

Nonsubstantive Change Request

**RAPID SURVEYS SYSTEM**

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

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## Table of Contents

<b>1. Circumstance Making the Collection of Information Necessary</b>	<b>3</b>
<b>2. Purpose and Use of Information Collection</b>	<b>4</b>
<b>12. Estimates of Annualized Burden Hours and Costs</b>	<b>4</b>
<b>15. Explanation for Program Changes or Adjustments</b>	<b>5</b>

### List of Attachments

A	Rapid Survey System Round 3 Questionnaire
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## Rapid Surveys System – Round 3

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

### A. Justification

#### 1. Circumstance Making the Collection of Information Necessary

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

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

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

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

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

Each round's questionnaire will consist of four main components: (1) basic demographic information on respondents to be used as covariates in analyses; (2) new, emerging, or supplemental content proposed by NCHS, other CDC Centers, Institute, and Offices, and other HHS agencies; (3) questions used for calibrating the survey weights; and (4) additional content selected by NCHS to evaluate against relevant

benchmarks. NCHS will use questions from Components 1 and 2 to provide relevant, timely data on new, emerging, and priority health topics to be used for decision making. NCHS will use questions from Components 3 and 4 to weight and evaluate the quality of the estimates coming from questions in Components 1 and 2. Components 1 and 2 will contain different topics in each round of the survey. NCHS submits a 30-day Federal Register Notice with information on the contents of each round of data collection.

## **2. Purpose and Use of Information Collection**

In the third round of the RSS, contributed content includes family health history and barriers to collecting health history; genetic testing for hereditary forms of cancer and heart disease; employment status, work arrangements, leave availability, employer insurance coverage; and sexual health including communication with partners and healthcare providers, sexual health services utilization, and sources for sexual health information.

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

Finally, several questions that were previously on NHIS will be used for benchmarking to evaluate data quality. Panelists in the RSS will be asked about health status, chronic conditions, disability, healthcare access and utilization, health behaviors, and food insecurity. The questionnaire for round 3 is included as Attachment A and the content justification is included as Appendix A within this document.

## **12. Estimates of Annualized Burden Hours and Costs**

### **A. Time Estimates**

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

The NCHS RSS Round 3 (2024 data collection is based on 13,100 complete surveys (4,367 hours) and 20 cognitive interviews (20 hours) using the same survey instrument. The total number of responses is 13,120 and the total burden is 4,387 hours.

Estimated Annualized Burden Hours

Type of Respondents	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden
Adults 18+	Survey: NCHS RSS Round 3 (2024) Cognitive Interviews	13,100	1	20/60	4,367
Adult 18+	Cognitive Interviews	20	1	1	20
Total					4,387

**B. Cost to Respondents**

At an average wage rate of \$21.00 per hour, the estimated annualized cost for the 4,387 burden hours is \$92,127 for round 3.

Estimated Annualized Burden Costs

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent
Adult + Household	Cognitive Interviews	4,387	\$21.00	\$92,127

**15. Explanation for Program Changes or Adjustments**

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

## **Appendix A: Justifications for Content from Sponsors**

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

1. Family health history and barriers to collecting family health history
2. Genetic testing for hereditary forms of cancer and heart disease
3. Employment status, work arrangements, leave availability, and employer insurance coverage
4. Sexual health, communication with partners and healthcare providers about sexual health, sexual health services utilization, sources for sexual health information

The justification for each of these topic questions follows. Each of the topic areas must be consistent with at least one of the following four considerations for inclusion of a topic area in the RSS:

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

## Family health history and barriers to collection

Program: Deputy Director for Public Health Science and Surveillance (DDPHSS) Office of Genomics and Precision Public Health (OGPPH)

Background/Rationale:

People who have genetically close relatives with diseases, such as cancer, diabetes, and heart disease, are more likely to develop those diseases.<sup>1</sup> Family health history is an important risk factor that reflects inherited genetic susceptibility, shared environment, and common behaviors. In 2004, 96% of survey respondents reported that their family history was somewhat or very important for their own health, but only about 30% had actively collected health information from their relatives, with differences in collection by ethnicity and educational attainment.<sup>2</sup>

Understanding current perceptions of the importance of family health history, current practices regarding active collection and sharing of this information, and barriers to collection can inform communications and educational interventions to help people benefit from their potentially life-saving family history information.

### Concepts Measured

- How important is knowing family health history
- Amount of knowledge about health history of:
  - Mother
  - Father
  - Maternal grandparents
  - Paternal grandparent
- Have you created personal record of family health history
- Have you shared family health history with:
  - Doctors or health care providers
  - Other relatives
- Difficulty collecting family health history
- Reasons for difficulty in collecting family health history because of:
  - Not knowing what to collect
  - Difficulty organizing or storing information
  - Not in contact with relatives or relatives are deceased
  - Uncomfortable asking relatives
  - Other reason

### Available data or duplication and measurement on other national surveys

Current measures of perception of importance, knowledge of specific family member's history, collection, and barriers to collection of family health history are not available from a single national survey. The Health Information National Trends Survey 2013 (HINTS 4 Cycle 3) and HealthStyles assessed importance of family health history but does not include other related topics such as barriers to collection.

### Proposed Use of the Data

- RSS data will be used to update and extend the 2004 HealthStyles survey and HINTS understanding of public perceptions of the importance of family health history and practices regarding active collection of family health history.
- RSS will be used to develop new actionable assessments of barriers to family health history collection and current practices regarding sharing family health history information with health care providers and family members.
- RSS will be analyzed by demographic subgroups to understand differences in knowledge, collection, and barriers to collection of family health history across groups and guide targeted educational and communications interventions.
- RSS data will be used to inform educational and communications interventions to address deficiencies in family health history knowledge and barriers to family health history collection, to improve risk assessment for chronic diseases, like diabetes, cancer, and heart disease, which can benefit from preventive interventions.

### Justification for Rapid Surveys System

- There is a need for a better understanding of the public's **knowledge, attitudes, and behaviors** related to family health history of and genetic testing for common chronic diseases. Family health history underlies effective risk assessment for common chronic diseases and serves as both a guide and a gatekeeper for certain preventive services. For example, family health history is important for identifying people for referral to cancer genetics services according to U.S. Preventive Services Task Force recommendations.<sup>3</sup>

### References

1. Valdez R, Yoon PW, Qureshi N, Green RF, Khoury MJ. Family history in public health practice: a genomic tool for disease prevention and health promotion. *Annu Rev Public Health*. 2010; 31:69-87.
2. Centers for Disease Control and Prevention (CDC). Awareness of family health history as a risk factor for disease—United States, 2004. *MMWR Morb Mortal Wkly Rep*. 2004 Nov 12; 53(44):1044-7.
3. US Preventive Services Task Force; Owens DK, Davidson KW, Krist AH, et al. Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2019 Aug 20;322(7):652-665.



## Genetic testing for hereditary forms of cancer and heart disease

Program: DDPHSS/OGPPH

Background/Rationale:

About 1-2% of the U.S. population have genetic variants that dramatically increase their risk of serious diseases such as cancer and heart disease.<sup>1</sup> Most people with these genetic variants do not know that they are at high risk, and thus cannot benefit from early detection, disease prevention, and timely treatment that can improve health outcomes.<sup>2</sup> Current clinical guidelines generally support genetic testing only among certain population subgroups based on personal and family health history characteristics indicative of increased risk or in certain clinical settings.<sup>3</sup> At the same time, mainstream clinical testing labs, including a new offering from Quest, are advertising genetic tests for hereditary forms of cancers and heart disease directly to consumers.<sup>4</sup>

### Concepts Measured

- Ever had:
  - Heart attack
  - Stroke
- Biological relative ever had:
  - Heart attack
  - Stroke
  - Cancer
- Knowledge of genetic test for cancer or heart disease
- Ever had genetic test for cancer or heart disease
- Interested in receiving genetic test for cancer or heart disease
- Reasons for interest in (more) genetic testing for cancer or heart disease:
  - Could share results with relatives
  - It would change health care decisions
  - It would change health habits
  - Doctor recommended
  - Other reason
- Reasons not interested in (more) genetic testing for cancer or heart disease:
  - Would cause stress/anxiety
  - Would not be helpful
  - Doctor has not recommended it
  - Worried it could impact ability to get/keep insurance or a job
  - Concerned would be misused or inappropriately shared
  - Other reason

### Available data or duplication and measurement on other national surveys

- Current measures of awareness of and interest in genetic tests for cancer and heart disease risk from national surveys are not available.

- The HINTS 2022 (HINTS 6) assessed awareness and use of certain types of genetic tests, including “specific disease testing,” but these questions do not differentiate testing for cancer and heart disease. Additionally, this survey does not include questions about interest in health-related genetic testing or reasons for interest or lack of interest in genetic testing. Other HINTS cycles have assessed various aspects of genetic testing awareness and use, but these data do not address the data needs of the current proposal.
- The 2023 National Health Interview Survey (NHIS) assessed family health history of cancer, but not interest in genetic tests to assess cancer risk. The National Health and Examination Survey (NHANES) included a family health history question on early onset heart disease from 1999-2020, but not questions about genetic tests to assess heart disease risk.

### Proposed Use of the Data

- RSS data will be used to understand knowledge of and interest in genetic testing to assess risk of heart disease and cancer and how this varies by personal and family health history of these diseases (based on questions asked in “Family health history and barriers to collection” section above).
- RSS data will be analyzed by demographic subgroups to understand differences knowledge of and interest in genetic testing to assess risk of heart disease and cancer risk, including reasons for or against testing. This will be used to guide targeted educational and communications interventions.

### Justification for Rapid Surveys System

- There is a need for a better understanding of the public’s **knowledge, attitudes, and behaviors** related to family health history of and genetic testing for common chronic diseases. Understanding interest in and hesitation toward having genetic testing for cancer and heart disease among the public, in relation to personal and family health history of these diseases, and reasons for high or low interest in having genetic tests, can inform communications, educational, and other programmatic interventions. RSS data could be used to decide if there is a need to better inform the public about evidence-based use of genetic tests for hereditary risk of cancer, heart disease, and other health conditions of public health importance.

### References

1. Hart MR, Biesecker BB, Blout CL, et al. Secondary findings from clinical genomic sequencing: prevalence, patient perspectives, family history assessment, and health-care costs from a multisite study. *Genet Med.* 2019 May; 21(5):1100-1110.
2. Nordestgaard BG, Chapman MJ, Humphries SE, et al. European Atherosclerosis Society Consensus Panel. Familial hypercholesterolaemia is underdiagnosed and undertreated in the general population: guidance for clinicians to prevent coronary heart disease: consensus statement of the European Atherosclerosis Society. *Eur Heart J.* 2013; 34:3478–390a.
3. Daly MB, Pal T, Berry MP, et al. Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic, Version 2.2021, NCCN Clinical Practice Guidelines in Oncology. *J Natl Compr Canc Netw.* 2021 Jan 6;19(1):77-102.

4. Quest Consumer Inc. Genetic Insights. 2023.  
<https://www.questhealth.com/product/genetic-insights-GSS.html>. Accessed September 22, 2023.
5. US Preventive Services Task Force; Owens DK, Davidson KW, Krist AH, et al. Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2019 Aug 20;322(7):652-665.

## **Employment status, work arrangements, leave availability, employer insurance coverage**

Program: National Institute for Occupational Safety and Health (NIOSH) Division of Field Studies and Engineering

Background/Rationale:

Unemployment has been associated with poor health in a variety of studies. However, details of what may cause this association, such as how employment status (including duration unemployed) relates to health care access and outcomes in the United States have been limited.<sup>1</sup> Work status affects access to employment compensation and benefits, including health care insurance and paid sick leave. Access to these benefits often differ by work arrangement.

Work schedules can also be a key source of stress. Night shifts or irregular schedules can be a barrier to adequate sleep and the ability to engage in other important life activities. Several national surveys include questions about employment. In addition, NIOSH has sponsored questions in several national surveys on major dimensions of work schedules, including total weekly hours, shift length, schedule predictability and variability (including mandatory overtime), schedule flexibility, shift, and access to paid leave.<sup>2</sup> The pandemic raised interest in identifying workers who lack paid leave and thus have a strong incentive to report to work when sick, and workers who lack unpaid leave and so risk losing their job if they miss work due to illness.

The 2018 National Academies Report: A Smarter National Surveillance System for Occupational Safety and Health in the 21st Century<sup>3</sup> highlighted the need for more robust occupational safety and health data within public health surveys.

NCHS consulted with the Bureau of Labor Statistics Office of Survey Methods Research and made revisions to the questions based on their review and recommendations.

### Concepts Measured

- (if not working) Actively looking for work
- (if not working) Main reason not working
- (if employed) Number of jobs currently working
- (if employed) Number of hours worked at main job
- (if employed and work more than one job) Number of hours worked at all jobs
- (if employed) Whether respondent wants to work more hours, about the same hours, or fewer hours
- (if employed) At (main) job, is respondent:
  - Employed directly by business, company, government, or nonprofit
  - Employed by a temporary employment agency
  - Employed at a contract firm other than a temporary employment agency
  - An independent contractor
  - Self-employed, not an independent contractor
  - Other
- (if employed) (At main job) Are taxes deducted or withheld from pay?

- (if employed) (At main job) Does respondent receive paid leave
- (if employed) (At main job) Is respondent allowed to take leave without pay
- (if not working) Last time respondent worked for pay?
- Is respondent covered by any of the following:
  - Insurance through own or family member's employer or union
  - Insurance purchased directly from an insurance company
  - Medicare
  - Medicaid, Medical Assistance, or another government-assistance plan
  - TRICARE or other military health care
  - VA health care
  - Indian Health Service
  - Other
- (if employed and have private insurance) Is health insurance through an employer, union, or professional association?
- (if health insurance not obtained through employer) Does employer offer health insurance?
- (if health insurance not obtained through employer) Do you have health insurance through a family member's employer or union?

Available data or duplication and measurement on other national surveys

- A study using 2009–2010 NHIS data found that unemployed U.S. adults were more likely than their employed counterparts to report being unable to afford to fill needed prescriptions and to pay for medical care.<sup>4</sup> Health care access was worst among the uninsured, followed by the publicly insured, and best among those privately insured.<sup>4</sup> The inability to afford care adversely affects health outcomes,<sup>5-7</sup> further linking work, and health insurance associated with work, to health in the United States.
- Using data from the 2018-2019 Behavioral Risk Factor Surveillance System (BRFSS), Silver et al.<sup>1</sup> found that the prevalence of adverse health outcomes increased with unemployment duration and were highest for those unable to work. They found both short-term unemployment and self-employment were associated with poor healthcare access. However, in BRFSS, unemployment duration is dichotomized at one year, precluding more granular assessment of associations between this metric and healthcare access, healthcare utilization, and health outcomes. In addition, BRFSS provides little information on work arrangements.
- According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries, fatality rates are over four times higher among the self-employed, and temporary staffing agency workers have been found to have significantly higher injury rates than their regular employee counterparts working in the same industries.<sup>8,9</sup> However, fewer studies have evaluated relations between employment category and health conditions other than injury and fatality. Silver et. al.<sup>1</sup> found that self-employed workers were more likely to report poor physical and mental health than employed respondents, but prevalence of specific health conditions were similar in the two groups.

### Proposed Use of the Data

- RSS data will be used to understand the associations between employment status (including duration unemployed) and labor market participation with health care coverage/utilization and health status/outcomes.
- RSS data will be used to understand whether and how detailed data on employment status and unemployment duration relates to health care access/utilization and health status.
- RSS data will be used to understand the relationships between work arrangements, health care coverage/utilization, and health status/outcomes.
- RSS data will be used to understand the associations between tax withholding status, employment categorization, health care access, health care utilization, and health status/outcomes.

### Justification for Rapid Surveys System

- The RSS offers an opportunity for **developmental work** to develop questions and enable CDC to assess whether modifications to work-related questions on major CDC surveys such as BRFSS and NHIS would benefit from collecting more granular data about unemployment duration, labor market attachment, or health care access. The results will also be of interest to other governmental agencies that conduct surveys involving employment.

### References

1. Silver SR, Li J, Quay B. Employment status, unemployment duration, and health-related metrics among US adults of prime working age: Behavioral Risk Factor Surveillance System, 2018–2019. *Am J Ind Med.* 2022; 65: 59–71. 10.1002/ajim.23308
2. Alterman T, Luckhaupt SE, Dahlhamer JM, Ward BW, Calvert GM. Prevalence rates of work organization characteristics among workers in the U.S.: data from the 2010 National Health Interview Survey. *Am J Ind Med.* 2013 Jun;56(6):647-59. doi: 10.1002/ajim.22108. Epub 2012 Aug 21. PMID: 22911666; PMCID: PMC4557703.
3. National Academies of Sciences, Engineering, and Medicine. 2018. A Smarter National Surveillance System for Occupational Safety and Health in the 21st Century. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24835>.
4. Driscoll AK, Bernstein AB. Health and Access to Care Among Employed and Unemployed Adults: United States, 2009-2010. National Center for Health Statistics; 2012:83.
5. Campbell DJ, Manns BJ, Weaver RG, Hemmelgarn BR, King-Shier KM, Sanmartin C. Financial barriers and adverse clinical outcomes among patients with cardiovascular-related chronic diseases: a cohort study. *BMC Med.* 2017;15(1):33.
6. Ramsey SD, Bansal A, Fedorenko CR, et al. Financial insolvency as a risk factor for early mortality among patients with cancer. *J Clin Oncol.* 2016;34(9):980-986.
7. Van Alsten SC, Harris JK. Cost-related nonadherence and mortality in patients with chronic disease: a multiyear investigation, National Health Interview Survey, 2000-2014. *Prev Chronic Dis.* 2020;17:E151.

8. Al-Tarawneh IS, Wurzelbacher SJ, Bertke SJ. Comparative analyses of workers' compensation claims of injury among temporary and permanent employed workers in Ohio. *Am J Ind Med.* 2020 Jan;63(1):3-22. doi: 10.1002/ajim.23049. Epub 2019 Sep 20. PMID: 31541504.
9. Foley M. (2017). Factors underlying observed injury rate differences between temporary workers and permanent peers. *Am J Ind Med.* <https://onlinelibrary.wiley.com/doi/10.1002/ajim.22763>

## **Sexual health, communication with partners and health care providers, health services utilization, sources for health information**

Program: National Center for HIV, Viral Hepatitis, STD, TB Prevention (NCHHSTP) Division of STD Prevention (DSTDP)

### Background/Rationale:

In recent years, several national reports have noted that the United States has yet to achieve a cohesive sexual health approach that focuses on health rather than disease. In 2021, the U.S. Department of Health and Human Services (HHS) released a roadmap for sexually transmitted infection (STI) prevention as a first step in addressing this challenge. The HHS STI National Strategic Plan – 2021-2025 (STI Plan) calls for a whole-of-nation approach to promote sexual health as a critical activity to help prevent STIs.<sup>1</sup>

We now have the roadmap to preventing STIs but lack core indicators that broadly describe the state of sexual health in the United States. Moreover, we trail behind other advanced countries that have well-established national-level surveys assessing domains of knowledge, communication, attitudes, service access and utilization, behaviors, relationships/partnerships, and adverse health outcomes across time.

DSTDP is working with the National Coalition for Sexual Health (NCSH) to develop a national campaign to improve sexual health among young adults (18-26 years old). This is the first campaign of its kind in many years, if ever. Initial audience research found that young adults lack the skills to create positive relationships, to treat their partners well and with respect, and to communicate about sexuality and sexual health. Furthermore, there is a need for expanded, inclusive sexual health research on young adults, especially related to young adults' knowledge of protective actions and recommended sexual health care services; sources of sexual health information; attitudes about sex; and insight on relationship development, consent, and sexual satisfaction among young adults. These data are also lacking among older adults. RSS provides an opportunity to examine these constructs for generational differences.

The proposed questions are designed to improve the measurement of sexual health, healthy relationships, and drivers of sexual health-seeking behaviors among all adults. Collecting better measures of sexual health may also help address the ongoing rises in STI rates. Data collected through the RSS will provide a critical baseline for measuring the success of the NCSH multi-year campaign. Additionally, it will help efforts to manage other syndemics such as HIV, substance use, and mental health disorders, and emerging STIs, like mpox. Collecting and monitoring this information is in line with the goals of the HHS STI Plan and is in alignment with DSTDP's Strategic Plan.<sup>2</sup>

### Concepts Measured

- Ever had a sexual relationship (vaginal, oral, or anal sex)
- Agreement with knowing how to build and maintain a positive intimate relationship
- Is respondent comfortable talking to sexual partner about sexual health
- In sexual relationships, frequency of communicating:
  - Relationship intentions and expectations
  - Sexual likes and dislikes
  - Sexual boundaries



- How sexual situation make you feel physically and emotionally
- Potential reasons for hesitation to talk to a sexual partner about sexual health:
  - Do not want to offend partner
  - Do not think will get an honest answer
  - Do not have the words to describe feelings
  - Do not think they will understand
- Are sexual relationships fulfilling most of the time
- Before having sex with a new partner how often do you discuss the following:
  - Condoms
  - Hormonal birth control
  - HIV PrEP
  - Other prevention methods
  - STI testing
  - HIV testing
- Are you comfortable talking with health care provider about sexual health, relationships, and behaviors
- (Past 12 month) Have you had sex with:
  - Men
  - Women
  - Both
  - Not had sex
- (Past 12 months) Receiving any sexual health services
- (If yes) Location of the services:
  - Doctor's office
  - Community or public health clinic
  - Hospital including ER and outpatient clinics
  - Urgent care and in-store health clinics
  - Telehealth appointment
- Are you hesitant to talk to health care providers about sexual health, relationships, and behaviors for following reasons:
  - Fear they would judge
  - Do not feel like can trust them
  - Do not have the words to describe feelings
  - Do not think they would understand
- Sources of sexual health information
  - Family members
  - Partner
  - Peers or friends
  - Therapist
  - Doctor or health care provider
  - Internet or social media
  - Another source
  - None of above
- Relationship type:

- o Causal relationship
- o Committed relationship
- o Not in relationship

#### Available data or duplication and measurement on other national surveys

- There are no national US data sources that consistently measure sexual/relationship attitudes, behaviors, and service utilization. The United States does not have a comprehensive survey of sexual health, but many other countries do (e.g., Australia, Canada, France, Germany, Ireland, Latvia, Malta, The Netherlands, Portugal, Spain, and the United Kingdom).
- Existing data systems that yield national estimates for potential indicators for sexual health do not provide a comprehensive assessment of sexual health across the lifespan. They do not examine domains of knowledge, communication, attitudes, service access and utilization, behaviors, relationships/partnerships, and adverse health outcomes. For example, the National Survey of Sexual Health and Behavior is conducted infrequently (2009; 2018) and is limited to people aged 14-49 years.
- Some related question (having sex, receiving sexual health services in the last year, and location of the services) are available from other federal sources, such as the National Survey of Family Growth. However, this survey is limited to people aged 15-49 years.<sup>3</sup>

#### Proposed Use of the Data

- RSS data will be used to understand the sexual health of all adults and how sexual health varies by generation.
- RSS data will provide a baseline measure of the state of sexual health knowledge, attitudes, and behaviors in the United States among adults.
- RSS may be used to further examine associations between sociodemographic characteristics, behaviors, and relationship status and to conduct frequency, bivariate, and regression analyses.
- RSS data will be used to monitor progress toward the objectives of the HHS STI Plan, the DSTDP Strategic Plan, and to guide research and programmatic efforts, including justifying intervention development and implementation.
- These data may also be used to inform policy guidance for CDC, HHS, and other federal partners involved in STI/HIV prevention and control.

#### Justification for Rapid Surveys System

- RSS offers an opportunity for **developmental work** to improve the concept measurement of sexual health and what constitutes healthy relationships and drives sexual health-seeking behaviors among all adults. This is consistent with a proposed national sexual health framework, which was based on an emphasis on wellness, focus on positive and respectful relationships, acknowledgment of sexual health as a component of overall health, and integrated approach to prevention.<sup>4</sup>
- There is a **time-sensitive data need** to provide information about sexual health and STIs for the HHS STI Plan and accompanying Federal Implementation Plan<sup>2</sup> and to establish a

baseline measurement of sexual health knowledge and attitudes prior to implementing the campaign.

- The RSS also offers opportunity to inform questions related to **public health attitudes and behaviors** on STI. Over the last decade, we have witnessed the sexually transmissible nature of many epidemics (e.g., Zika, Ebola, mpox, intimate contact within COVID-19), but have not had readily available data on sexual health attitudes, partnerships, health care seeking, or communication to inform how best to reach the populations/communities impacted by these infections.

## References

1. U.S. Department of Health and Human Services. 2020. Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025. Washington, DC. [Sexually Transmitted Infections \(STI\) National Strategic Plan: 2021-2025 \(hhs.gov\)](https://www.hhs.gov/sexually-transmitted-infections-national-strategic-plan-2021-2025)
2. National Center for HIV, Viral Hepatitis, STD, and TB Prevention. (2022, September 12). *Division of STD Prevention Strategic Plan 2022-2026*. Centers for Disease Control and Prevention. <https://www.cdc.gov/std/dstdp/dstdp-strategic-plan-2022-2026.htm>
3. Centers for Disease Control and Prevention. (2022, February 16). *National Survey of Family Growth*. National Center for Health Statistics. [https://www.cdc.gov/nchs/nsfg/about\\_nsfg.htm](https://www.cdc.gov/nchs/nsfg/about_nsfg.htm)
4. Ivankovich MB, Fenton KA, Douglas JM Jr. Considerations for national public health leadership in advancing sexual health. *Public Health Rep.* 2013 Mar-Apr;128 Suppl 1(Suppl 1):102-10. doi: 10.1177/00333549131282S112. PMID: 23450891; PMCID: PMC3562752.
5. Altarum Institute and the Convenient Care Association. (2021). *Expanding the Role of Retail Health Clinics in Addressing Sexually Transmitted Infections: Selected Findings from a Qualitative Study and Recommendations for the Future*. [https://nationalcoalitionforsexualhealth.org/sexual-health/Retail-Health-Clinics-and-Sexual-Health\\_NCSH-and-CCA.pdf](https://nationalcoalitionforsexualhealth.org/sexual-health/Retail-Health-Clinics-and-Sexual-Health_NCSH-and-CCA.pdf)
6. Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2021. U.S. Department of Health and Human Services; 2021. <https://www.cdc.gov/std/statistics/2021/default.htm>
7. Ford JV, Ivankovich MB, and Coleman E (2023) Sexual health indicators for the United States: Measuring progress and documenting public health needs. *Front. Public Health* 10:1040097. doi: 10.3389/fpubh.2022.1040097
8. National Academy of Public Administration. *The Impact of Sexually Transmitted Diseases on the United States: Still Hidden, Getting Worse, Can Be Controlled*. National Coalition of STD Directors; 2018. <https://www.ncsddc.org/resource/the-impact-of-sexually-transmitted-diseases-on-the-united-states-still-hidden-getting-worse-can-be-controlled/>
9. National Academy of Public Administration. *The STD Epidemic in America: The Frontline Struggle*. National Coalition of STD Directors; 2019. <https://www.ncsddc.org/wp-content/uploads/2019/11/NCSD-Phase-II-Final-Report.pdf>
10. National Academies of Sciences, Engineering, and Medicine. *Prevention and Control of Sexually Transmitted Infections in the United States. Adopting a Sexual Health Paradigm*; 2021. <https://www.nationalacademies.org/our-work/prevention-and-control-of-sexually-transmitted-infections-in-the-united-states>
11. U.S. Department of Health and Human Services. 2020. Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025. Washington, DC.

12. U.S. Department of Health and Human Services. 2023. Sexually Transmitted Infections Federal Implementation Plan for the United States: 2021–2025. Washington, DC.