

HHS Public Access

Author manuscript *Stata J.* Author manuscript; available in PMC 2021 August 18.

Published in final edited form as:

Stata J. 2018 June 1; 18(2): 357–378. doi:10.1177/1536867x1801800204.

cvcrand and cptest: Commands for efficient design and analysis of cluster randomized trials using constrained randomization and permutation tests

John A. Gallis,

Duke University, Department of Biostatistics and Bioinformatics, Duke Global Health Institute, Durham, NC

Fan Li,

Duke University, Department of Biostatistics and Bioinformatics, Durham, NC

Hengshi Yu,

University of Michigan, Department of Biostatistics, Ann Arbor, MI

Elizabeth L. Turner

Duke University, Department of Biostatistics and Bioinformatics, Duke Global Health Institute, Durham, NC

Abstract

Cluster randomized trials (CRTs), where clusters (for example, schools or clinics) are randomized to comparison arms but measurements are taken on individuals, are commonly used to evaluate interventions in public health, education, and the social sciences. Because CRTs typically involve a small number of clusters (for example, fewer than 20), simple randomization frequently leads to baseline imbalance of cluster characteristics across study arms, threatening the internal validity of the trial. In CRTs with a small number of clusters, classic approaches to balancing baseline characteristics—such as matching and stratification—have several drawbacks, especially when the number of baseline characteristics the researcher desires to balance is large (Ivers et al., 2012, Trials 13: 120). An alternative design approach is covariate-constrained randomization, whereby a randomization scheme is randomly selected from a subset of all possible randomization schemes based on the value of a balancing criterion (Raab and Butcher, 2001, Statistics in Medicine 20: 351-365). Subsequently, a clustered permutation test can be used in the analysis, which provides increased power under constrained randomization compared with simple randomization (Li et al., 2016, Statistics in Medicine 35: 1565–1579). In this article, we describe covariateconstrained randomization and the permutation test for the design and analysis of CRTs and provide an example to demonstrate the use of our new commands cvcrand and cptest to implement constrained randomization and the permutation test.

Keywords

st0526; cvcrand; cptest; covariate-constrained randomization; cluster randomized trials; permutation test

1 Introduction

The cluster randomized trial (CRT), which randomizes clusters (for example, schools or clinics) of individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms. Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

A frequent practical limitation of cluster randomization designs is that a small number of clusters are randomized mostly because of availability or resource constraints. Fiero et al. (2016) found that of the 86 studies included in their review of CRTs, about 50% randomized 24 or fewer clusters. In CRTs related to cancer published between 2002 and 2006, Murray et al. (2008) found similar results, with about 50% randomizing 24 or fewer clusters. Additionally, in their review of 300 CRTs published between 2000 and 2008, Ivers et al. (2011) found that, of the 285 studies reporting number of clusters randomized, at least 50% randomized 21 or fewer clusters.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which

may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates, there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms. Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

randomized 21 or fewer clusters.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates, there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters are recruited at the beginning of the trial, which is the setting of interest in this article. individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy

Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms. Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

A frequent practical limitation of cluster randomization designs is that a small number of clusters are randomized mostly because of availability or resource constraints. Fiero et al. (2016) found that of the 86 studies included in their review of CRTs, about 50% randomized 24 or fewer clusters. In CRTs related to cancer published between 2002 and 2006, Murray et al. (2008) found similar results, with about 50% randomizing 24 or fewer clusters. Additionally, in their review of 300 CRTs published between 2000 and 2008, Ivers et al. (2011) found that, of the 285 studies reporting number of clusters randomized, at least 50% randomized 21 or fewer clusters.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates, there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a

few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters are recruited at the beginning of the trial, which is the setting of interest in this article. individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms. Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

A frequent practical limitation of cluster randomization designs is that a small number of clusters are randomized mostly because of availability or resource constraints. Fiero et al. (2016) found that of the 86 studies included in their review of CRTs, about 50% randomized 24 or fewer clusters. In CRTs related to cancer published between 2002 and 2006, Murray et al. (2008) found similar results, with about 50% randomizing 24 or fewer clusters. Additionally, in their review of 300 CRTs published between 2000 and 2008, Ivers et al. (2011) found that, of the 285 studies reporting number of clusters randomized, at least 50% randomized 21 or fewer clusters.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance

increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates, there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters are recruited at the beginning of the trial, which is the setting of interest in this article. individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms.

Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

A frequent practical limitation of cluster randomization designs is that a small number of clusters are randomized mostly because of availability or resource constraints. Fiero et al. (2016) found that of the 86 studies included in their review of CRTs, about 50% randomized 24 or fewer clusters. In CRTs related to cancer published between 2002 and 2006, Murray et al. (2008) found similar results, with about 50% randomizing 24 or fewer clusters. Additionally, in their review of 300 CRTs published between 2000 and 2008, Ivers et al. (2011) found that, of the 285 studies reporting number of clusters randomized, at least 50% randomized 21 or fewer clusters.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates, there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters are recruited at the beginning

of the trial, which is the setting of interest in this article. individuals to intervention arms, is a study design used in many fields of research. The cluster randomization design is typically chosen for logistical reasons, such as when there is a high probability of treatment contamination across study arms, when the intervention is group based, or when individual randomization is not feasible (Turner et al. 2017a). For example, in the Thinking Healthy Program Peer-Delivered Plus study, the researchers recruited depressed women in their third trimester of pregnancy from 40 villages in Pakistan, and each village was randomized to either the intervention or enhanced usual care (Sikander et al. 2015; Turner et al. 2016). Because this was a public health intervention delivered by community health workers, the risk of contamination across study arms would be too high if individual women were randomized, especially if a woman receiving intervention and a woman receiving enhanced usual care live close to each other.

There is a variety of cluster randomization designs described in the literature (Turner et al. 2017a). Here we focus on the most common one, the two-arm parallel design (for example, intervention arm and control arm). In this design, a set of clusters is identified at the beginning of the study, and each one is randomly assigned to one of two intervention arms. Although the clusters are the units of randomization, outcomes are typically measured at the individual level. At the analysis stage, outcomes from both arms are compared to determine whether the intervention is effective by accounting for correlation because of the clustered design.

A frequent practical limitation of cluster randomization designs is that a small number of clusters are randomized mostly because of availability or resource constraints. Fiero et al. (2016) found that of the 86 studies included in their review of CRTs, about 50% randomized 24 or fewer clusters. In CRTs related to cancer published between 2002 and 2006, Murray et al. (2008) found similar results, with about 50% randomizing 24 or fewer clusters. Additionally, in their review of 300 CRTs published between 2000 and 2008, Ivers et al. (2011) found that, of the 285 studies reporting number of clusters randomized, at least 50% randomized 21 or fewer clusters.

When a small number of clusters are randomized, cluster characteristics that are expected to be predictive of the outcome ("prognostic" covariates) could be unevenly distributed across arms under simple randomization. The chance of such baseline covariate imbalance increases as the number of available clusters decreases and as the number of predictive covariates increases. Implications of baseline imbalance include lack of internal validity of the trial, reduced statistical power, insufficient precision of effect estimates, and the possibility that additional statistical adjustment will be needed in the analysis phase, which may make the analysis more challenging (Ivers et al. 2012). These concerns could threaten the face validity of the trial.

To address these issues, several restricted randomization procedures, such as stratification, matching, and minimization, have been proposed to help achieve balance on important baseline covariates. When the total number of clusters is small, stratification and matching have several limitations. Specifically, stratified randomization is feasible only if the number of stratification variables is small. When there is more than a few stratification covariates,

there is a risk of creating strata with only a single cluster, which may lead to unequal allocation of clusters as well as imbalance on the very variables stratification was intended to balance (Ivers et al. 2012). Ivers et al. (2012) recommend that the maximum number of strata should be limited to about one-fourth to one-half of the total number of clusters, and in CRTs with a small number of clusters, this is only possible with no more than a few stratification variables. On the other hand, matching may suffer from severe power loss when one cluster is lost to follow-up, because its match will be removed from the matched analysis (Ivers et al. 2012). Loss to follow-up can occur, for example, if a cluster that initially gave consent to participate in the trial withdraws consent before or during the follow-up phase. Further, matching may not be effective when the matching characteristics are poorly correlated with the outcome, and the subsequent matched analysis may lose power (Diehr et al. 1995). Matched clusters will also make it challenging to properly calculate the intracluster correlation coefficient, a measure of clustering that is recommended to be reported in all CRTs (Donner and Klar 2004; Klar and Donner 1997; Campbell et al. 2012). In addition, there is debate on how best to analyze matched trials (Diehr et al. 1995). Minimization could be used when clusters are recruited sequentially over time, but may have limited application when all clusters are recruited at the beginning of the trial, which is the setting of interest in this article. are recruited at the beginning of the trial, which is the setting of interest in this article. Therefore, given the limitations of stratification and matching for this setting, alternative strategies for restricted randomization are needed, especially when only a few clusters are randomized or a number of baseline covariates need to be balanced.

1.1 Covariate constrained randomization

An alternative form of restricted randomization that can be used to achieve baseline covariate balance in CRTs with all clusters enrolled before randomization is covariate constrained randomization (sometimes referred to simply as "constrained randomization"). Under simple randomization, a randomization scheme (that is, a unique allocation of clusters to study arms) is randomly chosen from the space of all $\binom{k}{g}$ randomization schemes, where k is the total number of clusters and g is the number of clusters assigned to one study arm. For example, if we design a CRT with 12 clusters, 6 of which are assigned to intervention and 6 to control, there are $\binom{12}{6} = 924$ unique allocations of 12 clusters evenly assigned to two arms.

In a review of 300 randomly selected CRTs published between 2000 and 2008, approximately half randomized 21 or fewer clusters, but 44% of the 300 did not use any form of restricted randomization in the trial design even though the probability of baseline covariate imbalance is not small (Ivers et al. 2011, 2012). Of the 56% that used some form of restricted randomization, most (57%) used stratification; very few used covariate constrained randomization. One reason for the infrequent use of covariate constrained randomization or matching may be that practitioners find it challenging to implement. Therefore, to address this potential barrier, we have created a user-friendly, easy-to-implement command, cvcrand, to perform covariate constrained randomization for the design of CRTs and to implement an appropriate method in the analysis phase. Before

introducing the commands, we briefly review key features of the approach, including the choice of balance metrics.

When a researcher applies covariate-constrained randomization, a randomization scheme is randomly selected from a subset of all possible schemes based on the value of a prespecified balance metric (Raab and Butcher 2001; Moulton 2004; Carter and Hood 2008; de Hoop et al. 2012; Li et al. 2016). A full description of covariate-constrained randomization designs is provided in Li et al. (2017). In brief, to carry out a covariate-constrained randomization design, a researcher will i) specify important cluster-level covariates; ii) either enumerate all randomization schemes or simulate a large number of potential randomization schemes; iii) remove the duplicate randomization schemes, if any; iv) choose a constrained space containing a subset of schemes where sufficient balance across covariates is achieved according to some prespecified balance metric; and v) randomly sample one randomization scheme from this constrained space. This randomly sampled scheme will be used to assign clusters to study arms. Note that cluster-level data supplied for constrained randomization may also be aggregated from individual-level data. In practice, however, it is not always possible to obtain individual-level data at the design phase.

In principle, any sensible method for creating a balance metric may be selected. Here we describe two commonly used metrics. First, the *I*2 balance metric was proposed by Raab and Butcher (2001) and studied by Li et al. (2016) and Li et al. (2017). Following the notation of Li et al. (2017), for a given randomization scheme, this balance metric is defined as

$$B_{(l2)} = \sum_{j=1}^{n} \omega_j (\bar{x}_{Tj} - \bar{x}_{Cj})^2$$
(1)

where *n* is the total number of variables to balance, ω_j is a variable-specific weight, \bar{x}_{Tj} is the average of the *j*th variable in the intervention clusters, and \bar{x}_{Cj} is the average of the *j*th variable in the control clusters. Using the balance metric, we can compute balance scores for every potential randomization scheme. The *I*2 balance metric is defined for both continuous and binary variables (including p-1 dummy variables created from a *p*-level categorical variable). For binary variables, the mean is simply the proportion with level "1" of the variable. The weights are often chosen to be the inverse of the standard deviation of the *j*th cluster-level covariate across the two intervention arms. Thus, any number of continuous or categorical variables can be included to compute the balance score using this balance metric. In practice, we recommend to include only variables that are hypothesized to be correlated with the outcome. If the number of variables to be constrained on is quite large relative to the number of clusters, then when these variables are accounted for in the analysis stage, a subset may need to be selected to avoid overfitting. This subset should include the variables that are identified a priori to be the most predictive of the outcome, based on expert knowledge (Li et al. 2017).

Researchers may choose to assign larger weights to cluster characteristics considered "more important" than others. For example, suppose that, at the design stage, researchers have variables they consider more important to balance than others. This can be accomplished by

specifying a larger weight on these variables. Such user-defined weights are distinct from the inverse standard deviation weights ω_i in (1). We can add a weight to (1) by

$$B_{(l2)} = \sum_{j=1}^{n} d_j \omega_j (\bar{x}_{Tj} - \bar{x}_{Cj})^2$$
(2)

where d_j is the user-defined weight for variable *j*. If not specified, d_j defaults to 1 for each variable.

An alternative metric is the l balance metric, in which the square in (1) is replaced with an absolute value:

$$B_{(11)} = \sum_{j=1}^{n} \omega_j |\bar{x}_{Tj} - \bar{x}_{Cj}|$$
(3)

User-defined weights can be added to this equation in a similar manner to (2). It can be seen from (1) and (3) that the smaller the value of the balance score, the more balanced the n selected baseline cluster-level covariates will be between the two intervention arms.

1.2 Clustered permutation tests

After performing covariate-constrained randomization to balance cluster-level characteristics in the design of a CRT, the researcher should select an appropriate analysis technique to analyze the data collected during the implementation phase of the CRT. Using a simulation study, Li et al. (2016) provide evidence that even after balancing baseline cluster-level covariates in the design stage, analysis-based adjustment for prognostic covariates is necessary. Two prominent options include mixed model F-tests and clustered permutation tests (Li et al. 2016; Turner et al. 2017b). Li et al. (2016) showed that under covariate constrained randomization, adjusted clustered permutation tests provide increased power under constrained randomization compared with simple randomization. Clustered permutation tests are carried out in the constrained space and have the desirable property that they preserve the nominal type I error rate even for very small CRTs as long as the design is not overly constrained (Li et al. 2016). In a later article, Li et al. (2017) show that only a subset of prognostic variables that are balanced for in the constrained randomization design must be adjusted for in the analysis, although in practice the researcher may wish to include all covariates on which the design was balanced. In addition, individual-level covariates may be included in the analysis to increase the precision of the test (Li et al. 2017).

To perform a valid clustered permutation test using data collected in a CRT, the researcher must analyze the outcome data at the individual level to avoid loss of information from aggregating up to the cluster level. In a clustered permutation test, the individual-level data are first analyzed using a regression that omits intervention arm as a variable. The regression method (for example, linear or logistic) depends on the distribution of the outcome. From this regression, the residuals are obtained (for example, on the logit scale for logistic regression), then the cluster-level average residual is computed for each cluster. From these

residuals, we calculate the observed test statistic by multiplying this vector of residuals by the vector of the selected scheme with -1 substituted for 0, then taking the absolute value. For example, suppose that the final randomization scheme for a trial with six clusters is given by

```
(1\ 1\ 0\ 0\ 1\ 0)
```

where 1 is assignment to intervention, 0 is assignment to control, and the average clusterlevel residuals are

> 0.84 0.54 -0.19 -0.22

0.43 -0.32

Thus, the observed test statistic is

				0.84	
				0.54	
(1	1	1 1 1	1)	-0.19	- 12 541 - 2 54
(1	1	-1 -1 1	-1)	-0.22	= 2.34 =2.34
				0.43	
				-0.32	

Next, we calculate the null "permutational distribution" by computing the value of the test statistic under all other possible randomization schemes in the randomization space. Under simple randomization, this space consists of all $\binom{k}{g}$ randomization schemes; under constrained randomization, the space includes only those randomization schemes where the belows again a below the sutoff (that is the constrained mass from which the final

the balance score is below the cutoff (that is, the constrained space from which the final randomization scheme was chosen). The observed test statistic is referenced against this permutational distribution to obtain a *p*-value for the intervention effect that accounts for both the clustered design of the CRT and the covariate constrained randomization used in selecting the final randomization scheme. This *p*-value is obtained by computing the percentage of times test statistics corresponding to other randomization schemes in the constrained space are greater than the test statistic corresponding to the randomization scheme used to assign clusters to intervention arms. For an adjusted permutation test, we simply control for the relevant cluster- and individual-level covariates in the regression model and use those residuals to obtain an adjusted test statistic. A sufficient condition under which the permutation test is valid is that an equal number of clusters are assigned to each arm (Gail et al. 1996). This means that if the number of clusters randomized to intervention is not the same as the number randomized to control, the test may be anticonservative (that is, the type I error may be larger than the nominal level). See Gail et al. (1996) for more technical details. Our command cptest implements the permutation test in both its unadjusted and adjusted forms. The steps are illustrated in the example in section 4.

2 The cvcrand command

In this section, we introduce the cvcrand command, explaining the available options in detail and "going under the hood" to examine the inner workings of the program. The command implements covariate-constrained randomization and can handle a variety of situations. The command requires that the user provide a dataset where each row of data corresponds to one cluster and each column contains information on characteristics of the clusters. Those characteristics can be either cluster-level characteristics or individual-level data aggregated to the cluster level (for example, percentage of cluster that is female). All continuous variables must be numeric, but categorical variables can be of either numeric or string type. Categorical variables should be supplied to the categorical() option because they will be converted to dummy variables for the command. The results of the command are sensitive to which level of a multicategorical variable is removed. The user may wish to recode some categorical variables before running cvcrand to set which level of the categorical variable will be removed after transformation to dummy variables.

The cvcrand command requires that ntotal_cluster() and ntrt_cluster() be specified by the user. The total number of clusters (ntotal_cluster()) specified must equal the number of rows in the dataset. The number of clusters in the treatment (intervention) arm (ntrt_cluster()) must be less than the total number of clusters. The command can be used whether an equal number or an unequal number of clusters are assigned to each study arm. In addition, the command can handle an odd total number of clusters. However, if the number assigned to each study arm is unequal, then when analyzing the final data, the clustered permutation test may be anticonservative, as mentioned in section 1.2.

To avoid prohibitive computations associated with matrices with extremely high dimensions, the command will automatically simulate 50,000 randomization schemes if the simple randomization space contains more than 50,000 schemes. This can be overridden by the user if the user specifies the nosim option. The command allows the user to implement one of the two balance metrics mentioned in section 1.1, the I and I, with I being the default.

The default cutoff of the balance score below which a randomization scheme is selected is 0.1, but this can be modified using the cutoff() option. Simulations have shown that a cutoff of 10% works well in some scenarios (number of clusters k = 16 and 26) (Li et al. 2017). Ideally, this number should be small, but not too small. In practice, if the number of clusters is even less than 10, the researcher may wish to choose a larger value of the cutoff to avoid overly constraining the design, in which case there would be few randomization schemes in the constrained space.

All the randomization schemes that make up the selected constrained space can be saved to a dataset by specifying the savedata() option, and we strongly recommend that this option be selected. The dataset obtained from this command is required to implement the clustered permutation test in the analysis. In addition, the user may specify the savebscores() option to save the column vector of balance scores to a dataset and produce a histogram of the balance scores.

Inside the program, the user-supplied data are passed to a Mata program. As noted above, if the total number of randomization schemes is less than or equal to 50,000, the entire randomization space is enumerated; otherwise, the program simulates 50,000 randomization schemes, of which the unique schemes are kept. To create a vector of balance scores corresponding to (1), we first create a cluster-level design matrix, with each row indicating a cluster and each column corresponding to a variable in varlist. This cluster-level design matrix is standardized such that each element is centered by the column-specific (that is, variable-specific) mean and scaled by the column-specific standard deviation. In other words, each column has zero mean and unit variance. The matrix of unique randomization schemes (with a value of 0 corresponding to control and 1 corresponding to intervention) is then multiplied by the standardized design matrix to obtain a new matrix. The row sums of squared elements from this new matrix are proportional to the *I*² balance metric, and these computed balance scores will be used to rank the balance of each randomization scheme. A subset of randomization schemes is obtained by applying the prespecified cutoff value to the set of balance scores, and a final randomization scheme is sampled from this subset. A similar algorithm is used to implement constrained randomization with the *I*l balance metric corresponding to (3). A complete description of this algorithm is available in Li et al. (2017).

2.1 Syntax

cvcrand varlist, ntotal_cluster(#) ntrt_cluster(#) [clustername(varname) categorical(varlist) balancemetric(string) cutoff(#) numschemes(#) nosim size(#) weights(numlist) stratify(varlist) seed(#) directory(string) savedata(string) savebscores(string)]

2.2 Options

ntotal_cluster(#) specifies the total number of clusters to be randomized. This value must be a positive integer and must be equal to the number of rows in the dataset. ntotal_cluster() is required.

ntrt_cluster(#) specifies the number of clusters that the researcher desires to assign to the treatment (intervention) arm. It must be a positive integer less than the total number of clusters. Often, this is equal to half the number of total clusters. ntrt_cluster() is required.

clustername(*varname*) specifies the name of the variable that is the identification variable of the cluster. This is used when the command summarizes the variables after constrained randomization. If no cluster identification variable is specified, the default is to label the clusters by the order they appear in the dataset (that is, 1, 2, 3, ...).

categorical (*varlist*) specifies categorical variables. Each categorical variable will be turned into p-1 dummy variables, where p is the number of levels of the categorical variable. Note that the results are sensitive to which level is excluded. Categorical variables may be recoded to specify which level to exclude by setting this level to be the lowest number or earliest in the alphabet. If the weights() option is used, then all categorical variables must be specified last in the overall *varlist* for the command to work correctly.

balancemetric(*string*) sets the balance metric. The default is balancemetric(12). The 11 metric may be specified instead if desired.

cutoff(#) specifies the percentile cutoff of the distribution of the balance score below which we randomly sample the final randomization scheme. The value will range between 0 and 1. The default is cutoff(0.1) (that is, 10%). A smaller balance score indicates better balance based on our balancing criterion. Therefore, we are "constraining" the randomization space and sampling only from the set of randomization schemes corresponding to the "best" values of balance score. The cutoff can be overridden by the numschemes() option.

numschemes(#) specifies the number of randomization schemes to form the constrained space from which the final randomization scheme is selected. This overrides the cutoff() option. If this option is specified, the command will randomly sample the final randomization scheme from the randomization schemes corresponding to the *S* smallest balance scores, as in numschemes(*S*).

nosim overrides the command's default procedure of simulating when the number of randomization schemes is over 50,000 and will instead enumerate all randomization schemes, regardless of the size of the randomization space. Note: this can consume a lot of memory and may cause Stata to produce an error message and stop the command. For example, with 30 clusters and 15 assigned to treatment, the total randomization space is a $\binom{30}{15} = 155, 117, 520 \text{ row by 30 column matrix.}$

size(#) specifies the number of randomization schemes to simulate if the size of the simple randomization space is greater than 50,000 unique schemes (as happens when, for example, there are 20 clusters and 10 assigned to intervention: $\binom{20}{10} = 184,756$). The default is size(50000). Simulation can be overridden by the nosim option.

weights(*numlist*) allows the specification of user-defined weights. These are distinct from the inverse standard deviation ω_j weights in (1) and (3). Instead, these user-defined weights correspond to d_j in (2). Note that these weights could be used to induce stratification on variables. For instance, if one variable is given a large weight, say, 1,000, and all other variables are given a weight of 1, the randomization scheme chosen will be stratified by the variable with the large weight, assuming a reasonably low cutoff value has been chosen. Stratification is directly implemented by the stratify() option. The weights() option cannot be specified at the same time as the stratify() option. See section 4.3 for more details.

Weights must be replicated for categorical variables (for example, a three-category variable must be given two weights, one for each dummy variable), and categorical variables should be specified last in *varlist* if weights() is specified.

stratify(*varlist*) specifies variables the user wishes to stratify on. These variables must be categorical variables and placed last in the overall *varlist*. Variables specified in stratify() will be assigned an arbitrarily large weight of 1,000, which will induce stratification on these variables (if possible). Stratification will not be possible, for example, if one of the levels of a categorical variable contains an odd number of clusters. See section 4.3 for more details. This option cannot be used with the weights() option.

seed(#) specifies the seed for simulation and random sampling, which is needed so that the randomization can be replicated if desired. The default is seed(12345).

directory(*string*) is the directory in which the constrained randomization space and balance scores are saved. The default is to save them in the current working directory.

savedata(*string*) saves the constrained randomization space into a dataset specified by *string*. The dataset will be saved into the current working directory or the directory specified in the directory() option and will also contain an indicator variable specifying which row of the constrained space was chosen as the final randomization space. The constrained randomization space will be needed for the analysis once the CRT is completed.

savebscores(*string*) saves the vector of all balance scores (across the entire randomization space) as a dataset specified by *string*. When this option is specified, a histogram is also produced that displays the distribution of all balance scores with a red line on the graph indicating the selected cutoff. The histogram will not be automatically produced when either the stratify() or weights() option is specified.

3 The cptest command

In this section, we introduce the cptest command, which is used to implement a clustered permutation test. The command requires the user to provide a list of variables that will be passed to a regression procedure. Therefore, the first variable in *varlist* must be the outcome variable, and all variables following are the independent variables in the regression model. Outcome data must be at the individual level, not the cluster level. The independent variables passed to the regression procedures should not include the intervention assignment variable.

The user must indicate which variable identifies clusters using clustername(). This cluster identification variable must be the same across all individuals in the same cluster. The user must also specify the name of the dataset containing the constrained randomization space (saved in Stata format by the cvcrand command) using cspacedatname(), along with the directory where this dataset is stored using the directory() option.

In the command, Stata takes the *varlist* provided by the user and runs a regression model with type of model determined by the required outcometype() option. Residuals are obtained and then averaged by cluster. The vector of residuals and the permutation matrix are passed to Mata, at which point Stata carries out the procedure described in section 1.2 to produce the *p*-value for the clustered permutation test.

It is possible to provide the command with only the outcome and no independent variables (an unadjusted permutation test) or only a subset of the variables constrained on in the design phase of the study. To achieve higher power, one should include all variables that are predictive of the outcome (Li et al. 2017). However, the permutation tests are robust to regression model misspecification and will maintain the nominal type I error even when some prognostic variables are left out (Gail et al. 1996). Note that this command could also be used to perform a clustered permutation test under simple randomization by supplying the design matrix containing the simple randomization space.

3.1 Syntax

cptest varlist, clustername(varname) directory(string) cspacedatname(string)
outcometype(#) [categorical(varlist)]

3.2 Options

clustername(*varname*) specifies the name of the variable that is the identification variable of the cluster. clustername() is required.

directory(*string*) specifies the directory where the constrained randomization space (saved by command cvcrand) dataset is saved. directory() is required.

cspacedatname(*string*) gives the name of the dataset containing the saved randomization space. This dataset contains the permutation matrix, as well as a variable indicating which row of the permutation matrix was saved as the final scheme. cspacedatname() is required.

outcometype(*string*) specifies the type of regression model that should be run. Options are continuous for linear regression fit by Stata's regress command (suitable for continuous outcomes) and binary for logistic regression fit by Stata's logit command (suitable for binary outcomes). outcometype() is required.

categorical(*varlist*) specifies categorical variables. These variables will be turned into p - 1 dummy variables, where p is the number of levels of the categorical variable. The user must ensure that the same level of the categorical variable is excluded as was excluded when running cvcrand by coding the variables the same way as in the design phase.

4 Example: Increasing up-to-date immunization rates

We now illustrate the use of cvcrand and cptest through an example. We use the data described and published in Dickinson et al. (2015). In this CRT, the researchers wished to compare two approaches (interventions) for increasing the "up-to-date" immunization rate in 19- to 35-month-old children. They planned to randomize 16 counties in Colorado in a 1:1 ratio to either a population-based reminder or recall approach or practice-based reminder or recall approach. These approaches are described in detail in Kempe et al. (2015).

4.1 Covariate-constrained randomization

Prior to randomization, the researchers identified eight county-level variables potentially related to the outcome. For illustration, we will randomize by constraining on a subset of these variables. This subset contains the following five variables: % of children ages 19–35 months with 2 immunization records in the Colorado Immunization Information System, estimated % of children already up to date on their immunizations, % Hispanic, location (urban or rural), and average income categorized into tertiles. Note that we could have left average income as a continuous variable, but we chose to categorize it to illustrate the use of cvcrand on multicategory variables. Note also that we truncated the % in Colorado Immunization Information System variable at 100%, because the value for one county published in Dickinson et al. (2015) exceeded 100%.

After loading this county-level data into Stata, we performed covariate-constrained randomization with an equal number of counties in each intervention arm. The command cvcrand requires mm_subsets() from the moremata package (Jann 2005) and the table1 command from the table1 package (Clayton 2013). The user will be prompted to download these if not already installed.

- use dickinson_data.dta
- . label variable number "# of children"
- . label variable upt "% up-to-date"
- . label variable incomecat "Average income"

We used the default balance metric (12) and the default cutoff (0.1). We specified that two of the variables are categorical and used the savedata() option to save the constrained space as a dataset named dickinson_constrained, which will be needed for later analysis. Selected output from the program is given below.

- . cvcrand inciis uptodate hispanic location incomecat,
- > categorical(location incomecat) ntotal_cluster(16) ntrt_cluster(8)
- > clustername(county) seed(10125) cutoff(.1) balancemetric(12)
- > savedata(dickinson_constrained) savebscores(dickinson_bscores)

(output omitted)

Summary Stats	Balance Score
Mean	24.00
Std. Dev.	14.88
Min	1.16
p5	5.85
p10	7.72
p20	10.94
p25	12.38
p30	14.03
p50	21.07
p75	32.25
p95	52.98
Max	97.71

Cutoff value = 7.72 Value of selected balance score = 7.07 Row of constrained matrix = 903

	county	_allocation
1.	1	0
2.	2	1
3.	3	0
4.	4	1
5.	5	0
6.	6	0
7.	7	0
8.	8	1
9.	9	0
10.	10	1
11.	11	1
12.	12	1
13.	13	0
14.	14	0
15.	15	1
16.	16	1

(output omitted)

First, the command provides summary statistics of the balance scores and the selected cutoff value. This is equal to p10 (10th percentile of the distribution) because we decided to use the default value. We are also given the value of the selected balance score, which is slightly below the 10th percentile of the balance score distribution. Any randomization scheme with a balance score of less than or equal to 7.72 could have been selected.

The command automatically saves a variable named _allocation (which contains the final selected randomization scheme) back onto the input dataset. To summarize balance across arms, it then summarizes or tabulates each variable by _allocation, using the table1 command on each variable in variist individually. However, we may run the community-contributed table1 command on all variables in variist together to easily summarize the results in one table:

. table1, by(_allocation)

> vars(inci contn $\$ uptod contn $\$ hisp contn $\$ loc cat $\$ incomecat cat)

> format(%2.1f)

Factor	Level	_allocation = 0	_allocation = 1	p-value
Ν		8	8	
% in CIIS, mean (SD)		88.2 (5.8)	85.8 (8.8)	0.51
% up-to-date, mean (SD)		40.4 (9.1)	41.2 (8.0)	0.84

Factor	Level	_allocation = 0	_allocation = 1	p-value
% Hispanic, mean (SD)		21.6 (14.8)	23.0 (11.7)	0.84
Location	Rural	5 (62%)	3 (38%)	0.32
	Urban	3 (38%)	5 (62%)	
Average income	Low	3 (38%)	2 (25%)	0.82
	Med	3 (38%)	3 (38%)	
	High	2 (25%)	3 (38%)	

We see that all covariates are reasonably well balanced between the intervention arms. Note, for example, that the binary variable location is not perfectly balanced between intervention arms, because five out of eight rural counties are in one of the interventions compared with three out of eight in the other intervention. If the researchers desired to stratify on this variable (to obtain perfect balance) while also constraining on other variables, they can use user-defined weights. We will show an example of this functionality in section 4.3.

4.2 Clustered permutation test analysis

At the end of the study, the researchers will have ascertained the outcome in the 16 counties. As discussed in section 1.2, the outcome data must be at the individual level. In the case of the Dickinson et al. (2015) data, the researchers will have up-to-date immunization information on a subset of children from the 16 counties. For this example, we have created a simulated dataset to illustrate how to use cptest. Suppose that allocation = 1denotes the practice-based intervention and that this intervention succeeds in improving up-to-date immunization rates much more than the community-based intervention. Suppose also that the researchers were able to assess 300 children in each cluster. We simulated correlated outcome data at the individual level using a generalized linear mixed model to induce correlation by including a random effect. The intracluster correlation was set to be 0.01, using the latent response definition provided in Eldridge, Ukoumunne, and Carlin (2009). This is a reasonable value of the intracluster correlation for population health studies (Hannan et al. 1994). We simulated one dataset, with the outcome data dependent on the county-level covariates used in the constrained randomization design, and a positive intervention effect so that the practice-based intervention increases up-to-date immunization rates more than the community-based intervention. Summarizing the data, we find that about 86% of the children in the practice-based intervention ($_$ allocation = 1) are up to date on immunization at the end of the study, while 79% of the children in the community-based intervention ($_$ allocation = 0) are up to date.

. use dickinson_data_corr_outcome, clear

- . label define scheme 1 "Practice" 0 "Community"
- . label values _allocation scheme
- . tab _allocation, summarize(outcome)

	Summary of outcome				
_allocation	Mean	Std. Dev.	Freq.		
Community	.78916667	.40798529	2,400		
Practice	.85958333	.34749121	2,400		
Total	.824375	.38054044	4,800		

After loading these data into Stata, we run an adjusted clustered permutation test by including the outcome variable (outcome) followed by all the variables we used in the constrained randomization in *varlist*. We specify where the constrained randomization space dataset is located and use outcometype(Binary) to indicate that we would like to perform logistic regression. In the analysis, one should ensure that for a *p*-category variable, the same level of the variable is excluded when converting into the p-1 dummy variables as was removed when cvcrand was run.

. cptest outcome inciis uptodate hispanic location incomecat,

> clustername(county) directory(P:\Program\Stata Journal)

> cspacedatname(dickinson_constrained)

> outcometype(binary) categorical(location incomecat)

Logistic regression was performed

Final chosen scheme used by the cptest program: 1

1	0
2	1
3	0
4	1
5	0
6	0
7	0
8	1
9	0
10	1
11	1
12	1
13	0
14	0
15	1
16	1

Clustered permutation test p-value = 0.0047

```
Note: test may be anti-conservative if number of intervention clusters does
not > equal number of control clusters
```

The command outputs a column vector displaying the randomization scheme implemented in the study. The user can compare this with his or her dataset to check that it matches the order of clusters in the dataset. Following the procedure laid out in section 1.2, we obtain an adjusted clustered permutation test *p*-value, which in this case shows evidence of a difference in effect between the interventions. For illustration, we assume that only county-level covariates are available in the analysis. In practice, if individual-level data are available, we may also include those individual-level variables in the permutation test to improve power (Li et al. 2017).

More details about the programs and the above example can be found in our recent Stata conference presentation slides (Gallis et al. 2017).

4.3 Stratified covariate constrained randomization

As discussed in section 1.1, user-defined weights can be used to allow researchers to provide more weight to variables of their choice. For example, larger weights can be given to variables considered more important to balance than other covariates [see (2)]. These user-defined weights can also be used to induce stratification on categorical variables by setting very large weights for such variables. This is implemented with the stratify() option. For example, suppose we specify a weight of 1,000 to the location variable. Then, in all cases where location is not perfectly balanced between arms, at least 1,000 will be added to the balance score (if location is perfectly balanced, then $\bar{x}_{Tj} - \bar{x}_{Cj}$ reduces to 0 for j = location). Thus, for a reasonably low cutoff value, the randomization schemes where location is unbalanced will have no chance of being included in the constrained space and hence no chance to be selected as the final randomization scheme.

This can be illustrated by the code below. Because of the way cvcrand processes macros, all categorical variables should be placed at the end of the overall *varlist* if the stratify() or weights() option is specified. In addition, variables specified in the stratify() option should be placed at the very end of the overall *varlist* and at the end of the *varlist* in the categorical() option. Below we place the location variable in the stratify() option. This assigns the location variable a weight of 1,000, while all other variables receive the default weight of 1.

- . label variable number "# of children"
- . label variable upt "% up-to-date"
- . label variable incomecat "Average income"
- . cvcrand inciis uptodate hispanic incomecat location,
- > categorical(incomecat location) ntotal_cluster(16) ntrt_cluster(8)
- > clustername(county) seed(10125) cutoff(0.1) balancemetric(12)
- > savedata(dickinson_constrained_strat) stratify(location)

[.] use dickinson_data, clear

Number of clusters assigned to treatment is 8; number assigned to control is 8

You have specified the stratify option. Please be sure the stratification > variables are placed at the end of the overall variable list, and last in the variable list of the categorical option. Using the 12 (squared) balance metric

Summary Stats	Balance Score
Mean	4.00e+06
Std. Dev.	5.49e+06
Min	1.16
p5	6.22
p10	9.22
p20	16.45
p25	21.00
p30	28.37
p50	3.75e+06
p75	3.75e+06
p95	1.50e+07
Max	6.00e+07

Cutoff value = 9.22 Value of selected balance score = 4.76 Row of constrained matrix = 903

(output omitted)

```
. table1, by(_allocation)
```

```
> vars(inci contn \ \ number contn \ \ uptod contn \ \ hisp contn \ \ loc cat \
```

```
> incomecat cat) format(%2.1f)
```

Factor	Level	_allocation = 0	_allocation = 1	p-value
Ν		8	8	
% in CIIS, mean (SD)		85.4 (5.2)	88.6 (9.0)	0.39
# of children, mean (SD)		3000.4 (3356.6)	5392.6 (5249.3)	0.30
% up-to-date, mean (SD)		40.4 (9.2)	41.2 (7.9)	0.84
% Hispanic, mean (SD)		23.2 (15.1)	21.4 (11.3)	0.78
Location	Rural	4 (50%)	4 (50%)	1.00
	Urban	4 (50%)	4 (50%)	
Average income	Low	3 (38%)	2 (25%)	0.82

Factor	Level	_allocation = 0	_allocation = 1	p-value
	Med	3 (38%)	3 (38%)	
	High	2 (25%)	3 (38%)	

Equivalently, this stratification can be accomplished with the following code, using the weights() option:

- . cvcrand inciis uptodate hispanic location incomecat,
- > categorical(location incomecat) ntotal_cluster(16) ntrt_cluster(8)
- > clustername(county) seed(10125) cutoff(0.1) balancemetric(12)
- > savedata(dickinson_constrained_strat) weights(1 1 1 1000 1 1)

(output omitted)

Now any randomization scheme with imbalance on location is appreciably larger than randomization schemes where location is balanced, ensuring that a randomization scheme stratified on location is chosen and assuming the user has specified a cutoff below the 50th percentile (because randomization schemes at the 50th percentile and above correspond to huge balance scores related to imbalance on location). We see from the table1 output that location is now perfectly balanced across arms, because there are four out of eight rural counties in each arm.

An alternative strategy to achieving stratification is to perform covariate constrained randomization within each strata defined by location. This strategy could be carried out by applying the code in section 4.1 to subsets of the full data.

5 Discussion

We have introduced the cvcrand command to aid in the design of CRTs and the cptest command to aid in the subsequent analysis of CRTs designed using covariate constrained randomization. These commands are simple to use and do not require advanced programming skills, making them accessible to many researchers. Still, researchers should carefully consider features of the design—such as important baseline characteristics related to the outcome—and analysis, and a priori decide which covariates to include and which options to specify (for example, what metric and cutoff value to use). Importantly, the cvcrand command should be run only once on any given dataset rather than rerunning until a desirable randomization scheme is selected, because this would technically alter the type I error.

There are some limitations to the commands. The cvcrand command will not work for a trial with more than two intervention arms. In addition, it handles only randomization for a parallel-arm CRT design. These limitations reflect the current state of the research on constrained randomization. As the literature develops more, we plan to add more features and options to the command. Additionally, the command does not currently allow for modeling count outcomes using a Poisson regression. Most cluster trials have binary or

continuous outcomes (Fiero et al. 2016), but we plan to extend the program to handle Poisson regression in the future.

Another consideration is that the permutation test provides only a test of significance without reporting an intervention effect estimate or confidence interval. In practice, researchers may wish to use mixed-effects regression models or generalized estimating equations to obtain the intervention effect estimate and its confidence interval. Such procedures have been shown to perform satisfactorily if the prognostic covariates used to perform covariate-constrained randomization in the design phase are appropriately adjusted for in the analysis phase (Li et al. 2016, 2017). Nevertheless, the permutation test is attractive because it maintains the nominal test size, so it could be used to evaluate the statistical significance of the intervention effect, even when a model-based approach is used.

We recommend using some form of restricted randomization when designing and implementing CRTs. Constrained randomization is ideally suited for this task when the number of clusters to be studied is small, especially when there are a relatively large number of baseline characteristics to balance. Our new command cvcrand and cptest will facilitate constrained randomization and clustered permutation test analysis in CRTs, with the goal of providing more efficient design and analysis of CRTs, particularly those with a small number of clusters.

Acknowledgments

The authors would like to thank Alyssa Platt, Joe Egger, and Ryan Simmons of the Duke Global Health Institute Research Design and Analysis Core for testing and providing feedback on the programs. This research was funded in part by National Institutes of Health grant R01 HD075875 (PI: Dr. Joanna Maselko). In addition, the program cvcrand has already been applied to the design of the study *Evaluation of an Early Childhood Development Intervention for HIV-Exposed Children in Cameroon* (PI: Dr. Joy Noel Baumgartner). We also thank an anonymous reviewer whose comments helped improve the final version of this article.

About the authors

John A. Gallis, ScM, currently works as a biostatistician at Duke University in the Department of Biostatistics and Bioinformatics and at the Duke Global Health Institute. His research interests include the design and analysis of CRTs and the analysis of data with other forms of clustering, including longitudinal and spatial data.

Fan Li, M.Sc., is a PhD student in the Department of Biostatistics and Bioinformatics at Duke University School of Medicine. His primary research interests include statistical methodology in the design and analysis of CRTs, longitudinal and spatial data analysis, and Bayesian methods.

Hengshi Yu, MSc, is a PhD student in the Department of Biostatistics at the University of Michigan. His research interests focus on multivariate statistics, including the analysis of correlated data from CRTs.

Elizabeth L. Turner, PhD, is an assistant professor in the Department of Biostatistics and Bioinformatics and in the Duke Global Health Institute at Duke University. Her primary research interest is the design and analysis of CRTs with a special focus on translating methods to be accessible to the practitioner. She heads the Duke Global Health Institute Research Design and Analysis Core and has led the design and analysis of a range of CRTs in global mental health, malaria, and cardiovascular disease in multiple settings around the world, including Kenya, Tanzania, Nepal, China, and Pakistan.

7 References

- Campbell MK, Piaggio G, Elbourne DR, and Altman DG. 2012. Consort 2010 statement: Extension to cluster randomised trials. British Medical Journal345: e5661. [PubMed: 22951546]
- Carter BR, and Hood K. 2008. Balance algorithm for cluster randomized trials. BMC Medical Research Methodology8: 65. [PubMed: 18844993]
- Clayton P2013. table1: Stata module to create "table 1" of baseline characteristics for a manuscript. Statistical Software Components S457730, Department of Economics, Boston College. https://ideas.repec.org/c/boc/bocode/s457730.html.
- Dickinson LM, Beaty B, Fox C, Pace W, Dickinson WP, Emsermann C, and Kempe A. 2015. Pragmatic cluster randomized trials using covariate constrained randomization: A method for practice-based research networks (PBRNs). Journal of the American Board of Family Medicine28: 663–672. [PubMed: 26355139]
- Diehr P, Martin DC, Koepsell T, and Cheadle A. 1995. Breaking the matches in a paired *t*-test for community interventions when the number of pairs is small. Statistics in Medicine14: 1491–1504. [PubMed: 7481187]
- Donner A, and Klar N. 2004. Pitfalls of and controversies in cluster randomization trials. American Journal of Public Health94: 416–422. [PubMed: 14998805]
- Eldridge SM, Ukoumunne OC, and Carlin JB. 2009. The intra-cluster correlation coefficient in cluster randomized trials: A review of definitions. International Statistical Review77: 378–394.
- Fiero MH, Huang S, Oren E, and Bell ML. 2016. Statistical analysis and handling of missing data in cluster randomized trials: A systematic review. Trials17: 72. [PubMed: 26862034]
- Gail MH, Mark SD, Carroll RJ, Green SB, and Pee D. 1996. On design considerations and randomization-based inference for community intervention trials. Statistics in Medicine15: 1069– 1092. [PubMed: 8804140]
- Gallis J, Li F, Yu H, and Turner EL. 2017. cvcrand and cptest: Efficient design and analysis of cluster randomized trials. Presented July 28, 2017, at the Stata Conference 2017, Baltimore. https://www.stata.com/meeting/baltimore17/slides/Baltimore17_Gallis.pdf.
- Hannan PJ, Murray DM, Jacobs DR Jr, and McGovern PG. 1994. Parameters to aid in the design and analysis of community trials: Intraclass correlations from the Minnesota Heart Health Program. Epidemiology5: 88–95. [PubMed: 8117787]
- de Hoop E, Teerenstra S, van Gaal BG, Moerbeek M, and Borm GF. 2012. The "best balance" allocation led to optimal balance in cluster-controlled trials. Journal of Clinical Epidemiology65: 132–137. [PubMed: 21840173]
- Ivers NM, Halperin IJ, Barnsley J, Grimshaw JM, Shah BR, Tu K, Upshur R, and Zwarenstein M. 2012. Allocation techniques for balance at baseline in cluster randomized trials: A methodological review. Trials13: 120. [PubMed: 22853820]
- Ivers NM, Taljaard M, Dixon S, Bennett C, McRae A, Taleban J, Skea Z, Brehaut JC, Boruch RF, Eccles MP, Grimshaw JM, Weijer C, Zwarenstein M, and Donner A. 2011. Impact of CONSORT extension for cluster randomised trials on quality of reporting and study methodology: Review of random sample of 300 trials, 2000–8. British Medical Journal343(d5886): 1–14.
- Jann B2005. moremata: Stata module (Mata) to provide various functions. Statistical Software Components S455001, Department of Economics, Boston College. https://ideas.repec.org/c/boc/ bocode/s455001.html.
- Kempe A, Saville AW, Dickinson LM, Beaty B, Eisert S, Gurfinkel D, Brewer S, Shull H, Herrero D, and Herlihy R. 2015. Collaborative centralized reminder/recall notification to increase immunization rates among young children: A comparative effectiveness trial. JAMA Pediatrics169: 365–373. [PubMed: 25706340]

- Klar N, and Donner A. 1997. The merits of matching in community intervention trials: A cautionary tale. Statistics in Medicine16: 1753–1764. [PubMed: 9265698]
- Li F, Lokhnygina Y, Murray DM, Heagerty PJ, and DeLong ER. 2016. An evaluation of constrained randomization for the design and analysis of group-randomized trials. Statistics in Medicine35: 1565–1579. [PubMed: 26598212]
- Li F, Turner EL, Heagerty PJ, Murray DM, Vollmer WM, and DeLong ER. 2017. An evaluation of constrained randomization for the design and analysis of group-randomized trials with binary outcomes. Statistics in Medicine36: 3791–3806. [PubMed: 28786223]
- Moulton LH2004. Covariate-based constrained randomization of group-randomized trials. Clinical Trials1: 297–305. [PubMed: 16279255]
- Murray DM, Pals SL, Blitstein JL, Alfano CM, and Lehman J. 2008. Design and analysis of group-randomized trials in cancer: A review of current practices. Journal of the National Cancer Institute100: 483–491. [PubMed: 18364501]
- Raab GM, and Butcher I. 2001. Balance in cluster randomized trials. Statistics in Medicine20: 351– 365. [PubMed: 11180306]
- Sikander S, Lazarus A, Bangash O, Fuhr DC, Weobong B, Krishna RN, Ahmad I, Weiss HA, Price L, Rahman A, and Patel V. 2015. The effectiveness and cost-effectiveness of the peer-delivered Thinking Healthy Programme for perinatal depression in Pakistan and India: The SHARE study protocol for randomised controlled trials. Trials16: 1–14. [PubMed: 25971836]
- Turner EL, Li F, Gallis JA, Prague M, and Murray DM. 2017a. Review of recent methodological developments in group-randomized trials: Part 1—Design. American Journal of Public Health107: 907–915. [PubMed: 28426295]
- Turner EL, Prague M, Gallis JA, Li F, and Murray DM. 2017b. Review of recent methodological developments in group-randomized trials: Part 2—Analysis. American Journal of Public Health107: 1078–1086. [PubMed: 28520480]
- Turner EL, Sikander S, Bangash O, Zaidi A, Bates L, Gallis J, Ganga N, O'Donnell K, Rahman A, and Maselko J. 2016. The effectiveness of the peer-delivered Thinking Healthy Plus (THPP+) Programme for maternal depression and child socio-emotional development in Pakistan: Study protocol for a three-year cluster randomized controlled trial. Trials17: 442. [PubMed: 27608926]