EVALUATION OF THE NEBRASKA ADULT TOBACCO SURVEY (ATS)

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EXECUTIVE SUMMARY

As part of a demonstration project for evaluation of surveillance systems, the University of Nebraska Public Policy Center conducted an evaluation of the Nebraska Adult Tobacco Survey (ATS) for Tobacco Free Nebraska (TFN) – the state's comprehensive tobacco prevention and cessation program based at the Nebraska Department of Health and Human Services (NDHHS). Key findings from the evaluation include the following:

- Data gathered from the ATS is highly valued by a variety of stakeholders in Nebraska engaged in a variety of tobacco prevention and cessation efforts.
- Stakeholders desire further information on e-cigarettes, co-morbidities, and various subpopulations of interest, such as racial/ethnic minorities, LGBT populations, prospective or recent mothers, military populations, and others.
- Stakeholders value the close and positive relationships they have with TFN staff, which facilitates easy communication and answering questions users have about the surveillance data.
- There are robust quality assurance methods in place for administration of the ATS.
- Materials generated by TFN to report ATS data are easy to use and accessible, and program staff provide valuable assistance to users. Stakeholders suggested more visually appealing reporting materials.

INTRODUCTION

This evaluation is part of a demonstration project conducted for the Nebraska Department of Health and Human Services (NDHHS). The goal of the overall project is to develop an evaluation protocol based on the Centers for Disease Control and Prevention's (CDC) guidelines for evaluating public health surveillance systems[1]. The CDC's guidelines provide a general, task-oriented framework for evaluating surveillance systems, and are based on the recognition that surveillance system evaluations should be relevant and adapted to the specific surveillance system and questions of interest. The evaluation protocol tested in this demonstration project is for a brief evaluation that emphasizes making choices about the highest priorities for the evaluation, rather than completing the entire evaluation outlined in the CDC guidelines.

This evaluation is of the Nebraska Adult Tobacco Survey (ATS). The Nebraska Adult Tobacco Survey includes collection of comprehensive data on tobacco use from adult Nebraskans. The data is used to inform Tobacco Free Nebraska (TFN), the state's comprehensive tobacco prevention and cessation program housed at the Nebraska Department of Health and Human Services.

STAKEHOLDERS

EVALUATION TEAM

As administrator of the ATS, TFN is the principal stakeholder in its evaluation. The four main goals of TFN are:

- Helping people quit;
- Eliminating exposure to secondhand smoke;
- Keeping youth from starting; and
- Eliminating tobacco-related disparities.

Representatives of TFN and the NDHHS Office of Community Health and Performance Management, both within the Division of Public Health, served on the Evaluation Team. Representatives from the University of Nebraska Public Policy Center lead the evaluation team through the evaluation process and collected the evaluation data.

[1] Centers for Disease Control and Prevention (2001). Updated guidelines for evaluating public health surveillance systems: Recommendations from the guidelines working group. *MMWR, 50*(13), 1-35. Retrieved from http://www.cdc.gov/mmwr/PDF/rr/rr5013.pdf.

Additional Stakeholders

Since its inception, TFN has regularly and intentionally worked to further its efforts with a variety of partners in a statewide coalition model. These partners also rely on data collected through the ATS. Stakeholders include:

- Community coalitions – Local coalitions which receive funding from TFN and other sources to pursue tobacco prevention and cessation efforts within their communities. Coalitions are often based out of/affiliated with local health departments.
- Advocacy groups – Nebraska-based chapters of national organizations which actively lobby lawmakers for tobacco prevention and cessation policies, such as the American Cancer Society or American Lung Association.
- Behavioral health prevention programs – Partnerships based out of Nebraska's Regional Behavioral Health system which address substance abuse and mental health issues in the community.
- Internal Nebraska DHHS programs – Other state DHHS programs active in community health, such as in dental health, cancer, diabetes, or other chronic conditions.

Representatives of these groups were interviewed for this evaluation. Also, representatives of the contractor who conducts the ATS for DHHS provided information about the data collection process.

Description of the System

Purpose

The purpose of the ATS is to annually gather data on adult Nebraskans' use of tobacco products, cessation behavior, exposure to secondhand smoke, knowledge of tobacco use and health, attitudes towards tobacco use and smoking-related policies, and other issues. TFN, partners, and coalition members use this data to track trends and monitor policy attitudes. Data from the ATS is reported in a Data and Trends report published every two years and annual factsheets via the TFN website. Additionally, the health surveillance specialist analyzes and provides data to partners and coalition members upon request.

Development, Administration, and Dissemination

The initial version of the ATS was first implemented in 2002. The survey content, methods, and administration have all changed since its inception. The ATS collects data by landline and cell phone, which was included in sampling for the first time in 2013. There are over 100 question items on the ATS. Core questions on the ATS are asked every year on usage of tobacco products,

cessation methods, exposure to tobacco smoke, smoke free environmental policies, knowledge of tobacco and health, health behavior, and other issues.

Many of the core questions on the ATS are adopted from the National Adult Tobacco Survey, which was developed and recommended by the Office on Smoking and Health (OSH) in the Centers for Disease Control and Prevention (CDC). However, TFN staff members also develop ATS questions specific to Nebraska. For example, the ATS is used to gauge support for prospective or existing tobacco prevention and cessation laws, such as the Nebraska Clean Indoor Air Act passed in 2008. Members of the staff regularly monitor tobacco-related trends and issues in Nebraska and nation-wide, and make changes to ATS questions accordingly. The TFN staff members receive ideas about the survey from colleagues at NDHHS, other state departments, local health departments, and tobacco prevention and cessation advocacy groups they work with. As part of this process, TFN conducts regular meetings with members of its community coalitions. The CDC also reviews the ATS annual report and provides recommendations on how to improve it.

Because the ATS is used to monitor long-term trends, changes to the survey are largely incremental. Periodic changes are made to the survey to add new items, for example, assessing potential or recent policy changes, such as the Nebraska Clean Indoor Air Act, or monitoring new tobacco-use trends, such as the recent popularity of new and emerging tobacco products (e. g., e-cigarettes).

During the 4th quarter of each year, draft changes to the ATS are finalized by TFN. The survey is also translated into Spanish by the NDHHS. The final survey is then provided to the University of Nebraska-Lincoln Bureau of Sociological Research (BOSR), which administers the ATS under contract for TFN.

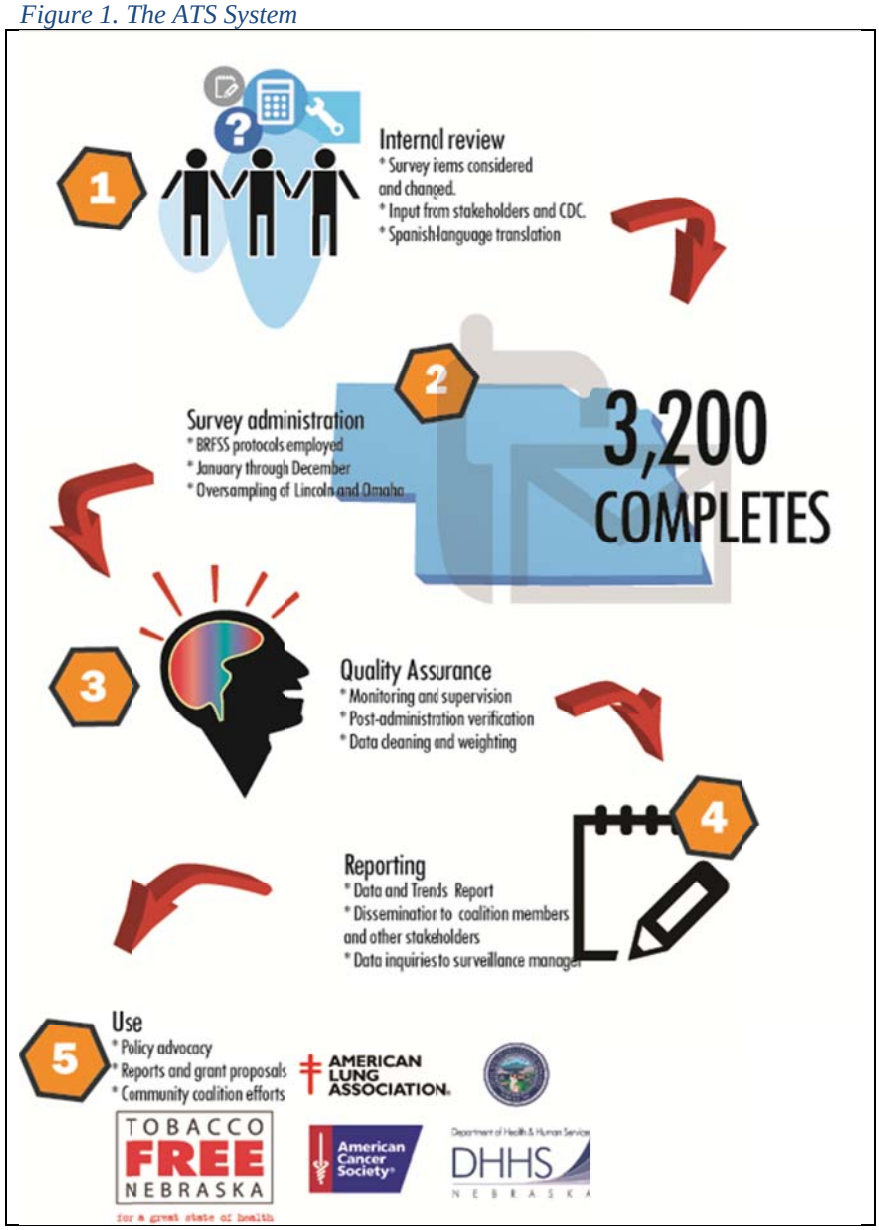
Currently, the BOSR administers the ATS throughout the calendar year (January through December), aiming to obtain approximately 400 completed surveys per each of the state's six behavioral health regions by the end of the year. Two counties are oversampled – Lancaster and Douglas – for an additional 400 completes each. In total, the annual target is thus 3,200 completes for all of Nebraska. The BOSR aims to obtain roughly half of the completed surveys from cellphone respondents and the remaining half from landline telephone respondents. Each year the target completes are based on the estimation that roughly 42% of adult Nebraskans currently use cellphones as their principal or only telephone. The BOSR retains bilingual English/Spanish interviewing staff and supervisors to conduct and oversee interviews in Spanish, thus allowing them to administer the Spanish-language version of the ATS.

In administering the ATS, the BOSR utilizes the survey protocols of the annual Behavioral Risk Factor Surveillance System (BRFSS), which it also administers for NDHHS throughout the year. This includes a framework for generating the call sample, call interview schedules, number of call attempts, identification of the appropriate respondent for each household, and data entry and

troubleshooting procedures. However, both the ATS and the BRFSS are separate samples and not mixed. Upon completion of data gathering for the ATS, the BOSR computes survey sample weights, and then provides the completed dataset to TFN.

As previously noted, TFN develops a Data and Trends report with statewide information on results that is published every two years. The report is made available on its webpage (http://dhhs.ne.gov/publichealth/Pages/tfn.aspx) along with factsheets and other materials, and also provided to coalition members and other users. The surveillance specialist with TFN is also available to answer specific questions from users of ATS. For example, community coalitions may request specific data on trends in their communities (see Figure 1).

Figure 1. The ATS System



EVALUATION DESIGN

Given that the protocol being tested by this evaluation emphasizes setting evaluation priorities to fit the time, funding, and other constraints faced by surveillance systems, a critical step in this evaluation is determining the key questions of interest, which then define the subsequent evaluation activities.

The evaluation team met several times to determine the overall questions of interest that should be addressed in the evaluation of the ATS. There were two principal evaluation questions identified: 1) How useful is the data collected by the ATS? 2) What measures are in place for quality assurance of the data collected by BOSR?

The evaluation team then decided that interviewing key stakeholders would be the most appropriate approach to gathering data about these evaluation questions. Key stakeholders were identified from 5 different groups: 1) community coalitions – local associations that work with TFN in tobacco prevention and cessation efforts within their communities; 2) advocacy groups – associations involved in tobacco prevention and cessation policy-related lobbying and advocacy at a statewide level; 3) behavioral health prevention programs – programs based out of Nebraska's six behavioral health regions that work in substance abuse and mental/behavioral health services; 4) other state public health programs – NDHHS staff from other programs than TFN who utilize ATS data for their programs; and 5) BOSR – the contractor responsible for administering the ATS in the field.

The evaluation team developed two sets of interview questions for the various stakeholder groups (see Appendix A). To facilitate the interview process, TFN sent a warm-up email to all individuals who had been identified by the evaluation team, notifying them of the evaluation and asking for their cooperation. PPC researchers then identified a sample of individuals, some of them randomly, to contact and invite to a phone interview. During the course of the interviews, additional stakeholders were identified, contacted and interviewed. Twelve total interviews were conducted (See Table 1). Detailed notes were taken from all interviews.

Table 1. Stakeholder Interviews

Community coalitions	3
Advocacy groups	3
Behavioral health prevention programs	2
Other state public health programs	3
BOSR	1
TOTAL	12

RESULTS

HOW USEFUL IS THE DATA COLLECTED BY THE NEBRASKA ADULT TOBACCO SURVEY?

Stakeholders we interviewed had very positive impressions of the ATS, ATS program staff, and TFN. Individuals interviewed universally thought that ATS data is important to their programs and activities. The usefulness of the data and how it is used varies depending on the missions and programs of data users.

Some interviewees indicated that they rely on ATS data for development of strategic priorities for their community coalitions or policy advocacy efforts. The ATS data is often highlighted in grants or reports to funders or policymakers:

> *"We do a 3 year strategic plan and evaluate our strategies. We look at: are user rates going down? Do we want to change strategies? It also informs what we want to look at policy-wise. We are working in smoke free parks and multi housing units. So we look at that data and monitor those issues."*

Several interviews indicated that the long-term monitoring of use trends, perceptions of smoke free environments, and policy attitudes are useful information that is communicated to policymakers:

> *"The ATS helps me inform legislators about successes we have had, if we see for instance declining adult use, it helps me to be able to discuss that with legislators as needed."*

> *"When the state smoke free air law was implemented, there were pre and post implementation questions added regarding support for the law so that could be tracked over time so we knew what trends looked like. That law has been in place for over 5 years now and support for that law has remained high. That support started at 40% and has grown to 60% statewide."*

WHAT ADDITIONAL INFORMATION COULD BE COLLECTED BY THE ATS?

We asked all interviewees what changes could be made to the ATS to improve it. Several interviewees offered topical additions to the ATS, or information specific to sub-populations. The most oft-cited topical suggestion was for the ATS to include information on e-cigarettes. Questions on e-cigarettes were first added onto the 2014 version of the ATS, and analysis of those results has not yet been published.

As far as any particular sub-populations of interest, interviewees indicated that they desired more information on racial/ethnic minorities, military populations, LGBT populations, and expecting

mothers or parents/guardians with young children in the house. Other interviewees suggested adding items that would allow users to identify smokeless tobacco rates among young athletes and rural youth, since these are considered target or at-risk populations for chewing tobacco:

> *"The most valuable would be information on smokeless tobacco (chewing) and e-cigarettes….We want data on Native American population, we have a large Hispanic population. We have a small but growing population of Marshallese Islanders. We are also interested in use among pregnant women. We have a couple of prenatal outreach programs that could make use of that."*

> *"This year we focused on the military and LGBT community, and focused resources towards them. We don't have specific data on those communities."*

This question received the most consistent responses, so themes with the largest number of responses are all requests for additions to the survey. A summary of frequently mentioned themes for additional content is displayed in Table 2.

Table 2. Frequently Mentioned Themes

Survey content	*Most desired*: E-cigarettes, taxes and policy preferences
	Also mentioned: Smokeless tobacco (chew)
Populations of interest	*Most desired*: LGBT, youth, minorities
	Also mentioned: Military communities, expecting or recent mothers/parents, lower SES in general, individuals with behavioral health conditions, pre-diabetics

A few interviewees believed that the ATS could be a valuable source of information for analyzing trends related to co-morbidities, either physical or behavioral. For example, tobacco usage and attitude data among pre-diabetic populations, substance abusers, or individuals with mental illnesses might be helpful to various community outreach, peer to peer, or self-management programs. They recommended adding more questions on the ATS about this data, but had no specific items in mind.

Upon review of the ATS questions, some of this data is already collected in the survey to an extent, suggesting that individuals we interviewed may not have been very familiar with all the survey items, or the reporting documents that TFN produces. This is not surprising given the length of the survey, and the fact that most of the users we recommended were not primarily data analysts, but outreach or advocacy professionals.

A few interviewees active in advocacy work also suggested that they would like to be able to use ATS data aggregated by state legislative districts, or policy attitudes data broken down by party affiliation. This would allow them to report or present survey data on use rates or attitudes on tobacco prevention and cessation policies to state senators by legislative district and party affiliation. Similarly, a few interviewees indicated that they would like to see analysis from the

ATS about the extent to which tobacco taxes were a disincentive for smoking across different income levels. This would help inform questions about the extent to which tobacco taxes were regressive.

How are stakeholders using the ATS fact sheets and data trends reports? How can they be improved?

Many of the interviewees reported that they actively use the fact sheets and the Data and Trends report published by TFN, and believed them to be high quality and very accessible. Interviewees appreciated the fact that they presented information in clear, straightforward ways:

> *"I think they are good, they are high quality. They have very good, high quality information, and are user friendly."*

This was important because the majority of interviewees were not data analysts and likely not overly familiar with statistical methods. The users thus rely heavily on having TFN analyze and present the ATS results for them in ways that are easy to understand and use for grant writing, reports, outreach and advocacy.

One recommendation that was made by several interviewees was for ATS data to be reported in visually appealing ways. They indicated that having infographics would allow them to easily communicate the ATS data through social media feeds like Facebook:

> *"I think their graphics could be improved a little. Could use a little improvement in visual appeal. They look pretty generic."*

> *"The one area that would be most helpful would be increased graphic quality so they can be used in social media as informative and appealing infographics. Something that could be cut and paste into a webpage or a report."*

> *"They could be more visually appealing – it resonates more with volunteers. It's easier for lawmakers to focus in on 1 page infographics, rather than a lot of text."*

How are stakeholders making suggestions or requesting further information about the ATS?

All of the interviewees stated that there was a strong and positive relationship between TFN staff and users. This facilitated regular communication that helped users understand the survey more. Interviewees indicated that there were regular meetings between community coalitions and TFN staff. Several of the interviewees specifically thought it was extremely valuable that TFN employed a data analyst who could respond to requests for data analysis:

> *"I am not good at research and I do not interpret data. I glance over it. If I need anything, I ask the data person at TFN and they interpret it for me…. I always*

drop an email to the data person at ATS. She usually gets me answers fast. We do quarterly meetings and one large conference a year as well. They do technical assistance by phone or email. They are always asking us for feedback at the meetings. They are very responsive."

"Because there is a designated surveillance manager in the program, that makes the data very accessible for others. They can call her and ask for local data that may not be in the report. Having that person on staff makes the program responsive to detailed data requests."

WHAT MEASURES ARE IN PLACE FOR QUALITY ASSURANCE OF THE DATA COLLECTED?

Interviews with representatives from the BOSR indicated that there was a robust, multi-method quality assurance framework in place for administration of the ATS. The protocols employed by the BOSR follow those based on administration of the BRFSS. The BRFSS protocol for data collection is based on best survey administration practices and legal regulations the CDC and partnering states use to obtain the highest quality data.

Data collection follows a suggested interviewing schedule, with all calls for a given survey month completed in the same sample month. A predetermined number of calling attempts are made for each landline and cell phone number. Final disposition codes are assigned for calls, which are then used to calculate response, refusal, or ineligibility rates.

WHAT EVIDENCE EXISTS SHOWING ADHERENCE TO PROTOCOLS?

The BOSR interviewing and phone bank system allows supervisors to observe data entry and listen to interviews during survey administration. This systematic monitoring is integrated into BRFSS protocols, and is a routine practice at the BOSR. Interviewer supervisors randomly monitor 5-10% of interviewing in real time for quality assurance. Feedback is then provided to the interviewer for improvement and correction. An additional 5-10% of complete respondents are re-contacted for to double-check demographic data, investigate missing data, and assess the politeness of the interviewer and quality of the interview experience. Interviews with BOSR staff indicated that the post-interview quality assurance confirmed the high quality of interviewing procedures and adherence to initial protocols. This quality assurance is done for all interviews, both English and Spanish. The BOSR indicated that there were no out of the ordinary concerns specific to recruitment of non-English speakers or racial/ethnic minorities into the survey. Because BOSR employs Spanish language survey administration staff who also review and suggest changes to wording of the Spanish language version of the ATS.

Additionally, interview staff regularly track issues that come up through survey administration, such as questions from respondents about particular items on the ATS or the survey overall. Supervisory staff regularly discusses issues that arise with the ATS, and develop standard responses to help clarify questions respondents may have. Interviewees indicated that having

additional information about the ATS as part of a "Frequently Asked Questions" document is very helpful to interview staff when questions arise from survey respondents.

There were no specific suggestions from the BOSR for improving the data quality assurance framework. Existing protocols are well-tested and have been employed for many years by BOSR. Additionally, any questions about survey administration that arise are always promptly addressed, and BOSR staff indicated that there is good communication with TFN for troubleshooting concerns or issues.

WHAT IS CURRENT PRACTICE ON TRACKING REFUSALS AND COMPLYING WITH LEGAL REDIALING LIMITATIONS?

Refusals are tracked by the interviewers based on an assigned disposition code. Four types of refusals exist: 1) Upon a calling attempt, there is an immediate hang-up and thus it is unclear if the contact phone number belongs to an eligible household or an ineligible household/business; 2) There is a household level refusal, and it is unclear if there is an eligible respondent in the household; 3) There is an eligible respondent in the household, but they refuse to take part in the survey; 4) A survey begins with an eligible respondent, but the survey is not completed. The total refusal rate for 2015 as of October 31 was 18.2%, and the total response rate was 51.9% (See Table 3). There are 15 maximum redial attempts for landlines and 6 for cell phones, in compliance with legal redialing limits. Two refusals end redialing attempts. Interviewers also are trained to track "hard refusals" such as verbally abusive persons. Those numbers are placed on do not call lists.

Table 3. Response and refusal rates

Landline Response Rate	Cell Phone Response Rate	Combined Response Rate*
47.8%	54.2%	51.9%
Landline Refusal Rate	Cell Phone Refusal Rate	Combined Refusal Rate †
22.6%	13.2%	18.2%

*Based on AAPOR Response Rate 4.

†Based on AAPOR Refusal Rate 2.

There are instances in which respondents are successfully contacted but may not speak English or Spanish. If a household selection process identifies a potentially eligible respondent but that individual does not speak either English or Spanish, the number is flagged with a language issue code. A redial is attempted, and if the same situation is encountered, the number is not attempted again.

CONCLUSIONS AND RECOMMENDATIONS

Our evaluation of the ATS indicated that the system is working well. All stakeholders interviewed had positive views of the ATS, and none offered negative impressions. There are robust quality assurance methods in place at the point of data gathering, which follow well-established protocols in survey administration. The resulting data gathered is employed by stakeholders in important ways, including advocating for public health policies, identifying strategic priorities, and in communications and public education.

The TFN program shows maturity in its use and management of the ATS, and an understanding of the needs of its primary users. The program staff has developed positive relationships with stakeholders that facilitate cooperation and communication, and generate easy to use and accessible reporting documentation. TFN employs a surveillance manager who can serve to continually manage the ATS, and respond to questions about data from stakeholders. This structure is responsive to the needs of the coalition of primary users across the state – stakeholders who may not have the time or skills to interpret data on their own, but rely on the data in their advocacy and community efforts.

Overall, there are few recommendations to make of the current ATS system. As previously noted, stakeholders did suggest some changes to the content of the survey. However, it was apparent this may be because they were unfamiliar with the current items, especially newer items that have not yet been released in published reports. Adding more items to the survey also implicates cost, and survey response rates. These are considerations that TFN staff could consider on an ongoing basis. One significant recommendation that came up was the desire for TFN to produce more "visually-appealing" reporting materials of ATS data – i.e. infographics that could be easily used by stakeholders in their communications and advocacy efforts. This might be easily achievable if NDHHS has a communications or graphic design staff on hand who could work with TFN to develop such materials.

Summary of ATS Recommendations:

1. Consider additional efforts to familiarize project partners and other stakeholders with the questions asked on the ATS, reporting materials, and the types of data analysis that could be made available. This can be accomplished in a variety of ways, including the regular meetings with coalition members, fact sheets about the types of data collected and how each can be used, and sharing of the final survey each year with project partners.
2. Have ongoing discussions with stakeholders in about collecting additional demographic and/or geographic information (such as racial/ethnic minorities, military populations, LGBT populations, expecting mothers, parents/guardians with young children, age groups, income categories, political party affiliation, and/or state legislative district) to meet stakeholder needs for additional break-downs of information, if the current survey does not have these items. Sample size, costs, and respondent burden are factors that

should be considered in weighing any benefits to adding more questions. This discussion can inform strategic decisions about the overall content of future versions of the ATS.
3. Familiarize stakeholders with additional data sources that can help answer some of their questions, such as the BRFSS or Youth Risk Behavior Survey (YRBS). Fact sheets describing data available from all surveys conducted by NDHHS could be used for this and other purposes.
4. Work with program partners to develop new, visually appealing ways to present data for program purposes such as public education. Ask project partners for examples of other fact sheets or infographics they like and find useful, and work to create similar materials about the ATS and its results.

Our evaluation of the ATS may also inform development of policies or practices that extend beyond TFN to the Division of Public Health or Department of Health and Human Services as a whole. Some of these considerations include:

1. Develop brief fact sheets for major surveillance systems being used. Fact sheets could include basic information on the content, use, and administration of the surveillance system, and may be helpful for internal departments, partner agencies and stakeholders, and members of the public.
2. Identify demographic groups for which having surveillance data would increase the success of public health efforts, such as LGBT or recent immigrant populations. Identify strategies for including these populations in future surveillance system activities across NDHHS.

Recommended Use of Evaluation Results

A key reason for conducting evaluation is to ensure surveillance systems do what they are intended to, and to identify improvements to increase usability and/or efficiency of the system. Thus, it is essential that the results and recommendations from this evaluation be carried forward to inform future TFN and NDHHS endeavors.

Recommended next steps for the use of these evaluation results are:

1. Use this evaluation to inform TFN strategic planning, develop a quality improvement (QI) plan, and/or a plan for future ongoing evaluation. Document changes resulting from the plans.
2. Share this evaluation report and discuss results within NDHHS and with TFN stakeholders.
3. Use this evaluation to help inform development of an overall vision and strategy for evaluation of surveillance systems for the NDHHS.

APPENDIX A: STAKEHOLDER INTERVIEW QUESTIONS

A.1 QUESTIONS FOR STAKEHOLDERS/PARTNERS

These questions were asked of representatives from groups that use ATS data. These groups are: 1) community coalitions, 2) advocacy groups, 3) behavioral health prevention programs, and 4) other state public health programs,

1. What organization do you represent, what is your role, and what is your relationship to the ATS/TFN?
2. How familiar are you with the ATS?
3. What does your organization do related to tobacco use? How does your organization use data from the ATS? (tell us some examples)
    a. Do you work with specific populations of interest, e.g. racial/ethnic minorities, youth, LGBT, renters? Does the ATS gather data that meets your needs related to these groups or areas of interest?
    b. Are there specific ways you would like to see data aggregated and reported to you? I.E. specific demographic categories or geographic units.
    c. What other common sources of data do you typically use? Are there ways that the ATS can better align with these data sources?
4. Is there additional information that would be helpful to you that is not being asked on the ATS? (If so, what is it?)
5. How often do you use factsheets or the data and trends report created by TFN, and for what? How can they be improved? (please cite examples of improvements)
6. Have you ever requested additions or suggestions to the ATS? If so, what happened? (and how can that process be improved?)
7. Anything else you think is important about the ATS?

A.2 Questions for the Bureau of Sociological Research (BOSR)

1. What data control protocols does BOSR have in place? Do you use the BRFSS protocol only, or do you also add your own protocols? Please send a description of your protocols.
2. What evidence can you provide for how well you are following the protocols?
3. What are your current practices on refusals to take part in the survey? How do you track these? How can you ensure that you are complying with recent federal law to not re-contact people who refuse to participate in the survey?
4. What is the general process for clarifying issues that arise about the ATS during survey administration (e.g. questions from respondents, questions from interviewers)? Is there anything that could be improved?
5. Are there any specific issues that arise with the Spanish-language version of the ATS? If so, how can they be best addressed?
6. What other languages do your interviewers commonly encounter that might suggest translation into a third (or more) language is needed?