

Nonsubstantive Change Request

RAPID SURVEYS SYSTEM

OMB No. 0920-1408, Expiration Date 06/30/2026

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Rapid Surveys System – Round 5

This is a request for approval of a nonsubstantive change to the Rapid Surveys System (RSS) (OMB No. 0920-1408, Exp. Date 06/30/2026), conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). This nonsubstantive change requests is for the fifth round of the RSS.

A. Justification

1. Circumstance Making the Collection of Information Necessary

Section 306 of the Public Health Service (PHS) Act (42 U.S.C.), as amended, authorizes that the Secretary of Health and Human Services (HHS), acting through NCHS, collect data about the health of the population of the United States.

RSS collects data on emerging public health topics, attitudes, and behaviors using cross-sectional samples from two commercially available, national probability-based online panels. The RSS then combines these data to form estimates that approximate national representation in ways that many data collection approaches cannot. The RSS collects data in contexts in which decision makers' need for time-sensitive data of known quality about emerging and priority health concerns is a higher priority than their need for statistically unbiased estimates.

The RSS complements NCHS's current household survey systems. As quicker turnaround surveys that require less accuracy and precision than CDC's more rigorous population representative surveys, the RSS incorporates multiple mechanisms to carefully evaluate the resulting survey data for their appropriateness for use in public health surveillance and research (*e.g.*, hypothesis generating) and facilitate continuous quality improvement by supplementing these panels with intensive efforts to understand how well the estimates reflect populations at most risk. The RSS data dissemination strategy communicates the strengths and limitations of data collected through online probability panels as compared to more robust data collection methods.

The RSS has three major goals: (1) to provide CDC and other partners with time-sensitive data of known quality about emerging and priority health concerns; (2) to use these data collections to continue NCHS's evaluation of the quality of public health estimates generated from commercial online panels; and (3) to improve methods to communicate the appropriateness of public health estimates generated from commercial online panels.

The RSS is designed to have four rounds of data collection each year with data being collected by two contractors with probability panels. A cross-sectional national sample will be drawn from the online probability panel maintained by each of the contractors.

Each round's questionnaire will consist of four main components: (1) basic demographic information on respondents to be used as covariates in analyses; (2) new, emerging, or supplemental content proposed by NCHS, other CDC Centers, Institute, and Offices, and other HHS agencies; (3) questions used for calibrating the survey weights; and (4) additional content selected by NCHS to evaluate against relevant benchmarks. NCHS will use questions from Components 1 and 2 to provide relevant, timely data on new, emerging, and priority health topics to be used for decision making. NCHS will use questions from Components 3 and 4 to weight and evaluate the quality of the estimates coming from questions in Components 1 and 2. Components 1 and 2 will contain different topics in each round of the survey.

NCHS submits a 30-day Federal Register Notice with information on the contents of each round of data collection.

2. Purpose and Use of Information Collection

In the fifth round of the RSS, contributed content includes content on positive childhood experiences and childhood vaccinations. Both topics are in support of the CDC's 2023-2024 Collaborative Initiative of Supporting Young Families. The questions in round 5 will be answered by panelists who are a parent/guardian of one randomly sampled child in the household.

NCHS calibrates survey weights from the RSS to gold standard surveys. Questions used for calibration in this round of RSS, over and above the standard demographic variables, will include chronic conditions, social and work limitation, civic engagement, language used at home and marital status. All these questions have been on the National Health Interview Survey (NHIS) in prior years allowing calibration to these data.

Finally, several questions that were previously on NHIS will be used for benchmarking to evaluate data quality. Panelists in the RSS will be asked health status, chronic conditions, developmental delay and disability, anxiety and depression, injury, COVID, healthcare access and utilization, health insurance, stressful life events for the selected child and social determinates including ability to pay medical bill, SNAP participation, and food insecurity at a family or household level. The questionnaire for round 5 is included as Attachment A and the content justification is included as Appendix A within this document.

12. Estimates of Annualized Burden Hours and Costs

A. Time Estimates

This nonsubstantive change request seeks approval to the OMB data collection that was approved on 06/30/2023 (OMB# 0920-1408, expires 06/30/2026). The average burden for the fifth round survey cycle is shown in the table below.

The NCHS RSS Round 5 (2024) data collection is based on 8,000 complete surveys (2,664 hours) and 20 cognitive interviews (20 hours) using the same survey instrument. The total number of responses is 8,020 and the total burden is 2,684 hours.

Estimated Annualized Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden
Adults 18+	Survey: NCHS RSS Round 5 (2024) Cognitive Interviews	8,000	1	20/60	2,664
Adult 18+	Cognitive Interviews	20	1	1	20
Total					2,684

B. Cost to Respondents

At an average wage rate of \$21.00 per hour, the estimated annualized cost for the 2,684 burden hours is \$56,364 for round 5.

Estimated Annualized Burden Costs

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Adult + Household Member	Cognitive Interviews	2,684	\$21.00	\$56,364

15. Explanation for Program Changes or Adjustments

There is no additional burden. The burden is included in the original submission that was approved on June 30, 2023.

Appendix A: Justifications for Content from Sponsors

The new, emerging, or supplemental content in this round of RSS includes the following topic areas:

1. Positive Childhood Experience
2. Childhood Vaccination Perceptions, Attitudes, and Messaging

The justification for each of these topic questions follows. Each of the topic areas must meet criteria for at least one of the four possible reasons for inclusion of a topic area in RSS:

- 1) **Time-sensitive data needs**
- 2) **Public health attitudes and behaviors** (e.g., opinions, beliefs, stated preferences, and hypotheticals)
- 3) **Developmental work** to improve concept measurement/questionnaire design
- 4) **Methodological studies** to compare, test, and develop approaches to data collection and analysis

Positive Childhood Experience Strategies

Program: National Center for Injury Prevention and Control (NCIPC) Division of Violence Prevention (DVP)

Background/Rationale:

Positive childhood experiences (PCEs) are protective experiences in childhood that provide children with safe, stable, nurturing relationships and environments and allow them to develop a sense of belonging and connection and build resilience (Sege & Browne, 2017; Guo et al, 2021). PCEs are essential to children's healthy development, and their impacts accumulate throughout their lives. In contrast, adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years), such as neglect and experiencing or witnessing violence, that can negatively impact physical, mental, emotional, and behavioral development (Crandall et al., 2019). ACEs and their associated harms are preventable, and research demonstrates that PCEs can prevent and mitigate the consequences of ACEs (Bethell et al., 2019; Crandall et al., 2019). However, population-level research on PCEs is scarce, and more information is needed to understand the prevalence of PCEs. Very little is known about the prevalence of PCEs, and what little we know is from asking adults about their retrospective experiences during childhood. Little information is available about children's current experiences of PCEs.

Proposed Use of the Data

- RSS data will be used to understand the prevalence of individual types of PCEs overall and by demographic characteristics, including child's age, gender, race and ethnicity, disability status, parent education or income, and whether they live in an urban or rural area.
- RSS data will be used to better understand inequities in experiences of PCEs among children across demographic subpopulations and disability status.
- RSS data will also be used to better understand the underlying factor structure and psychometric properties of potential new composite measures on PCEs.

Justification for Rapid Surveys:

- RSS offers an opportunity for **developmental work** to improve the concept measurement of Positive Childhood Experiences and better understand how parents and caregivers respond to questions about their children's PCEs.

Concepts Measured

- (Past 12 months) Someone to turn to day-to-day emotional support with parenting and raising children
- Support from relatives when someone has family problems
- Support from friends, neighbors, or other nonrelatives in the community when someone has a family problem
- Presence of sidewalks or walking paths in the neighborhood
- Presence of park or playground in the neighborhood
- Presence of recreation center, community center, or Boys and Girls club in the neighborhood
- Level of safety for children to play outside during the day in the neighborhood
- Hours spent outdoors by child on average weekend day

- (If child is 6 years old or older) Does child have difficulty making friends
 - (If child is 6 years or older and has some or no difficulty making friends) Hours spent playing or hanging out with friend in person on an average weekend day
 - (If child is 6 years or older and has some or no difficulty making friends) Hour spent talking with friends on video or other voice interactions
 - (If child is 12 years or older and some or no difficulty making friends) How much can child rely on their friends for help with a serious problem
 - (If some of no difficulty and child is 6 years old or older) How much can child open up to their friends to talk about worries
- (If child is 6 years old or older) can you and child share ideas or talk about things that really matter
- (If child is 6 years old or older) Other than adults in the home, is there at least one other adult in the child's school, neighborhood, or community who know the child well and who the child can rely in for advice and guidance
- (In the last seven days) which of the following activities have you and child done together: read a book or told a story together, cooked or enjoyed a meal together, educational activities, spent time outdoors including walks and sports, watched TV or other media together, played a video game together, or playing board or card games together
- (If child is 6 years or older) Is child currently participating in: organized sports, sports lessons, or practice, club, organization, or organized lessons or practice, such as music, dance, language or other arts, community service or volunteer work at school, place of worship, or in the community.
- (If child is 6 years or older) In an average week, does child spend free time doing the following: music, writing, visual, or performing arts, reading books or listening to audiobooks
- (If child is 6 years or older) In the past week, how many days did child exercise, play a sport, or participate in physical activity for a least 60 minutes
- (If enrolled in school) how close child to people at school
- (If enrolled in school) Teachers care about child
- (If enrolled in school) Child feels like part of the school
- (If child is 6 years or older) Child feels close to people in neighborhood
- (If child is 6 years or older) Neighbors care about child
- (If child is 6 years or older) Child feels like part of the neighborhood

Duplication and measurement on other national surveys

Some questions on the survey have been included on other national surveys. These items have been intentionally selected to serve as useful benchmarks to compare RSS results with results from other methodologies. Questions 1, 4-6, 14, 15, and 19 are all taken from the National Survey of Children's Health (NSCH), which is also a parent-reported survey. Having results that are directly comparable to a higher-quality well-established parent-reported survey will be helpful for interpreting all other results on the RSS. The benchmark items have been specifically chosen due to the varied domains that they cover and their validity. In addition to NSCH, some questions on this RSS were adapted from National Health Interview Survey Teen (NHIS-Teen), UNICEF's Child Functioning Module, the Familism Scale, and the COVID Experiences (CovEx) Survey. These items were selected based on their cognitive testing results, validity in performance in published research, and/or specificity of PCE domain covered.

Proposed Data Dissemination

Estimates and the microdata will be made publicly available after each round. These include a set of web-tables with basic descriptive statistics, an online interactive dashboard where users can select pre-tabulated estimates including standard errors/confidence intervals, and a public-use file. All of these analytic products will include highly visible and transparent information regarding any limitations and data quality. In particular, the documentation will indicate that Rapid Surveys is not designed to replace NCHS' higher-quality established data collections, and it will highlight key methodological differences that may increase the risk of bias in Rapid Surveys estimates. A set of simple infographics are also planned that can be readily disseminated via social media. They will also include a link to the data use disclaimers. Following each round, each data collection contractor will produce a methodology report that describes the composition and representativeness of the sample.

References

Sege, R. D., & Browne, C. H. (2017). Responding to ACEs with HOPE: Health outcomes from positive experiences. *Academic pediatrics*, 17(7), S79-S85.

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive childhood experiences and adult mental and relational health in a statewide sample: Associations across adverse childhood experiences levels. *JAMA pediatrics*, 173(11), e193007-e193007.

Guo, S., O'Connor, M., Mensah, F., Olsson, C. A., Goldfeld, S., Lacey, R. E., ... & Priest, N. (2021). Measuring positive childhood experiences: Testing the structural and predictive validity of the Health Outcomes from Positive Experiences (HOPE) framework. *Academic pediatrics*.

Whitaker, R. C., Dearth-Wesley, T., & Herman, A. N. (2021). Childhood family connection and adult flourishing: associations across levels of childhood adversity. *Academic Pediatrics*, 21(8), 1380-1387.

Crandall, A., Miller, J. R., Cheung, A., Novilla, L. K., Glade, R., Novilla, M. L. B., ... & Hanson, C. L. (2019). ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. *Child Abuse & Neglect*, 96, 104089.

Childhood Vaccination Perceptions, Attitudes, and Messaging

Program: National Center for Immunization and Respiratory Disease (NCIRD) Immunization Service Division (ISD)

Background/Rationale:

In the wake of the COVID-19 pandemic, disruptions in routine health services resulted in many children missing or delaying routine vaccination. Given the changing nature of parental vaccine hesitancy, variability in perceived risk of infection and constant threat of widespread epidemics due to vaccine preventable diseases, data collection is necessary to design effective interventions addressing parental hesitancy driving decreases in vaccination coverage.

It is important for CDC to understand how perceived social norms, barriers to vaccination, and trusted sources of information impact shifting parental attitudes towards both routine vaccines like MMR and Tdap and seasonal vaccines like influenza and COVID-19.

Concepts Measured

- Has selected child received all recommended childhood vaccines
- (Past 12 months) has selected child received a flu vaccinations
- Has selected child ever received a COVID-19 vaccinations
- (If select child is 12 years old or older) has selected child received an HPV vaccine
- Has selected child received measles vaccine
- Parental hesitance about COVID-19 vaccine for children
- Parental hesitance in other vaccines
- Parental confidence/ important in COVID-19 vaccine benefits for selected child
- Parental confidence/ importance in other childhood vaccine benefits for selected child
- Parental confidence in safety of COVID-19 vaccine for child
- Parental confidence in safety of other vaccines
- Parental request of a school or daycare vaccine exemptions
- Concern about too many vaccines at one time for child
- Concern about serious, long term side effects from vaccines
 - Did concerns lead to delay in vaccines, reduced number of vaccines in single visit, decline some vaccines, or decline all vaccines
- Personal knowledge of anyone with serious, long-term effects from a vaccine
- Communication sources for information about childhood vaccines
 - (If communication source includes a doctor or health care provider) how did they communicate vaccine recommendations
 - (If communication source includes a doctor or health care provider) besides routine childhood vaccines, did they recommend chicken pox, flu, COVID-19, or HPV
- Is doctor or health care provider most trusted source for information on childhood vaccines
- Receptiveness to communications about vaccines coming from child's school or daycare
- Ease of getting selected child vaccinated
 - (If difficult) Is it difficult due to lack of reliable transportation
 - (If difficult) Is it difficult due to cost
 - (If difficult) Is it difficult to find time

- Discussion of childhood vaccination on social media, television news, and with family and friends
- Discussion of measles as a health risk in the United States and in child's city or town
- (In past 6 months) heard anything about recent measles outbreak in the United States
- Disruptions in child education if unvaccinated child is exposed

Proposed Use of the Data

- RSS data will help CDC gain an understanding of how perceived social norms, barriers to vaccination, and trusted sources of information drive parental vaccine decisions.
- RSS data will help CDC design effective interventions to ensure high vaccination coverage among children and mitigate the threat of a resurgence of epidemic-prone childhood diseases for both children less than five years and school aged children.
- RSS data will help inform school and daycare-based interventions and provider-based interventions to improve vaccine uptake.

Justification for Rapid Surveys:

- There is a need for a better understanding of parental **knowledge, attitudes, and behavior** related to childhood vaccinations and potential differences in vaccine hesitancy for routine versus seasonal vaccines. Additional focus will be put on perceived barriers to vaccination, the effect of perceived social norms on parental vaccination decisions and understanding the role of parental perceptions of the risks posed by different diseases on the acceptance of individual vaccines.
- There is little evidence describing parental preferences for vaccine communications outside of the clinical setting. RSS presents an opportunity to understand parent **knowledge, attitudes, and behaviors** toward vaccine information originating from the non-clinical, school setting.
- The RSS offers an opportunity for **developmental work** to develop questions beyond the typical single item for vaccination intention to better understand the characteristics of parents who are unsure about whether they will vaccinate their children.

Duplication and measurement on other national surveys

- Data on parental vaccine intentions and vaccine hesitancy are available from National Immunization Survey (NIS) Child Modules, and NIS Child COVID Modules in select years, but there is not current data from this set of questions.
- Information on trusted sources of vaccine information was recently asked on a Porter Novelli survey of parents conducted in August 2023, however, this survey did not include questions about school or daycare as trusted sources of information, or whether staff were trusted vaccine messengers.

Proposed Data Dissemination

Estimates and the microdata will be made publicly available after each round. These include a set of web-tables with basic descriptive statistics, an online interactive dashboard where users can select pre-tabulated estimates including standard errors/confidence intervals, and a public-use file. All of these analytic products will include highly visible and transparent information regarding any limitations and data quality. In particular, the documentation will indicate that Rapid Surveys is not designed to replace NCHS' higher-quality established data collections, and

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References

Tull F, Borg K, Knott C, Beasley M, Halliday J, Faulkner N, Sutton K, Bragge P. Short Message Service Reminders to Parents for Increasing Adolescent Human Papillomavirus Vaccination Rates in a Secondary School Vaccine Program: A Randomized Control Trial. *J Adolesc Health*. 2019 Jul;65(1):116-123. doi: 10.1016/j.jadohealth.2018.12.026. Epub 2019 Mar 14. PMID: 30879881.

Szilagyi PG, Schaffer S, Rand CM, Goldstein NP, Hightower AD, Younge M, Albertin CS, DiBitetto K, Yoo BK, Humiston SG. School-Located Influenza Vaccination: Do Vaccine Clinics at School Raise Vaccination Rates? *J Sch Health*. 2019 Dec;89(12):1004-1012. doi: 10.1111/josh.12840. Epub 2019 Oct 14. PMID: 31612491.

Deas J, Bean SJ, Sokolovska I, Fautin C. Childhood Vaccine Attitudes and Information Sources Among Oregon Parents and Guardians. *Health Promot Pract*. 2019 Jul;20(4):529-538. doi: 10.1177/1524839918778830. Epub 2018 Jun 8. PMID: 29884085.

Kang GJ, Culp RK, Abbas KM. Facilitators and barriers of parental attitudes and beliefs toward school-located influenza vaccination in the United States: Systematic review. *Vaccine*. 2017 Apr 11;35(16):1987-1995. doi: 10.1016/j.vaccine.2017.03.014. Epub 2017 Mar 18. PMID: 28320592; PMCID: PMC5401629.