NCHS Rapid Surveys System

NATIONAL CENTER FOR HEALTH STATISTICS

Technical Notes

Round 6: Data collected February-March 2025

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CDC
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Introduction

The National Center for Health Statistics (NCHS) Rapid Surveys System (RSS) is a platform that utilizes commercially available probability-based online panels to provide time-sensitive data about emerging and priority health concerns. RSS began fielding in 2023, and has a different questionnaire administered each round of data collection.

To provide timely access to selected point estimates based on RSS content, a dashboard may be released following each round of data collection. Percentages are shown by selected population subgroups such as age group, sex, race and Hispanic origin, education, household income as a percentage of the federal poverty level, region, and urbanicity.

Methods

Data source

The target population of RSS Round 6 (RSS-6) is all U.S. adults aged 18 and older. Data were collected in February-March 2025 from two commercial panel providers using the same questionnaire (www.cdc.gov/nchs/data/rss/round6/questionnaire.pdf). Data were collected from 7,923 adult participants this round using two panels – Amerispeak (conducted by NORC at the University of Chicago) and KnowledgePanel (conducted by Ipsos). The combined completion rate for both panels was 57.0% (1).

Both panel providers collect profile information from their panelists on a regular basis, including several sociodemographic and geographic characteristics. As these data were already available for RSS respondents as part of their panel profile data, questions about these characteristics were not re-asked on the RSS questionnaire. These measures were harmonized into common categories, but the information was collected separately from RSS, at different times and using different questions in each panel.

Details on data collection, sampling methods, response rates, weighting methodologies, and other data processing components can be found in the Survey Description www.cdc.gov/nchs/data/rss/round6/survey-description.pdf) and the Quality Profile (https://www.cdc.gov/nchs/data/rss/round6/quality-profile.pdf).

Estimation procedures

The RSS-6 questionnaire included several variables which were used to calibrate survey weights to NHIS population totals. These final calibrated weights were used to generate the estimates in the released dashboard. All estimates shown meet the NCHS Data Presentation Standards for Proportions.

Cases with missing data are excluded from the analysis, unless otherwise mentioned. Data would be considered missing for a variable if, for example, the respondent refused or didn't know how to respond, or if they skipped the question on the web. These are henceforth referred to as nonresponse. Overall, item nonresponse rates were low, averaging <2% per item in the combined file. Several of the sociodemographic characteristics used in the dashboard have very low or no missing values, as they were imputed when missing for weighting purposes. None of the variables related to measures in the RSS-6 dashboard had an item nonresponse higher than 5% in the combined dataset. Data users using variables on the combined file with higher item nonresponse are encouraged to consider the impact of nonresponse, if applicable to their analysis/research. Please see the Quality Profile (https://www.cdc.gov/nchs/data/rss/round6/quality-profile.pdf) for more information.

Data limitations

Although much faster than in-person surveys, online panel surveys face different threats to accuracy and usability. Online panel surveys often have lower response rates than large-scale national surveys and may underrepresent certain subpopulations. Panel survey nonresponse occurs at many stages, including panel recruitment, panel retention, and at the individual survey level. The RSS aims to compensate for nonresponse through calibration and weighting of RSS data to gold standard NCHS surveys. However, the effectiveness of these weighting adjustments for nonresponse may vary across survey estimates and will depend on the availability of appropriate gold standard survey data. The RSS also includes a benchmarking component which is used to provide context on the effectiveness of the weighting adjustments and quality of estimates generated from RSS. For an evaluation of the quality of RSS-6 data, including the calibration of weights and benchmark analysis, please see the Quality Profile (https://www.cdc.gov/nchs/data/rss/round6/quality-profile.pdf).

Another limitation of RSS is that some of the sociodemographic and geographic variables are drawn from panel profile variables, which are collected separately from RSS, and are collected at different times than the RSS health topic content and using different questions in each panel. Although they are updated regularly, it is not known whether any of these characteristics had changed between the last time the panel collected the information and the respondent completed the RSS-6 questionnaire.

The Rapid Surveys System is particularly well suited for time sensitive data needs, measuring public health attitudes, developmental work to improve concept measurement, and methodological studies, but is intended to complement and not replace the current household survey systems at NCHS, including the National Health Interview Survey.

Variance estimation and statistical reliability

All estimates shown meet the NCHS standards of reliability as specified in *National Center for Health Statistics Data Presentation Standards for Proportions* (2). Unreliable estimates are indicated with an asterisk (*) and are not shown. Reliable estimates with an unreliable complement are also not shown but are indicated with two asterisks (**). Complements are calculated as 100 minus the percentage. The standards are applied directly for percentages. Two-sided 95% confidence intervals are calculated using the Clopper-Pearson method adapted for complex surveys by Korn and Graubard (2). Standard errors used in this calculation were obtained using SUDAAN software, which takes into account the complex sampling design of RSS. The Taylor series linearization method was used for variance estimation.

Definitions of selected terms

Sociodemographic and geographic characteristics from panel profile data

The following sociodemographic and geographic characteristics used as covariates in these dashboards and tables were collected as part of the panel profile information (not RSS questionnaire) and harmonized between the two panels.

Age – Age is recorded in single years and grouped into categories for the dashboard.

Education – Categories of education are based on years of school completed or highest degree obtained. GED is General Educational Development high school equivalency diploma.

Household income as a percentage of the federal poverty level – Categories presented are Less than 100% FPL, 100% to less than 200% FPL, and 200% FPL and greater. FPL is federal poverty level.

Region – In the geographic classification of the U.S. population, states are grouped into four regions used by the U.S. Census Bureau:

> *Northeast*: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
> *Midwest*: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin
> *South*: Alabama, Arkansas, Delaware, District of Columbia, Kentucky, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia
> *West*: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Sex – Respondents are classified as Male or Female.

Urbanicity – Based on the 2013 NCHS Urban-Rural Classification Scheme for Counties (3) which groups U.S. counties and county-equivalent entities into six categories: large central metropolitan, large fringe metropolitan, medium metropolitan, small metropolitan, micropolitan, and non-core. For the RSS dashboards, medium and small metropolitan are combined into a single group, and micropolitan and non-core are combined into a single group (nonmetropolitan).

Sociodemographic characteristics collected on the questionnaire

The following sociodemographic characteristics used as covariates in this dashboard were collected on the RSS-6 questionnaire.

Race and Hispanic origin – Per guidance from OMB (Federal Register :: Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity), starting in RSS-5 and continued in subsequent rounds, race and Hispanic origin were collected using different questions than previous rounds. Two different categorizations of race and Hispanic origin are presented in the dashboard:

Race and Hispanic origin – Single race: American Indian or Alaska Native alone; Asian alone; Black or African American alone; Hispanic or Latino alone; Middle Eastern or North African alone; Native Hawaiian or Pacific Islander alone; White alone; Multiracial and/or Multiethnic.

Race and Hispanic origin – Multiple races: American Indian or Alaska Native alone or in combination; Asian alone or in combination; Black or African American alone or in combination; Hispanic or Latino alone or in combination; Middle Eastern or North African alone or in combination; Native Hawaiian or Pacific Islander alone or in combination; White alone or in combination.

Select outcomes collected on questionnaire

Estimates for most measures are generated from a single question on the questionnaire. For exact wording of questions, please see the questionnaire (www.cdc.gov/nchs/data/rss/round6/questionnaire.pdf). Below are additional details on some of the outcomes shown in the dashboard.

HPV test self-collection – Women were considered open to self-collected vaginal specimens for HPV testing, hereafter referred to as HPV test self-collection, if they responded that they either would a) prefer it over testing by a doctor or nurse, or b) had no preference. Among those who were open to HPV test self-collection, estimates are shown for those who were open to doing this self-collection at home. This includes those who responded they would prefer doing this self-collection at home, as opposed to in a clinic or doctor's office, or had no preference where to do the self-collection. Among women ages 21–65 who preferred to do HPV test self-collection at home, estimates are shown for four selected specific reasons for their preference, including more convenience, more privacy, difficulty accessing a clinic or doctor's office, and a dislike of physical exams by doctors or nurses. Respondents may have selected more than one reason. Among women ages 21–65, estimates are included for four perceived benefits of HPV test self-collection, including more privacy, less stress, more convenience, and the option to avoid physical exams by doctors or nurses. Respondents may have selected more than one perceived benefit.

Produce prescription plans – Several measures in this section were asked of adults who have received any health care in the past 12 months, which includes any care received at a health center, urgent care, clinic including one in a drug store or grocery store, mobile or worksite clinic, doctor's office, outpatient clinic, hospital, or hospital emergency room. One question asked respondents who had received health care if they received information about a food assistance program, such as information on websites, addresses or phone numbers for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), or food stamps. Another question asked respondents about being signed up/receiving help initiating food services to

manage a medical condition and specified that these meals and groceries are tailored for people with diet-related conditions. For example, an adult with high blood pressure or hypertension may receive low sodium meals or groceries tailored to treat their disease.

Adults who had a health care visit in the past 12 months were considered to have received information on food services or assistance during those visits if they responded that during those visits, they received information about places that help with free food such as a food pantry, food bank or church, if they received information about how to get home-delivered meal services like Meals on Wheels or another service that delivers free meals, or if they received information about a food assistance program such as WIC, SNAP, or food stamps.

Adults who had a health care visit in the past 12 months were considered to have received help initiating food services or assistance if they responded that during those visits they had someone help sign them up for or call to connect them with places that help with free food such as a food pantry, food bank or church, or with a church, shelter or home-delivered meal service like Meals on Wheels or another place that helps with free meals, or with a food assistance program such as WIC, SNAP, or food stamps.

Stroke signs and symptoms - Respondents were asked the best thing to do in response to each of 5 stroke symptoms (sudden drooping of the face, numbness or weakness in an arm or leg, slurred or garbled speech, trouble seeing, and trouble with walking, dizziness, or balance). The options were: Wait 1 day then decide, Wait 1 hour then decide, Call doctor's office immediately, or Call 911 or another emergency number immediately. Estimates are shown in the dashboard for the percentage of adults who responded they would call 911 or another emergency number immediately in response to each of the 5 stroke symptoms.

The FAST acronym stands for Face (drooping), Arm (weakness or numbness), Speech (slurring or difficulty), Time (to call 911), and represents common symptoms of stroke and a reminder of the urgency they require. The Spanish translation of this question used RÁPIDO, an alternate version of this acronym used by the American Stroke Association in Spanish-language educational resources on recognizing stroke signs and symptoms. The Spanish acronym RÁPIDO stands for Rostro caído, Alteración del equilibrio, Pérdida de fuerza en el brazo, Impedimento visual repentino, Dificultad para hablar, Obtén ayuda, llama al 911.

Further information

Data users can obtain the latest information about RSS by periodically checking the website (https://www.cdc.gov/nchs/rss/rapid-surveys-system.html). This website will feature downloadable public-use data and documentation for RSS, as well as important information about any modifications or updates to the data or documentation.

References

1. National Center for Health Statistics. Rapid Surveys System (RSS): Round 6 survey description. 2025. Available from: www.cdc.gov/nchs/data/rss/round6/survey-description.pdf.
2. Parker JD, Talih M, Malec DJ, Beresovsky V, Carroll M, Gonzalez JF Jr, et al. National Center for Health Statistics data presentation standards for proportions. National Center for Health Statistics. Vital Health Stat 2(175). 2017.
3. National Center for Health Statistics. NCHS urban–rural classification scheme for counties. Available from: https://www.cdc.gov/nchs/data_access/urban_rural.htm#2013_Urban-Rural_Classification_Scheme_for_Counties.

Suggested citation

Recommended citations for specific tables and charts are included in the notes at the end of each page. The citation for the Technical Notes is as follows, although it should also include the date accessed as it may be edited periodically when new changes are made.

Technical Notes. NCHS Rapid Surveys System. Round 6. July 2025. National Center for Health Statistics. Available from: **www.cdc.gov/nchs/data/rss/round6/technical-notes.pdf**.