

Nonsubstantive Change Request

RAPID SURVEYS SYSTEM

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

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Rapid Surveys System – Round 2

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 nationally representative 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 second round of the RSS, contributed content is included on adult ADHD prevalence and treatment, ADHD drug shortages, and the use of telehealth services for ADHD; suicidal ideation; knowledge of a suicide; feelings of social isolation and connectedness during online activities; swimming skills; water exposure; use of alcohol near water; CPR knowledge and water safety training; harm reduction and treatment for drug use including attitudes regarding drug use and naloxone; shared decision making for chronic pain; reproductive health access and changes in access to contraception; technology-facilitated sexual violence; and fit testing of hearing devices.

NCHS calibrates survey weights from the RSS to gold standard surveys. Questions used for calibration in this round of RSS 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; social determinants of health; healthcare access and utilization; and health behaviors will be used to benchmark the RSS to NCHS survey. The questionnaire for round 2 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 second round survey cycle is shown in the table below.

The NCHS RSS Round 2 (2023) 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 2 (2023) 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 2.

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

This round of the RSS includes 8 new, emerging, and supplemental topics. These topics are:

1. Adult ADHD prevalence, treatment, drug shortages, and use of telehealth services for ADHD
2. Suicidal ideation, knowledge of a suicide, and feelings of social isolation and connectedness during online activities
3. Swimming skills, water exposure, alcohol and water, CPR knowledge, and water safety training
4. Harm reduction and treatment, including attitudes regarding drug use and naloxone
5. Shared decision making for chronic pain
6. Reproductive health access and changes in access to contraception
7. Technology-facilitated sexual violence
8. Fit testing of hearing devices

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

- 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

Adult ADHD prevalence, treatment, drug shortages, and use of telehealth services for ADHD

Program: National Center on Birth Defects and Developmental Disabilities (NCBDDD)

Background/Rationale: MarketScan commercial claims data show that the percentage of adolescent and adult females and adult males receiving prescription stimulant fills increased by an average of 1.4% annually between 2016-2021, and 13.9% during 2020-2021¹. In 2020, with the COVID-19 pandemic, there were changes in rules about prescribing controlled substances including stimulants used for treating ADHD.² The Drug Enforcement Agency (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) have extended the COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications through November 11, 2024³. Data on the potential impact of removing these flexibilities now that the COVID-19 pandemic has concluded will be important for informing governmental agencies as they establish new telemedicine policies after November 11, 2024.

Currently, there are no known estimates of the prevalence of adult ADHD in the United States. Similarly, there is a lack of U.S. clinical guidelines for adults with ADHD. However, the American Professional Society for ADHD and Related Disorders (APSARD) and Child and Adults with ADHD (CHADD) are currently in the process of developing guidelines⁴. Data on ADHD prevalence, treatment, telehealth, and insurance payment for treatment of ADHD would provide valuable information to creating new guidelines.

It is important that CDC understands how the COVID-19 pandemic and increasing access to telehealth may have influenced these trends in stimulant prescribing, particularly in the face of the ongoing stimulant shortage in the United States⁵. The reasons for this increase are unclear but could be informed by the data from the Rapid Surveys System (RSS).

Concepts Measured

- Ever diagnosed with ADHD by a doctor or health professional
- Age first diagnosed with ADHD
- Currently have ADHD
- (Past 12 months) receive counseling or therapy from a mental health professional to help you with your ADHD
- (Past 12 months) prescribed medication to help you with your ADHD
- (Past 12 months) any difficulty getting your prescription for ADHD filled because was not available
- (Past 12 months) what medications were taken for ADHD
- (Past 12 months) did health insurance pay for any healthcare costs for ADHD
- Ever receive any telehealth services for ADHD
- Diagnosed with ADHD during telehealth visits, in-person visits, or both
- (Since March 2020) use telehealth to have a first-time visit with a doctor, nurse, or health professional about ADHD
- (Since March 2020) use telehealth to visit with a doctor, nurse, or health professional to get a prescription for ADHD medication
- Since 2020 use telehealth to visit with a doctor, nurse, or health professional to receive counseling or therapy to help with ADHD
- Did health insurance pay for any costs of telehealth visits for ADHD

- (Next 3 months) plan to have another telehealth visit to get a prescription for ADHD medications
- (Next 3 months) plan to use telehealth to receive counseling or therapy for ADHD

Available data or duplication and measurement on other national surveys

- According to a global systemic review and meta analysis approximately 6.8% of adults have symptomatic ADHD.⁶
- Healthcare claims data were used in the March 2023 MMWR report on stimulant use. Limitations healthcare claims data include limited (or no) information on race/ethnicity, lack of information on the indication for stimulant prescriptions, lack of information on types of telehealth visits, and general lack of knowledge on how well ADHD is documented in billing records, particularly if it is not related to the reason for the encounter or not paid for with insurance.

Proposed Use of the Data

- The estimated prevalence of ADHD is around 5% of the adult population in the U.S. RSS result will provide more information that can be used in refining this estimate.
- RSS data will be used to understand the use of therapy and medication for ADHD.
- RSS data will be used to understand access to ADHD medication including any difficulty with access and the use of health insurance to pay for.
- RSS data will be used to understand use of telehealth for diagnosis of ADHD, filling prescriptions, and for therapy.
- RSS data will be used to understand the use of health insurance to pay for telehealth will help to address issues of access to telehealth services for ADHD.
- The American Professional Society for ADHD and Related Disorders (APSARD) and Child and Adults with ADHD (CHADD) are developing practice guidelines for adult ADHD, which do not currently exist in the United States. The data collected from the proposed RSS data can inform these guidelines.
- There is currently a shortage of stimulant medication in the United States. There are few data available to assess the extent to which increases in prescribing have contributed to this shortage, the impact on individuals' ADHD treatment, and how best to plan for immediate and long-term future needs.

Justification for Rapid Surveys System

- There is a **time-sensitive data need** for data on attention-deficit/hyperactivity disorder (ADHD) to provide important context to the findings presented in a March 2023 MMWR report, "Trends in Stimulant Prescription Fills Among Commercially Insured Children and Adults – United States, 2016-2021," which showed marked increases in stimulant medication fills during 2020-2021, particularly among females and adult males.
- Additionally, there is a **time-sensitive data need** for data about ADHD to inform guidelines for treatment of ADHD in adults. These guidelines are being developed now, so information is especially time sensitive.
- The Drug Enforcement Agency (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) extended the COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications through November 11, 2024. These flexibilities allow prescription of certain controlled medications, including some stimulants used to treat ADHD, via telemedicine. Data on the potential impact of removing these flexibilities is **time-sensitive**; they will be

important for informing governmental agencies as they establish telemedicine policies after this extension.

References

1. Danielson ML, Bohm MK, Newsome K, et al. Trends in Stimulant Prescription Fills Among Commercially Insured Children and Adults — United States, 2016–2021. *MMWR Morb Mortal Wkly Rep* 2023;72:327–332. DOI: <http://dx.doi.org/10.15585/mmwr.mm7213a1>
2. Office of the Assistant Secretary for Planning and Evaluation. Flexibilities in controlled substances prescribing and dispensing during the COVID-19 pandemic. Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; 2022. Accessed November 23, 2022. <https://aspe.hhs.gov/reports/covid-flexibilities>
3. U.S. Food and Drug Administration. FDA Announces Shortage of Adderall. Available: <https://www.fda.gov/drugs/drug-safety-and-availability/fda-announces-shortage-adderall>.
4. Substance Abuse and Mental Health Administration. DEA, SAMHSA Extend COVID-19 Telemedicine Flexibilities for Prescribing Controlled Medications for Six Months While Considering Comments from the Public. Available: <https://www.samhsa.gov/newsroom/press-announcements>.
5. American Professional Society for ADHD and Related Disorders. U.S. Based Guidelines for Adults with ADHD. Available: <https://apsard.org/us-guidelines-for-adults-with-adhd>.
6. Song P, Zha M, Yang Q, Zhang Y, Li X, Rudan I. The prevalence of adult attention-deficit hyperactivity disorder: A global systematic review and meta-analysis. *J Glob Health*. 2021 Feb 11;11:04009. doi: 10.7189/jogh.11.04009. PMID: 33692893; PMCID: PMC7916320.

Suicidal ideation, knowledge of a suicide, and feelings of social isolation and connectedness during online activities

Program: National Center for Injury Prevention and Control (NCIPC)

Background/Rationale: In 2021, suicide ranked as the 11th leading cause of death in the United States with 48,183 deaths¹. Provisional mortality data from January – September 2022 indicate a 3% increase in the number of suicides compared to the same period in 2021.

Suicide is a complex phenomenon, and rarely does it stem from a single factor. Suicide risk is influenced by a range of factors at the individual, relationship, community, and societal levels, potentially including exposure to suicidal ideation. Some of these factors may increase the risk of suicide, while others may mitigate or protect against it, depending on various circumstances. However, suicide rates and methods vary by age, sex, and race/ethnicity. Changes in suicide rates over time can be influenced, among other factors, by online forums that may make people feel a part of a community and/or isolated from others.

It is a challenge to determine whether social media, online games or online message boards have contributed to rising suicide rates over the past decade, especially for any particular age group. Part of a Report to Congress covers what is known about how suicide methods are posted and shared online; as well as the benefits and harms of online engagement. Much of the survey work in this area is evolving as is the nature of online engagement. Conversely, online forums may increase connectedness and serve as a source help-seeking which are known strategies to prevent suicides. More information is needed to inform suicide prevention efforts. The objective of this data collection is to better understand key suicide risk and protective factors related to social media use and connectedness. Collecting this information on online risk and protective factors aligns with NCIPC's mission to develop and evaluate strategies to prevent and control injuries, and this data collection aligns with NCIPC's research priorities for suicide prevention.

Concepts Measured

- Seriously think about trying to kill yourself in the past 12 months
- Personally know anyone who has died by suicide
- How often do you use social media
 - When I use social media, I feel socially isolated from others
 - When I use social media, I feel like I'm a member of a community
- How often do you play online games
 - When I play online games, I feel socially isolated from others
 - When I play online games, I feel like I'm a member of a community
- How often do you visit online message boards
 - When I visit online message boards, I feel socially isolated from others
 - When I visit online message boards, I feel like I'm a member of a community

Available data or duplication and measurement on other national surveys

- Measures on suicidal thoughts and behavior are available on national surveys (e.g., NSDUH). However, the measures cannot be linked to questions about how technology may be a suicide risk and protective factors.

Proposed Use of the Data

- RSS data will be used to understand the extent to which adults feel socially connected or isolated for each online activity.
- RSS data will be used to understand feeling socially connected or isolated for online activities may also be examined by demographic groups.
- The data will also be used to examine the association between online activity and suicidal thoughts to better understand suicide risk and protective factors related to social media use, connectedness, and isolation.

Justification for Rapid Surveys System

- There is a **time-sensitive data need** for the Division of Injury Prevention to update a Report to Congress on Suicide Rates, Sodium Nitrite-related Suicides, and Online Forums. Part of this Report to Congress covers what is known about the benefits and harms of online engagement. Much of the survey work in this area is evolving as is the nature of online engagement. The intersection of suicide, mental health and social media has wide interest.

References

1. Centers for Disease Control and Prevention. Facts About Suicide. Available: Facts <https://www.cdc.gov/suicide/facts/index.html>

Swimming skills, water exposure, alcohol and water, CPR knowledge, and water safety training

Program: National Center for Injury Prevention and Control (NCIPC)

Background/Rationale: Drowning is a preventable injury. It is the leading cause of death among very young children and is among the leading causes of unintentional injury death for older children and young adults. Black and American Indian or Alaska Native children and young adults drown at higher rates than White children and young adults.⁶

To develop effective prevention strategies for unintentional drowning, it is important to understand the prevalence of risk and protective factors. Known protective factors for drowning include having basic swimming and water safety skills, and early and effective training in CPR. Known risk factors for drowning include exposure to water bodies and alcohol use.

There are significant disparities in drowning death rates by race and age.⁶ Previous research, for example, suggests that Black persons report more limited swimming ability than persons from other racial and ethnic groups. However, recent data on swimming ability among Black persons are not available, and swimming ability among persons from other racial and ethnic groups have not been previously reported. Current data on swimming ability, exposure to water, and participation in swimming lessons are critical to understand determinants that might contribute to racial and ethnic disparities in drowning and provide information needed to begin addressing barriers to drowning prevention in populations at increased risk of drowning.

The objective of this data collection is to better understand swimming ability and water exposure among adults. Collecting this information on risk and protective factors aligns with NCIPC's mission to develop and evaluate strategies to prevent and control injuries. These data directly aligns with NCIPC's drowning prevention research priorities, specifically: describe the risk and protective factors associated with drowning with an emphasis on persons who may be disproportionately affected.

Concepts Measured

- Swimming skill level
- Ever taken private swim lessons from professional/certified instructor
- Ever taken group swim lessons from professional/certified instructor
- Learned to swim from friend or relative
- Taught self to swim
- Never taken swim lesson
- (Last 6 months) time spent in or around a swimming pool
 - (If more than never) Of those time, how often drinking alcohol
- (Last 6 months) how often swimming, boating, fishing, or participating in water sports in another body of water
 - (If more than never) Of those time, how often drinking alcohol
- Trained in CPR
- Taken CPR training in the last 2 years
- Ever trained how to help a drowning person without putting yourself in danger

Available data or duplication and measurement on other national surveys

- Mortality data show that drowning is the leading cause of death among children aged 1-4 and the second leading cause of death among children aged 5-14.⁶
- Several small studies examine ability to swim among youth and find differences by race.^{1,2}

Proposed Use of the Data

- RSS data will be used in a descriptive analysis that reports univariate distributions of the indicators of swimming ability, water exposure, alcohol consumption, and CPR training and bivariate cross tabs of these measures by demographic variables
- NCIPC plans to publish and promote a journal article describing the findings from these data as well as create and disseminate social media messages highlighting the prevention implications of the key findings, in advance of the 2024 water safety season.
- RSS data will be used to inform drowning prevention campaigns.

Justification for Rapid Surveys System

- There is a need for a better understanding of the public's **knowledge, attitudes, and behaviors** related to swimming and water safety. These analyses will provide important context and baseline burden for several CDC upcoming drowning prevention projects. Having these measures collected before the Spring of 2024 would provide CDC with information for research, community-based projects, and communication outreach.
- Collecting these data in Fall 2023 will maximize recall of **public health behaviors** that occurred during the summer season, when activities around water are most common.

References

1. Irwin CC, Irwin RL, Ryan TD, Drayer J. Urban minority youth swimming (in)ability in the United States and associated demographic characteristics: toward a drowning prevention plan. *Inj Prev* 2009;15:234–9. <https://doi.org/10.1136/ip.2008.020461>
2. Pharr J, Irwin C, Layne T, Irwin R. Predictors of swimming ability among children and adolescents in the United States. *Sports (Basel)* 2018;6:17. <https://doi.org/10.3390/sports6010017>
3. Irwin CC, Pharr JR, Irwin RL, Layne TE. Youth swimming ability and associated factors in the United States, 2010–17. *Am J Health Behav* 2018;42:32–42. <https://doi.org/10.5993/AJHB.42.5.3>
4. Clemens T, Moreland B, Lee R. Persistent Racial/Ethnic Disparities in Fatal Unintentional Drowning Rates Among Persons Aged ≤29 Years — United States, 1999–2019. *MMWR Morb Mortal Wkly Rep* 2021;70:869–874. DOI: <http://dx.doi.org/10.15585/mmwr.mm7024a1>
5. Moreland B, Ortmann N, Clemens T. Increased unintentional drowning deaths in 2020 by age, race/ethnicity, sex, and location, United States. *J Safety Res.* 2022 Sep;82:463-468. doi: 10.1016/j.jsr.2022.06.012. Epub 2022 Jul 2. PMID: 36031277; PMCID: PMC9418042.
6. Centers for Disease Control and Prevention. Drowning Facts. Accessed online: <https://www.cdc.gov/drowning/facts/index.html>. July 7, 2023.

Harm reduction and treatment, including attitudes regarding drug use and naloxone

Program: National Center for Injury Prevention and Control (NCIPC)

Background/Rationale: The drug overdose crisis remains a complex public health concern. Rapid data on perceptions of safety related to purchasing medications online, harm reduction strategies (i.e., use of naloxone), treatment and stigma/discrimination are needed to understand where to target CDC's programmatic and communications efforts. Harm reduction strategies and treatment for substance use disorders exist yet are underutilized. Specifically, naloxone, a medication used to reverse opioid overdoses, was made available over the counter in March 2023. It is important to understand public knowledge and perceptions related to this recent change to inform tailored outreach and communication. Stigma and discrimination are a constant undercurrent in addressing the drug overdose crisis – better understanding of public perception of individuals with substance use disorders and treatment of overdoses is crucial to informing prevention and mitigation strategies and tailoring messaging.

Concepts Measured

- Ever ordered prescription pills or medication online without a prescription
 - (If yes) Level of concern about the ingredients in prescription pills or medications ordered online without a prescription
 - (If no) Level of concern about the ingredients in prescription pills or medications if you did order them online without a prescription
- Ever heard of naloxone or Narcan
- Aware that naloxone or Narcan is available over the counter without a prescription
- Know where people can get naloxone or Narcan
- Currently carry naloxone or Narcan
- Should naloxone or Narcan be available at different places (businesses, colleges, schools k-8, schools 9-12, places of worship, public libraries)
- Level of comfort being in committed relationship with person who misuse prescription opioids or uses illegal drugs such as cocaine or heroin
- Think a person who misuses prescription opioids or uses illegal drugs is to blame for their drug use
- Level of comfort working closely with a person who misuses prescription opioids or uses illegal drugs such as cocaine or heroin

Available data or duplication and measurement on other national surveys

- While the National Survey on Drug Use and Health (NSDUH) asks questions related to stigma in relation to whether a respondent sought treatment for their substance use disorder, it does not ask about stigma/discrimination of others who may have substance use disorder.

Proposed Use of the Data

- RSS data will be used to understand purchasing pills and medications online without a prescription.
- RSS data will be used to understand the perceived safety of these purchases and will help to gauge the extent to which adults consider risks when purchasing prescription medications online without a prescription.
- RSS data will be used to inform efforts to increase access to naloxone in specific community locations.

- RSS data will be used to understand stigma against problem drug use and whether stigma is associated with public health attitudes regarding naloxone.

Justification for Rapid Surveys System

- There is a **time-sensitive data need** to provide information that can help CDC/NCIPC understand where to target CDC's programmatic and communications efforts. Naloxone, a medication used to reverse opioid overdoses, was made available over the counter in March 2023. It is important to understand public knowledge and perceptions related to this recent change to inform tailored outreach and communication.
- The questions ask about **public health attitudes** regarding perceptions of safety related to purchasing medications online, harm reduction strategies (i.e., use of naloxone), treatment, and stigma/discrimination associated with drug use. These attitudes may be developing and changing in light of the opioid crisis and the increased availability of naloxone. The Rapid Surveys System is more appropriate than annual national surveys for assessing such attitudes.

References

1. Barry CL, McGinty EE, Pescosolido BA, et al. 2014. Stigma, Discrimination, Treatment Effectiveness, and Policy: Public Views About Drug Addiction and Mental Illness. *Psychiatric Services* 65: 1269-1272; DOI: 10.1176/appi.ps.201400140

Shared decision making for chronic pain

Program: National Center for Injury Prevention and Control (NCIPC)

Background/Rationale: In 2021, roughly 21% of U.S. adults experienced chronic pain defined as pain occurring every day or most days during the past 3 months¹. Chronic pain can be debilitating and lead to a reduced quality of life without effective treatment. The effectiveness of treatment strategies involving opioid, nonopioid, physical, and behavior therapy vary by patient. Given this, in November of 2022 CDC released updated guidance to help clinicians and patients work together to make informed, patient-centered decisions about pain management². An important aspect of these guidelines is to facilitate discussions about the risks and benefits of treatments and shared decision making that takes patients' cultural experiences into account. A better understanding of the extent to which patient-centered decision practices are being used for pain management will help inform CDC's programmatic and communications efforts.

Concepts Measured

If (Past 3 months) experience pain most days or every day:

- Currently receiving medical care from a healthcare provider for your pain
- (Past 12 months) any decisions need to be made with your health care provider regarding your treatment for pain
- (Past 12 months) how often were you treated with respect by your health care provider when you were seeking care for pain
- (Past 12 months) how often did your health care provider listen carefully to you when you were seeking care for pain
- (Past 12 months) how often did your health care provider ask for your opinions or beliefs about your medical care or treatment for pain

Available data or duplication and measurement on other national surveys

- In the past, the Medical Expenditure Panel Survey (MEPS) included a series of shared decision-making questions asking how often your clinician (1) asked you to help decide, (2) showed respect for alternative treatments, (3) listened carefully to you, (4) explained things so they were easy to understand, (5) showed respect for you, and (6) spent enough time with you.³ An additional question asked if your clinician presented all the treatment options to you. While this data from MEPS provides information about shared decision making, it was about general decision-making rather than specific to decisions about pain.
- In 2017 NHIS included a series of questions about patients' experiences with health care providers understanding and respecting their beliefs⁴. These questions focused on culturally and linguistically appropriate services (CLAS) and did not specify experiences in the context of pain management.

Proposed Use of the Data

- RSS data will be used to understand patients' perceptions of shared decision making with clinicians.
- RSS data will be analyzed by demographic subgroups to inform differences in the prevalence of patient centered decision making across groups and potential inequities in barriers to pain care.

Justification for Rapid Surveys System

- There is a **time-sensitive data need** to provide information that can help CDC/NCIPC understand where to target programmatic and communications efforts. A better understanding of patient-centered decision practices related to pain management will help inform CDC’s programmatic and communications efforts to address the opioid crisis.

References

1. Rikard SM, Strahan AE, Schmit KM, Guy GP Jr.. Chronic Pain Among Adults — United States, 2019–2021. MMWR Morb Mortal Wkly Rep 2023;72:379–385. DOI: <http://dx.doi.org/10.15585/mmwr.mm7215a1>.
2. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>.
3. Levine, D. M., Landon, B. E., & Linder, J. A. (2017). Trends in patient-perceived shared decision making among adults in the United States, 2002–2014. *The Annals of Family Medicine*, 15(6), 552-556.
4. 2017 National Health Interview Survey English Questionnaire. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2017/english/qadult.pdf

Reproductive health access and changes in access to contraception

Program: National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Background/Rationale: CDC remains steadfastly committed to promoting equitable and optimal reproductive, maternal, and infant health. The Division of Reproductive Health (DRH) proposes to collaborate with NCHS to conduct a national assessment of attitudes, behaviors, and barriers to contraception using the RSS. The proposed questions are designed to better understand access to contraception and current method of contraceptive use among women of reproductive age. It will also highlight recent changes in contraceptive use.

Concepts Measured

- (Females aged 18-49) Sexual intercourse with male partner in the past 12 months
- Did you or your partner do anything to prevent pregnancy
- (Past 12 months) Methods of birth control used (IUD/implant, shot, pill/ring/patch, emergency contraception, sterilization, other method)
- (Past 12 months) have you changed or stopped method used to prevent pregnancy
- Why changed or stopped a method to prevent pregnancy (effective method, less expensive method, did not like it, concerns about state laws, concerns about privacy/confidentiality, wanted to become pregnant, another reason)
- (Past 12 months) Change in difficulty of access to birth control (IUD, shots, pills/ring/patch, emergency contraception)

Available data or duplication and measurement on other national surveys

- Some similar constructs are available (contraceptive attitudes, behaviors, and experiences; preferred method of contraception; recent changes in contraceptive method use and reasons; and barriers to preferred method of contraception) from other Federal sources, such as the Behavioral Risk Factor Surveillance System or National Survey of Family Growth.

Proposed Use of the Data

- Analyses of the resulting data will help understand changes in difficulty obtaining desired method of birth control, recent use of specific contraceptive methods, and reasons for changing method of birth control over the past 12 months among women aged 18-49.
- Depending on subgroup sample sizes, it may be feasible to look at some of the above measures by demographic characteristics that can be important indicators of possible disparities, such as age group, race/ethnicity, geographic region, disability status, employment status, insurance status, or other factors.

Justification for Rapid Surveys System

- There is a **time-sensitive data need** to understand access to affordable, high-quality contraception and family planning. Executive Orders 14076 and 14079 take action to protect access to reproductive healthcare services, and there is a need for timely data to inform strategies to support such access. Also, the Division of Reproductive Health has a **time-sensitive data need** to document gaps and disparities in access to contraception.

References

1. Executive Order 14076 of July 8, 2022 (Protecting Access to Reproductive Healthcare Services): [Executive Order on Securing Access to Reproductive and Other Healthcare Services | The White House](#)

2. Executive Order 14079 of August 3, 2022 (Securing Access to Reproductive and Other Healthcare Services): [Executive Order on Securing Access to Reproductive and Other Healthcare Services | The White House](#)

Technology-facilitated sexual violence

Program: National Center for Injury Prevention and Control (NCIPC)

Background/Rationale: The increased integration of technology in multiple domains in people's lives has changed social interactions. Technology is now used in violence perpetration and victimization.¹ Technology-based engagement platforms (e.g., social media, video gaming texting applications) allow for the emergence of new ways to perpetrate violence, including technology-facilitated sexual violence (SV).² The definition of SV is "a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone unable to consent or refuse."³ Technology-facilitated SV is a "non-contact sexual act"⁴ that occurs without consent.⁵ By including technology-facilitated SV as a form of SV³ the science may start moving away from the dichotomy of in-person vs. online violence, which minimizes the harms from SV victimization using technological domains.^{6,7}

The consequences of technology-facilitated SV victimization are tangible and mirror those of contact SV.^{8,9} Victims of technology-facilitated SV report worse mental health when compared to those without victimization, including increased depression, anxiety, and suicide risk.^{10,11} Decreased physiological health and higher somatic symptoms and stress is also reported more often by victims than non-victims.^{8,12} Technology-facilitated SV victims also report behavioral consequences that directly impact mental and physical health, like avoidance coping by engaging in substance use after victimization.^{8,13} The documented consequences of victimization through online domains are similar to documented in-person SV experiences. This type of violence is an area for public health action.¹⁴

Concepts Measured

- To your knowledge, anyone ever emailed, texted, or electronically posted a revealing or sexual photo or video of you without your consent
- Anyone ever threatened to share a revealing or sexual picture or video of you, through the internet, social media, email, or text message to get you to do something
- Why did they threaten to share a revealing or sexual picture or video of you (send additional pictures or videos, have sexual relationship with them, pay money, stay in relationship with them, other reason)
- Anyone ever used technology to create and share fake pornographic photos or videos of you online without your consent

Available data or duplication and measurement on other national surveys

- A meta-analysis of nineteen studies, totaling approximately 32,200 participants, provide the main source of prevalence rates of technology-facilitated sexual violence victimization and perpetration within three categories, distribution, associated threats, and creation of sexually explicit materials.² The pooled prevalence rates for reporting victimization were 8% for distribution of sexually explicit materials, 7.2% for associated threats using sexually explicit materials, and 17.6% for creation of sexually explicit materials.
- ResearchR from a multinational study among 16–64-year-olds reported lifetime victimization prevalence of pornographic deepfakes among individuals in Australia (13.1%), New Zealand (15.5%), United Kingdom (13.8%), and perpetration in Australia (6.9%), New Zealand (8.7%), United Kingdom (7.3%).¹⁵

Proposed Use of the Data

- RSS data will help understand the rates of self-reported victimization of three forms of technology-facilitated SV among US adults.
- As the sample allows, RSS data will let us examine patterns (e.g., prevalence differences, differences in risk) in victimization across demographic groups.

Justification for Rapid Surveys System

- The RSS offers an opportunity for a **methodological study** to assess the feasibility of collecting measures of technology facilitated sexual violence.
- There is also a **time sensitive data need** since DVP does not have any other surveillance activities in 2023 that can capture self-reports of technology facilitated sexual violence.

References

1. Bailey J, Henry N, Flynn A. Technology-Facilitated Violence and Abuse: International Perspectives and Experiences. In: The Emerald International Handbook of Technology-Facilitated Violence and Abuse.2021:1-17.
2. Patel U, Roesch R. The Prevalence of Technology-Facilitated Sexual Violence: A Meta-Analysis and Systematic Review. Trauma Violence Abuse. 2022;23(2):428-443.
3. Basile KC, Smith SG, Breiding MJ, Black MC, Mahendra R. Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements. Centers for Disease Control and Prevention;2014. Version 2.0. Atlanta (GA).
4. DeGue S, Niolon PH, Estefan LF, et al. Effects of Dating Matters® on Sexual Violence and Sexual Harassment Outcomes among Middle School Youth: a Cluster-Randomized Controlled Trial. Prevention Science. 2021;22(2):175-185.
5. Ringrose J, Milne B, Mishna F, Regehr K, Slane A. Young people's experiences of image-based sexual harassment and abuse in England and Canada: Toward a feminist framing of technologically facilitated sexual violence. Women's Studies International Forum. 2022;93.
6. Dunn S. Is it Actually Violence? Framing Technology-Facilitated Abuse as Violence. In: The Emerald International Handbook of Technology-Facilitated Violence and Abuse. Emerald Publishing Limited; 2021:25-45.
7. McGlynn C, Johnson K, Rackley E, et al. 'It's Torture for the Soul': The Harms of Image-Based Sexual Abuse. Social & Legal Studies. 2020;30(4):541-562.
8. Champion AR, Oswald F, Khera D, Pedersen CL. Examining the Gendered Impacts of Technology-Facilitated Sexual Violence: A Mixed Methods Approach. Arch Sex Behav. 2022;51(3):1607-1624.
9. Say GN, Babadagi Z, Karabekiroglu K, Yuce M, Akbas S. Abuse Characteristics and Psychiatric Consequences Associated with Online Sexual Abuse. Cyberpsychol Behav Soc Netw. 2015;18(6):333-336.
10. Champion A, Oswald F, Pedersen CL. Technology-facilitated sexual violence and suicide risk: A serial mediation model investigating bullying, depression, perceived burdensomeness, and thwarted belongingness. Canadian Journal of Human Sexuality. 2021;30(1):125-141.
11. Echevarria SG, Peterson R, Woerner J. College Students' Experiences of Dating App Facilitated Sexual Violence and Associations with Mental Health Symptoms and Well-Being. J Sex Res. 2022:1-13.

12. Ruvalcaba Y, Eaton AA. Nonconsensual pornography among US adults: a sexual scripts framework on victimization, perpetration, and health correlates for women and men. *Psychology of violence*. 2020;10(1):68.
13. Bates S. Revenge Porn and Mental Health: A Qualitative Analysis of the Mental Health Effects of Revenge Porn on Female Survivors. *Feminist Criminology*. 2016;12(1):22-42.
14. Basile KC, Smith SG. Sexual Violence Victimization of Women. *American Journal of Lifestyle Medicine*. 2011;5(5):407-417.
15. Flynn A, Powell A, Scott AJ, Cama E. Deepfakes and Digitally Altered Imagery Abuse: A Cross-Country Exploration of an Emerging form of Image-Based Sexual Abuse. *The British Journal of Criminology*. 2022;62(6):1341-1358.

Fit testing of hearing devices

Program: National Institute for Occupational Safety and Health (NIOSH)

Background/Rationale: Loud noise is one of the most common occupational hazards in the United States and across the world. Data from the 2014 National Health Interview Survey indicate that approximately 22 million U.S. workers (14%) are currently exposed to hazardous noise at work. The prevalence of noise exposure is highest in the Mining, Construction, and Manufacturing sectors; however, every occupational sector has some workers exposed to high levels of noise.¹

Occupational noise-induced hearing loss is nearly always preventable. When noise control solutions cannot reduce noise to a safe level, workers use hearing protection devices to reduce their noise exposure. In the U.S., hearing protection devices are labeled with a Noise Reduction Rating (NRR) to indicate their noise reduction potential. The NRR is a laboratory-derived statistical estimate that cannot be accurately applied to an individual worker and has been repeatedly shown to underestimate real-world sound reduction.¹ The solution is to measure attenuation on each individual worker.

The concept of hearing protector fit testing has been around since the 1970s. However, early systems required racks of large equipment that were not amenable to use in workplace hearing loss prevention programs. Advances in computer technology have enabled the development of more portable and economical fit testing systems. Several commercial fit-test systems are currently on the market, and these have seen gradual uptake by U.S. employers and occupational hearing testing companies.² A recent study of workplace hearing loss prevention program found that the four facilities which utilized fit-testing in their study of hearing conservation program effectiveness achieved the lowest rates of hearing shift among the fourteen participating sites within the same company.³ Still, barriers to universal hearing protector fit-testing remain.

By Congressional mandate, the National Institute for Occupational Safety and Health (NIOSH) publishes recommendations for controlling occupational hazards and preventing work-related diseases and condition. NIOSH published its original *Criteria for a Recommended Standard: Occupational Exposure to Noise* in 1972⁴ and updated it in 1998.⁵ NIOSH is in the early stages of revising this *Criteria* document. A major update will concern recommendations for fit-testing hearing protectors on individual workers to ensure they are getting sufficient noise reduction.

Concepts Measured

- Ever used hearing protectors when exposed to loud noise at work
- Knowledge that hearing protectors can be fit-tested
- Ever had your hearing protectors fit-tested
- Importance of having hearing protectors fit-tested

Available data or duplication and measurement on other national surveys

- Information about fit testing for hearing protectors is scarce in the scientific literature. NIOSH staff recently completed a Cochrane review (in press) on the effect of hearing protector fit testing on the noise reduction obtained by workers using hearing protectors and on adherence to hearing protector use. The review found only four controlled studies and fifteen uncontrolled studies, all

of which were limited to evaluating various instruction methods used in conjunction with fit-testing. No studies on the prevalence of fit-testing among workers exposed to noise or its impact on compliance with hearing protector use were identified.

Proposed Use of the Data

- RSS data will be used to understand the use of hearing protectors at work, and the proportion of hearing protectors that have been fit-tested will be used to understand the prevalence of fit-testing.
- RSS data will help to gauge the extent to which workers value the use of fit-testing hearing protectors.

Justification for Rapid Surveys System

- There is a public health need for information about **knowledge, attitudes and behaviors** related to hearing protector fit testing. These data will provide information that can help NIOSH update its recommendations regarding workplace noise exposure and preventive activities. One recent development in occupational hearing loss prevention is the ability to fit-test hearing protectors on individual workers to ensure they are getting enough noise reduction. NIOSH does not have data the current prevalence or acceptance of hearing protector fit testing in occupational hearing loss prevention programs.

References

1. Themann CL, Masterson EA (2019). Occupational noise exposure: A review of its effects, epidemiology, and impact with recommendations for reducing its burden. *J Acoust Soc Am*, 146(5):3879-3805.
2. Edwards RG, Broderon AB, Green WW, Lempert BL. A second field investigation of noise reduction afforded by insert type hearing protectors. *Noise Control Eng J*. January 1983;20(1):6015.
3. Saylor SK, Rabinowitz PM, Cantley LF, Galusha D, and Neitzel RL (2018). Costs and effectiveness of hearing conservation programs at 14 US metal manufacturing facilities." *Int. J. Aud.* 57, S3–S11.
4. National Institute for Occupational Safety and Health. Criteria for a Recommended Standard. Occupational Exposure to Noise. National Institute for Occupational Safety and Health, Health Services and Mental Health Administration, Department of Health, Education, and Welfare; 1972. Publication No. HSM 73011001.
5. National Institute for Occupational Safety and Health. Criteria for a Recommended Standard - Occupational Noise Exposure: Revised Criteria. Cincinnati, Ohio: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health; 1998. DHHS (NIOSH) Publication No. 98-126.
6. Green DR, Masterson EA, Themann CL (2021). Prevalence of hearing protection device non-use among noise-exposed US workers in 2007 and 2014. *Am J Ind Med*, 64(12):1002-1017.