LISA WAGNER: At this time, all participants are in a listen-only mode. Today's call is being recorded. If you have any objections, you may disconnect at this time. Draft slides are available on this webinar's announcement page for anyone joining by telephone. My name is Lisa Wagner, and I am on the policy team at the National Center for Health Statistics, or NCHS. I am pleased to introduce today's speakers, Dr. Paul Scanlon and Dr. Katherine Irimata. Paul has been with NCHS since 2012 as a survey methodologist in the Division of Research and Methodology's Collaborating Center for Questionnaire Design and Evaluation Research. His work focuses on developing mixed methodologies for the study of measurement error and the evaluation of cross-cultural questionnaires. Katherine has been with NCHS since 2018 as a mathematical statistician in the Division of Research and Methodology's Collaborating Center for Statistical Research and Survey Design. Her current focus is on methodological research related to survey estimation and calibration. Katherine and Paul will discuss the Research and Development Survey, or RANDS, during COVID-19. Their presentation will discuss how RANDS was transformed to meet the more immediate needs of the COVID response and will highlight the release of experimental data from the RANDS on reduced access to health care, loss of work due to illness with COVID-19, and the use of telemedicine during the COVID-19 pandemic. The presentation will be followed by a question-and-answer session. As a reminder, the audience is currently in a listen-only mode. Questions or comments may be entered through the Q&A feature, and we will address them as time permits during the question-and-answer session. And now I turn it over to Paul and Katherine.

DR. PAUL SCANLON: Thanks, Lisa. Good afternoon, everybody. As Lisa just mentioned, my name is Paul Scanlon, and I'm a survey methodologist and behavioral scientist within NCHS's Division of Research and Methodology, or DRM. I'm joined today by my colleague Katherine Irimata. And we're part of the team that runs the National Center for Health Statistics's Research and Development Survey, or RANDS. Today, Katherine and I will be giving a high-level -- a high-level overview of the RANDS program, explain how we adapted the program during the pandemic to produce experimental estimates on a series of coronavirus-related topics, explain our estimation approach, show some results, and finally talk a little about data access and future plans. So just to start, the National Center for Health Statistics is the statistical agency for the U.S. Department of Health and Human Services. So we are one of the centers within the Centers for Disease Control and Prevention, and are a part of the federal statistical system. Staff at NCHS collect, analyze, and disseminate health data for public health policymaking and research. So as the federal statistical agency for health, it's our role to provide the foundational health statistics that inform policymaking and research. We do this through a series of survey and data collection systems, such as the National Health Interview Survey, or NHIS; the National Health and Nutrition Examination Survey, or NHANES; our National Health Care Surveys; and our Vital Statistics program. One of our newer data collection systems is called RANDS, and that's what we're here to talk about today. RANDS, or the Research and Development Survey, is a program within NCHS's Division of Research and Methodology. So RANDS is substantially different than most of our other data systems in that it is designed to function as a testbed for DRM's methodological work, and uses a recruited commercial survey panel as its sample source. In general, we use RANDS to assess the usefulness of recruited commercial survey panels, and to explore how the center can use these commercial panels in coordination with our other data systems. Within this general realm of "methodological research," RANDS facilitates two distinct research areas. First, we use RANDS to explore how commercial survey panel data compare to those data collected by our traditional household surveys, and how we can use panel data to supplement the traditional surveys' estimates. We can think of this goal as two sides of the same coin. Can we combine data from RANDS with NCHS's other surveys, or can we use data from the traditional surveys to calibrate RANDS' estimates? Well, the pie-in-the-sky idea here is that you could eventually use a supplementary commercial panel to administer some of the detailed questions that are now on our longer traditional surveys, thus leveraging the data from a survey like the NHIS but reducing its overall burden. The other side of RANDS deals with measurement error. And basically we're interested in developing ways to use survey data in our evaluation of questions and questionnaires. Our main method for question evaluation is cognitive interviewing, which is a qualitative method designed to uncover how people understand questions, and the patterns of interpretation they use when answering survey items. However, because cognitive interviewing uses a purposive sample, we cannot statistically extrapolate findings from that sample to a population. RANDS gives us an opportunity to take our question evaluation studies a step further by exploring these interpretations on a statistically sampled survey. To do this, we use both experimental designs and set cognitive probes, which we typically refer to as web probes, to try and uncover respondents' interpretations of the survey items. And by doing this, we can then determine what types, and, depending on the wording of probe we use, the amount of measurement error that a certain survey question produces. We're going to look at the various rounds of RANDS so far. We began in 2015 with RANDS 1, and followed that in 2016 with RANDS 2. Both of these rounds focused on general health conditions and behavioral items from the NHIS, and were used to begin our calibration

research and develop web probing as an evaluation method. RANDS 3 conducted in 2018 focused mainly on opioid questions and evaluating potential NHIS question changes. RANDS during COVID-19, which we are going to talk about in detail today, was conducted in response to the outbreak of the coronavirus pandemic, and is both providing estimates of coronavirus-related topics and being used by NCHS to refine coronavirus-related questions for other surveys. So, so far we have two rounds of RANDS during COVID-19 planned. One is complete and provides that estimates that Katherine will be discussing in a few moments, and the other is currently being fielded. We may also field an additional round in the late fall or early winter, but a final decision hasn't been made yet. In addition to RANDS during COVID-19, RANDS 4 is also currently being fielded. The survey focuses on disability statistics and opioids. In addition, and at the moment, we have one round of RANDS planned for next year, which will focus on an evaluation of National Survey of Family Growth questions. Yeah, a term I've used a bit so far has been recruited commercial survey panels. So let me briefly explain what I mean by that. So, first, these are panels of potential survey respondents that private companies develop and maintain. So this allows us a bit of flexibility and speed as compared to NCHS's traditional surveys since we're dealing with commercial vendors who routinely contract, set up, and program, and administer surveys with quick turnaround times. However, the quality of the private companies' survey frames have limitations in terms of the -- in terms of population coverage as compared to the frames that we we typically use on NCHS surveys. And this point is key. We have to consider the implications of the quality of these frames on the resulting data quality of the survey. So, as a result, RANDS uses methods to correct for this characteristic of recruited panels, and Katherine will explain that method in a bit. "Recruited" refers to the fact that these companies actively go out and recruit people into the panel from a known sampling frame. So these aren't opt-in panels such as the ones you may see come across your social media feeds or on news websites. Because panelists are recruited from an underlying frame, probabilities of selection can be assigned to the panelists. Though of course that's a -- there's an assumption there of complete coverage when assigning these probabilities. One important aspect of the surveys that come out of these panels as compared to NCHS's traditional surveys is that we really have to consider the impact of multiple opportunities for nonresponsive potential attrition. And what I -- what I mean by that is that these companies go out and recruit the panels by an initial survey, to which of course there is some nonresponse. And then, once the individuals are part of the panel, they can choose to either participate or not in each individual survey that's presented to them. So we have risk of nonresponse at multiple stages. And, additionally, individuals can leave the panel at any time. So this all factors into the eventual cumulative response rate for an individual survey and then its resulting data quality. So, overall, recruited panels are comparatively high-quality versus opt-in survey panels but lower than the sample quality NCHS typically uses in its traditional household surveys. Across the RANDS surveys we've conducted and planned so far, we've actually used two separate panels. The first two rounds used the Gallup organization's Gallup Panel, and, since then, we've been working with NORC at the University of Chicago and using their AmeriSpeak Panel. So I just want to briefly touch on the last bullet for each of these, what panels do with non-Internet users. So these panels are mostly -- they mostly function as web panels, which is nice because web surveys are cheaper and faster and easier to program and conduct. But this leads to a separate coverage issue. Obviously, we don't have universal Internet access in the United States, and, on top of that, some people just aren't comfortable using Internet devices. So each panel has its own way of dealing with this. Gallup offered phone and mail options for non-Internet respondents, but we never used that as part of their panel. NORC phones non-Internet respondents, which is a feature we are currently using. So RANDS 1 through 3 were just of web respondents, and thus excluded non-Internet panelists from their samples. For RANDS during COVID-19, as well as RANDS 4, we're including non-Internet panelists by telephone interviews. Beyond helping with the coverage issue, this allows us to continue our methodological exploration of these panels, and how their web and telephone respondents may differ from one another. And so I mentioned that RANDS is designed to be used as a methodological survey so that we can supplement our question evaluation studies, and explore the characteristics of survey data derived from recruited commercial survey panels. However, our experience with these panels so far has allowed us to adapt RANDS in response to the coronavirus outbreak. As I noted a few moments ago, one of the advantages is RANDS is that it's nimble as compared to NCHS's traditional surveys. So we could develop a questionnaire and get it fielded in a matter of months as compared to half a year or better, or longer. And this ability became important because the coronavirus pandemic impacted many of NCHS's traditional surveys. For instance, the NHIS had to rework its approach, and only use telephone interviews, and NHANES was out of the field entirely. So, given the impacts on our traditional surveys and the flexibility of the RANDS program, NCHS worked to repurpose RANDS during the pandemic to provide a small set of experimental estimates on coronavirus-related concepts. And Katherine will get more into the details, but the estimates from RANDS during COVID-19 are considered experimental as research to understand potential sources of measurement error and to improve our estimation calibration approach is ongoing. So then what exactly is RANDS during COVID-19? It is a two-, and, as I mentioned, potentially a three-round

multimode survey with a longitudinal design component. The same set of AmeriSpeak respondents were invited to participate in the first two rounds, which started about six weeks apart from one another. NORC agreed to provide NCHS with at least 6,000 respondents in the first round and 5,000 in the second round because obviously they'll be some attrition between the rounds. The primary mode is self-response web, though we are also, as I mentioned, including some telephone interviews in order to alleviate the coverage issues I talked about before. We developed the questionnaire in consultation with other divisions in NCHS, and the topics range from general health status and affect, to health care access, telemedicine, and coronavirus-related behaviors and outcomes. The bolded topics in this list are the ones that we're releasing experimental estimates on. We're not releasing estimates on the other topics, but we'll be using those data for methodological research. For the three areas where we are releasing estimates, RANDS is providing data that are not available from other federal statistical agency sources. NCHS's Collaborating Center for Questionnaire Design and Evaluation Research conducted a series of cognitive interviews using NCHS staff as respondents in order to evaluate the quality of the questions on this questionnaire. And we refined the questionnaire based on those findings. Unfortunately, we didn't have time to conduct a full cognitive interviewing evaluation prior to RANDS during COVID-19 going into the field, but we are about to begin that and we will be able to present those findings at a later date so that data users can better understand what constructs each question captures and to factor that into their analysis. So here's an overview of the data for the first round of RANDS during COVID-19, which took place between June 9th and July 6th of this year. 8,663 randomly selected adult panelists were invited to participate in the survey. We obtained a completion rate of 78.5%. Of the 6,800 completed responses, 94% were completed by web respondents whereas the other six were obtained by phone interviews. So, overall, RANDS during COVID-19 Round 1 had a weighted cumulative response rate of 23%, which takes into account the panel recruitment response rate in addition to the survey completion rate -- yeah, survey completion rate. So now I'm going to turn it over to Katherine who will discuss the estimates. Katherine?

DR. KATHERINE IRIMATA: Thanks, Paul. So, in this next section, I'll be presenting estimates from the RANDS during COVID-19 survey. Experimental estimates were produced for the three topics that Paul had described previously. These experimental estimates were produced using calibrated weights, which account for the survey design. In the analysis of surveys, sample weights are used in the calculation of the estimates in order to account for the survey design. Since RANDS is a probability survey, it comes with weights which are used to calculate the estimates. However, as Paul had mentioned earlier, RANDS during COVID-19 differs from the survey design approaches which are generally used at NCHS. Since this is a recruited commercial panel survey, and it's conducted primarily using the Internet, we know that there could be potential bias due to differences in coverage and sample variability. So, in this study, the RANDS sample weights were calibrated to the 2018 National Health Interview Survey sample adult weights in order to adjust for differences in selected demographic and health factors. And these factors included things such as age, sex, race and Hispanic origin, education, income, census region, marital status and four diagnosed chronic conditions, which included high cholesterol, asthma, hypertension, and diabetes. The distribution of some of these variables, including age, marital status, income and the diagnosed chronic conditions, varied between RANDS and the NHIS. By calibrating using raking, we adjusted the marginal totals of RANDS to match the marginal population totals of the NHIS, which allows us to account for differences between the two populations represented. These calibrated weights allow us to provide nationally representative estimates in the study. Calibration utilizes the strength of existing surveys to adjust for possible differences in the survey design through the weights. I apologize about that. So, for example, here are some of the data systems that we have at NCHS. We can utilize these data systems and surveys to adjust for possible differences seen in the RANDS data using calibration. In the case of previous rounds of RANDS, including the RANDS during COVID survey, the National Health Interview Survey has been used for producing calibrated weights and evaluating the estimates of the outcomes. For the planned round of RANDS that Paul introduced earlier, we'll use the National Survey of Family Growth for calibration in comparisons with the RANDS data. For the Round 1 release of RANDS during COVID-19, experimental estimates were produced at the national level as well as for selected subgroups. These findings were reported on the NCHS website earlier this month. The three main topic areas reported included loss of work due to illness, telemedicine, and reduced access to care. In the next part of this webinar, we'll show some of the findings from the survey. Statistical testing will be noted in the presentation, including subgroup comparisons which were evaluated using the Rao-Scott chi-square test. The first results we'll show are related to loss of work due to illness. NCHS was interested in evaluating the inability of U.S. adults to work at any point in the past week due to being sick or having a family member sick with COVID-19. Survey panelists who did not work for pay at a job or a business in the previous week were asked if they were unable to work because of illness with COVID. From the Round 1 results, we found that overall 0.9% of U.S. adults were unable to work due to personal or family member illness with COVID-19. This next slide shows two plots for loss of work due to illness. The plot on the left reports the percent of work loss by race and Hispanic origin. The percent of adults unable to work varied significantly between race

and Hispanic origin groups. The percent of non-Hispanic black adults and Hispanic adults who are unable to work due to illness with COVID-19 were higher than the percent of non-Hispanic white and other non-Hispanic adults. The percent of non-Hispanic black adults who are unable to work was nearly twice as high as Hispanic adults and was five times higher than white non-Hispanic and other non-Hispanic adults. The plot on the right reports loss of work by education. The percent of adults unable to work varied significantly by education level. Adults with some college education had the highest percent of work loss due to COVID-19, at 1.6%, while adults with a bachelor's degree or above had the lowest percent of work loss at 0.2%. Adults with some college education were two times more likely to miss work due to personal or a family member sickness with COVID-19 compared to those with a high school degree or less. This slide shows the percent of adults who experience loss of work by sex and by diagnosed chronic conditions. For comparisons by sex, females and males did not have statistically significant differences in loss of work. 0.7% of males reported loss of work due to COVID, while 1% of females reported loss of work. For adults with diagnosed chronic conditions, the percent unable to work were similar across these four selected diagnoses. These were not statistically tested since there's overlap between the diagnoses. However, the rates of work loss ranged from 0.7% for diagnosed diabetes to 1% for current asthma and one or more chronic conditions. One or more chronic conditions included a diagnosis by a doctor or other health professional of hypertension, high cholesterol, coronary heart disease, current asthma, COPD, emphysema or chronic bronchitis, cancer, or diabetes. RANDS during COVID-19 also included questions to measure the access and use of telemedicine, which includes video and telephone appointments before and during the pandemic. To measure telemedicine access, survey panelists were asked if their provider offered them an appointment by video or phone before the pandemic and in the last two months. Panelists were able to answer yes, no, or do not know. To measure telemedicine usage, survey panelists were asked if they had a telemedicine appointment in the last two months. From this study, we found that 14.1% of adults in the U.S. have a provider that offered telemedicine prior to the pandemic. In addition, 36.6% of adults in the U.S. reported having a provider that offered telemedicine in the last two months, which was asked at the time of the survey. This timeframe is referred to as the last two months, which is how panelists were asked on the questionnaire, but this covers the timeframe from the beginning of April to the end of the study in early July. For all subgroups, we also saw an increase in access to telemedicine from before the pandemic to more recently. We'll take a closer look at some of the differences within groups during these two time frames. Here we see two plots which show telemedicine access before the pandemic and in the last two months by age group. Each plot displays reported telemedicine access, which can be categorized as yes, no, or do not know. No usual source of care indicates that a person does not have a place that they usually go to when they need health care, and so they wouldn't have a usual provider that would offer them telemedicine. We can see that telemedicine access varied significantly by age group before the pandemic and also varied significantly by age group more recently. Adults 65 years and older reported the most access to telemedicine with 46% of adults 65 years and older reporting access to telemedicine in the last two months. In addition, adults age 18 to 44 years were less likely to have a usual source of care and were less likely to know if their provider offered telemedicine compared to adults 45 years and older. This slide display similar plots for telemedicine access for comparisons by sex. Before the pandemic, telemedicine access did not significantly differ between males and females. 14% of males and 14% percent of females reported access to telemedicine, and the percent of males and females with the usual provider were fairly similar. However, in the last two months, we see that telemedicine access significantly differed with 33% of males reporting access to telemedicine and 40% of females reporting access to telemedicine. Here are two plots with telemedicine access by education for both time periods. Access varied significantly by education before the pandemic and in the last two months. Although all education levels reported higher telemedicine access since the pandemic began, in both charts we can see that adults with a bachelor's degree or above had the most access to telemedicine and were more likely to have a usual source of care compared to adults with a high school diploma or less, or some college education. In the plot on the right, we can see that 40% of adults with a bachelor's degree or above reported access to telemedicine in the last two months compared to 35% for adults with a high school diploma or less, and 35% for adults with some college education. Here are comparisons of telemedicine access by urbanization. Before the pandemic, telemedicine access significantly differed by metropolitan and nonmetropolitan areas. From the plot on the left, we can see that 15% of adults living in metropolitan areas had access to telemedicine, while 12% of adults living in nonmetropolitan areas had access to telemedicine. However, in the last two months, telemedicine access is more similar between metropolitan and nonmetropolitan areas. We can see that 37% of adults in metropolitan areas and 36% of adults in nonmetropolitan areas had access to telemedicine. Although fewer adults in metropolitan areas reported having a usual source of care, there was not a statistically significant difference in access to telemedicine between the two areas more recently. In addition to telemedicine access, RANDS during COVID-19 was used to assess telemedicine use among adults in the United States. Overall, 24.2% of adults in the U.S. reported having one or more telemedicine appointments in the last two

months, which covers the timeframe from the beginning of April to the end of the study on July 6th. The two plots shown on the screen report telemedicine usage by age group and sex. Telemedicine usage varied significantly by age group, with adults 65 years and over reporting the highest usage of telemedicine at 32%. Telemedicine usage was also significantly different between males and females, with over 26% of females reporting using telemedicine one or more times compared to 22% of males. Here we see three graphs, which show telemedicine usage by race and Hispanic origin, education, and urbanization. Statistical testing indicated that there were not significant differences within each of these subgroups. Although telemedicine usage was similar across race and ethnicity groups, we see that telemedicine usage ranged from 19.9% to 27.4%. In addition, telemedicine usage by education ranged from 23.1% to 25.4%. And adults living in metropolitan and nonmetropolitan areas reported telemedicine usage of 24.4% and 22.6%, respectively. For comparisons across diagnosed chronic conditions, we did not statistically test for differences since there's overlap between the different chronic condition diagnoses. However, we see that the reported telemedicine usage ranged from 31.6% for adults with one or more chronic conditions, to 44.4% for adults with diagnosed diabetes. Adults with diagnosed chronic conditions, such as one shown here, reported a higher telemedicine usage compared to the national average of 24.2%. The final indicator that was reported from RANDS during COVID-19 was reduced access to care. NCHS was interested in evaluating the inability of adults in the U.S. to receive medical care for any reason, which includes reasons related to the coronavirus pandemic, and the inability to receive medical care due specifically to the coronavirus pandemic. Survey panelists were asked if they were unable to get any of the following types of care for any reason, and if they were unable to get any of the following types of care because of the coronavirus pandemic. Nine different types of care were evaluated, as well as an overall measure for one or more of these specified care types. Overall, 48.4% of U.S adults reported missing one or more types of care in the last two months for any reason, which was measured from the time of the survey, and 38.7% of U.S adults missed one or more types of care in the last two months due to the coronavirus pandemic. The one or more types of care listed includes the nine types of care that were mentioned on the previous slide. Among those nine individual types of care, the amount of missed care varied greatly by care type. The most missed care for any reason and due to the pandemic was reported for dental care while the least missed care for any reason was reported for hearing care, and the least missed care due to the pandemic was reported for urgent care. Additional results for the different care types will be shown soon. In this slide, we can see the percent of missed care for one or more types of care by sex and education. The blue bar shows the percent of missed care for any reason while the gray bar shows the percent of missed care due to the pandemic. For sex, the percent of missed care significantly varied for any reason and due to the pandemic between males and females. Females were more likely to report missing care compared to males for any reason and due to the pandemic. Similarly, for education, the percent of missed care significantly varied for any reason and due to the pandemic among the three levels of education. By education level, adults with a bachelor's degree or above were more likely to report missing care for any reason and due to the pandemic. Here, we have a graph of missed care by race and Hispanic origin. We can see that the percent of adults who missed care for any reason, shown with the blue bars, are very similar to one another and did not statistically significantly differ. However, the percent of adults missing one or more types of care due to the pandemic, which is shown in the gray bars, statistically significantly differed by race and ethnicity. We can see that the percent of missed care due to the pandemic ranges from 29.9% for black non-Hispanic adults, which was the least care missed due to the pandemic, to 41.4% for white non-Hispanic adults, which was the most care missed due to the pandemic. Evaluating differences and access to care by age group and urbanization did not reveal any significant differences within either subgroup. Reduced care was consistent across age groups for any reason and due to the pandemic. The percent of missed care for any reason ranged from 46.3% to 51.5%, while the percent of missed care due to the pandemic ranged from 36.5% to 41.8%. Similarly, the percent of reduced care for any reason and due to the pandemic were very close for metropolitan and nonmetropolitan areas. Estimates of missed care for any reason were around 48% to 49%, and estimates of missed care due to the pandemic were close to 39%. This plot shows estimates of reduced access to care by selected chronic conditions. While these were not statistically compared, we see fairly similar estimates of missed care for any reason across the reported chronic conditions, ranging from 53.3% missed care for one or more chronic conditions, to 59.3% for current asthma. We also see similar estimates of missed care due to the pandemic. These range from 42.6% for adults with diagnosed hypertension to 46.9% for adults with current asthma. This slide displays the percent of missed care for any reason and due to the pandemic for each of the nine types of care that were reported on RANDS during COVID-19. There are a few different items to know. First, we see that certain types of care were missed more than others. On the left side of the plot, starting with dental care, we see types of care that were missed more often, while on the right side of the plot, ending with hearing care, we see types of care that were not missed as often. And, importantly, the type of care is related to how often it's missing. For example, dental care, regular checkups, and vision care were missing most often for any reason and due to the pandemic. However, these are very common types of care.

Many adults may have annual checkups with their physician or two dental appointments a year, so it's more likely these types of care will be missed. On the other hand, types of care such as surgical procedures, urgent care, and hearing care appointments are not as common, and we wouldn't expect to see such a large percentage of missed care for these care types. The second item to know is that certain types of care were impacted by the pandemic more than others. For certain types of care, the percent of missed care due to the pandemic, which is shown in the gray bar, is large relative to the percent of missed care for any reason, which is shown in the blue bar. And we can see this for care types such as dental care, vision care, and surgical procedures. However, for some of the other types of care, such as urgent care or prescription drugs or medications, the percent of missed care due to the pandemic is small relative to the percent of missed care for any reason, which indicates that types of cares -- that these types of care were less impacted by the pandemic. There are many other comparisons that can be made within subgroup for certain types of care as well as additional estimates for the other topics discussed, but these findings give you an overall picture of some of the results from RANDS. As a recap, RANDS is an existing platform that was designed for methodological purposes, including conducting survey question evaluation and statistical research. However, in a rapid response to the COVID-19 pandemic, NCHS adopted RANDS to produce timely data on outcomes related to COVID-19, including loss of work due to illness, telemedicine, and reduced access to care. As I mentioned earlier, the findings presented today are only a selection of the results from the RANDS during COVID-19 survey. The complete release of experimental estimates from the first round are available online. There is a second round of RANDS during COVID-19, which began on July 31st and is currently being conducted. Experimental estimates will be calculated for the same outcomes that were discussed today, and the findings from this round will be available online in late September. In combination with Round 1 of the RANDS during COVID-19 survey, we will be able to report and compare results from two periods from the summer of 2020. June, which was collected in the first round and was shown in this presentation, and August, which will be covered by Round 2. As Paul mentioned earlier, we're also considering whether to conduct a third round in late fall or early winter. In addition to the releases of these experimental estimates, NCHS will be publishing reports that discuss the additional survey questions, which were collected for methodological research purposes. We will also be releasing a questionnaire evaluation report that combines the RANDS findings with findings from a series of cognitive interviews focused on the coronavirus -- focused on coronavirus-related survey questions. NCHS is still determining how to best release a public-use file for RANDS during COVID-19. However, more information about the survey can be found online, and there are public-use files which are currently available for previous rounds of RANDS and can be found on the NCHS website. Thank you for attending this webinar today to learn more about RANDS and the recent RANDS during COVID-19 survey. Paul and I would be happy to take any questions at this time.

WAGNER: Thank you, Paul and Katherine. We are now entering the question-and-answer session. As time allows, the presenters will address questions from the Q&A feature. Please submit your questions through the Q&A feature now. If your comments or questions are not addressed, please direct that to paoquery@cdc.gov. That's paoquery@cdc.gov. So, Katherine and Paul, we do have one question so far. Are the weights that you mentioned early on in your presentation representative of the general U.S population?

DR. IRIMATA: They're normalized to the sample size of the RANDS samples, so we aren't able to estimate totals, but we can have representative estimates of proportions, which were reported in the study.

WAGNER: Great. The next question is, how does this method perform for the American Indian and Alaska Native population? So I guess can we get more information on that specific subgroup through what you have done so far?

DR. IRIMATA: That's a great question. The information that we have for race and ethnicity is published online. We didn't specifically look at that subgroup, and that wasn't something we targeted in the RANDS survey or that we have looked at in previous rounds.

WAGNER: The next question is, can a common subject such as opioid data be pooled from year-to-year?

DR. SCANLON: Probably not. We don't -- well, we don't know right now what the composition of each survey from the panel looks like, and I think we're doing more methodological research on the statistical side to see, basically, can we do something like pool across? But these are -- because we don't know everything about the panel composition between the rounds, we certainly wouldn't recommend pooling at this point.

WAGNER: Great. So, the next question is, what incentive was provided to participants, if any? And does RANDS have the ability to theoretically provide any sort of state-specific estimates?

DR. SCANLON: On the incentive side of the question, NORC does provide some incentive, nonmonetary incentive, to its panelists for answering surveys. And I think this isn't, like, a set amount, and they, I think, have a -- basically a fake currency, like AmeriSpeak points or something, and people earn points. In terms of the state estimates -- Katherine, you know, jump in here, too, but we don't have the sample size to do state estimates. We have state as a variable on the files, but we don't have a large enough sample to do state estimates.

DR. IRIMATA: Yeah, and if there is any interest in looking at the state level, we -- there would be a disclaimer about sample size. But it's not available on the public-use file, but we do have access through the RDC. You can look that up on the NCHS website. So, if you're interested, you can put in a request to look at state-level estimates for RANDS.

WAGNER: Great. Thanks. The next question is around the people reporting missed care -- I guess reduced access to care. So the question is around, could you please address what appears to be a disparity between the various categories of care missed, and the much larger share of chronically ill people reporting missing care?

DR. IRIMATA: Yes. So, as I mentioned in terms of different types of care, we do see that certain types of care were missed more, but a lot of -- some of that can be explained by differences in types of care. So, for example, when we see that things like physician, like regular checkups or dental care missed, that is not as concerning because we do know that people have that type of care more often. But there are certainly types of care that we're interested in seeing why they were missed, especially if it's something more urgent like urgent care. In terms of disparities, we did see that the percent of -- that -- adults with chronic conditions reported a higher percent of missed care. And that's something we're really interested in. Part of it is related to the care that they get, and so it's -- adults with chronic conditions may have more appointments compared to adults without chronic conditions, and so that's something that we'd like to look into more when we correct for those differences between how much care they may need usually.

WAGNER: So there's another question on weighting. So the result -- the results that you presented today include the weighting?

DR. IRIMATA: Yes, the results that were presented today used the calibrated weights that we produced at NCHS.

WAGNER: Okay. And then the next question is on the sample size. This question is on -- is it possible to expand the sample size? Why was it limited to the particular number? This person in particular says they often see larger sample size on web-based surveys. So what is that sort of process?

DR. SCANLON: That's a good question. So, for kind of typical web surveys that I think we see in the media landscape, we are I think at this point used to seeing massive sample sizes, but those typically come from those opt-in panels that draw the sample from people who kind of click on a link on a social media feed or see a news article and agree to take a survey in order to gain access to that. And that's an opt-in survey, and some of those panels are very large. The recruited survey panels tend to be smaller because of each of the companies. And there's only about half a dozen companies in the U.S that run -- companies and organizations -- some of them are not commercial firms -- that run these panels. And it just takes a lot of resources on their end to maintain the panel, so the recruited commercial survey panels that we use for RANDS are much smaller than these kind of massive opt-in panels. So our surveys are going to be necessarily smaller than some of those big ones, and we also had to work with our provider -- in this case is NORC -- you know, was operating other surveys at the same time. And, you know, we wanted to avoid overburdening their panel, and there were some framing effects that we had to consider. If a panelist receives five surveys about COVID, how does that incentivize or disincentivize them answering the survey? And, also, does that affect the results? So we worked with NORC to come up with the best sample size we could to kind of limit those affects.

WAGNER: Great. Thanks. There is a question, just a follow-up, from the comments on, I think, the state-level question where we said that it's possible to access research data in the RANDS through the RDC. Could you clarify, you know, that data access and what that person could get from the RDC access and request?

DR. IRIMATA: Yeah. So, at NCHS, we have a Research Data Center and that is, like, a space where data that isn't publicly available on the web can be accessed. And so, if you look up the RDC on the NCHS website, there is a process where you can put in a proposal to access the data, and there is certain requirements, and you have to provide information on what type of analyses you would be interested in, and that would be reviewed within -- internally in the RDC. So, yeah, I would recommend looking on there. Our data is available on there. And if you're interested in seeing what types of variables in addition to the state are there, we have on our RANDS website on the -- on RANDS's website on the NCHS's website, there is a data dictionary so you can find all of the other variables that we have available from our previous rounds.

WAGNER: The next question is around the upcoming rounds of RANDS, so the second and third rounds. Will you focus on the same topics for COVID-19 in the second round? If not, are there any new sort of topics that you're planning for? And how comparable do you think that those will be for Rounds 2 and 3?

DR. SCANLON: So, in terms of the variables that we're going to release estimates on, so the things that Katherine ran through, we have made no changes between Rounds 1 and Round 2, or Round 1 and Round 2. We did change the questionnaire a little bit. We are still, as I mentioned, using RANDS during COVID-19 as a methodological survey, and we are, you know, providing question evaluation research not only to NCHS but to other agencies across the federal statistical system. And so we did -- we did change the questionnaire just a bit for those ends, but the variables of -- the estimation variables will stay the same across both rounds. And if we do a Round 3, we'll include those as well.

Katherine, maybe you want to talk about the comparability?

DR. IRIMATA: Sure, so we -- for the Round 2 release in September, we'll be releasing the same types of experimental estimates, which were released for this first round. So, for all of the three topics that were discussed today and the different subgroups, we'll publish the same estimates for Round 2. We won't recommend make anything comparisons between Round 1 and Round 2 because there is correlation between the two rounds, since we'll be asking the same panelists to respond to both -- the questionnaire in both cases, but NCHS will be releasing a report, which gives information about statistically testing those accounting for the correlation between the panelists in both rounds.

WAGNER: Great. There's a question here on disability status. Is disability status available in Rounds 2 or 3 for all the different types of disabilities?

DR. SCANLON: Not for all the different types of disabilities. We have included affects questions. We've specifically included the Washington group for disabilities statistics anxiety and depression questions, and we've also included the PHQ and GAD-2. So we only have affect, no other -- no other types of disability.

WAGNER: Great. So the next question is, do you have any other additional resources you would recommend for a population-based information on any race and ethnicity experiences with COVID-19 outside of RANDS work that might be happening and if there's any sort of efforts around that?

DR. SCANLON: NCHS eventually will be releasing NIHS data, which will we obviously say that you should consult. That is our benchmark survey in terms of household surveys. Other statistical agencies are doing some work right now. We have collaborated -- NCHS has collaborated with the Census Bureau and other federal statistical agencies on the Pulse survey, which -- some of those data are available on the NCHS website as well. If you look up our COVID results, you'll see that data.

WAGNER: So there's a follow-up question on a disability question from before. And the question is, is it self-reported diagnosis of disabilities, or something else?

DR. SCANLON: Yeah, it's self-reported diagnosis. So the Washington group questionnaire is available online. If you just Google the Washington group for disability statistics, you'll find the various sets of questions that NCHS and other organizations have worked many years on developing and evaluating and validating. And so it's self-response. And then the GAD and PHQ-2s are in -- the mode is obviously self-response, but those are more about the feelings than you can score them to get a -- either an anxiety or depression flag, basically.

WAGNER: There's another question on the access to care. Are the access-to-care measures only among people who needed care?

DR. IRIMATA: So, for access to care, there is -- it's among anybody who responded that they were unable to get care within the last two months or -- yeah, or before -- right within the last two months at the time of the survey, which covers from April to July. So that's one thing that we would need to account for in further analyses of this data.

WAGNER: Great. There's a question on the response rate. So this individual commented that the response rate isn't really much lower than maybe other NCHS or CDC surveys. Are there any efforts that you all are making maybe in Rounds 2 or 3 to increase any of the response rates? Or do you have any concerns about that or not?

DR. SCANLON: Go ahead, Katherine.

DR. IRIMATA: Okay. I would -- I would say, in terms of the cumulative response rate, we do acknowledge that it's not very high, but part of that isn't -- it has to do with the panel, and who is invited to participate in the panel, and panelists choosing -- it's out of our control, and it's more on NORC's side in how they handle the panel. In terms of the rate of response that we got just within our group of panels that were selected, we're fairly happy with it. It was 78.5%, which is pretty high, especially compared to the previous rounds of RANDS that we've had.

WAGNER: Great. All right, if there are any other questions, please put them in the Q&A feature. There is another question here. Are there any plans to ask people with chronic illness whether their condition worsened or -- and whether -- in particular to any access-to-care issues?

DR. SCANLON: Not right now. That's an interesting concept. If we do a third -- a third round of RANDS during COVID, there will be some possibility for kind of -- for us to expand the questionnaire and consider other topics. You know, one of the issues that we have -- and we certainly ran into it here -- is that we typically do full cognitive interviewing projects before we put questionnaires into the field. So we kind of know what the questions are going to perform like before they go on a survey. In this case, we did, as I mentioned, a small cognitive interviewing project within NCHS on NCHS staff. So, if we do a question like that, we would really need to do some serious cognitive evaluation before we put it on another round.

WAGNER: Well, great. Thank you, Paul and Katherine, for your presentation and answers during today's webinar. For those of you who might have additional questions, please email paoquery@cdc.gov. Paoquery@cdc.gov. Thanks so much.