

OVERVIEW: BRFSS 2001

1. BACKGROUND

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC), and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Surveillance Branch, is an on going data collection program designed to measure behavioral risk factors in the adult population 18 years of age or older living in households. The BRFSS was initiated in 1984, with 15 states collecting surveillance data on risk behaviors through monthly telephone interviews. The number of states participating in the survey increased, so that by 2001, 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands were participating in the BRFSS. A table showing type of participation in the survey by area is in *Appendix I*. In this document, the term Astate@ is used to refer to all areas participating in the surveillance system, including the District of Columbia, Guam, the Virgin Islands and the Commonwealth of Puerto Rico.

The objective of the BRFSS is to collect uniform, state-specific data on preventive health practices and risk behaviors that are linked to chronic diseases, injuries, and preventable infectious diseases in the adult population. Factors assessed by the BRFSS include tobacco use, health care coverage, HIV/AIDS knowledge or prevention, physical activity, and fruit and vegetable consumption. Data are collected from a random sample of adults (one per household) through a telephone survey.

The BRFSS field operations are managed by the health departments with guidelines provided by the CDC. These health departments participate in developing the survey instrument and conduct the interviews either in-house or through use of contractors. The data are transmitted to the CDC's National Center for Chronic Disease Prevention and Health Promotion's Behavioral Surveillance Branch for editing, processing, weighting, and analysis. An edited and weighted data file is provided to each participating health department for each year of data collection, and summary reports of state-specific data are prepared by CDC. Health departments use the data for a variety of purposes, including identifying demographic variations in health-related behaviors, targeting services, addressing emergent and critical health issues, proposing legislation for health initiatives and measuring progress toward state and national health objectives (1).

The health characteristics estimated from the BRFSS pertain only to the adult population aged 18 years and older living in households. As noted above, respondents are identified through telephone-based methods. Although approximately 95 percent of U.S. households have telephones, coverage ranges from 87 to 98 percent across states and varies for subgroups as well. For example, persons living in the South, minorities, and those in lower socioeconomic groups typically have lower telephone coverage (2); see also *Estimated Telephone Coverage-March 1999* on the BRFSS Web site, www.cdc.gov/brfss, *Documents and Survey Data* page. No direct method of compensating for non-telephone coverage is employed by the BRFSS; however, post-stratification weights are used,

and may partially correct for any bias caused by non-telephone coverage. These weights adjust for differences in probability of selection and nonresponse, as well as noncoverage, and must be used for deriving representative population-based estimates of risk behavior prevalence.

2. DESIGN OF THE BRFSS

A. The BRFSS Questionnaire

The questionnaire has three parts: 1) the core component; 2) optional modules; and 3) state-added questions.

Core component. The *core* is a standard set of questions asked by all states. It includes queries about current health-related perceptions, conditions, and behaviors (e.g., health status, health insurance, diabetes, tobacco use, selected cancer screening procedures, and HIV/AIDS risks) and questions on demographic characteristics.

Optional CDC modules. These are sets of questions on specific topics (e.g., cardiovascular disease, oral health) that states elect to use on their questionnaires. In 2001, 14 modules were supported by CDC, (See *2001 BRFSS Modules Used By States, Appendix I* for a list of modules used by reporting areas.)

State-added questions. These are questions developed or acquired by participating states and added to their questionnaires. State-added questions are not edited or evaluated by CDC.

Each year, the states and CDC agree on the content of the core component and optional modules. For comparability, many questions are taken from established national surveys, such as the National Health Interview Survey or the National Health and Nutrition Examination Survey. This practice allows the BRFSS to take advantage of questions that may have been tested and allows states to compare their data with those from other surveys. Any new questions proposed as additions to the BRFSS must go through cognitive testing and field testing prior to their inclusion on the survey. BRFSS protocol specifies that all states ask the core component questions without modification; they may choose to add any, all, or none of the optional modules; and states may add question(s) of their choosing at the end of the questionnaire.

Although CDC supported 14 modules in 2001, it is not feasible for a state to use them all. States are selective with their choices of modules and state-specific questions to keep the questionnaire at a reasonable length (though there is wide variation across states in the total number of questions for a given year, ranging from a low of about 90 to 150 or more). New questionnaires are implemented in January, and usually remain unchanged throughout the year. However, the flexibility of state-added questions does permit additions, changes, and deletions at any time during the year. The 2001 core and module questionnaire is in *Appendix VI* of this document.

Annual Questionnaire Development

Before the beginning of the calendar year, CDC provides states with the text of the core component and the optional modules that will be supported for the coming year. States select their optional modules and choose any state-added question(s). Each state then constructs its questionnaire. The core component is asked first, optional modules are asked next, and state-added questions last. This ordering ensures comparability across states and follows CDC protocol. Generally, the only changes allowed are the limited insertion of state-added questions on topics related to core questions. Such exceptions are to be agreed upon in consultation with CDC. However, even with these exceptions, the policy has not been followed in every instance. Deviations from policy are noted in the *comparability of data* section of this document.

Once the content (core, modules, and state-added) of the questionnaire is determined by a state, a paper version of the instrument is constructed and a paper or electronic copy sent to CDC. For states with Computer Assisted Telephone Interview (CATI) systems, this copy is used for CATI programming and general reference. The questionnaire is used without changes for one calendar year. The topics included on the 2001 questionnaire are shown in *BRFSS Questionnaire*. If a significant portion of the state population does not speak English, states have the option of translating the questionnaire into other languages. At the present time, CDC only provides a Spanish version of the core questionnaire and optional modules.

B. Sample description

Sample records in order to meet the BRFSS standard for the participating states' sample designs must be justifiable as a probability sample of all households with telephones in the state. All participating areas met this criterion in 2001. The sample designs used by states in the 2001 BRFSS survey are shown in the table *2001 Sampling Information* in *Appendix I*. Fifty-one projects used a disproportionate stratified sample (DSS) design. Puerto Rico, Guam and the Virgin Islands used a simple random sample design.

In a DSS design as most commonly practiced in the BRFSS, telephone numbers are divided into two groups, or strata, which are sampled separately. One group, the high-density stratum, contains telephone numbers, that are expected to contain a large proportion of households. The other group, the low-density stratum, contains telephone numbers, that are expected to contain a small proportion of households. Whether a telephone number goes into the high-density or low-density stratum is determined by the number of listed household numbers in its hundred block. A hundred block is a set of one hundred telephone numbers with the same area code, prefix, and first two digits of the suffix and all possible combinations of the last two digits. Numbers that come from hundred blocks with one or more listed household numbers (1+ blocks, or banks) are put in the high-density stratum. Numbers that come from hundred blocks with no listed household numbers (0 blocks, or banks) are put in the low-density stratum. Both strata are sampled to obtain a probability sample of all households with telephones. The high-density stratum is

sampled at a higher rate than the low-density stratum (that is, disproportionately) to obtain a sample that contains a larger proportion of household numbers than would be the case if all numbers were sampled at the same rate.

In most cases, each state constitutes a single stratum. In order to provide adequate sample sizes for smaller geographically defined populations of interest, however, 25 states sampled disproportionately from strata defined to correspond to sub-state regions. In 2001, the states with disproportionately sampled geographic strata are Alaska, Arizona, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Iowa, Kentucky, Maryland, Massachusetts, Missouri, Montana, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Puerto Rico, Rhode Island, Utah, Virgin Islands, and Wisconsin.

Data for a state may be collected directly by the state health department or through a contractor. The *2001 Sampling Information* table in *Appendix I* shows the agency or organization collecting the data by state. Fourteen state health departments collected their data in-house; forty contracted data collection to university survey research centers or commercial firms in 2001.

In 2001, the Behavioral Surveillance Branch provided sample to fifty-three states or territories purchased from Genesys (Marketing Group Systems). Nevada purchased sample from Survey Sampling, Inc..

3. DATA COLLECTION

A. Interviewing Procedures

Interviews for 2001 were conducted through computer-assisted telephone interviewing (CATI) by 54 areas. CDC supports CATI programming using the Ci3 CATI software package. This support includes programming of the core and module questions states, providing questionnaire scripting of state-added questions via a contract with a commercial firm for states requiring assistance and contracting with a Ci3 consultant who is available to assist states. Following specifications provided by CDC, state health personnel or contractors conducted interviews. The core portion of the questionnaire lasts an average of 10 minutes. Interview time for modules and state-added questions is dependent upon the number of questions used, but generally extend the interview period by an additional 5 to 10 minutes.

Interviewer retention is very high among states that conduct the survey in-house. The state coordinator or interviewer supervisor usually conducts the training using materials developed by CDC covering seven basic areas: overview of the BRFSS, role descriptions for staff involved in the interviewing process, the questionnaire, sampling, codes and dispositions, survey follow-up and practice sessions. Contractors typically use interviewers who have experience conducting telephone surveys, but these interviewers are given additional training on the BRFSS questionnaire and procedures before they are Acertified@ to work on BRFSS. Further specifics on interviewer training and procedures can be found on the BRFSS web site.

Monitoring of interviewers is expected. In 2001, all surveillance projects had the capability to monitor their interviewers. The system used for monitoring interviewers varied from listening to the interviewer only at an on-site location to listening to both the interviewer and respondent at a remote location. Verification call-backs were also used by some states in lieu of direct monitoring. Contractors typically conducted systematic monitoring by monitoring each interviewer a certain amount of time each month. All states had the capability to tabulate disposition code frequencies by interviewer. These data were the primary means for quantifying interviewer performance. All states were required to do verification callbacks for a sample of completed interviews as part of their quality control practices.

Telephone interviewing was conducted during each calendar month, and calls were made 7 days per week, during both day and evening hours. Standard procedures in the interviewing were followed for rotation of calls over days of the week and times of the day. BRFSS procedural rules are contained in the *BRFSS User=s Guide, 1998 (3)*. A summary of rules for respondent selection, call-backs per sample piece, refusal conversion, answering machines, and monthly interviewing periods are shown in *Appendix I*.

Detailed information on interview response rates and item non-response rates are discussed in the *2001 Summary Data Quality Report* in *Appendix II*.

4. DATA PROCESSING

A. Preparing for data collection and data processing

Data processing is an integral part of any survey. Because data are collected and sent to CDC during each month of the year, there are routine data processing tasks that need attention at all times during the year. In addition, there are tasks that need to be conducted at different points in the annual BRFSS cycle.

The preparation for the survey involves a number of steps that take place once the new questionnaire is finalized. This includes developing the edit specifications, programming portions of the Ci3 CATI software, programming the PC-EDITS software, and producing telephone sample estimates for states that require them and ordering the sample from the contract vendor. A Ci3-CATI data entry module for each state that uses this software is produced. Skip patterns, together with some consistency edits, and response-code range checks are incorporated into the CATI system. Incorporating edits and skip patterns into the CATI instrument reduces interviewer errors, data entry errors, and skip errors. Data conversion tables are developed to read the survey data from the entry module and call information from the sample tracking module and to combine information into the final format specified for the data year. CDC also creates and distributes a Windows based editing program that can perform data validations on properly formatted survey results files. This program is used to output lists of errors or warning conditions encountered in the data.

CDC begins to process data for the survey year as soon as states or their contractors begin submitting data to the data management mailbox, and continues processing data throughout the survey year. CDC receives and tracks monthly data submissions from the states. Once data are received from the state, editing programs and cumulative data quality checks are run against the data. Any problems in the file are noted, and a CDC programmer works with the state until the problems are resolved, or agreement is reached that no resolution is possible. Response rate data quality reports are produced and shared with the project officers and state coordinators, who review the reports and discuss any potential problems with the state. Once the entire year of data for a state has been received and validated, several year-end programs are run on the data. These programs perform some additional, limited data cleanup and fixes specific to the state and data year, and produce reports that identify potential analytic problems with the data set. Once these programs are complete, the data are ready for assigning weights and adding new variables.

Not all of the variables that appear on the public use data set are taken directly from the state files. CDC prepares a set of SAS programs that implement the end of year data processing. These programs prepare the data for analysis and add weighting and risk factor calculations as variables to the data file. The following variables are examples of results from this procedure, and are created for the user's convenience: `_RFSMOK2`, `_MRACE`, `_AGEG`, `_TOTINDA`. To create these variables, several variables from the data file are combined. Creation of the variables vary in complexity; some only combine codes, while others require sorting and combining selected codes from multiple variables.

Almost every variable derived from the BRFSS interview has a code category labeled `Arefused@` and generally given a value of "A9", "A99", or "A999" value. Typically, the category consists of non-interviews and persons for whom the question was not applicable because of a previous response or a personal characteristic (i.e., age). However, this code may capture some responses that were supposed to be answered, but for some reason were not, and appeared as a blank or other symbol. The combination of these types of responses into a single code require vigilance on the part of data file users who wish to separate respondents who were skipped out of a question from those who were asked, but whose answer was unknown or who refused to answer a particular question.

B. Weighting the data

When data are used without weights, each record counts the same as any other record. Implicit in such use are the assumptions that each record has an equal selection probability and that noncoverage and nonresponse are equal among all segments of the population. When deviations from these assumptions are large enough to affect the results obtained from a data set, then weighting each record appropriately can help to adjust for assumption violations. An additional, but conceptually unrelated, reason for weighting is to make the total number of cases equal to some desired number, for state BRFSS data this is the age 18 and older state population. In the BRFSS, post-stratification serves as a blanket adjustment for noncoverage and nonresponse and forces the total number of cases to equal population estimates for each geographic stratum, which for the BRFSS is usually a state.

Following is a general formula that reflects all the factors taken into account in weighting the 2001 BRFSS data. Where a factor does not apply its value is set to one for calculation.

$$\mathbf{FINALWT = STRWT * 1 OVER NPH * NAD * POSTSTRAT}$$

FINALWT is the final weight assigned to each respondent.

STRWT accounts for differences in the basic probability of selection among strata (subsets of area code/prefix combinations). It is the inverse of the sampling fraction of each stratum. There is almost never a complete correspondence between strata, which are defined by subsets of area code/prefix combinations, and regions, which are defined by the boundaries of government entities.

1/NPH is the inverse of the number of residential telephone numbers in the respondent=s household.

NAD is the number of adults in the respondent=s household.

POSTSTRAT is the number of people in an age-by-sex or age-by-race/ethnicity-by-sex category in the population of a region or a state divided by the sum of the preceding weights for the respondents in that same age-by-sex or age-by-race/ethnicity-by-sex category. It adjusts for non-coverage and non-response and forces the sum of the weighted frequencies to equal population estimates for the region or state.

REFERENCES

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2. Bureau of the Census. Phoneless in America. Statistical Brief 94-16. U. S. Department of Commerce, Bureau of the Census. July 1994.
3. Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System User=s Guide. 1998.