INTRODUCTION

Understanding the Problem

Governments worldwide are balancing contrasting needs to curtail the toll that coronavirus disease 2019 (COVID-19) takes on lives and health care systems and to preserve their economies. In the United States (US), the federal government has instructed each state to determine the best time to implement its suggested guidelines for either the entire state or regions of the state. To make an informed determination, states need detailed regional information about COVID-19 health and economic impacts. However, existing information at the state or county levels is consigned to tracking COVID-19 prevalence (eg, the Johns Hopkins Coronavirus Resources Center) or economic impact data (eg, the US Current Population Survey). Although these individual sources are useful, having health and economic data from a single source would help
states to determine the potential impact of any policy or program on health and economic well-being. Furthermore, because the pandemic is dynamic and changes quickly, data on population risks are outdated in less than a week. To understand the impacts of policy and program decisions, governments must be able to measure change before, during, and after new policies and programs are implemented.

To help inform these decisions and understand how they impact Ohioans, the state of Ohio launched the Ohio COVID-19 Survey (OCS). The OCS leverages a prior Ohio, statewide population survey from which a panel of prospective survey participants was built. The OCS is a weekly web- and telephone-based tracking survey that is representative of Ohio residents and is designed to provide information on health and behavioral measures such as the respondent’s COVID-19 testing status and compliance with social distancing and economic measures such as employment status and consumer confidence. This paper explains the OCS methods, which ensure it is generalizable to the Ohio population, and provides paradata from each wave of implementation.

Panel Surveys

Studies measuring emergent public health related topics such as COVID-19 face a challenge in trying to quickly recruit representative respondents who are willing to participate. This is especially true of studies which track health measures over time. To overcome this challenge, survey methodologists can turn to an existing panel to recruit study participants. Panels come in 2 varieties: (1) opt-in or voluntary panel, and (2) probability-based panel.

Opt-in or voluntary panels consist of a collection of persons who chose to be part of a panel and subsequently choose which surveys they participate in. Opt-in panels are not representative of the population for 2 reasons: (1) they skew toward high internet users, and (2) they usually suffer from low (ie, single digit) response rates. For these reasons, opt-in panels were not considered for the OCS.

Probability-based panels are sets of persons randomly recruited to be a part of a panel. A non-web-based method is used for the recruitment (eg, a random digit dial (RDD) or address-based sample) in order to ensure non-internet users are included. Therefore, these panels are generally representative of the entire population. Probability-based panels require a 2-stage process to conduct a survey. The recruitment stage is first, and the participation stage follows where panel members are invited to take a particular survey. Because of this multi-stage process, response rates are presented for recruitment and participation. The recruitment response rate is the product of the recruitment stage and participation stage. These rates can be low and survey weights are required at each stage to correct for potential biases. However, the participation stage response rates can be high depending on the survey topic. National probability-panels such as the Understanding America Study (UAS) have been used to quickly pivot and study emergent topics such as COVID-19. However, these national panels are relatively small (between 10,000 and 60,000 members spread across all 50 states). Therefore, at the state level, it is difficult for the national panels to obtain a large enough sample to produce reliable estimates. The OCS used a probability-based panel approach, but, to generate reliable estimates, developed its own panel in order to ensure adequate coverage of the entire state.

METHODS

Setting

The OCS is a general population survey of residents of Ohio. The survey was conducted via web and telephone by RTI International.

Design

The OCS has 3 overall analytic objectives: (1) estimate Ohio statewide and regional health and economic indicators related to COVID-19, concentrating on how they change over the progression of the pandemic; (2) understand how individual health and economic statuses and behaviors change over time; and (3) compare current health and economic statuses to prepandemic statuses. To achieve these analytic objectives, the OCS employed a rotating panel design with a 10-minute web-/telephone-based survey.

Panel construction. The OCS sampling frame is a statewide representative panel of Ohioans developed from respondents to the 2019 Ohio Medicaid Assessment Survey (OMAS). The OMAS is a biannual survey of Ohio residents that collects data on health insurance status, health statuses, access to care, determinants of health, and demographics. The 2019 OMAS, conducted from September to December 2019, obtained 30,068 adult interviews using a dual cell phone and landline RDD frame. The OMAS is weighted to be representative at the statewide and Ohio regional levels. At the end of the OMAS survey, respondents were asked if they were willing to be recontacted. Among the respondents, 24,029 (79.9%) agreed to be recontacted; of these, 16,438 (68.4%) provided telephone and email contact information and 7,591 (31.6%) provided only a telephone number. Because not all OMAS respondents agreed to be recontacted, analysts adjusted survey weights for the panel members using a generalized exponential model (GEM) with key demographic and health characteristics to correct for potential panel selection bias. After this panel inclusion adjustment, the design-based weights for each panel member in OCS fully represent the state and subdomain populations within the state.

Sample design. To achieve the 3 analytic goals, we used a rotating panel design which allowed the OCS to obtain 18 weekly, statewide, cross-sectional estimates and up to 3 repeated interviews with panel members. Under this design, the full panel was randomly split into 6 rotation groups of approximately 4,000 panel members each. Each rotation group was further randomly split into 20 replicates of 200 panel members each. The weights for each replicate were adjusted to represent the full population by multiplying the design-based weights by 120 (the total number of replicates created). Each week for the first 6 weeks a set of repli-
The OCS included 5 items from the 2019 OMAS. These items, italicized in Table 1, include health and economic indicators such as self-rated health statuses and food insecurity. In wave 1, the experience of symptoms reference period for the OCS was March 1, 2020. Note that the reference period for time associated questions was modified to “in the past 30 days” for fielding waves 2 and 3.

**Statistical Analysis**

Two types of analytic weights were created to allow for generalizable inference to the Ohio population: (1) cross-sectional weights, and (2) longitudinal weights.

The cross-sectional weights were produced after each weekly rotation group release. The design-based weights had 3 adjustments made. First, a rotation group and replicate release adjustment was implemented. Because each replicate has weights that represent the full state, the initial replicate weights for each weekly release were adjusted by dividing the weights by the number of replicates released that week. Second, a nonresponse adjustment was made. Because the OCS panel was constructed from the 2019 OMAS, a rich set of characteristics exists and was used to adjust for potential nonresponse biases, including demographic, geographic, financial (income), employment, and health characteristics. Third, a post-stratification adjustment was made for any potential coverage error caused in the creation of the panel rotation groups. Because the design-based weights were not equal (although the expectation was that each randomly created rotation group represents the full population), some variation in the weight totals may exist. Therefore, the weights adjusted for nonresponse were post-stratified to the Ohio population using 2018 American Community Survey estimates. The nonresponse adjustment and post-stratification adjustment was conducted using GEM, an iterative raking procedure.

The longitudinal weights were produced after wave 3 was completed among the set of respondents who participated in all 3 waves. The base longitudinal weight was the wave 1 weight for each rotation group because they are the set of sampled persons eligible for the longitudinal analysis. Within each rotation group, a

**Participants**

The OCS target was 700 to 1000 interviews over a 7-day period (weekly) for 18 weeks of data collection split across 3 waves. A rotation group sample was released each Monday. The rotation groups did not overlap in the field. An initial invitation was sent by text and email (if available). Three text/email reminders were sent between Tuesday and Wednesday morning. Telephone calling began on Wednesday for all sample members who had not yet responded via web. Up to 3 call attempts per sample member were made through Sunday evening. All panel members who indicated they still lived in the state of Ohio were eligible to take the survey. All respondents were offered a $5 incentive for completing the survey. Wave 1 was collected from April 20, 2020, until May 31, 2020; wave 2 was collected from June 1, 2020, to July 19, 2020; and wave 3 was collected from July 20, 2020, to August 30, 2020.

**Measures/Outcomes**

The OCS instrument was a 10-minute survey that obtained critical health, behavioral, and economic indicators. Table 1 details the topics covered in the OCS. To achieve the third analytic objective, the OCS included 5 items from the 2019 OMAS. These items, italicized in Table 1, include health and economic indicators such as self-rated health statuses and food insecurity. In wave 1, the experience of symptoms reference period for the OCS was March 1, 2020. Note that the reference period for time associated questions was modified to “in the past 30 days” for fielding waves 2 and 3.

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![Figure 1. Rotating Panel Design for the OCS by Wave and Week](image-url)
The response rate in the 2019 OMAS was 22.2%. The response rate was the highest in wave 1 (53.9%) and decreased in wave 2 and wave 3 to 42.4% and 39.2%, respectively, due to panel attrition. The wave specific conditional response rates were consistent within each wave’s rotation groups. The attrition rate was 66.7% between wave 1 and wave 2 and 75% between wave 2 and wave 3.

The majority of respondents chose to answer via the web mode with an average 58.0% of respondents selecting this mode across the 3 waves. The percentage of web respondents increased in waves 2 and 3 compared to wave 1 (54.1% in wave 1 compared to 60.1% in wave 2 and 61.2% in wave 3).

The refusal rate, the percentage of sample who explicitly indicated they did not want to take the survey, was consistent across the waves, averaging 34.6% and varying by less than 1.2% in any given wave. However, the ineligibility rate increased across waves from 3.0% to 5.5% to 7.1%. This increase in the ineligibility rate is likely due to sample members moving out of Ohio during the 4-month data collection window.

DISCUSSION

The OCS is an example of how prior statewide surveys can be leveraged to develop a panel to track and measure the impact of COVID-19 on health, behavioral, and economic indicators. Three benefits worth highlighting are that: (1) with a panel who recently agreed to participate in a survey and the high saliency of COVID-19 as the topic, the response rate for the study is much higher compared to other statewide surveys; (2) our methodology allows for both a cross-sectional time series and longitudinal analyses; and (3) this survey can be linked to the 2019 OMAS allowing for health and economic comparisons to a prepandemic period estimate.
For rapidly emergent health topics, like COVID-19, where quick collection of data is critical to understanding and tracking how an event impacts the population of interest, having access to an available panel can be very important to the success of a study. If no panel were available and a new sample needed to be recruited the data collection time would be prohibitive to tracking analyses. For example, the 2019 OMAS, which is the source of the panel used in the OCS, took 5 months to recruit 30 000 participants. Therefore, what made the OCS successful was the inclusion of a question asking OMAS participants if they could be recontacted in the future. Having that agreed upon in advance allowed for the OMS respondents to be used as a panel, which facilitated OCS data collection within 3 weeks of study inception.

Another key issue in the design is how to best mitigate attrition rates. We utilized 2 methods, reducing the number of recontacts and capping the number of waves. Our study chose to recontact persons every 6 weeks. We believed this time interval would allow us to understand how the pandemic’s impact changed for each panel wave without overly burdening the respondents, which can accelerate attrition. Additionally, we capped the panel at 3 waves. While the panel could have been maintained for longer than 4 months, attrition rates would have continued to accelerate making the representativeness of the panel less useful.

As the COVID-19 pandemic continues through the fall of 2020 and into 2021, the OCS has continued with a second panel. Because of the high participation stage response rate, only 13 214 of the 24 000 panel members were invited (Table 2). Therefore, there are approximately 11 000 panel members who could participate in a second OCS iteration without concern of prior panel fatigue.

The main limitation of the design is the low recruitment response rates. While these rates are in line with or slightly higher than national probability-based panels, the rates are still considered low by most survey standards. To mitigate the impact of this limitation we implemented a robust weighting methodology which utilized several correlated outcomes from the OMAS instrument to better calibrate the survey weights. Having health and socioeconomic measures which are typically not available for weighting models, and which are highly correlated to the severity of COVID-19 and its economic impact, can greatly reduce the impact of nonresponse bias.

### PUBLIC HEALTH IMPLICATIONS

The OCS is providing Ohio the data it needs to understand how COVID-19 is affecting its residents’ health and economic welfare. The study continues to produce statewide and sub-state estimates over time, allowing state officials to factor for how policy changes may affect residents in different parts of the state during a pandemic. The OCS maintained a high participation stage response rate (over 45%) across the 3-wave period, demonstrating that a panel can be quickly constructed to conduct a survey on a salient topic like the COVID-19 epidemic to produce estimates that can be immediately operationalized for policy and resource decisions.

### REFERENCES

https://www.whitehouse.gov/openingamerica/

https://doi.org/10.1093/poq/nfq048

### Table 2. Disposition Status and Response Rates for the OCS by Wave

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Total</th>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Wave 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Released sample</td>
<td>35 700</td>
<td>13 214</td>
<td>11 676</td>
<td>10 810</td>
</tr>
<tr>
<td>Total completes</td>
<td>17 032</td>
<td>6 894</td>
<td>5 299</td>
<td>4 839</td>
</tr>
<tr>
<td>Web</td>
<td>9 879</td>
<td>3 732</td>
<td>3 187</td>
<td>2 960</td>
</tr>
<tr>
<td>Telephone</td>
<td>7 153</td>
<td>3 162</td>
<td>2 112</td>
<td>1 879</td>
</tr>
<tr>
<td>Breakoffs</td>
<td>807</td>
<td>388</td>
<td>246</td>
<td>173</td>
</tr>
<tr>
<td>Web</td>
<td>161</td>
<td>95</td>
<td>41</td>
<td>25</td>
</tr>
<tr>
<td>Telephone</td>
<td>646</td>
<td>293</td>
<td>205</td>
<td>148</td>
</tr>
<tr>
<td>Nonrespondent (refusal)</td>
<td>12 351</td>
<td>4 468</td>
<td>4 185</td>
<td>3 698</td>
</tr>
<tr>
<td>Web</td>
<td>370</td>
<td>189</td>
<td>105</td>
<td>76</td>
</tr>
<tr>
<td>Telephone</td>
<td>11 981</td>
<td>4 279</td>
<td>4 080</td>
<td>3 622</td>
</tr>
<tr>
<td>Nonrespondent (unknown eligibility)</td>
<td>3699</td>
<td>1 069</td>
<td>1 299</td>
<td>1 331</td>
</tr>
<tr>
<td>Ineligible</td>
<td>1811</td>
<td>395</td>
<td>647</td>
<td>769</td>
</tr>
<tr>
<td>Participation stage response rate</td>
<td>45.2%</td>
<td>53.9%</td>
<td>42.4%</td>
<td>39.2%</td>
</tr>
<tr>
<td>Recruitment response rate</td>
<td>10.0%</td>
<td>12.0%</td>
<td>9.4%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Note. The total counts are cumulative across the 3 waves and do not represent unique persons.


