NATIONAL HEALTH INTERVIEW SURVEY QUESTIONNAIRE REDESIGN

Marcie Cynamon, *Director*

Stephen Blumberg, *Associate Director for Science*

Renee Gindi, *Redesign Coordinator*

Division of Health Interview Statistics

NCHS Board of Scientific Counselors Meeting

May 20, 2016

Outline

- Overview of the redesign
- Redesign process
- Structure
  - Challenges and proposed solutions
- Overview of proposed content
  - Content that is largely the same
  - Content that is restructured
  - Content that is new
- Next steps

**Breaks for questions and feedback following each section*

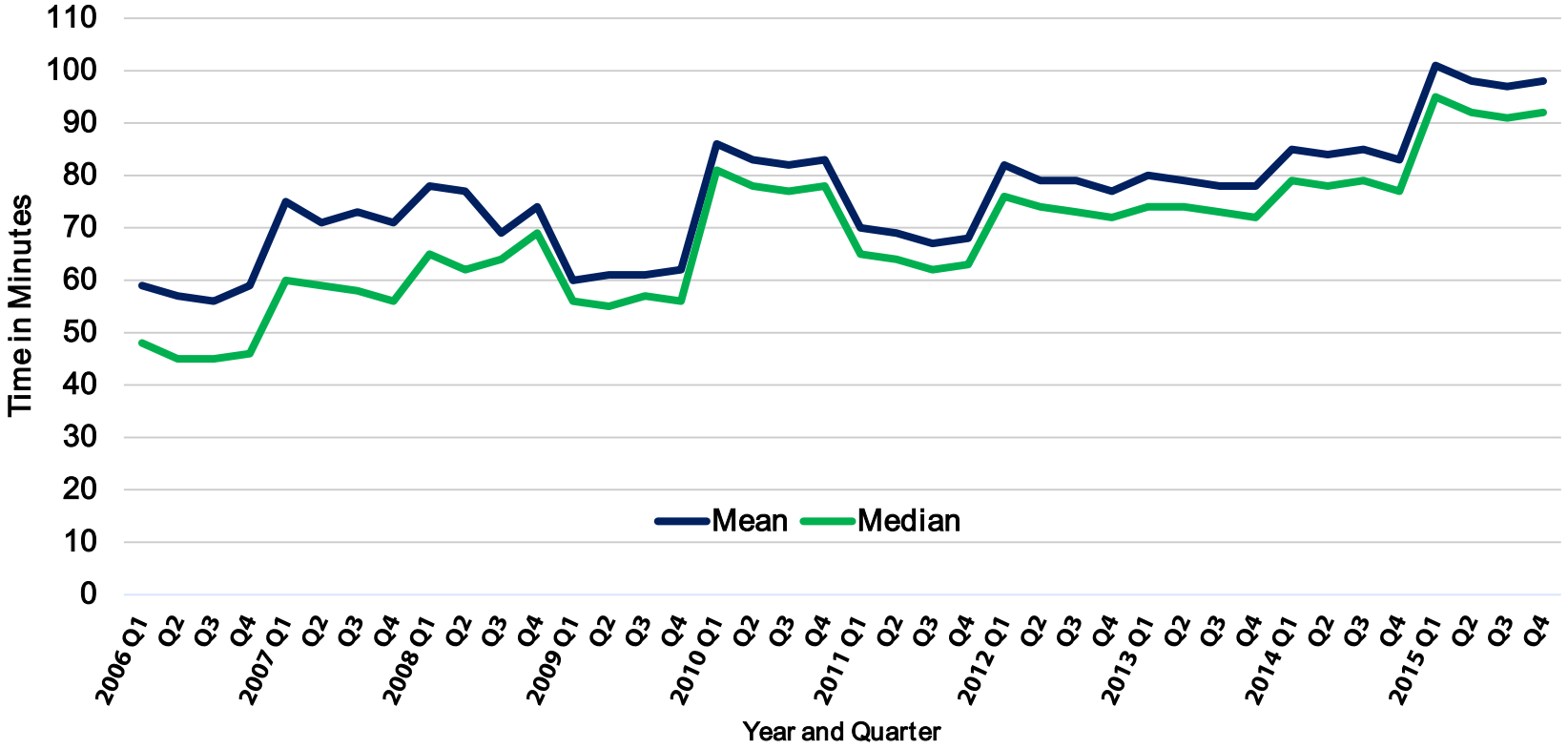
Background: National Health Interview Survey

- **Purpose**: To monitor the health of the US population through the collection and analysis of data on a broad range of health topics
- **Sample**: Address-based, multi-stage, clustered national sample of housing units from every state, to be representative of the civilian noninstitutionalized US population
- **Mode**: In-person interviews by Census interviewers, with follow-up by telephone if needed
- **Data collection**: Continuous, with quarterly and annual data files
- **Target sample size**: Complete interviews for 35,000+ households
- **Anticipated content redesign**: January 2018

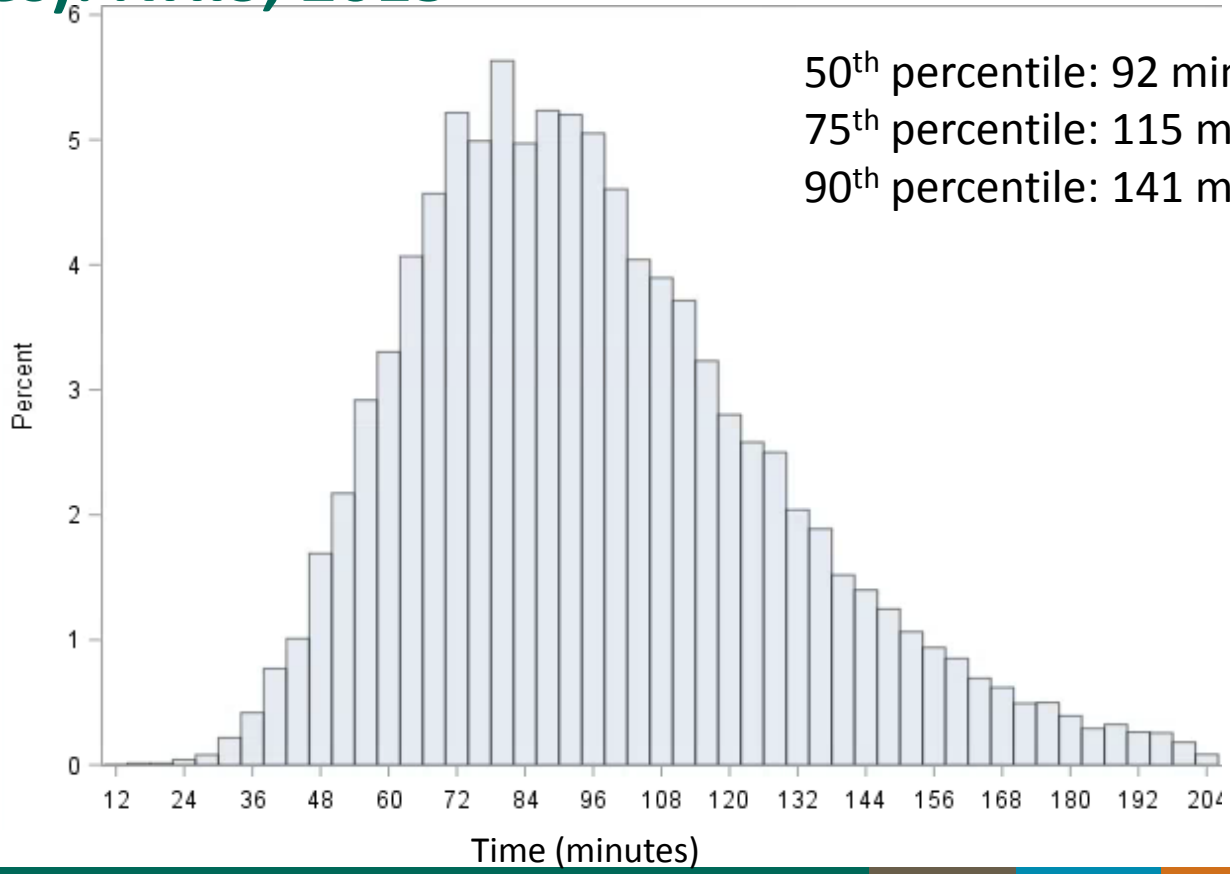
Goals of the 2018 Content Redesign

- Improve the relevance of covered health topics, better meeting the needs of the Department of Health and Human Services and other data users
- Focus on leading causes of morbidity/mortality, their known risk and protective factors, and targets of health promotion initiatives
  - Health insurance and health care access
- Harmonize overlapping content with other federal heath surveys
- Reduce respondent burden and improve data quality
  - Shorten questionnaire and reduce variation in interview times
  - Eliminate or reduce content better covered by other methods
  - Establish a long-term structure of periodic topics

Length of Completed Interviews (in minutes), by Quarter: NHIS, 2006-2015

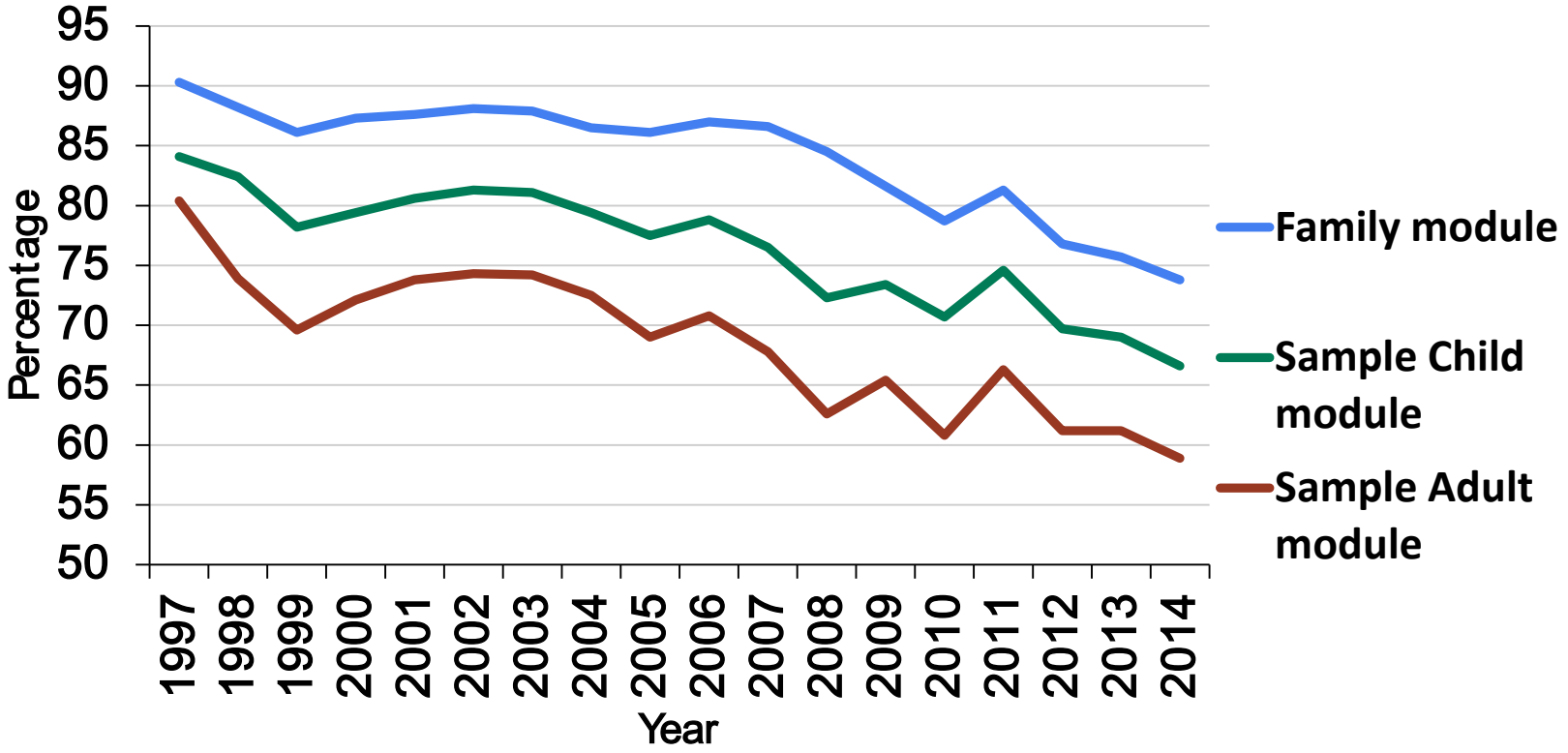


Distribution of Length of Completed Interviews (in minutes): NHIS, 2015



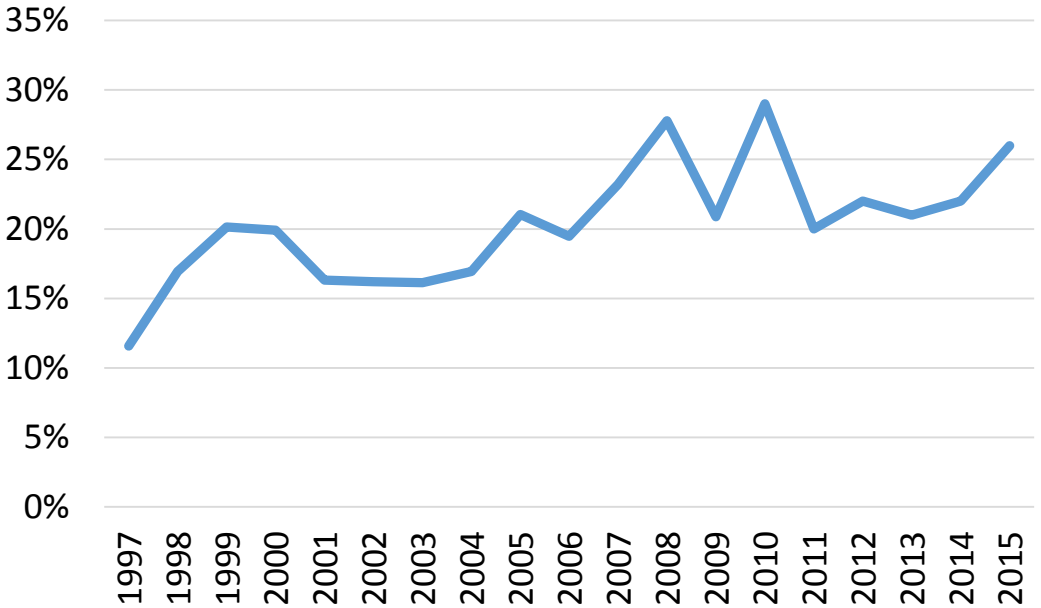
50th percentile: 92 minutes
75th percentile: 115 minutes
90th percentile: 141 minutes

NHIS Family, Child, and Adult Response Rates, NHIS 1997-2014



Breakoffs: Proportion of Cases on the Data Files with Incomplete Data, NHIS 1997-2015

- The proportion of partial interviews almost tripled between 1997 and 2010.



Why Now?

- Most recent content redesign was 1997
- Necessary sampling frame redesign in 2016 introduced additional complexity
- Final measurements for Healthy People 2020 objectives can be completed in 2016 and 2017
- Long-term planning can help sponsors target content
- Desire to slow the decline in response rates

We've Been Here Before…

- Despite periodic revisions to the Core questionnaire, Supplements played an increasingly important role in the survey as a means of enhancing topic coverage.
- Eventually, certain Supplements … were incorporated in the NHIS Core on an annual basis.
- The unintended result was an increasingly unwieldy survey instrument and longer interviewing sessions: **Recent interviews averaged two hours.**
- This imposed an unacceptable burden on NCHS staff, U.S. Bureau of the Census interviewers, the data collection budget, and, most importantly, on the NHIS respondents.
- **Furthermore, the excessive length of NHIS interviews contributed to declines in both response rate and data quality.**

– 1997 NHIS Survey Description document

Key Roles for the NHIS

- Provide objective scientific data for DHHS from a well-established, high-quality, in-person survey on topics including health conditions, health behaviors, health insurance, and health care utilization.
- Provide “gold standard” estimates for federal and private surveys to use for benchmarking and for adjusting estimates.
- Maintain a large sample size for quarterly national estimates and for annual estimates among population subgroups.
- Maximize stability over time so that trends are reliable.

Key Content Areas for the NHIS

- Functioning and disability
- Health status and conditions
- Health insurance coverage
- Health care access and utilization
- Health risk behaviors
- Demographics
- Social and economic determinants

Criteria for Prioritizing Content

- **Strong link to public health**: Leading causes of morbidity/mortality, known risk or protective factors, priority populations at risk, intermediate outcomes
- **Relevant to HHS agency goals**: Part of HHS strategic plan, HHS initiatives
- **Needed for long-term monitoring**: leading health indicators
- **High quality measurement**: Content can be measured well in household interviews
- **Consistent with other federal surveys**: Measure is used by others for calibration, does not duplicate detail collected by targeted HHS surveys
- **Can be estimated reliably with one or two years of data**: Less focus on rare conditions or behaviors

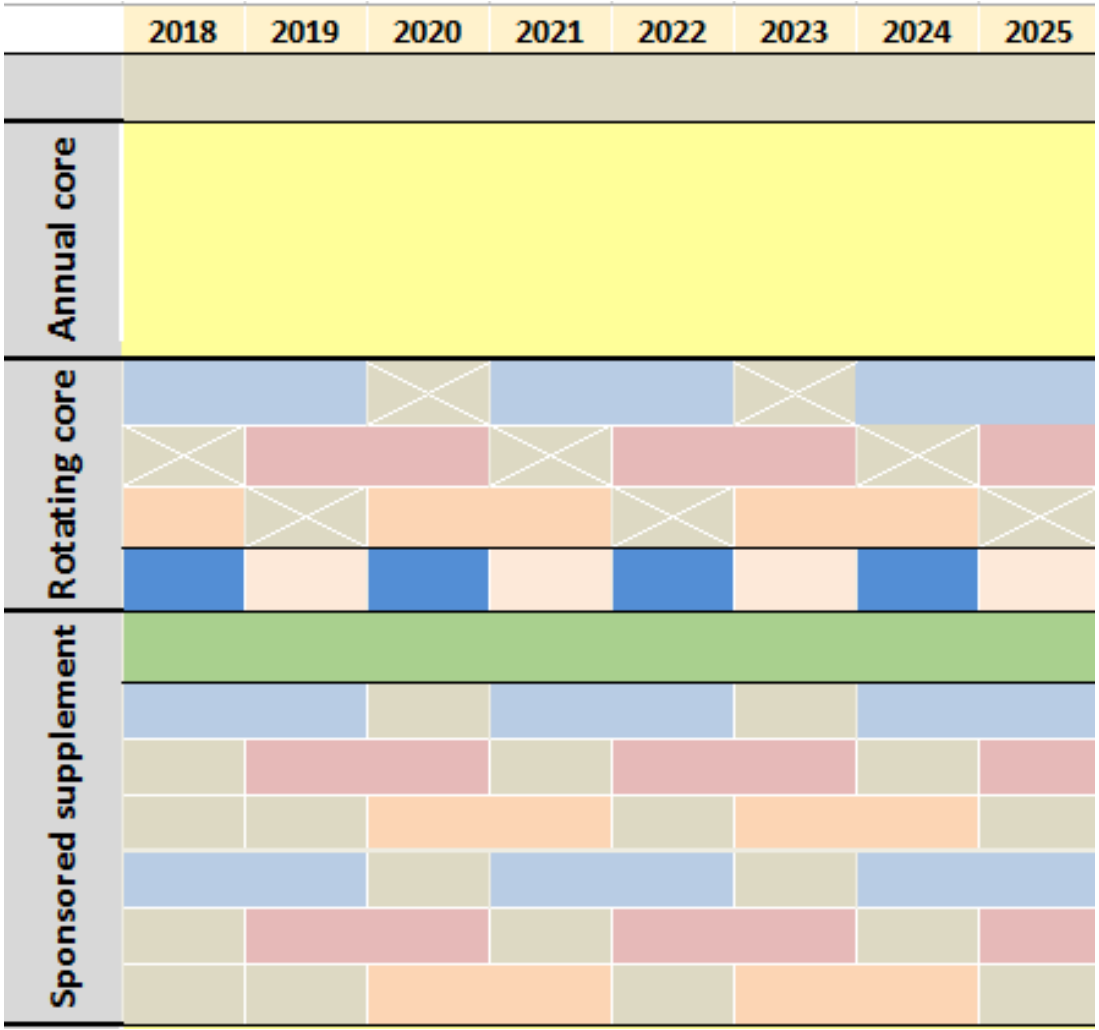
Additional Considerations

- **Balance**: collecting relevant health content and crucial covariates with respondent burden and funding constraints

- **Options to consider**:
  - Matrix sampling
  - Administrative or alternative data
  - Alternate modes
  - Rotating content

The Quilt

- Annual core
  - Key measures
  - Sociodemographics
- Rotating core
  - Newer topic areas
  - Expanded detail
  - Varying periodicity
- Sponsored supplements
  - “Sustaining” sponsors
  - 1- or 2-year modules
  - 5 min or less



Proposed Changes: Structure

- Shifting content from collection in family module to collection in sample adult and/or sample child modules

1997-2017 NHIS Structure: Core Modules

Family Core

- General information on all family members
- Family data
- Allows proxy respondents
- Fielded each year

→ Demographic, family relationships, and family income; proxy general health data

Sample Adult Core

- Self-response (unless unable)
- Fielded each year

Sample Child Core

- Knowledgeable adult responds for child
- Fielded each year

→ Health insurance, utilization, conditions, behaviors, and additional demographic data

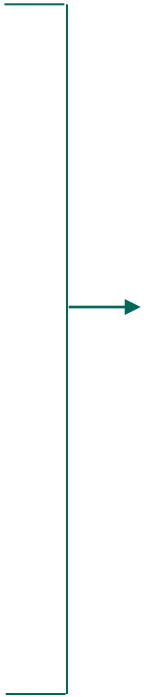
2018 NHIS Structure: Proposed Core Modules

Sample Adult Core

- Self-response (unless unable)
- Relevant family-level data
- Fielded with fixed periodicity

Sample Child Core

- Knowledgeable adult responds for child
- Relevant family-level data
- Fielded with fixed periodicity



Demographics, some family relationships, and family income; Health insurance, utilization, conditions, and behaviors

Proposed Changes: Structure

- Shifting content from collection in family module to collection in sample adult and/or sample child modules
- Changes in:
  - Respondent for adult health status and disability: ***From proxy to self***
  - Salience: ***Gets to the health questions quickly***
  - Demographic detail: ***Collected primarily for people for whom we collect health information***
  - Respondent for demographics and insurance: ***From family respondent to sample adult***

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- QUESTIONS?

Redesign Process: Evaluating Uses of NHIS Data

- Annual report to Congress: *Health, United States*
- Policy-relevant data for Department of Health and Human Services (DHHS)
  - Healthy People 2020 monitoring and 2030 planning
  - NHIS is the source for 69 Healthy People 2020 Objectives
- Review of published research
  - 2013-2015 PubMed and Google Scholar search yielded approximately 400 studies

Published Research – 2013-2015

- Frequently used survey content
  - Cancer Screening
  - Complementary and Alternative Medicine
  - Health Behaviors (e.g. tobacco/alcohol use)
  - Health Care Utilization
  - Health Disparities
  - Health Conditions
    - Child: Asthma, Mental and Developmental Disorders
    - Adult: Diabetes, Asthma, Cancer, Obesity

Published Research – 2013-2015

- Adult studies ~ 320 articles
- Child studies ~ 80 articles
- Family studies – 21 articles
  - Health characteristics of multiple individuals – 7 articles
  - Family characteristic associated with a health outcome – 12 articles
  - Family-level outcome - 2 articles

Redesign Process: Outreach

- 2014 – 2015: Stakeholder identification and engagement
  - CDC centers, agency partners, Healthy People federal interagency working group, professional associations, conference presentations

Redesign Process: Outreach

- October 2015: First call for public comment
  - Proposed the possibility of rotating content
  - Asked for content areas to eliminate
  - Listserv, web announcements
  - 60 e-mails from CDC, agency partners, academia, non-profit, small business, general public
  - Common themes:
    - Importance of broad disability measures
    - Maintain health insurance and utilization measures

Redesign Process: Outreach

- November 2015: Proposed structure and adult content drafts presented to NCHS senior staff
- December 2015: Proposed structure and adult content drafts presented to HHS Assistant Secretary for Planning and Evaluation (HHS/ASPE)
- ~~January 2016: Proposed structure and adult content drafts presented to NCHS Board of Scientific Counselors (NCHS/BSC)~~

Redesign Process: Outreach

- February 2016: Second call for public comment
  - Proposed to focus data collection on sample adult and sample child
  - Asked for consequences of proposed design, sufficiency of content, suggestions for validated questions for areas under development
  - Listserv, web announcements, gained wider dissemination through other outlets
  - 319 total e-mails (55 substantive e-mails) from CDC, federal agencies, academia, non-profit, small business, general public
  - Common themes: importance of family structure and context, improving mental health measures

Redesign Process: Outreach

- March 2015: Proposed structure and adult content drafts presented to OMB Desk Officer
- March 2015: Briefed NCHS DHANES leadership
- April 2016: Proposed child content drafts presented to NCHS senior staff
- April 2016: Briefed NCHS Office of Analysis and Epidemiology staff, National Academy of Sciences
- May 2016: Briefed the Children's Forum, Congressional staffers, NCHS BSC, multiple briefings of ASPE staff

Redesign Process: Outreach

Anticipated this summer:

- June 2016: Briefings with the American Economic Association, Council of Professional Associations on Federal Statistics, HHS/ASPE
- Third call for public comment
  - First release of child-specific content draft
- Federal register notice
  - First release of draft questionnaire text

Redesign Process: Seeking Technical Expertise

- Asked for input from experts working in:
  - Child health
  - Income
  - Pain
  - Injury

Child Health Technical Expert Panel I

- **Three Meetings**: 2/2/16, 2/25/16, 3/8/16
- **Number of Members**: 12
- **Affiliations**: University of Illinois College of Medicine at Chicago, Maternal and Child Health Bureau, Children's Hospital of Pittsburgh, Duke University School of Medicine, USF College of Public Health, Harvard Medical School, UC Berkeley School of Public Health, RTI International, The Lucile Packard Foundation for Children's Health, Boston Public Health Commission, Abt Associates, UNC Gillings School of Global Public Health

Child Health Technical Expert Panel II

- **Two Meetings**: 4/21/16, 4/28/16
- **Number of Members**: 5
- **Affiliations**: Population Reference Bureau, Johns Hopkins Bloomberg School of Public Health, Office of Minority Health, American Academy of Pediatrics

Child Health Technical Expert Panels

- **Major points of consideration**:
  - Increase emphasis on social determinants of health
  - Expand coverage on children's mental health
  - Use functioning as the framework for measurement of disability
  - Decrease focus on rare health conditions
  - Address the gap created by limited collection of family relationships
  - Focus on key measures for which benchmarks and long-term trends are needed, as well as identification of priority populations at elevated risk of poorer health or receiving poorer health care

Income Technical Expert Panel

- **Two Meetings**: 4/07/16, 4/28/16
- **Number of Members**: 8
- **Affiliations**: Agency for Healthcare Research and Quality, National Center for Health Statistics' Division of Research and Methodology, Office of the Assistant Secretary for Planning and Evaluation, University of Michigan's Survey Research Center, U.S. Census Bureau

Income Technical Expert Panel

- **Major points of consideration**:
  - Retain but condense “source of income” questions
  - Consider changing reference period for the income question to “past 12 months” to be consistent with health care access and utilization measures
  - Ensure a clear definition of family prior to collecting data on family income

Pain Technical Expert Panel

- **Two meetings**: 5/4/16, 5/17/16
- **Number of Members**: 7
- **Affiliations**: CDC/National Center for Chronic Disease Prevention and Health Promotion, Group Health Research Institute, National Institute of Neurological Disorders and Stroke, Stanford University
- **Major points of consideration**:
  - Focus questions on the impact of chronic pain
  - Use the recently published National Pain Strategy as a framework

Injury Technical Expert Panel

- **Monthly Meetings**: 5/2015 – 2/2016
- **Number of Members**: 30
- **Affiliations**: Agency for Healthcare Research and Quality, CDC/National Center for Chronic Disease Prevention and Health Promotion, CDC/National Center for Injury Prevention and Control, CDC/National Institute for Occupational Safety and Health, Center for Injury Research and Policy, The Research Institute at Nationwide Children's Hospital, Colorado School of Public Health, Colorado State University, Johns Hopkins Center for Injury Research and Policy, Liberty Mutual, National Safety Council, Pacific Institute for Research and Evaluation, The Children's Hospital of Philadelphia, University of Iowa College of Public Health , University of Maryland School of Medicine

Injury Technical Expert Panel

- **Major points of consideration**:
  - Assess utility of poisoning questions
  - Closely examine the current requirement for injury ICD-10 coding
  - Assess domains of injury most pertinent for epidemiology and surveillance
  - Discuss alternate ways of collecting information currently captured in NHIS injury section

Redesign Process: Survey Alignment Across HHS

- Several federal surveys have overlapping content in other health areas:
  - National Health and Nutrition Examination Survey (NHANES)
  - Medical Expenditure Survey (MEPS)
  - National Survey of Drug Use and Health (NSDUH)
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - National Survey of Children's Health (NSCH)
- Several federal surveys have overlapping covariate content:
  - American Community Survey (ACS)
  - Survey of Income and Program Participation (SIPP)
  - American Housing Survey (AHS)

Redesign Process: Survey Alignment Across HHS

HHS Data Council workgroups convened in 2015-2016 considered:

- Sexual orientation
  - NHIS questions considered HHS standard
- Health insurance
  - NHIS questions considered HHS standard for health insurance detail
- Mental health and substance use
  - Workgroup recommended use of PHQ and GAD
  - Standards for reference period for alcohol use TBD
- Tobacco use
  - HHS standard TBD

- QUESTIONS?
- FEEDBACK?

Proposed changes: Structure

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Minnesota Population Center

Home of the IPUMS, NHGIS, and IHIS

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Action Alert: Proposed questionnaire redesign for the National Health Interview Survey

Crucial Content May Be Cut from the National Health Interview Survey

On February 22, 2016 the National Center for Health Statistics announced a plan to dramatically overhaul the NHIS questionnaire and is requesting comments on these changes. They have only provided a **21-day period for public comment**, so you must act quickly to make your voice heard. Responses to the proposed plan are due **March 15, 2016.** To provide comments, please send an email to healthsurveys@cdc.gov.

The most significant proposed change is **the elimination of the family questionnaire that collects basic demographic, socioeconomic, health status, disability, and health insurance information about everyone in the sampled household**. The revised survey will only collect this information for one sampled adult and one sampled child

Proposed Changes: Structure

- March 8, 2016: Action Alert released by Minnesota Population Center
- Shift from family focus to sample adult/child could result in loss of data on:
  - Family income and poverty status
  - Family structure (one-parent/two-parent, intact/stepfamilies)
  - Special populations (same-sex relationships, mixed-race households, blended and extended families, U.S.-born children of immigrants)
  - Health insurance eligibility and access of other family members

Proposed Changes: Structure

- **Most of these crucial context areas are still covered**

- **Still asked about <u>each</u> member of the household**
  - Age, sex, race/ethnicity, active duty status

- **Asked about <u>each</u> adult**
  - Employment

Proposed Changes: Structure

- **Still asked about the <u>family unit</u>**
  - Family structure/size
  - Family income/poverty
  - Highest level of educational attainment
  - Income transfer program participation (e.g. WIC, SNAP)
  - Housing owned/rented, rental assistance
  - Financial burdens of medical care
  - Whether any adult in family speaks English very well
  - Landline and wireless phones in home

Proposed Changes: Structure

- **Asked about the <u>sample adult</u>**
  - Marital status (including cohabitation and same-sex partnerships)
  - Born in US, years in US, citizenship
  - Detailed employment, hours worked last week, reasons for not working, health insurance at workplace
  - Veteran status
  - Education
  - General health status
  - Limited in work or unable to work due to health, level of difficulty with personal care
  - Detailed health insurance coverage/uninsured
  - Hospitalized overnight, saw health professional
  - Delays in care due to cost, non-receipt of care due to cost
  - Injuries

Proposed Changes: Structure

- **Asked about the <u>sample child</u>**
  - Born in US, years in US, citizenship
  - General health status
  - Detailed health insurance coverage/uninsured
  - Hospitalized overnight, saw health professional
  - Delays in care due to cost, non-receipt of care due to cost
  - Injuries
- **Asked about the <u>sample child's parents</u>**
  - Marital status (including cohabitation and same-sex partnerships)
  - Whether any resident parents were born outside the US

Proposed Changes: Structure

- **Not included in proposed questionnaire content**
  - Detailed relationships of all family members to household respondent
    - Hard to identify multigenerational or extended families
  - Country of birth
  - Number of months worked last year, personal earnings amounts
  - Active duty time periods
  - Detailed ADLs and IADLs, disability-associated conditions
  - Receipt of medical advice by phone, home care
  - Amounts family spent out of pocket for medical care

Proposed Changes: Structure

- **Following the path set by the 1997 NHIS redesign**
  - Prior to 1997, all information was collected in the family interview (and therefore by proxy)
  - The sample adult and sample child modules were introduced in 1997 to get more detailed information via self-report (for adults) or from a knowledgeable adult (for children)

Potential Challenges

- Identifying family relationships
- Identifying sociodemographic context for children's health
- Estimating economic context / poverty status
- Producing state-level estimates
- Producing sufficiently precise estimates for smaller population subgroups

Potential Challenges: Identifying Family Relationships

- In a redesigned NHIS that does not include a detailed roster with relationships to a family reference person, will we identify:
  - Multifamily households
  - The family unit
  - Same-sex couples
  - Parents of children?

Proposed Solutions: Identifying Family Relationships

- Multifamily households are not common in the NHIS
  - In 2014, 2.3% of households had multiple families, 85% of these were adults only
- Multifamily households with children are not common in the NHIS
  - In 2014, <1% of households had multiple families and a child under age 18
- Multifamily households can be identified by asking if the sample adult/child is related to all of the persons living in the household
  - More testing is needed for how to phrase a question on whether all members of the household are in the same family unit

Proposed Solutions: Identifying Family Relationships

- Previous work by the Williams Institute on identifying same-sex couples in the NHIS suggests that fewer than 2% of couples in the NHIS are same-sex couples.
- Same-sex couples can be identified by asking marital status (including cohabitation) and identifying the spouse from the household roster.

Proposed Solutions: Identifying Family Relationships

- Children's parents or primary caregivers can be identified from the household roster.
- If the child lives with one or more parents, questions can be included to classify them as biological, step, adoptive, or foster parents.
- If the child lives with two parents, a question can be asked about their marital status.
- If the child lives with no parents, a question can be asked about the primary caregivers' relationship to the child.

Potential Challenges: Identifying Sociodemographic Context For Children's Health

- In a redesigned NHIS that does not include detailed information collected on each person in the family, will we identify:
  - Multigenerational or extended families
  - Mixed-race families
  - Educational attainment of family members
  - Families with one or more disabled members
  - Immigrant families?

Potential Challenges: Identifying Sociodemographic Context For Children's Health

- In a redesigned NHIS that does not include detailed information collected on each person in the family, will we identify:
  - Multigenerational or extended families **(not currently)**
  - Mixed-race families **(yes)**
  - Educational attainment of family members **(yes)**
  - Families with one or more disabled members **(not currently)**
  - Immigrant families **(yes)**

Potential Challenges: Estimating Economic Context

- In a redesigned NHIS that does not include employment, earnings, and income source information on each adult in the family, will we identify:
  - Income transfer program participation (e.g. WIC, SNAP)
  - Poverty status of families
  - Working poor families?

Proposed Solutions: Estimating Economic Context

- Members of the Income TEP suggested that income transfer program participation be asked directly during the collection of family-level data.
  - Family-level receipt of these sources is sufficient to identify people whose health may be impacted by these sources of income.
  - Transfer programs should be asked separately rather than grouped.

Proposed Solutions: Estimating Economic Context

- Several federal poverty measures
  - Poverty measure used in official statistics: Census Bureau
  - Supplemental poverty measure: Census Bureau
  - Federal poverty guidelines: HHS
- All use family income, family size, and family composition

- Members of the Income TEP noted that NHIS has historically defined poverty differently than in official statistics
- Suggested that NHIS use a measure that best fits the need for context about health care access and utilization

Proposed Solutions: Estimating Economic Context

- Other input from Income TEP members:
  - Especially at the lower income levels, priming of multiple income sources is needed
    - Czjaka & Dunmead found that the 2002 NHIS had higher estimates of people living in poverty compared with other federal surveys
  - Income sources may be asked at the family level
  - Individual income sources (other than income transfer programs) may be grouped
  - Clearly defining ‘family’ will be important

Czjaka and Dunmead. Income Data for Policy Analysis: A Comparative Assessment of Eight Surveys. 2008.

Proposed Solutions: Estimating Economic Context

- In 2014, 12% of families with children had at least one member in the labor force and lived below the poverty line

- Most working poor families can be identified by asking one brief question on employment status for each adult in the family
  - Less detail needed than for sample adult
  - Including this question before the questions on income sources can help define the family for the respondent

A Profile of the Working Poor, 2014. BLS, 2016; Families by Presence of Children (Table FM-1). Census Bureau.

Potential Challenges: Producing State-level Estimates

- In a redesigned NHIS with one sample adult and one sample child per household (and therefore, a total sample size ~47,000), how will the new sample size impact production of state-level estimates?

- For analyses that use the outcomes previously found in the sample adult and sample child modules, there should be no impact.
- For analyses that use outcomes previously found in the family module (e.g., health insurance), there may be a reduction in the number of state-level estimates presented.
  - Analysis of the implications of the 2016 sample redesign still needed

Potential Challenges: Producing Subgroup Estimates

- In a redesigned NHIS with one sample adult and one sample child per household, how will the new sample size impact production of estimates for smaller subgroups?
  - Point estimates should be unbiased
  - Confidence intervals will be wider

Potential Challenges: Producing Subgroup Estimates

- In a redesigned NHIS with one sample adult and one sample child per household, how will the new sample size impact production of estimates for smaller subgroups?

- An NHIS internal working group found that in 2014:
  - the estimate of the uninsured population using all family members or just sample adults and children differed by 0.1 ppts
  - Differences were 1-2 ppts for smaller subgroups where CIs were widest (e.g., Asian, < high school, unemployed, poor, widowed, cohabiting)
  - estimated number of uninsured (in millions) remained relatively stable, even in smaller age groups (difference: 0.0 - 0.2 million)

A Potential Opportunity for Studying Family Health

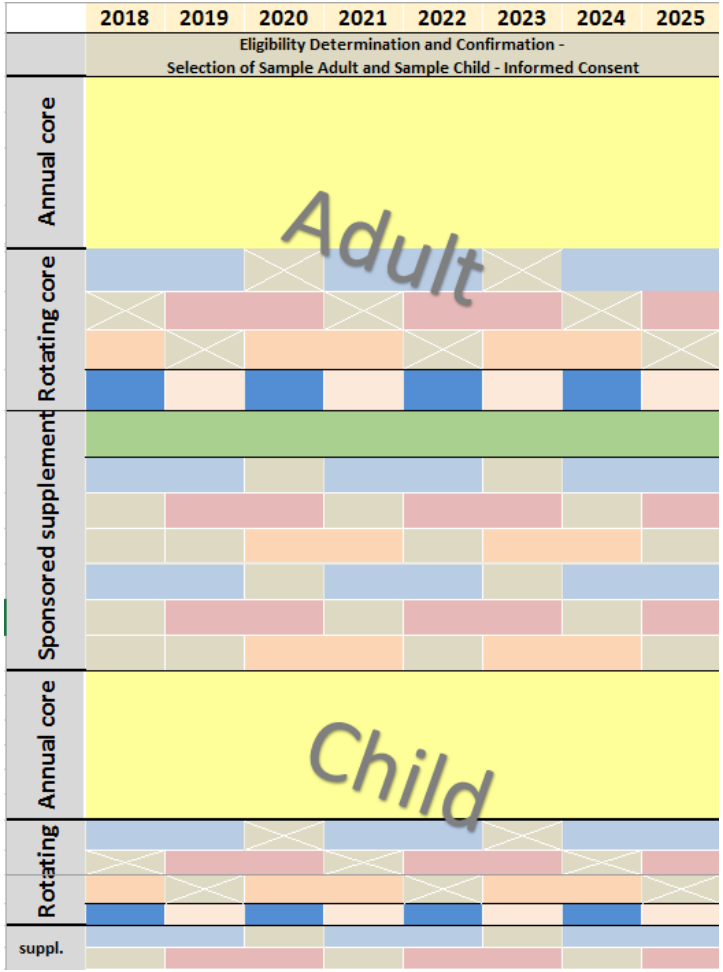
- In 2013, 33% of families in the NHIS had one or more children.
  - In 69% of these families, a parent was also the sample adult
    - 44% mother, 25% father, 31% other
  - Data users cannot currently make national estimates using associations between sample adult and sample child health
    - Parent's health not available for all sample children
    - Matched pairs are not representative of population

A Potential Opportunity for Studying Family Health

- Child Health TEP members provided studies from other surveys which used parent-child pairs as the unit of analysis
- Developed by National Survey of Drug Use and Health
  - Pair weights constructed to represent the population of eligible pairs
  - Resolved issues with multiplicity and population controls
- Permits national estimates of associations between child health and parent health

A Potential Opportunity for Studying Family Health

- Will be facilitated by alignment of adult and child content
- Alignment also permits
  - Estimates for whole population
  - Comparisons across age groups



- QUESTIONS?
- FEEDBACK?

Overview of Proposed Adult Content: Unchanged

- **General health status**
- **Health insurance:** coverage, type, details about plans, continuity
- **Access:** unmet needs, delayed care
- **Conditions:** hypertension, high cholesterol, cardiovascular conditions, asthma, cancer, diabetes, kidney problems, hepatitis, liver problems, arthritis
- **Body measurements:** self-reported height and weight
- **Utilization:** usual place for sick care, ER visits, any overnight hospital stay, vision care, mental health care, prescription medications, specialized therapy
- **Immunizations:** flu, pneumonia
- **Behaviors:** cigarette smoking and e-cigarette use, physical activity, sleep
- **Linkage**: consent to link with vital statistics and other health-related government records

Overview of Proposed Adult Content: Restructured

- **Disability**: from ADLs/IADLs to Washington Group international standards
- **Mental health**: from serious psychological distress to depression/anxiety screening
- **Pain:** from detailed body locations to impact and management
- **Barriers to care**: from “cost only” to “cost, transportation, and other reasons”
- **Employment**: focused more on current job or longest-held job in past year (if unemployed)

Overview of Proposed Adult Content: Additions

- **Preventive service use**: preventive medical visits, preventive dental visits, receipt of recommended screenings
- **Mental health care**: receipt of non-medication treatment/counseling
- **Content of care**: topics discussed with health providers
- **Urgent care center visits**
- **E-cigarettes**: use in smoking cessation
- **Walking**: frequency and duration
- **Social determinants**: housing security, housing stability, food insufficiency

Overview of Proposed Adult Content: Deletions

- **Demographics**: country of origin
- **Military service**: combat or noncombat, periods of active duty
- **Access**: problems accessing new providers, change in usual place, why no usual place
- **Utilization**: number of office visits, hospitalizations, surgeries, home visits, doctor phone calls
- **ER use**: visit on night or weekends, ER leading to hospital admissions, reasons for visit
- **Immunization**: shingles, hepatitis A/B, HPV, pertussis, tetanus
- **Acute conditions**: stomach illness, head/chest cold
- **Other conditions**: chickenpox, tooth loss, pregnancy, rare conditions
- **Costs of medical care**: amounts spent
- **Impacts**: bed days, change in health status in past year

Overview of Proposed Child Content: Unchanged

- **General health status**
- **Schooling:** missed school days, use of special education services
- **Health insurance:** coverage, type, details about plans, continuity
- **Access:** unmet needs, delayed care
- **Conditions:** asthma, developmental and learning disabilities
- **Utilization:** usual place for sick care, ER visits, any overnight hospital stay, vision care, mental health care, prescription medications, specialized therapy
- **Immunizations:** flu
- **Linkage**: consent to link with vital statistics and other health-related government records

Overview of Proposed Child Content: Restructured

- **Disability**: from ADLs to Washington Group international standard
- **Mental health**: from short to complete Strengths and Difficulties Questionnaire
- **Barriers to care**: from “cost only” to “cost, transportation, and other reasons”
- **Parent and family-level characteristics**: collected directly during sample child module or directly from sample adult

Overview of Proposed Child Content: Additions

- **Preventive service use**: details on medical preventive visit, preventive dental visit
- **Mental health care**: receipt of non-medication treatment/counseling, medication use
- **Urgent care center visits**
- **Behaviors**: physical activity, sedentary behavior, sleep
- **Social determinants**: housing security, housing stability, neighborhood safety, food insufficiency, stressful life events, quality of relationship between children and adults

Overview of Proposed Child Content: Deletions

- **Demographics**: country of origin
- **Access**: problems accessing providers, change in usual place of care,
  reasons for no usual place of care
- **Utilization**: number of office visits, hospitalizations, surgeries, home visits, doctor phone calls
- **ER use**: visit on night or weekends, ER leading to hospital admissions, reasons for visit
- **Acute conditions**: stomach illness, head/chest cold
- **Other conditions**: rare conditions, chickenpox

- QUESTIONS?
- FEEDBACK?

Next Steps

- May 2016
  - Board of Scientific Counselors meeting
  - Third call for public comment (1st release of child content draft)
- June 2016
  - Briefings with the American Economic Association, Council of Professional Associations on Federal Statistics, HHS/ASPE, others
  - Review of public comments
  - Development of initial draft of questionnaire text
- Summer 2016
  - Federal register notice (1st release of draft questionnaire text)

Next Steps

- Fall – Winter 2016:
  - More briefings and reviews of public comments
  - Continue to review quality of existing NHIS questions
  - Continue to revise content and questionnaire text
  - Harmonize content with other surveys where appropriate
  - Examine programming and editing procedures to increase automation and efficiency
  - Work with Census to standardize and improve Spanish translation
- 2017: Program survey instrument and test new procedures

What More Can You Do?

- Continue to make us aware of perceived gaps in the redesign process
- Continue to identify tradeoffs you think we should consider
- Encourage your organizations to provide evidence-based input on the redesign content, recognizing the need to reduce respondent burden
- Advocate on our behalf for the redesign

Redesigns are infrequent, but inevitable.

NCHS data are a vital public resource for health information. To maintain and enhance this resource, NCHS must assure that these data are relevant, accurate, timely, and accessible.

For More Information

http://www.cdc.gov/nchs/nhis/2018_quest_redesign.htm