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

OMB Control No. 0920-1204, Exp. Date 11/30/2023

Supporting Statement

Revision

Part A: Justification

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Goal: The Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS) will produce state or jurisdiction level data about asthma. The goal of this information collection is to add in-depth data about those with asthma (e.g., symptoms, environmental factors, medication use etc.) and their experiences (e.g., activity limitation, health system use, self-management education, etc.) to the BRFSS (OMB Control OMB No. 0920-1061, expiration date 12/31/2024).

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

Methods to be used to collect data: Data will be collected through a follow-up survey approximately two days after the BRFSS survey is administered. Information collection is conducted in a continuous year round, two-part telephone interview: screening in BRFSS, participation in ACBS. Interviews are conducted on landline and mobile telephones. Each state or territory coordinates BRFSS administration within its jurisdiction.

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

Analysis techniques: Each state or territory submits a de-identified dataset to CDC for cleaning, weighting, and compilation. Because sample size varies by state or territory, CDC provides guidance on statistically appropriate uses of BRFSS ACBS data and technical assistance, as needed, on survey content and administration.

A. Justification

A.1 Circumstances Making the Collection of Information Necessary

As required by the Paperwork Reduction Act (PRA), the Centers for Disease Control and Prevention (CDC) is requesting approval from the Office of Management and Budget (OMB) to continue information collection for the "Behavioral Risk Factor Surveillance System (BRFSS) Asthma Call-back Survey (ACBS)" (OMB Control No. 0920-1204, expiration date 11/30/2023). OMB approval is requested for three years. CDC's authority to collect information for this purpose is provided by the Public Health Service Act Section 301 [241] **(Attachment 1**).

Asthma indicators are vital to the health of populations, and poor asthma control results in adverse health outcomes and burden on the health care system. Asthma is the third highest cause of asthma hospitalizations among children and costs the US $56 billion annually in medical costs, lost school and working days, and early deaths. States and other jurisdictions need asthma data to track the burden of the disease, monitor adherence to asthma guidelines, and to direct and evaluate interventions undertaken by asthma control programs located in their health departments. State- or jurisdiction-level health departments have the primary role of targeting resources to reduce the burden of asthma. To make asthma data available to them, the CDC National Asthma Control Program (NACP) saw the need to develop the ACBS at a state- or jurisdiction-level to provide more detailed asthma data for disease tracking and interventions. The NACP plays a critical role in addressing the health risk of persons with asthma. The program funds state or jurisdictions health department, territorial, and the District of Columbia (collectively called "states" or "jurisdictions" in this document) programs through the BRFSS (CDC-RFA-DP20-2007). The BRFSS request for applications (RFA) funds a state-based telephone survey coordinated by the CDC with data collection occurring concurrently in each of the 50 states, Washington DC, Guam, Puerto Rico and the US Virgin Islands.

The ACBS is an ongoing data collection administered for the NACP by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) through their BRFSS cooperative agreement with state health departments under CDC-RFA-DP20-2007 (BRFSS, OMB Control No. 0920-1061, expiration date 12/31/2024). The ACBS is an in-depth asthma

survey that contains questions such as medication use, symptoms, health care use, and disease management. The respondent will be either an adult (BRFSS respondent) or child (chosen using the Random Child Selection and Childhood Asthma Prevalence module) who has ever had asthma. The ACBS sample includes all cases meeting the qualification criteria in BRFSS. The ACBS will only conduct one call-back interview per household.

The list of states participating in ACBS is provided in **Attachment 3**. The information provided reflects the number of states that participated in 2022 and the most recent year of ACBS data released in 2020.

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

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

Past Three-Year Accomplishments and Summary of Proposed ACBS Revisions

ACBS released annual publicly available datasets on BRFSS website after BRFSS finalized its data (https://www.cdc.gov/brfss/acbs/index.htm). In response to the contours of 2020 Terms of Clearance,[1] the annual joint response rates from BRFSS and ACBS were reported with ACBS

[1] TERMS OF CLEARANCE: Previous terms continue: ACBS staff should continue to collaborate with BRFSS staff to transparently present a) joint response rates from BRFSS and ACBS and b) potential nonresponse bias. Tables of prevalence estimates and risk factors disseminated by CDC (either through its web page or publications) should clearly communicate the caveats of state-to-state comparisons. ACBS should continue to assess options for streamlining the instrument to

annual dataset. To communicate the caveats of state-to-state comparisons, the ACBS nonresponse bias and impact on prevalence estimation are being analyzed and reported as appendix tables of the annual data quality report released with the public use dataset for adult and child participants (https://www.cdc.gov/brfss/acbs/2020/pdf/sdq_report_acbs_20-508.pdf). The first table reports unweighted and weighted demographic distribution percentages for each participated state based on BRFSS-eligible asthma respondents, non-responding to the ACBS, and ACBS final completes. The second table reports estimated current asthma percentage among individuals who have ever been diagnosed with asthma. These two tables will help communicate the potential impact of nonresponse bias on the ACBS published dataset.

To provide clear communication about the caveats of state-to-state comparisons, we revised the tables of prevalence estimates for asthma risk factors based on ACBS and reduced the number of risk factor prevalence tables from 20 to 13. We deleted the tables (active asthma-related risk factors) which didn't provide enough information for state-to-state comparisons. A footnote with a hyperlink to the nonresponse report has been incorporated into the footnote for annual ACBS risk factor prevalence tables (see the updated tables available at: https://www.cdc.gov/brfss/acbs/2020_tables_LLCP.html).

Also, in response to OMB's 2020 Terms of Clearance,[1] the NACP undertook efforts to streamline the ACBS, reduce unnecessary burden, and ensure that the question wording is aligned with more recent studies. The questionnaires were re-evaluated by ACBS questionnaire working groups and the ACBS recipients. Question changes and additions to the 2024 ACBS questionnaire (Attachments 5e–5f) are further discussed in Section A.15. In summary, the NACP proposes to:

- Incorporate question changes and additions to the 2024 ACBS questionnaire (Attachments 5e-5f) based on the feedback from ACBS working groups and data analysis results. Changes to existing questions and additions of new questions to the 2024 child and adult ACBS questionnaires are included in Table. A15.1 and A15.2. A total of 6 proposed questions will be deleted from the questionnaire for adults and 17 questions will be deleted from the questionnaire for children. With the addition of 9 new questions to the adult's questionnaire and 10 questions to the child's questionnaire, the estimated time

reduce unnecessary burden and synchronize question wording with recent studies. (Issue Date 11/06/2020).

burden for the interview will remain unchanged from that of the 2021 questionnaire (10 minutes per response). Question changes are summarized by revised sections below, and details of changes are listed in Tables 15.1 and A15.2:

- Section 4 (history of asthma, Symptoms & Episodes in the past year, changes applied on both adult and child questions): move all asthma control related questions into section 4. Actions include adding 1 new quick relief medication question, deleting 1 question about the length of most recent asthma attack (Q4.7 2021 version), moving 1 activities limitation question from Section 5 (Q5.8 2021 version) into section 4 as Q4.8.

- Section 5 (health care utilization, child question only): combined Q5.4 (influenza vaccine) and Q5.5 (FluMistTM) into one new question asking if child had received either vaccine to streamline the question (Q5.4).

- Section 8 (medications, changes applied on both adult and child questions): added 1 new question (Q8.1, 2024 version) about taking any form of prescription asthma medication (inhaler, pills, syrup, nebulizer). Deleted 5 questions included over-the-counter medicine (Q8.1 2021 version), Inhaler used (Q8.2 2021 version), health professional watched you use the inhaler (Q8.4. 2021 version), use of spacer with Inhaler (Q8.13, 2021 version), and number of canisters of use (Q8.19, 2021 version).

- Section 10 (School-related asthma, child only): combined 7 school-related and daycare-related asthma questions together, deleted 7 daycare-related asthma questions, and eliminated the skip pattern for school/daycare age kids.

- Section 11 (additional child demographics, child only): child current height and weight were deleted.

- Section 11 (Adult) / Section 12 (Child), (family history of asthma and allergy): new section, total 7 new questions. One family asthma history question will be added to evaluate the genetic predisposition for developing asthma based on the close family member asthma history; the 6 allergy-related questions can provide measures at the state level to assess the effects of having allergy on people with asthma.

Revisions in Time Burden Requested

There are no proposed changes to the number of responses per respondent. For two instruments (ACBS Landline Screener-Child and ACBS Cell Phone Screener-Child) we will increase the estimated burden per response from one minute to two minutes. In addition, the NACP proposes the following changes to the estimated responses and burden hours from 2020 to 2024:

- Decrease the total number of responses from 68,886 to 57,812 responses (-10,074 responses).
- Decrease in the annual time burden from 6,615 to 6,073 hours (-542 hours), based on the changes to the number of responses.

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

A.2 Purpose and Use of the Information Collection

CDC's NCCDPHP Division of Population Health administers the BRFSS parent survey, which provides the foundation for the ACBS administration and data collection. The BRFSS questionnaire data (**Attachment 6**) and the ACBS questionnaire data (**Attachments 5e-5f**) are combined for the final ACBS analysis file to link demographics, behavioral, and risk factor data with the asthma-specific data on the ACBS at the state level. Data linking is done by a sequence number (person ID) that is scrambled on the public file.

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

- States use ACBS data to help them establish and track state and local asthma control objectives, plan asthma programs, implement asthma prevention and health promotion activities, and monitor trends.

- The ACBS data will be used to report asthma risk factor by state. See the 2020 risk factors prevalence tables for specific details

(https://www.cdc.gov/brfss/acbs/2020_tables_LLCP.html). State health department websites as well as a CDC website will be used as platforms to report ACBS data.

- The ACBS data will inform a variety of data resources, programs and organizations which use the data for asthma surveillance. These include but are not limited to National Institute for Occupational Safety and Health analysis and reporting of work-related asthma, The American Lung Association for asthma control assessment, and for calculating the Congressional Justification Measures.

- CDC disseminates a publicly available annual ACBS dataset at the BRFSS website (see the website at www.cdc.gov/brfss/ACBS). This dataset is frequently used by public health officials in government at the national, state, and local level as well as researchers at university and non-profit organizations. Information will be used for program evaluation and reporting related to health status, risk factors, health care system use, medication use, and various indicators of asthma such as asthma attacks, preventive behaviors, and asthma control levels. Data will be appropriate for trend analyses, significance testing to assess subgroup differences, multivariate analyses of health outcomes, and other statistical processes.

- The ACBS data may be used to draw comparisons from data taken from identical and/or similar questions on other surveys using other modes, thereby creating a means for validation and comparisons across population samples.

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

Additionally, the ACBS questionnaires (**Attachments 5e–5f**) include information about the health and experiences of people with asthma such as age at first diagnosis, which is important in estimating asthma incidence, asthma attack, preventive measures, medication use, treatment modalities, asthma severity. asthma control, as well as demographic information. Key

questionnaire features of the information collection help to address critical questions surrounding the health and experiences of persons with asthma, such as:

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

Consequences of not collecting the ACBS data are below:

- ACBS data are used to calculate and derive the NACP Congressional Justification Performance Measure, which cannot be produced if ACBS data are not collected.
- State-level adult and child asthma prevalence data will not exist.
- Data for the proposed Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities indicators will not be produced.
- State level incidence rates cannot be estimated.
- State level intervention planning and monitoring of asthma severity, asthma control, and self-management education as indicated in the NAEPP 2007 Expert Panel Report (EPR-3, available at: https://ginasthma.org/wp-content/uploads/2020/04/GINA-2020-full-

report_-final-_wms.pdf) on Asthma Diagnosis and Treatment Guidelines will not be conducted.

A.3 Use of Improved Information Technology and Burden Reduction

- The ACBS data will be collected using list-assisted random digit dialing (RDD) landline and cell phone telephone samples. Given the need for state-level samples that are large enough for statistical analyses, telephone surveys offer a cost-effective method of data collection. Interviewers will use Computer Assisted Telephone Interview (CATI) software to enter data directly into a database. Use of CATI software promotes efficiency in two ways: skip patterns can be programmed to route respondents only to questions that they are eligible to answer, and real-time quality control checks can be used to eliminate some errors which may have been caused by manual data entry procedures. As we have been informed by BRFSS operation team, future changes to the BRFSS methods may include the elimination of landline phone numbers in the sample. This is prompted by the low percentage (approximately 4%) of US residents without cell phones, the deterioration of the accuracy of landline samples, and the streamlining of methods which would result from a single sample of phone numbers. 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. Improvements in RDD sampling may result in more complete, especially the respondents moved from one state to another which could be lost to follow up in BRFSS.

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

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

The National Center for Health Statistics surveys collect data on asthma prevalence, asthma-related deaths (mortality), and several indicators of asthma-related illness (morbidity), such as hospitalizations and emergency department visits (the National Hospital Care Survey [formerly the National Hospital Discharge Survey, OMB Control No. 0920-0212, expiration date 12/31/2024], the National Hospital Ambulatory Medical Care Survey [NHAMCS, OMB Control 0920-0278, expiration date 09/30/2023], the National Ambulatory Medical Care Survey [NAMCS, OMB Control No 0920-0234, expiration date 11/30/2025]; national surveys such as the National Health Interview Survey [NHIS, OMB Control No. 0920-0214, expiration date 12/31/2023], and the National Health and Nutrition Examination Survey [NHANES; OMB Control No 0920-0950, expiration date 04/30/2025]), among others, offer data for prevalence estimates at the national level. These data provide a good basis for analyzing national trends, establishing national goals, and assessing progress toward those goals, but not all can be analyzed by states and they do not have detailed data needed at the state level. ACBS differs in that it samples at state levels, and produces direct, not modeled, estimates for all states and some local geographic jurisdictions. It also provides a state level public use dataset on a broad range of asthma related topics, many of which are not included in national surveys.

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

A.5 Impact on Small Businesses or Other Small Entities

There will be no impact on small businesses.

A.6 Consequences of Collecting the Information Less Frequently

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

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

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

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

A. A 60-day notice was published in the Federal Register on Monday, March 6, 2023, Vol. 88, No. 43, Page 13825 (**Attachment 2**). The CDC did not receive any comments, and thus, no response was provided.

B. The CDC BRFSS ACBS operation team is constantly seeking outside suggestions from other agencies for various topics, including data collection quality control, clarity of survey instruction, strategies to improve response rate, dataset uploading and downloading, and data public release elements. The ACBS operation team has a regular monthly conference meeting with outside agencies, including different states' BRFSS coordinators, ACBS data collectors, and asthma epidemiologists who are listed in Table

8.1 below. The ACBS operation team hosts an ACBS panel section during a yearly BRFSS conference to discuss and resolve issues related to ACBS operations. Our questionnaire and protocol modifications are based on their suggestions.

Table 8.1. 2020 ACBS External Consultations

Name	Title	Affiliation	Phone	Email
Carlene Robinson, DrPH	**Epidemiologist**	Alabama Department of Public Health	334 206-5051	Carlene.Robinson@adph.state.al.us
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Yan Tian, MS, PhD	**BRFSS Coordinator**	Michigan Department of Community Health	517-335-8144	TianY@michigan.gov

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Katie Long	**BRFSS Coordinator**	Missouri Department of Health and Senior Services	573-526-6660	Katie.Long@health.mo.gov
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Jeff Armitage, B.S.	**BRFSS Coordinator**	Department of Regulation and Licensure	402-471-7733	jeff.armitage@nebraska.gov
Kim Lim, PhD, MPH	**BRFSS Coordinator**	Division of Public Health Services	603-271-4671	kim.c.lim@dhhs.state.nh.us
Kenneth J. O'Dowd, Ph.D., M.S.	**BRFSS Coordinator**	NJ Dept. of Health and Senior Services	609-984-6703	Kenneth.ODowd@doh.nj.gov
Amber Dukes, PhD, MPH	**BRFSS Epidemiologist**	New Mexico Department of Health	505-476-3569	amber.dukes@state.nm.us
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Adam Johnson	**BRFSS Coordinator**	Pennsylvania Department of Health	717-547-3661	adamjohnson@pa.gov
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Karine Monteiro, MPH	**BRFSS Coordinator**	Rhode Island Department of Health	401-222-7628	karine.monteiro@health.ri.gov
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Shige Onda	**BRFSS Coordinator**	Utah Department of Health	801-538-9466	sonda@utah.gov
Kate Emmons, MPH	**BRFSS Coordinator**	Vermont Department of Health	802-651-1516	kate.emmons@vermont.gov

A.9 Explanation of Any Payment or Gift to Respondents

CDC will not provide payments or gifts to respondents.

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

The ACBS is implemented as a follow-up survey through the NCCDPHP BRFSS Program. As administered, the ACBS uses the same privacy protections as outlined in the BRFSS protocol (**Attachment 6a, 7**) and as summarized in the BRFSS Supporting Statement A Section A.10 (OMB Control No. 0920-1061, expiration date 12/31/2024) (**Attachment 6c**). The NCCDPHP BRFSS Program has determined that the Privacy Act does not apply to their data collection procedures. States are responsible for developing and maintaining procedures to ensure respondents' privacy, assure and document the quality of the interviewing process, and supervise and monitor trained interviewers.

Overview of the BRFSS and the ACBS Data Collection System

Random digit dialing (RDD) telephone samples will be delivered to the states on a monthly or quarterly schedule. Information collection will be implemented by state health departments or their designees. States will administer the core/rotating/emerging core questions without change. Field operations are managed by state health departments and/or their contractors following The Data Collectors' Protocol provided by the BRFSS (**Attachments 4, 7**). States submit data to CDC BRFSS operation team for final cleaning, weighting, the production of analysis datasets, and other technical assistance as needed. Computer-assisted telephone interviewing (CATI) programming is provided by the CDC to states to convert the BRFSS questionnaire into a CATI interface from which interviewers will read and record answers to each question. States may opt to use their own CATI programming software. States run edit checking programs (CDC-provided) against the data and submit to the CDC on a monthly/quarterly basis. CDC then conducts additional data quality processes and summarizes the data in YTD reports provided to the states. At the end of each calendar year, data are finalized and weighted.

Respondents for ACBS are the subset of BRFSS adults, 18 years and older, in participating states who report ever being diagnosed with asthma. Some states include children, below 18 years of age, who are randomly selected subjects in the BRFSS household. In participating states, parents

or guardians serve as ACBS proxy respondents for their children ever diagnosed with asthma. Children do not respond directly to the ACBS questionnaire. If both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in a flowchart (**Attachment 9**).

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

Items of Information to be Collected in ACBS

The ACBS questionnaire (**Attachment 5e-5f**) includes information on medication use, symptoms, health care use, and disease management, and environmental risk factor. The basic demographic information was transferred from BRFSS dataset. Other than phone numbers, which are part of the original sample files sent to the states, no information in individually identifiable form (IIF) will be collected from respondents during the telephone interviews. When states gained the ACBS consent in BRFSS, first names were asked to ensure that the ACBS interview is conducted with the same individual. The ACBS operation team uses the HHS Safe Harbor guidelines (https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html) to determine suppression of variables from public use information. Researchers who request access to information not provided in the public use dataset may use the Research Data Center (RDC) hosting agreement with the BRFSS and Asthma and Community Health Branch. States must develop and maintain procedures to ensure respondents' privacy, assure and document the quality of the interviewing process, and supervise and monitor trained interviewers. The CDC provides states with guidelines for training interviewers and standard procedures for monitoring a minimum of 10% of all interviews. ACBS data storage and confidentiality of responses followed the BRFSS protocol (**Attachment 6a, 7**).

IIF (e.g., first name, initials) is collected **(Attachments 5a–5d)** by the states during field operations as part of routine collection for the purposes of call back and to ensure completion of

the interview with the respondents. The final ACBS datasets delivered to CDC will not contain the participant's initials or name.

How Information Will Be Shared and For What Purpose

Since state health departments and/or their designees are the data collectors for the ACBS, information will originate with the states. States may determine whether and how their data will be released to third parties. The CDC maintains an upload website by which data are submitted monthly/quarterly. CDC does not transmit data from one state to any other, with the exception of cell phone interviews of persons who have an area code from one state, but who actually live in another state. Telephone numbers are not linked to respondents. Files containing RDD telephone samples are kept separately from files which include responses to questionnaire items. CDC receives only de-identified records. Sample files contain sequence numbers which are provided by the sampling vendor and used by data collectors (the states or their designees) to determine calling outcomes for each phone number. The CDC does not receive full phone numbers in the sample file. Sample files received by the CDC and states which have contracted data collection include only area code and prefixes of phone numbers which are associated with sequence numbers. States which have internal data collection systems and contracted data collectors have sole access to both sequence numbers and full phone numbers during the data collection process. States keep responses to the BRFSS questionnaire separately from sample files. After data collection, sequence numbers are recoded to prevent subsequent links of sample files and responses to questions by any person or organization involved in data collection. State level data sets are owned by individual states. A subset of state data sets is provided for public use. Public use data sets have been stripped of a number of variables which provide locational information on the respondents including zip codes, and county identifiers for counties with adult populations of less than 10,000, occupational information, uncategorized ages of respondents, and detailed race. CDC may provide data with locational information for internal users to produce small area estimates of health indicators.

Impact of the Proposed Collection on Respondents' Privacy

ACBS sample files from BRFSS asthma eligible respondents, include phone numbers only. Since sample files are separate from datasets, no phone numbers are included in the datasets. No

dates of birth, last names, or email address are obtained. Information that details race/ethnicity, occupation and small geographic residence (such as county or zip code) is transferred from BRFFS and suppressed in the public use dataset based on BRFSS protocol. In order to determine which variables to suppress, the BRFSS ACBS uses the HHS Safe Harbor guidelines (https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html).

How Individuals Are Informed That Providing Information Is Voluntary or Mandatory

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

Opportunities to Consent

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

How Information Will Be Secured

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

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

The ACBS information collection has been reviewed by the NCEH/ATSDR Human Subjects Contact. This CDC collection has been classified as a non-research public health surveillance

activity undertaken by a public health authority as defined in 45 CFR 46. Thus, IRB review is not required (**Attachment 8a**).

The BRFSS Program classifies its activity as exempt research as approved by the CDC Human Research Protection Office (**Attachment 6b**). Some state IRBs require that BRFSS respondents be specifically asked if their BRFSS responses could be linked to their ACBS responses. Other state IRBs do not. If consent is denied, the ACBS is not conducted and there will be no record in the file. The state-specific consent scripts are maintained by each participating state. Individuals participating in the ACBS are informed that they do not have to participate and that they may refuse to answer any question during the consent/permission process and before survey administration. See **Attachments 5e-5f** for CDC suggested consent templates.

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

A.12 Estimates of Annualized Burden Hours and Costs

The estimated burden to respondents is summarized in Table A12-1 below. Within the selected BRFSS household, ACBS respondents are adults 18 years or older with an asthma diagnosis or parents or guardians of a randomly selected child, below 18 years, with an asthma diagnosis. Children do not respond directly to the ACBS; parents or guardians provide proxy responses for children. Respondent burden is estimated separately for each step. The number of interviews varies from state to state, based on the population size, lifetime asthma prevalence, and response rate of each state. For states conducting both landline and cellphone samples, approximately 30 percent of interviews are currently conducted on landlines and 70 percent on cell phones. The burden calculation was computed based on the states that implemented both landline and cellphone samples in 2020 because this will be the data collection mode for all participating states starting in 2024. The estimated number of recipients will remain as approved in 2023 (n=40), in case program funding increases above the current 34 recipients. Since the cooperation rate (based on AAPOR cooperation rate #2 – **Attachment 12**) in 2020 was 58.0 percent for adult

landline respondents and 58.5 percent for adult cellphone respondents, it is estimated that 9,004 landline respondents (8,170 + 834) and 24,889 cell phone respondents (20,780 + 4,109) will complete the screening questions. The estimated burden per screening response is one minute for adults, and two minutes for children. The ACBS screener documents are provided in **Attachments 5a–5d**.

Respondents who are eligible for the ACBS and agree to participate will be contacted again within two days to complete the ACBS questionnaire or interview immediately after BRFSS interview if the respondent is willing (**Attachments 5e–5f)**. We estimate that total of 33,893 respondents screened on both landline and cell phones will participate in the ACBS data collection (28,950 adults and 49,43 children).

For the ACBS, states administer one questionnaire for adult respondents and a similar questionnaire for the randomly selected child in the household. Again, if both the BRFSS adult respondent and the selected child in the household have asthma, then only one or the other is eligible for the ACBS. The ACBS enrollment process is presented in **Attachment 9**.

We estimate the average burden for the ACBS survey at 10 minutes per response. The burden hour estimates reflect the landline and cell phone data collection method that will be used starting 2024.

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

The total time burden requested is **6,073** hours.

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

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hrs.)	Total Burden Hours
BRFSS Adults	ACBS Landline Screener – Adult	8,170	1	1/60	136
	ACBS Cell Phone Screener – Adult	20,780	1	1/60	346
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	834	1	2/60	28
	ACBS Cell Phone Screener – Child	4,109	1	2/60	137
ACBS Adults	ACBS Adult Consent and Survey	20,155	1	10/60	3359
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey	3,764	1	10/60	627
State BRFSS Coordinators	ACBS Adult Data Submission Layout	40	12	155/60	1,240
	ACBS Child Data Submission Layout	40	12	25/60	200
Total					6,073

Annualized burden costs are summarized in the table below. Hourly rates were taken from the Bureau of Labor Statistics May 2022 National Industry-Specific Occupational Employment and Wage Estimates (available at https://www.bls.gov/oes/current/oes_nat.htm#00-0000).

Occupation Code	Occupation Title	Mean Hourly Wage
00-0000	All Occupations	$29.76
11-9111	Medical and Health Services Managers	$61.53

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

Type of Information	Form Name	Number of Respondents	Total Burden Hours	Average Hourly	Total Respondent

Collection				Wage Rate	Costs
BRFSS Adults	ACBS Landline Screener – Adult	8,170	136	$29.76	$4,047
	ACBS Cell Phone Screener – Adult	20,780	346	$29.76	$10,297
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	834	28	$29.76	$833
	ACBS Cell Phone Screener – Child	4,109	137	$29.76	$4,077
ACBS Adults	ACBS Adult Consent and Survey – 2020	20155	3359	$29.76	$99,964
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey – 2020	3,764	627	$29.76	$18,660
State BRFSS Coordinators	ACBS Adult Data Submission Layout	40	1240	$61.53	$76,297
	ACBS Child Data Submission Layout	40	200	$61.53	$12,306
Total			6,073		$226,481

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

There are no maintenance or capital costs to respondents.

A.14 Annualized Cost to Federal Government

Costs that are presented below include data collection, weighting, and sampling as well as data distribution (i.e., websites and production of data sets). These are based on the 2022 funds provided to states for data collection as well as internal BRFSS costs.

Table 14.1. Annualized Cost to the Federal Government

Funds provided to 34 ACBS recipient states and Puerto Rico	$1,400,000
Funds provided to BRFSS (administration and data processing)	$600,000
Survey planning and documenting for Federal Employees	$200,000
Total	$2,200,000

A.15 Explanation for Program Changes or Adjustments

Proposed Questionnaire Changes

Question changes and additions to the 2024 ACBS questionnaire (**Attachments 5e-5f**) are based on the feedback from ACBS working groups and data analysis results. Changes to existing questions and additions of new questions to the 2024 child and adult ACBS questionnaires are included in Table. A15.1 and A15.2. A proposed total of 6 questions will be deleted from the adult's questionnaire and delete 17 questions from child's questionnaire. With the addition of 9 new questions to the adult's questionnaire and 10 questions to the child's questionnaire, the estimated time burden for the interview will remain unchanged from that of the 2021 questionnaire (10 minutes per response).

Question changes are summarized by revised sections below, and details of changes are listed in Tables 15.1 and A25,2:

- Section 4 (history of asthma, Symptoms & Episodes in the past year, changes applied on both adult and child questions): to facilitate the estimation of asthma control for data analysts using GINA definition (GINA Full Report 2020 Front, available at: https://ginasthma.org/wp-content/uploads/2020/04/GINA-2020-full-report_-final-_wms.pdf), all 4 questions (i.e., questions on daytime symptoms, nighttime symptoms, quick relief medications, and activity limitation) will be arranged in section 4. Actions include adding 1 new quick relief medication questions, deleting 1 question about the length of most recent asthma attack (Q4.7 2021 version), moving 1 activities limitation question from Section 5 (Q5.8 2021 version) into section 4 as Q4.8. Information about the asthma medicine use for quick relief of symptoms during an asthma attack or episode is one of four required impairment measures to define the asthma control status of people with asthma which is not in the current ACBS questionnaire. Therefore, one new

question on quick relief medicine, such as albuterol and salbutamol, to relief asthma symptoms was added into section 4 for both adult and child to measure asthma control status among persons with asthma using GINA definition. Based on the past responses, question about the length of time asthma attack lasted (Q4.7 2021 version) didn't provide useful information in defining asthma control status, therefore, will be deleted from the 2024 questionnaires.

- Section 5 (health care utilization, child question only): combined Q5.4 (influenza vaccine) and Q5.5 (FluMistTM) into one new question asking if child had received either vaccine to streamline the question. (Q5.4). This question is adopted from 2021 BRFSS question ""During the past 12 months, have you had either flu vaccine that was sprayed in your nose or flu shot injected into your arm?" available at: https://www.cdc.gov/brfss/questionnaires/index.htm

- Section 8 (medications, changes applied on both adult and child questions): add 1 new question (Q8.1, 2024 version) of taking any form of prescription asthma medication (inhaler, pills, syrup, nebulizer). The new question will ask asthma medication (inhaler, pills, syrup, or nebulizer) in one question, replacing the question asked about inhaler only (Q8.2 2021 version). This new question will help to identify persons using any forms of asthma medication (inhaler, pills, syrup, nebulizer) to ask the next question (Q8.5 SCR_MED1 2021 version). Deleted 5 questions included over the counter medicine (Q8.1 2021 version), Inhaler used (Q8.2 2021 version), health professional watched you use the inhaler (Q8.4. 2021 version), use spacer with Inhaler (Q8.13, 2021 version), and number of canisters of use (Q8.19, 2021 version). The medications listing tables (T8.1 inhaler, T8.2 pills, T8.3 syrup, T8.4 nebulizer) were updated to capture the most up-to-date information regarding asthma treatment in clinical practice, which is consistent with current asthma treatment guidelines, no impact on interview processing, impact CATI programming in the back only.

- Section 10 (School-related asthma, child only): combined 7 school related and daycare related asthma questions together, delete 7 daycare related asthma questions. School and

day care related asthma questions are combined to have statistical power for data analysis because not enough responses were obtained for most of the items when asked separately.

- Section 11 (additional child demographics, child only): child current height and weight were deleted because of 30% item non-response for 2019–2021 surveys and didn't provide reliable data to calculate body mass index among children.

- Section 11 (Adult) / Section 12 (Child), (family history of asthma and allergy): new section, total 7 new questions. One family asthma history question will be added to evaluate the genetic predisposition for developing asthma based on the close family member asthma history, which is adopted from the 2019–2020 NHANES questionnaire (NHANES 2019–2020 Medical Conditions, available at: https://wwwn.cdc.gov/nchs/data/nhanes/2019-2020/questionnaires/MCQ_K.pdf?). People with coexisting atopic conditions such as allergy and asthma are at greater risk for unfavorable health outcomes. The 6 allergy related questions can provide measures at state level to assess the effects of having allergy on people with asthma (2). These questions are adopted from the 2021 NHIS questionnaire (available at: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2021/EnglishQuest.pdf).

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

We propose the following modified (M) and new (N) questions for the 2024 ACBS compared with the original (O) 2021 ACBS Adult Questionnaire (OMB Control OMB No. 0920-1204, expiration date 11/30/2023).

STATUS	CHANGE	JUSTIFCATION OR SOURCES
SECTION 1 – INTRODUCTION		
O	No Changes	N/A
SECTION 2 – INFORMED CONSENT		
O	No Changes	N/A
SECTION 3 – RECENT HISTORY		
O	No Changes	N/A
SECTION 4 – HISTORY OF ASTHMA (Symptoms & Episodes in the Past Year)		
M	Modified the SKIP pattern:	To increase the item response

	O: If LASTSYMP (3.5) = 1, 2, 3, (last symptom 1 to 3 months) then continue whole section M: If LASTSYMP (3.5) = 1, 2, 3, 4 (last symptom 1 to 12 months) then continue whole section	
N	Add Question 4.6: During the past 30 days, on how many days did you take quick relief medicine such as albuterol and salbutamol to relief asthma symptoms? (QUICKRELIEF) __ __ DAYS/NIGHTS (88) NONE (30) Every day (77) DON'T KNOW (99) REFUSED READ IF NECESSARY: This quick relief medicine such as albuterol and salbutamol are breathed in through your mouth using a canister inhaler, a disk inhaler, or a nebulizer. A nebulizer is a small machine with a tube and facemask or mouthpiece that you breathe through continuously.	Information about the asthma medicine use such as albuterol and salbutamol for quick relief of symptoms during an asthma attack or episode is one of four required impairment measures to define the asthma control status of people with asthma (GINA Full Report 2020 Front Cover ONLY (ginasthma.org), which is not in the current ACBS questionnaire.
M	Move question from Section 5 to Section 4: Moved (Q5.9 2021 version) to Section 4: M: Q4.7. During just the past 30 days, would you say you limited your usual activities due to asthma not at all, a little, a moderate amount, or a lot?	No text changes. Make it easier for data users, we moved this question to section 4, where all other impairment questions (4.1, 4.3, 4.7) are. Four impairment questions (4.1, 4.3, 4.6, 4.7) are needed to define asthma control status (GINA Full Report 2020 Front Cover ONLY (ginasthma.org)).
M	Moved (Q5.8 2021 version) to Section 4: M: Q4.8. During the past 12 months, how many days were you unable to work or carry out your usual activities because of your asthma?	
D	Delete: O: Q4.7. How long did your MOST RECENT asthma episode or attack last?	Based on the past responses, this question didn't provide useful information in defining asthma control status
SECTION 5 – HEALTHCARE UTILIZATION		
M	NO text changes, Change the question's serious number O: Q5.10 to M: Q5.3	No text changes, modify questions number to maintain the series of question number

	O: Q5.1 to M: Q5.4 O: Q5.2 to M: Q5.5 O: Q5.3 to M: Q5.6 O: Q5.4 to M: Q5.7 O: Q5.5 to M: Q5.8 O: Q5.6 to M: Q5.9 O: Q5.7 to M: Q5.10	
SECTION 6 – KNOWLEDGE OF ASTHMA/MANAGEMENT PLAN		
O	No Changes	N/A
SECTION 7 – MODIFICATIONS TO ENVIRONMENT		
O	No Changes	N/A
SECTION 8 – MEDICATIONS		
N	Add Question Q8.1: In the <u>past 3 months</u>, did you take any forms of prescription asthma medication (inhaler, pills, syrup, nebulizer)? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	This question replaces the question asked about inhaler only (Q8.2 2021 version) and it helps to identify those using any forms of asthma medications (inhaler, pills, syrup, nebulizer) to ask the next question (Q8.5 SCR_Med 1 2021 version) or skip to Section 9.
M	Delete: Q8.1. Over-the-counter medication can be bought without a doctor's order. Have you ever used over-the-counter medication for your asthma?	Only one type of over-the-counter asthma medication is available (Primatene Mist) and not many persons with asthma use it to impact the outcome.
	Delete: Q8.2. Have you ever used a prescription inhaler?	Q8.1 is added to replace it.
	Delete: Q8.4. Did a doctor or other health professional watch you use the inhaler?	This question by itself will not provide useful information on asthma management, unless additional follow-up questions are asked to clarify if watching inhaler use will lead to using their inhaler accurately, if not, further education is provided or not.
	Delete: Q8.13. A spacer is a small attachment for an inhaler that makes it easier to use. Do you use a spacer with [MEDICINE FROM INH_MEDS SERIES]?	A spacer is needed for some but not all asthma inhaler meds. Can create bias in estimation.
	Delete: Q8.19. How many canisters of [MEDICINE FROM INH_MEDS (8.9) SERIES] have you used in the <u>past 3 months?</u>	Not all asthma inhaler medications come with canisters. Can create bias in estimation.

M	NO text changes, Change the question's series number O: Q8.5 to M: Q8.2 O: Q8.7 to M: Q8.3 O: Q8.3 to M: Q8.5 O: Q8.9 to M: Q8.6 O: Q8.10 to M: Q8.7 O: Q8.14 to M: Q8.8 O: Q8.15 to M: Q8.9 O: Q8.16 to M: Q8.10 O: Q8.17 to M: Q8.11 O: Q8.20 to M: Q8.12 O: Q8.21 to M: Q8.13 O: Q8.22 to M: Q8.14 O: Q8.23 to M: Q8.15 O: Q8.24 to M: Q8.16 O: Q8.25 to M: Q8.17 O: Q8.26 to M: Q8.18 O: Q8.27 to M: Q8.19 O: Q8.27A to M: Q8.20	No text changes, modify questions number to maintain the sequence of question number
M	Updated: Table 8.1 (Inhaler list); Table 8.2. (Pills List); Table 8.3 (Syrup listing); Table 8.4 (Nebulizer listing). Groups the medication based on the function No changes for interview questions, update list is for background CATI programming need, NO impact for interview processing	Update the asthma medication lists to capture the most up-to-date information regarding asthma treatment in clinical practice, which is consistent with current asthma treatment guidelines. Classification of medications based on their function makes data management and analyses easier, but doesn't affect the interview process
O	No Changes	N/A
SECTION 9 – COST OF CARE		
O	No Changes	N/A
SECTION 10 – WORK-RELATED ASTHMA		
O	No Changes	N/A
SECTION 11 – FAMILY HISTORY OF ASTHMA AND ALLERGY		
N	New question: Q11.1. Including living and deceased, were any of your close biological that is, blood relatives including father, mother, sisters or brothers, ever told by a health professional that they had asthma? 1) YES (2) NO (7) DON'T KNOW	Close biological relatives having asthma is a strong indication of genetic predisposition for developing asthma. Information will be useful in evaluating risk factors in developing asthma. This question is adopted from the 2019–2020 NHANES questionnaire (NHANES 2019-2020 Medical Conditions - MCQ

	(9) REFUSED	(cdc.gov).
N	Q11.2. Do you get symptoms such as sneezing, runny nose, or itchy or watery eyes due to hay fever, seasonal or year-round allergies? 1) YES (2) NO (7) DON'T KNOW (9) REFUSED	People with coexisting atopic conditions such as allergy and asthma are at greater risk for unfavorable health outcomes. These questions can provide information about the allergy status of survey participants in the participating states annually to assess the effects of having allergy on people with asthma. These questions are adopted from the 2021 NHIS questionnaire (https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2021/EnglishQuest.pdf)
N	Q11.3. Have you ever been told by a doctor or other health professional that you had hay fever, seasonal or year-round allergies? 1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	Question Text: The next question is about food allergies. People with food allergies have reactions such as hives, vomiting, trouble breathing, or throat tightening that occur within two hours of eating a specific food. Q11.4. Do you have an allergy to one or more foods? 1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	Q11.5. Have you ever been told by a doctor or other health professional that you had an allergy to one or more foods? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	The next question is about an allergic skin condition. Q11.6 Do you get an itchy rash due to eczema or atopic dermatitis 1) YES (2) NO (7) DON'T KNOW (9) REFUSED	

N	Q11.7 Have you ever been told by a doctor or other health professional that you had eczema or atopic dermatitis? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
End of Questions		

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

We propose the following modified (M) and new (N) questions for the 2024 ACBS compared with the original (O) 2021 ACBS Child Questionnaire (OMB Control OMB No. 0920-1204, expiration date 11/30/2023).

STATUS	CHANGE	JUSTIFCATION OR SOURCES
SECTION 1 - INTRODUCTION		
O	No Changes	N/A
SECTION 2 – INFORMED CONSENT		
O	No Changes	N/A
SECTION 3 – RECENT HISTORY		
O	No Changes	N/A
SECTION 4 – HISTORY OF ASTHMA (SYMPTOMS AND EPISODES IN THE PAST YEAR)		
M	Modified the SKIP pattern: O: If LASTSYMP (3.5) = 1, 2, 3, (last symptom 1 to 3 months) then continue whole section M: If LASTSYMP (3.5) = 1, 2, 3, 4 (last symptom 1 to 12 months) then continue whole section	To increase the item response
N	New Question 4.6: During the past 30 days, on how many days did {child's name} take quick relief medicine such as albuterol and salbutamol to relief asthma symptoms? (QUICKRELIEF) __ __ DAYS/NIGHTS (88) NONE (30) Every day (77) DON'T KNOW (99) REFUSED READ IF NECESSARY: This quick	Requiring the information about the asthma medicine, such as albuterol and salbutamol for quick relief of symptoms during an asthma attack or episode. This question is important to assess the asthma control status among persons with current asthma

	relief medicine such as albuterol and salbutamol are breathed in through your mouth using a canister inhaler, a disk inhaler, or a nebulizer. A nebulizer is a small machine with a tube and facemask or mouthpiece that you breathe through continuously.	
M	Move question from (Q5.6 from 2021 version) to Section 4: M: Q4.7. During just the past 30 days, would you say {child's name} limited {his/her} usual activities due to asthma not at all, a little, a moderate amount, or a lot?	No text changes. Moved and will ask all the questions related to asthma control monitor in Section 4
M	Delete: O: Q4.7. How long did {his/her} MOST RECENT asthma episode or attack last?	Based on the past responses, this question didn't provide useful information in defining asthma control status
M	No text changes. Modify the question number: O: Q4.5 to M: Q4.8	No text changes, modify questions number to maintain the continues number
SECTION 5 – HEALTH CARE UTILIZATION		
N/M	Combined Q5.4 and Q5.5 (2021 version) as one modified question: N: Q5.4. During the past 12 months, did {CHILD'S NAME} have a flu shot or a flu vaccine that is sprayed in the nose? (FLU_VACCINE) (1) YES (2) NO (7) DON'T KNOW (9) REFUSED O: Q5.4. A flu shot is an influenza vaccine injected in your arm. During the past 12 months, did {CHILD'S NAME} have a flu shot? O: Q5.5. A flu vaccine that is sprayed in the nose is called FluMistTM. During the past 12 months, did {he/she} have a flu vaccine that was sprayed in {his/her} nose?	Combined Q5.4 (influenza vaccine) and (FluMistTM) into one NEW question to streamline the question. This question is adopted from 2021 BRFSS question "During the past 12 months, have you had either a flu vaccine that was sprayed in your nose or a flu shot injected into your arm?" available at: https://www.cdc.gov/brfss/questionnaires/index.htm
M	NO text changes, Change the question's serious number O: Q5.14 to M: Q5.5 O: Q5.7 to M: Q5.6 O: Q5.8 to M: Q5.7	No text changes, modify questions number to maintain the series of question number

	O: Q5.9 to M: Q5.8 O: Q5.10 to M: Q5.9 O: Q5.11 to M: Q5.10 O: Q5.12 to M: Q5.11 O: Q5.13 to M: Q5.12	
SECTION 6 – KNOWLEDGE OF ASTHMA/MANAGEMENT PLAN		
M	No Changes	N/A
SECTION 7 – MODIFICATIONS TO ENVIRONMENT		
M	No Changes	N/A
SECTION 8 – MEDICATIONS		
N	New Question Q8.1: In the past 3 months, did {child's name} take any forms of prescription asthma medication (inhaler, pills, syrup, nebulizer)? asthma medication (inhaler, pills, syrup, nebulizer)? (ASTHMED) (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	This question replaces the question asked about inhaler only (Q8.2 2021 version) and it helps to identify those using any forms of asthma medications (inhaler, pills, syrup, nebulizer) to ask the next question (Q8.5 SCR_Med 1 2021 version) or skip to Section 9..
M	Delete: Q8.1. Over-the-counter medication can be bought without a doctor's order. Has {child's name} ever used over-the-counter medication for {his/her} asthma?	Only one Over-the counter medication on the market, not enough response
	Delete: Q8.2. Has [he/she} ever used a prescription inhaler?	NEW Q8.1 is added to replace it
	Delete: Q8.4. Did a doctor or other health professional watch {him/her} use the inhaler?	This question will not provide useful information unless additional follow-up questions are asked to clarify if after watching inhaler use, if usage was accurate, if not, further education is provided or not.
	Delete: Q8.13. A spacer is a small attachment for an inhaler that makes it easier to use. Does {he/she} use a spacer with [MEDICINE FROM INH_MEDS SERIES]?	A spacer is not needed for most of asthma inhaler meds, Can create bias in estimation
	Delete: Q8.19. How many canisters of [MEDICINE FROM INH_MEDS (8.9) SERIES] has {child's name} used in the past 3 months?	Not all asthma inhaler medications come in canisters. Can create bias in estimation

M	NO text changes, Change the question's series number O: Q8.5 to M: Q8.2 O: Q8.7 to M: Q8.3 O: Q8.3 to M: Q8.5 O: Q8.9 to M: Q8.6 O: Q8.10 to M: Q8.7 O: Q8.14 to M: Q8.8 O: Q8.15 to M: Q8.9 O: Q8.16 to M: Q8.10 O: Q8.17 to M: Q8.11 O: Q8.20 to M: Q8.12 O: Q8.21 to M: Q8.13 O: Q8.22 to M: Q8.14 O: Q8.23 to M: Q8.15 O: Q8.24 to M: Q8.16 O: Q8.25 to M: Q8.17 O: Q8.26 to M: Q8.18 O: Q8.27 to M: Q8.19 O: Q8.27A to M: Q8.20	No text changes, modify questions number to maintain the series of question number
M	Updated: Table 8.1 (Inhaler list); Table 8.2. (Pills List); Table 8.3 (Syrup listing); Table 8.4 (Nebulizer listing). Groups the medication based on the function No changes for interview questions, update list is for background CATI programming need, NO impact for interview processing	Update the asthma medication lists to capture the most up-to-date information regarding asthma treatment in clinical practice, which is consistent with current asthma treatment guidelines. Grouping the medications based on function makes data management and analyses easier, but doesn't affect the interview process
SECTION 9 – COST OF CARE		
O	No Changes	N/A
SECTION 10 – SCHOOL-RELATED ASTHMA		
M	Q10.1. O: Does {child's name} currently go to school or pre-school outside the home? M: Does {child's name} currently go to school or pre-school or day care outside the home?	No enough responses from day care related questions. Combined school and day care questions could increase the item responses, provide more statistical power to produce reliable estimation. Combined school and day care questions could reduce the skip patterns, and the survey burden time remain the same Add 'or Day care' to School related questions Add 'or Day care' to School related

		questions
M	Q10.2 O: What is the main reason {he/she} is not now in school? M: What is the main reason {he/she} is not now in school or day care?	Add ‘or Day care’ to School related questions
M	Q10.3. O: What grade was {he/she} in the last time {he/she} was in school? M: What grade was {he/she} in the last time {he/she} was in school or day care?	Add ‘or Day care’ to School related questions
M	Q10.5. O: Does the school {he/she} goes to allow children with asthma to carry their medication with them while at school? M: Does the school {he/she} goes to allow children with asthma to carry their medication with them while at school or day care?	Add ‘or Day care’ to School related questions
M	Q10.6. O: Does {child’s name} have a written asthma action plan or asthma management plan on file at school? M: Does {child’s name} have a written asthma action plan or asthma management plan on file at school or day care?	Add ‘or Day care’ to School related questions
M	Q10.8. O: Are you aware of any mold problems in {child’s name} school? M: Are you aware of any mold problems in {child’s name} school or daycare?	Add ‘or Daycare’ to School related questions
M	Combined the school related and daycare related asthma questions together and deleted day care related questions Delete: Q10.10. Does {child’s name} go to day care outside his/her home? Q10.11. Has {he/she} gone to daycare in the past 12 months? Q10.12. During the past 12 months, about how many days of daycare did {he/she} miss because of {his/her} asthma?	No enough responses from day care related questions. Combined school and day care questions could increase the item responses, provide more statistical power to produce reliable estimation.

	Q10.13. Does {child's name} have a written asthma action plan or asthma management plan on file at daycare? Q10.14. Are there any pets such as dogs, cats, hamsters, birds or other feathered or furry pets in {his/her} room at daycare? Q10.15. Are you aware of any mold problems in {his/her} daycare? Q10.16. Is smoking allowed at {his/her} daycare?	
SECTION 11 – ADDITIONAL CHILD DEMOGRAPHICS		
M	Delete questions: Q11.1. How tall is {child's name}? Q11.2. How much does [he/she} weigh?	30% item non-response for 2019–2021 surveys, and didn't provide reliable data to calculate body mass index among children
	NO text changes, Change the question's series number O: Q11.3 to M: Q11.1. O: Q11.4 to M: Q11.2.	NO text changes, Change the question's sequence number
SECTION 12 – FAMILY HISTORY OF ASTHMA AND ALLERGY		
N	Q12.1. Including living and deceased, were any of {child's name} close biological that is, blood relatives including father, mother, sisters or brothers, ever told by a health professional that they had asthma? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	Close biological relatives having asthma is a strong indication of genetic predisposition for developing asthma. Information will be useful in evaluating risk factors in developing asthma. This question is adopted from the 2019–2020 NHANES questionnaire (NHANES 2019-2020 Medical Conditions - MCQ (cdc.gov)
N	Q12.2. Does {child's name} get symptoms such as sneezing, runny nose, or itchy or watery eyes due to hay fever, seasonal or year-round allergies? (1) YES (2) NO (7) DON'T KNOW	People with coexisting atopic conditions such as allergy and asthma are at greater risk for unfavorable health outcomes. These questions can provide information about the allergy status of survey participants in the participating states annually to assess the

	(9) REFUSED	effects of having allergy on people with asthma. These questions are adopted from the 2021 NHIS questionnaire These questions are adopted from the 2021 NHIS questionnaire, available at: https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2021/EnglishQuest.pdf
N	Q12.3. Has {child's name} ever been told by a doctor or other health professional that {child's name} had hay fever, seasonal or year-round allergies? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	Question Text: The next question is about food allergies. People with food allergies have reactions such as hives, vomiting, trouble breathing, or throat tightening that occur within two hours of eating a specific food. Q12.4. Do {child's name} have an allergy to one or more foods? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	Q12.5. Has {child's name} ever been told by a doctor or other health professional that {child's name} had an allergy to one or more foods? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	The next question is about an allergic skin condition. Q12.6. Does {child's name} get an itchy rash due to eczema or atopic dermatitis?	

	(1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
N	Q12.7. Has {child's name} ever been told by a doctor or other health professional that {child's name} had eczema or atopic dermatitis? (1) YES (2) NO (7) DON'T KNOW (9) REFUSED	
End of questions		

Revisions in Time Burden Requested

The total BRFSS sample size reduced from 476,217 in 2016 to 393,474 in 2020, as the result of decreasing BRFSS sample size, the eligible ACBS's BRFSS respondents, changed from 46,100 to 41,444 from 2016 to 2020. There are no proposed changes to the number of responses per respondent. For two instruments (ACBS Landline Screener-Child and ACBS Cell Phone Screener-Child) we will increase the estimated burden per response from one minute to two minutes. In addition, the NACP proposes the following changes to the burden estimation from 2021 (based on 2016 ACBS response data) to 2024 (based on 2020 response data):

- Decrease the total number of responses from 68,846 to 57,772 responses (-10,074 responses) due to:
    - a proposed decrease of 7,040 BRFSS consent screenings, from 40,933 to 33,893 respondents adjusted based on data from the states that implemented both landline and cellphone samples for adults and children in 2020: and
    - a proposed decrease of 3,034 ACBS respondents, from 26,953 to 23,919 respondents adjusted based on data from the states that implemented both landline and cellphone samples for adults and children in 2020.

- no change to the number of state BRFSS coordinators (n=40). For 2024, we have split the reporting for adult and child ACBS results into two rows in the burden table; therefore, this doubled the number of responses but did not affect the time burden requested (n=960 responses; n=1,440 hours). The time burden for adult and child ACBS reporting is based on the proportion of adult vs. child ACBS questionnaires per year (86.1% vs. 13.9%, respectively).

- Based on the above changes to the number of responses and respondents, we propose an decrease in the annual time burden from 6,615 to 6,073 hours (-542 hours).

Table A15.3. Net Change in Annualized Number of Responses and Time Burden in 2024 Relative to 2021

- There are no proposed changes to the number of responses per respondent. For two instruments (ACBS Landline Screener-Child and ACBS Cell Phone Screener-Child) we will increase the estimated burden per response from one minute to two minutes. Changes to the estimated number of respondents and resulting burden hours are reflected below.

Type of Respondents	Form Name	ICR Year	No. of Respondents	Total Burden Hours	Net Change in Responses and Burden Hours, 2021 to 2024
BRFSS Adults	ACBS Landline Screener – Adult	2021	17,800	297	-9630
		2024	8,170	136	-161
	ACBS Cell Phone Screener – Adult	2021	16,733	279	4,047
		2024	20,780	346	67
BRFSS Parents or Guardians of Children	ACBS Landline Screener – Child	2021	2,576	43	-1,742
		2024	834	28	-15
	ACBS Cell Phone Screener – Child	2021	3,824	64	285
		2024	4,109	137	73
ACBS Adults	ACBS Adult Consent and	2021	23,166	3,861	-3,011
		2024	20,155	3,359	-502

	Survey				
ACBS Parents or Guardians of Children	ACBS Child Consent and Survey	2021	3,787	631	-23
		2024	3764	627	-4
State BRFSS Coordinators	ACBS adult Data Submission Layout	2021	40	1240	0
		2024	40	1240	0
	ACBS Child Data Submission Layout	2021	40	200	0
		2024	40	200	0
Total Net Change in Responses and Burden Hours, 2024					Respondents = (-10,074)
					Burden Hours = (-542)

Table A.15.3 shows how the number of respondents by respondent type and form is estimated to change. The burden calculation for screening BRFSS adults and BRFSS parents/guardians was computed based on the states that implemented both landline and cellphone samples in 2020 because this will be the data collection mode for all participating states starting in 2024. Therefore, there will be a marked shift toward cellphone screening in 2024 for both BRFSS adults and BRFSS parents/guardians of children, relative to the burden estimates in 2024.

In 2024, there will be an estimated decrease in the distribution of BRFSS and ACBS adults and their time burden ([-5,583 respondents and -94 hours] vs. [-3,011 respondents and -502 hours], respectively). On the other hand, there will be an estimated decrease in the distribution of BRFSS and ACBS parents/guardians responding for their children ([-1,457 respondents and +58 hour] vs. [-23 respondents and -4 hours], respectively).

Table A.15.3 shows how the net decrease of -10,074 responses and -542 burden hours were derived.

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

Data collection for the ACBS 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 March. Editing, cleaning, and weighting of the data will take place until November. Final weighted data sets (see description below) will be returned to the states by December. Datasets and supporting technical documentation will be available for public use after 6 to 8 months of the following BRFSS core data public releasing.

A. 16 – 1 Project Time Schedule	
Activity	Approximate Time Schedule
Data collection	January 1 – March 31 of following calendar year
Monthly data submission	February- March of following calendar year
Quarterly data quality reports	March, June, September, December, March of following calendar year
Data cleaning and editing	March - December of current calendar year
Weighting	March - December of following calendar year
Final data sets to states	The following second March of calendar year
Final public use datasets with supporting documentation	The following second July of calendar year

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

The expiration date of OMB approval will be displayed.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

References

1. Rozwadowski FM, Chew GL, Zahran HS, Santorelli ML. Assessing Indoor Environmental Control Practices by Race/Ethnicity Among Children With Asthma in 14 US States and Puerto Rico, 2013–2014. Prev Chronic Dis 2019;16:190199. DOI: http://dx.doi.org/10.5888/pcd16.190199
2. Pate CA, Zahran HS, Malilay J, Hsu J. The shifting prevalence of asthma and allergic disease in US children. Ann Allergy Asthma Immunol. 2022 Oct;129(4):481-489. doi: 10.1016/j.anai.2022.06.030. Epub 2022 Jul 14. PMID: 35842086.
3. Qin X, Bailey CM, Zahran HS. Comparison response patterns on landline and cell phone in a call back survey: effects of demographic characteristics and lag days. Survey Methods Insights Field. 2019; 2019:10.13094/SMIF-2019-00019. doi:10.13094/SMIF-2019-00019