Oral Health program using questions from other surveys and from dental health professionals. These questions have not yet been cognitively tested and will follow the question adoption process (see Attachment 11) prior to use. Two newly listed modules (Fruits and Vegetables and Exercise (Physical Activity)) were previously on the rotating core every two years. Since the redesign of the core questionnaire, these items have been moved to a four-year cycle (see Attachment 16). In order to allow states to collect information on these topics in off years, they have also been added to the optional module list. One module listed for approval is the WGSS Disability module, which includes disability questions recently adopted by the NHIS. The BRFSS may use these questions in future iterations of the survey as replacements for the current disability core questions, with OMB approval, as them questions are adopted by other surveys. The move to these questions is in an effort to ensure that questions from surveys are harmonized to the extent possible to allow for comparisons of data across surveys. A final module on Well Bring is also included and may be used in future iterations of the BRFSS. Questions from this module will also be required to follow the steps for question adoption (see Attachment 11).

Data sets are submitted to CDC for cleaning and weighting (see Attachment 7) and returned to the state of origin for its use. In keeping with its historical role in promulgating standards that strengthen data quality and comparability, CDC, in collaboration with the states, provides standard protocols for BRFSS data collection which all states are encouraged to adopt. The BRFSS collaboration among CDC and states also develops and validates questions for both the core component(s) and the optional modules, and provides technical assistance to states on methodological issues such as sample selection, data quality, weighting, and the interpretation of findings (see Attachments 7 and 9). CDC makes state-level BRFSS data, as well as national datasets, broadly available through the BRFSS web site along with guidance on statistically appropriate uses of the data at www.cdc.gov/brfss.

The interactive partnership between CDC and BRFSS awardees results in the collection of surveillance information that is adaptive to both state and national needs, and uniform where states have common interests. Over time the BRFSS has developed into an important source of information for federal agencies and the public as well as state and local health departments. Therefore, although the BRFSS began primarily a state-based data collection system, in recognition of the fact that HHS uses BRFSS as a unique and influential source of public health information developed with federal assistance, CDC applied for and received OMB approval for BRFSS annual surveys beginning with the 2015 cycle of data collection. CDC also seeks to ensure comparability across data sets by reviewing questions on similar topics on other surveys. The process by which questions are adopted for use on the BRFSS is provided in Attachment 11. The process includes reviews of questions on other federal surveys.

CDC supports periodic updates of BRFSS content and/or the data collection system. Two types of routine updates are based on similar survey methods and are associated with the current Revision request (OMB No. 0920-1061). CDC submits each update to OMB on an annual basis. Although the updates are related, each will be submitted as a separate Change Request.

1. Annual field test of proposed changes. Each year's full-scale survey is fielded from January 1 – December 31. Approximately 5-8 months before the January 1st launch date, CDC conducts a limited field test to identify issues that may affect BRFSS implementation or data quality. The specifics of each year's field-testing plan are submitted to OMB through the Change Request

mechanism as an Annual Field Test Supplement. This will be submitted to the Change Request annually as Attachment 12-2022, -2023 and -2024.

2. Annual update of the BRFSS core survey and optional modules.

Approximately 3-5 months before the January 1st launch date of the annual survey, and after reviewing the results of field test, CDC submits a Change Request to OMB that includes the updated BRFSS core survey and optional modules for the upcoming year. This Change Request outlines all adjustments to the estimated number of respondents, estimated burden, or other issues. This will be submitted to the Change Request annually as Attachment 13-2022, -2023 and -2024.

BRFSS content and methods also are refreshed through information collection activities that involve different methods and are not part of this OMB number. These activities, which are separately submitted to OMB for approval (using the CDC/ATSDR Formative Research and Tool Development generic package (OMB #0920-1154) include methodological studies to strengthen data collection procedures and the utility of the information collected, for example, cognitive testing of questions, pilot tests, or other protocol enhancements or callback surveys (conducted to collect detailed information on a single health topic, such as asthma).

Recently, using the CDC/ATSDR Formative Research and Tool Development generic package (OMB #0920-1154), a series of pilots of data collection methods and sampling strategies was conducted. Some of these are still underway and results are not yet available. One of the pilots focused on diverting BRFSS respondents to the web. Following the release of results from this pilot, the BRFSS may standardize a protocol to allow respondents to complete the survey online. This will not be available in 2022 but may be used during the 2023 04 2024 annual data collection periods. If such changes are made, a change request will be submitted with a new Data Collectors Protocol. The current Data Collectors' Protocol is provided with this request as Attachment 10. Respondent Burden tables submitted with this request include a smaller number of participants who may opt to complete the survey online in 2023 and/or 2024. Prior to changes in the sampling frame an expert panel meeting will be convened. This panel will include statisticians, methodologist, and state health department representatives. In particular, representatives from the National Health Interview Survey will be included in the panel. The PHSB has convened expert panels in the past (approximately every three

years) to guide changes in methodology and recommend analytic innovation. The last expert panel was convened in 2017. An Expert Panel Meeting scheduled in 2020 was postponed due to the COVID Pandemic.

All additional information collection activities will be submitted to OMB in separate requests and may be requested under current generic approvals for cognitive testing and pilots of methods and sampling.

2. Purpose and Use of Information Collection

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

- BRFSS data are used by states to identify specific program needs and track health status over time.
- States use BRFSS data to help them establish and track state and local health objectives, plan health programs, implement disease prevention and health promotion activities, and monitor trends.
- BRFSS data is used to compare weighted state-level behavioral health risk and health status information taken from persons residing within all U.S. states, D.C., the U.S. Virgin Islands, Guam, and Puerto Rico.
- CDC disseminates a publicly available annual BRFSS dataset (see the BRFSS website at www.cdc.gov/brfss). 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. These data are used for program needs assessment, research and reporting related to health status, chronic disease indicators and health risk and risk preventive behaviors. Data have also been used for trend analyses, tests of differences among (demographic or jurisdictional) subpopulations, multivariate analyses of health outcomes and other statistical processes.
- State health department websites as well as a CDC website will be used as platforms to illustrate differences in health and behaviors using mapping and charting software. CDC is committed to improving its web-based tool by making the strengths and weakness of such comparisons more transparent.

- BRFSS data informs a variety of data resources, programs and organizations which use the data as a basis for smaller area estimation. These include but are not limited to the Health Indicators Warehouse, County Health Indicators, the Robert Wood Johnson Foundation, and HealthyPeople 2020.
- BRFSS 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.
- The BRFSS data collection system is also used by states as a vehicle to add state specific questions exclusively for state health department needs. Although these data are not part of the public use dataset, they are essential to state health departments for planning and evaluation of public health resources.

Data collection based on state-level sampling also permits the analyses of data at the local level when sample sizes within county or metro/micropolitan statistical areas (MSAs) are large enough for statistical interpretation. The ability to identify state and sub-state differences optimizes program interventions designed by state health departments.

The annual field test has distinct objectives. Field testing is the final check of changes in the questionnaire which have occurred in the preceding year. Field testing is conducted in a manner that mimics the full-scale project protocol, to the degree that is feasible. Field testing is the final means by which changes are made in data collection methods and data collection software is tested. Field tests are used to identify problems with instrument documentation or instructions, problems with conditional logic (e.g., skip patterns), software errors or other implementation and usability issues. Field tests are conducted in a single state, using only those parts of the questionnaire which have been substantively changed or sections of the extant questionnaire which lead into new or updated questions. In some instances, extant sections of the questionnaire may be field tested if they are topically related to new items on the questionnaire. For example, if a new question on disability is added, extant disability questions are included in the field testing to ensure that respondents do not feel that the questions are redundant or overlapping. Field testing is not intended to replace cognitive testing, it is only to check to be sure that questions which have already been thoroughly vetted are appropriately placed on the BRFSS. Sections of the questionnaire which are unchanged and unrelated to new or modified sections of the questionnaire are not field tested, although the demographic sections of the core are included in the

field test. Results of the field test are used to inform development of the upcoming year's BRFSS questionnaire(s) and the technical assistance and implementation guidance that CDC provides to BRFSS partners. Field test data are not incorporated into the analytic BRFSS datasets.

3. Use of Improved Information Technology and Burden Reduction

The BRFSS 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. In addition to their cost advantages, telephone surveys are especially desirable at the state and local level, where the necessary expertise and resources for conducting area probability sampling for in-person household interviews are available in many state health departments. 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. In 2021 new methods of developing samples of cell phone became available. These methods permit the sampling of persons who have moved from one state to another and retained a phone number. Previously the BRFSS would complete the core survey with these respondents if they were contacted but lived outside of the sampling state. As a result module information was often missing. Improvements in RDD sampling may result in more complete optional module data in 2022-2024. Future changes to the BRFSS methods may include the elimination of landline phone numbers in the sample. The proportion of interviews conducted by landline has decreased each year since 2011, when cell phone interviews were introduced. 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. However, some states, such as Alaska, rely on some landline interviews to reach respondents in areas where cell phone coverage is limited.

This request includes burden hours for respondents to complete the BRFSS online. An online option is not planned for 2022 but may be offered to respondents in 2023-2024. It is anticipated that online administration of the questionnaire will reduce respondent burden but may also reduce response rates. Full details on permitting the online option will be included in the 2023 and/or 2024 BRFSS Change

Requests if such an option is offered.

4. Efforts to Identify Duplication and Use of Similar Information

For most states and territories, the BRFSS provides the only sources of data amenable to state and local level health and health risk indicators. Extant data on these topics are available at the national level, but do not include sufficient sample size to determine whether there are measurable changes/trends in health risk behaviors at lower geographic levels. National surveys such as the National Health Interview Survey (NHIS, OMB No. 0920-0214), the National Health and Nutrition Examination Survey (NHANES; OMB No. 0920-0950) among others offer data for prevalence estimates at the national level. The BRFSS differs in that it samples at (sub) 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 topics, many of which are not included in national surveys.

In some cases, state prevalence may be modeled by other data collections. The National Adult Tobacco Survey and the National Health Interview Survey have both been used to model prevalence estimates at the state level. However they may not provide sufficient data from which direct state estimates can be derived nor do they allow for direct local area estimation. Moreover, in most instances state level data modeled from national surveys use national level control totals for weighting, while the BRFSS uses (sub) 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 cannot be used to evaluate interventions that public health at the state and local level may have implemented. Many states use BRFSS data to evaluate their public health interventions.

Data from the BRFSS provide a means by which states can tailor data collection to their unique needs. Optional modules which are important in one state may not be as salient in others. For example, the excess sun exposure optional module may be more critical in coastal states than in other jurisdictions. The addition of state-added questions is also a means by which specifically targeted information critical to a particular state may be obtained, using the infrastructure of the BRFSS.

5. Impact on Small Businesses or Other Small Entities

There will be no impact on small business.

6. Consequences of Collecting the Information Less Frequently

Annual data collection allows more detailed trend analyses than less frequent data collection. The BRFSS minimizes the number of questions included in the annual survey by including a rotating core (in even-/ odd-numbered years or in three- or four-year cycles) for a select number of indicators which have more detailed response sets.

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

There are no special circumstances.

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

A 60-day Notice was published in the Federal Register March 12, 2021. Vol. 86, No. 14115, Page(s) 14115-14116. No comments were received. A copy of the published notice is attached (Attachment 6).

9. Explanation of any Payment/Gift to Respondents

Not applicable.

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

Overview of the 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 core questions without change. States will determine which of the available optional modules will be included in their jurisdictions and whether the state will split the sample to allow for the inclusion of a large number of optional modules. Field operations are managed by state health departments and/or their contractors following The Data Collectors' Protocol provided

by the BRFSS (see Attachment 10). States submit data to CDC 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 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.

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 data set provided to the states is published on the BRFSS website for public use.

Items of Information to be Collected

The BRFSS core questionnaire (see Attachment) includes information on health status, health risk and risk preventive behaviors, as well as basic demographic information. Optional modules which are selected by individual states, based on their information needs, must also be implemented as written without changes in wording. Optional modules cover a range of health topics (see Attachment 4). 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. On occasions when states make appointments to call selected respondents back after portions of the survey have been completed, first names may be given to ensure that the remainder of the interview is conducted with the same individual. The BRFSS 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. 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. The Data Collectors' Protocol (Attachment 10) provides instruction to states about data storage and confidentiality of responses as well as data quality.

How Information Will Be Shared and For What Purpose

Since state health departments and/or their designees are the data collectors for the BRFSS, 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 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 several 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

BRFSS sample files include phone numbers, and some addresses. Addresses are only available for telephone numbers where the sample contractor has been able to match phone numbers and addresses. These addresses are used by some states to send advance letters to households in the sample. If a state does not send advance letters, addresses are not included in the sample files. Approximately 40 states use advance letters, with about 40% of the landline sample and about 30% of

the cell phone sample matching accurately to an address.

Since sample files are separate from datasets, no phone numbers or addresses 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 suppressed in the public use dataset. In order to determine which variables to suppress, the BRFSS 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 BRFSS are informed that they do not have to participate and that they may refuse to answer any question.

Opportunities to Consent

Verbal consent is obtained during the initial contact and screening process (see Attachment 5). The introductory script, including the voluntary nature of the survey, precedes the survey questions.

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.

Privacy Act Determination

The Privacy Act does not apply. The BRFSS data will be collected using list-assisted random digit dialing

(RDD) landline and cellular telephone samples. No IIF will be collected, filed, or retrieved by the name of the individual or other unique respondent identifier such as social security number.

Annual Field Test

The information collection procedures and privacy safeguards for the annual field test are modeled on procedures and privacy safeguards for the main BRFSS survey. Any departures from standard procedures will be identified in the annual field test IC request.

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

CDC has determined that the BRFSS information collection is exempt from the requirements of 45 CFR 46. IRB approval is not required.

The BRFSS includes standard demographic questions (such as race, gender identity and income category) which may be considered sensitive. In addition, some questions regarding preventive behaviors, such as HIV testing, may be considered sensitive. One module on adverse childhood experiences is also sensitive and interviewers are trained specifically to reassure respondent who respond to this module (see appendices in Attachment 14). Participating states have used these standardized questions on state behavioral risk surveys for many years. Sensitive questions are necessary to identify changes in behaviors and/or self-assessments of health status when aggregated to local or state levels. In order to assess changes in health risk behaviors, it is necessary to ask questions of a sensitive nature. This sensitive information would be pertinent to determine state needs for health programs and services.

12. Estimates of Annualized Burden Hours and Costs

Respondents are adults ≥ 18 years of age. Information collection is conducted in a continuous, three-part telephone interview: screening, participation in the common BRFSS core, and participation in optional modules. Respondent burden is estimated separately for each step.

Although the number of interviews varies from state to state--based on the needs, population size and diversity of each state--a minimum number of interviews is set by the state in the sampling process. The

estimated population for each U.S. state or territory, and the size of the BRFSS state-level sample for 2019 is provided in Attachment 8. Approximately 35% of interviews were conducted on landlines and 65% on cell phones in 2019. Each year the proportion of interviews conducted by cell phone has increased in response to the use of cell phones by the US populations (Blumberg & Luke, 2016). Therefore for the 2022-2024 BRFSS, a larger proportion (80%) of cell phone interviews is anticipated. The screening questions for the two groups are slightly different and are presented in Attachment 5. In 2019, approximately 83% of those who completed the screening process completed the survey. This is reported as the “cooperation rate” in the Summary Data Quality Reports (see Attachment 9). Therefore a conservative estimate of 80% of all screened was used to estimate the total number of persons screened based on the largest sample size of the BRFSS (480,000 participants). This estimated the number of persons screened by cell phone at 694,000 and the number screened by landline at 173,000. The estimated burden per screening response is one minute. In 2019 a total of 418,268 individuals participated in the BRFSS. The number in 2018 was larger at 437,436. In 2020 the numbers of interviews were reduced by suspension of data collection due to the COVID pandemic. Several states suspended operations in order to make adjustments for remote data collection. Approximately 11 states suspended data collection for one month or more during 2020, reducing the total number of surveys to about 358,000 for that year. Since the estimates of respondent burden provided here are based on the largest BRFSS sample it is not likely that burden will achieve this level in 2022-2024.

After completing the screening interview, respondents who are eligible and agree to participate will proceed to the core section of the BRFSS questionnaire. Questions in the core may be edited from one year to the next but topics remain standard. Editing occurs as a result of an outdated question (for example questions on preventive testing which refer to testing which is no longer recommended) or due to a minor format change. Large scale question changes are rare in the core and would be reported to the OMB as part of the annual review of the questionnaire. The rotating (even-/odd-/3-4 year cycle year) core includes standard topics and questions which may also include editorial changes from one administration to the next. The estimated burden per response for the core questionnaire is 15 minutes.

Each state participating in the BRFSS may customize its survey by appending additional questions to the core survey. These questions will be drawn from the set of approved questions for optional modules (see Attachment 4). A complete 2021 BRFSS questionnaire (including screening scripts, even-numbered

year core and annual list of available optional modules) is provided in Attachment 13. Each state will administer one or more state-specific versions of the instrument in English. Spanish language versions are also routinely administered. The CDC does not provide requirements for administration of the survey in a second language. A standard Spanish translation is provided to the states, which may or may not adopt it for use. States may opt to modify the translation in order to match Spanish dialects of their populations. For example, states with larger number of Cuban residents may have populations with different word usage than states larger proportions of Spanish speaking residents with other backgrounds. States may translate the questionnaire into other languages as budgets permit, although this is rare and is not anticipated in 2022-2024. The pre-call status of the landline sample alerts the states to the potential of a language barrier and in some cases bilingual interviewers are assigned to that segment of the sample. In other instances, states use a callback system of bilingual interviewers to return calls after interim dispositions indicate that the household or cell phone may have a language barrier. Differential weighting of surveys conducted in Spanish or other languages is not included in the post data collection methods, although race and Hispanic ethnicity are included in weighting margins.

A summary of optional modules fielded in 2016 was used as an initial estimate of burden for 2019 (see Attachment 15 for a list of 2019 optional modules by state). States may split their samples in order to include a wider range of topics in the questionnaire, without lengthening the time for each interview. The number of optional questions/modules varies from state to state and year to year, but states typically limit the total length of the BRFSS interview to no more than 30 minutes on average. We estimate an average burden across the states of 15 minutes for their choice of optional modules. The BRFSS experiences a very low drop off rate for respondents who complete the core but do not complete the optional modules. However, some optional modules are only asked of subsets of the respondents. For example, only those who indicate that they have been diagnosed with diabetes will be asked questions from the diabetes module. We estimate that 440,000 respondents will complete the optional modules, after completing the core questionnaire.

As was noted earlier in this request, the Division of Population Health does not anticipate using online questionnaires in 2022. However, it is likely that in 2023-2024, participants will be provided the option to complete the survey online. This would allow more convenience for respondents who are not available at the time of the call from their state health departments. Therefore burden hours have been calculated to allow for the possibility of online response. It is anticipated that online completion of the

survey will be shortened to 10 minutes for core questions and 10 minutes for optional modules. The number of respondents who may opt for this method is unknown, but burden hours have been included to allow for up to 100,000 respondents across all states and territories.

A field test is conducted each year prior to the implementation of new or changed portions of the questionnaire as a final check on their usability within the survey. Portions of the questionnaire which immediately precede and follow changed or new sections and those extant questions which are topically related are also included. The burden hours for the field test are included in the table below. The total estimated annual burden includes up to 500 respondents who will qualify through screening and then participate in the field test. The estimated burden per response for these respondents is 45 minutes, which includes burden for screening, all demographic questions in the core survey, and the questions being field tested. Burden varies for each year’s field test survey, depending on the number of proposed changes to the core survey, changes to the optional modules, and testing of questions that are related to new or modified questions. The estimated burden per response of 45 minutes is a generous estimate, which should accommodate all cases. In some years, the actual burden of the field test may be lower.

The burden estimate also includes 400 respondents who will be determined ineligible after screening or decline to participate in the field test. The estimated burden per response for these respondents is 1 minute.

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

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)
U.S. General Population	Landline Screener	173,000	1	1/60
	Cell Phone Screener	694,000	1	1/60
	Field Test Screener	900	1	1/60
Annual Survey Respondents	BRFSS Core Survey by Phone Interview	480,000	1	15/60
	BRFSS Optional	440,000	1	15/60

(Adults >18 Years)	Modules by Phone Interview			
	BRFSS Core Survey by Online Survey	100,000	1	10/60
	BRFSS Optional Modules by Online Survey	80,000	1	10/60
Field Test Respondents (Adults >18 Years)	Field Test Survey by Phone Interview	500	1	45/60

Annualized burden costs are summarized in Table A.12-2 below. These calculations assume the average hourly wage of \$26.00 for all jurisdictions included in the BRFSS. Hourly rates were taken from the most recent publicly available Current Employment Statistics of the Bureau of Labor Statistics and are based upon the average hourly earnings for January 2017 from the Current Employment Statistics survey conducted by the Bureau of Labor Statistics (available at <https://www.bls.gov/news.release/empsit.t19.htm>).

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

Type of Respondents	Form Name	Number of Respondents	Total Burden Hours	Average Hourly Wage Rate	Total Cost Burden
U.S. General Population	Landline Screener	173,000	2884	\$27.16	\$78,329
	Cell Phone Screener	694,000	11567	\$27.16	\$314,160
	Field Test Screener	900	15	\$27.16	\$407
Annual Survey Respondents (Adults ≥ 18 Years)	BRFSS Core Survey by Phone Interview	480,000	120,000	\$27.16	\$3,259,200
	BRFSS Optional Modules by Phone Interview	440,000	110,000	\$27.16	\$2,987,600
	BRFSS Core Survey	100,000	16,666	\$27.16	\$452,649

	by Online Survey				
	BRFSS Optional Modules by Online Survey	80,000	13,333	\$27.16	\$362,124
Field Test Respondents (Adults ≥18 Years)	Field Test Survey by Phone Interview	500	13333	\$27.16	\$362,124
Total			0		0

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

There are no maintenance or capital costs to respondents.

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 funds provided to states for data collection as well as internal BRFSS costs. States supplement Federal Government costs for the administration of the BRFSS.

Annualized Estimated Cost to the Federal Government

Estimated funds provided to states	21,467,312
Estimated CDC BRFSS budget	3,500000
Total	0

15. Explanation for Program Changes or Adjustments

The BRFSS Questionnaire is updated annually. This request includes the most current even-numbered core questionnaire sections (Attachment 3) and optional modules (Attachment 4). Final questionnaires for 2022-2024 will be submitted in the Annual Change Requests for corresponding years.

The total number of BRFSS interviews has declined in recent years. The estimated 480,000 completed telephone interviews may be higher than the number conducted. The proportion of the sample dedicated to cell phones has also increased to reflect phone usage of potential respondents.

16. Plans for Tabulation and Publication and Project Time Schedule

Data collection for the BRFSS is scheduled to begin on January 1st annually. Data will be submitted monthly to CDC for editing and cleaning. Quarterly data quality reports are provided to states by the CDC. Final data sets for each year will be received from the states by February. Editing, cleaning, and weighting of the data will take place until July. Final weighted data sets (see description below) will be returned to the states by September. Datasets and supporting technical documentation will be available for public use by October of the following year.

A. 16 - 1 Project Time Schedule	
Activity	Approximate Time Schedule
Annual CDC/BRFSS partner meeting to approve new questions/ modifications	Spring
Field testing of new or modified portions of the BRFSS core or optional modules	May - August of preceding year
Review of data collection modifications for coming year	August- October of preceding year
Data collection	January 1 - December 31 of current calendar year
Monthly data submission	February- January of current calendar year
Quarterly data quality reports	March, June, September, December
Data cleaning and editing	March - July of current calendar year
Weighting	January - July of following calendar year
Final data sets to states	By September of following calendar year
Final public use datasets with supporting documentation	By October of following calendar year

The CDC assists the states by weighting each state's dataset annually. Once all data are received from the states, CDC staff members apply individual respondent weights to ensure that the persons interviewed most accurately reflect the population of each state. Weighting is completed in two steps: a design weight to correct for the probability of selection and a raking (iterative proportional fitting) weighting process to match the demographic characteristics of the respondent to those of the population. See Attachment 7 for details on Weighting and Comparability of data across states and from year to year.

Design weights are based on the number of phones and eligible respondents in each household for landline phone numbers for each of the geostrata defined in the states' samples. Cell phone respondents are treated as single adult households in the design weights. The formulae for the design weights are:

Stratum weight ($_STRWT$) = (number of records in the strata)/(number of records selected)

Design Weight = $_STRWT$ * (1/number of phones within the household) * (number of eligible adults within the household)

Raking weights are based on population totals obtained from a private vendor (Neilson), the National Health Interview Survey (NHIS), and the American Community Survey (ACS). The vendor provides updated, county-level estimates and race/ethnicity totals which are not available from the Census in a timely manner. The following variables are used in the raking process: age, race, Hispanic ethnicity, home ownership, sex, phone ownership, (sub) state region, marital status, and education. While the same variables are used for weighting for each state, in some instances the categories are collapsed differently from one state to the next. For example, if the state has a very small number of Asian residents, then there might not be enough respondents to include Asian as a separate race category. In these cases, smaller groups may be collapsed into a single category. Once raking weights are assigned a final weight is provided for each respondent using the formula:

$$\text{Total Weight} = \text{Design weight} * \text{Raking weight}$$

Because states may ask optional modules to only portions of their samples (split samples) several sets of

weights are calculated for each state. These weights are also provided to the public on the BRFSS website (at www.cdc.gov/brfss) with technical documentation on the appropriate use of each weight assignment.

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

N/A. The expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.