SUPPORTING STATEMENT FOR HEALTH INSURANCE AND KEY DRIVER MODULES FOR THE SURVEY OF VETERAN ENROLLEES' HEALTH AND RELIANCE UPON VA
VA FORMS 10-21034j AND 10-21034k

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

Since the modules will become part of the Health and Reliance Survey 2900-0609, the statistical methodology remains the same for the health insurance module. The Key Drivers module is somewhat different since there are only 2,000 participants. However, the following basic descriptions still apply, except that estimates obtained from the key drivers module will be determined only at the national, not the VISN level. Overall basic survey methodology is described below, but with the May 2006 Terms of Clearance for this survey it is essential to note that, in addition to the descriptions below, VA has agreed to gather additional information on outcomes, test alternative procedures, and conduct methodological research to improve the methodology of this survey and assess the quality of information in the sampling frame of administrative records as well as potential non-response bias. More specifically, VA will work with their contractor to enhance the coding of case level outcomes to better understand reasons for non-response and conduct research that may include tracing veterans with inadequate contact information, increasing the number of call attempts, and testing strategies for identifying and handling veterans in institutions, etc. VA will share specific plans and will consult with OMB on this research before conducting these studies.

1. Provide a numerical estimate of the potential respondent universe and describe any sampling or other respondent selection method to be used. Data on the number of entities (e.g., households or persons) in the universe and the corresponding sample are to be provided in tabular format for the universe as a whole and for each stratum. Indicate expected response rates. If this has been conducted previously include actual response rates achieved.

The Health and Reliance Survey universe to be sampled is the enrollees specified at some point in time. For example, the approximately 7.5 million enrollees as of December 2003 was the population of interest for the 2003 survey. With respect to the core survey and the health insurance module, a random sample of approximately 100 in each of approximately 10 priority categories, for the pre and post enrollees in each of 21 healthcare networks is expected to yield an optimally stratified sample of approximately 42,000. The attached 2003 Health and Reliance Stratification show the potential priority group definitions and stratifications. The projected universe and sample size by strata, based on the 2003 enrollee survey, are included in these attachments. The pre- and post-enrollee strata have been combined in the 2003 enrollee survey strata attachment. The key drivers module varies from the above only in that the key drivers strata exclude VISN.

2. Describe the procedures for the collection of information, including: Statistical methodology for stratification and sample selection; the estimation procedure; the degree of accuracy needed for the purpose in the proposed justification; any unusual problems requiring specialized sampling procedures; and any use of periodic (less frequent than annual) data collection cycles to reduce burden.

a. SURVEY:

(1) For the Health and Reliance Survey, VA and the contractor have arrayed the VA enrolled population into strata by VISN, priority level, and pre and post enrollee status. The sampling methodology is to generate an optimally stratified random sample of approximately 100 per strata cells, and apply the "5 call-back" methodology ("maximum calls") to the 100 veterans in each cell. If, at the end of the 5 callbacks, 100 are not reached, another 100 will be randomly sampled and called (second step). If at the end of this second step 100 are not reached, a modified quota will be deemed sufficient. This conclusion (i.e., achieving a modified quota) will be discussed by all parties as to achievability for specific cell numbers based on various performance metrics that will be available. For a sample size of approximately 37,800, the methods will produce results for the overall sample that are accurate to within plus or minus 0.1 to 0.6 percentage points at the 95 percent confidence level. For each priority level combining pre and post enrollees within VISN, with a sample size of approximately 200, results will be produced to within 2.7 percentage points at the 95 percent confidence level. There are no unusual problems.

VA will provide the contractor a list of enrollees from which to draw. This survey will be repeated on an approximately annual basis.

(2) The 95% confidence intervals for data from the enrollee survey are a function of the number of cells in the tabulations. In the 2003 survey and for tables with 5 or fewer cells, the 95% confidence intervals ranged up to +/-1%. For tables with up to 12 cells, the 95% confidence intervals ranged up to +/- 3%. For tables with up to 105 cells, the maximum 95% confidence intervals ranged up to +/-4%. Finally, for tables between 126 and 252 cells, the 95% confidence intervals for income and priority were no more than +/-12%, while the confidence intervals for age were no more than +/-18%. In fact, most of the 95% confidence intervals for tabulated survey data were considerably smaller than these maximums.

(3) Over the years that the survey has been conducted, the questionnaire has evolved to meet VHA's increasingly complex data needs. In particular, some of the questions have changed little over time, as they probe for basic socioeconomic, demographic, and health-related data. However, other questions have been added, deleted, or expanded upon to address more and different sorts of issues of timely and topical interest to VHA. When questions change to reflect the Departmental emphasis and VHA's specific, forward-looking data needs and interests, OMB will be asked to approve the revised new survey and/or revised modules.

3. Describe methods used to maximize the response rate and to deal with issues of non-response. The accuracy and reliability of information collected must be shown to be adequate for intended uses. For collections based on sampling, a special justification must be provided for any collection that will not yield "reliable" data that can be generalized to the universe studied.

Veterans generally identify with the need to provide VA information to improve the system's ability to provide for their care. The response rates (AAPOR cooperation rates) for the Health and Reliance Survey have proved adequate for reliable and valid estimates, e.g., approximately 70 percent. This compares very favorably to response rates obtained in other national telephone surveys.

4. Describe any tests of procedures or methods to be undertaken. Testing is encouraged as an effective means of refining collections to minimize burden and improve utility. Tests must be approved if they call for answers to identical questions of 10 or more individuals.

Earlier (1999, 2000, 2002, 2003, and 2005) survey questions on the Health and Reliance Survey have been clarified based upon veteran or interviewer questions and input. Any proposed survey questions will be pre-tested on fewer than 10 veterans in order to work out any problems with wording or veterans' comprehension of questions, etc., before full implementation of the CATI surveys.

5. Provide the name and telephone number of individuals consulted on statistical aspects of the design and the name of the agency unit, contractor(s), grantee(s), or other person(s) who will actually collect and/or analyze the information for the agency.

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