

**SUPPORTING STATEMENT FOR SURVEY OF VETERAN ENROLLEES' HEALTH AND RELIANCE UPON VA  
VA FORM 10-21034g, OMB CONTROL NUMBER 2900-0609**

A. JUSTIFICATION

**1. Explain the **circumstances** that make the collection of information necessary. Identify legal or administrative requirements that necessitate the collection of information.**

Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, mandated VA to implement eligibility reforms with an annual enrollment. VA must enroll veterans by specified priorities as far down the priorities as the available resources permit. Each year VHA makes projections of enrollment, utilization, and expenditures that are considered by the Under Secretary for Health, Veterans Health Administration (VHA) and the Secretary of the Department of Veterans Affairs (VA) in the Secretary's enrollment level decision. The decision on the priority through which VA will enroll veterans in an upcoming period must be published in the Federal Register. There is no valid, recent information available in administrative databases on all enrollees' health status, income, or their reliance upon the VA system; all of which are elements critical to making valid projections. Basic socio-demographic and economic data in VA administrative files are generally neither complete nor valid for large enough segments of the VA enrollee population to be of much use in enrollment, utilization, and expenditures modeling or in enrollment based policy and budget development. Also, the magnitude of changes each year in enrollees, their enrollment decision processes, and their characteristics, the need for information on "hot topics" or specific areas of interest, as well as the need for good, timely, and relevant system policies make necessary annual surveys to capture this critical information for input into VHA's Enrollee Health Care Projection Model (EHCPM) and for use in related policy and budgetary analyses.

Increasing VHA budgetary and policy complexities have underscored the need for good survey-based "quantitative research" data on enrollees but have also made it clear that VHA needs good "**qualitative research**" data and information, as well, to help VHA understand ever deepening enrollment and health care issues. For example, changes over time in enrollee population characteristics, the evolution of veterans' enrollment and health care usage related decision processes, health risks including diabetes and obesity, personal computer and internet usage of our enrollee population, the impact of new Operation Enduring Freedom/Operation Iraqi Freedom veterans entering the system, the increasing impact of new and younger veterans upon VA even with the expanding roles of long-term care, Medicare related issues in VA budget and policy deliberations, and other special interest topics are major reasons good "qualitative research" data are needed to supplement VHA's annual enrollee survey data. Thus, VHA plans to include as an adjunct to its annual telephone survey of enrollees some "qualitative research" in the form of "Focus Group activities," i.e., Focus Groups combined with in-depth individual or small group interviews.

The purpose of the proposed qualitative research is:

To identify enrollees' or potential enrollees' different types of enrollment and health care related decision making processes, so as to obtain insights useful in forecasting changes in VA health care reliance and utilization, both critical components of VHA enrollee and long-term care demand modeling efforts;

To develop questions for use in future VHA reliance surveys that will refine **key driver** analyses. i.e., analyses of the key factors in veterans' enrollment and health care choices and their potential impact upon VA;

To identify significant or emergent issues for consideration in VHA's future-focused policy, budgetary, and strategic planning related activities.

**2. Indicate **how, by whom, and for what purposes** the information is to be used; indicate actual use the agency has made of the information received from current collection.**

Since 1999, VA Form 10-21034g, the VHA *Survey of Enrolled Veterans' Health and Reliance Upon VA*, has provided VHA with much "**quantitative research**" data that is simply not available from any VHA administrative files. These surveys result in model projections, which provide the Secretary with current information for sound decisions that affect the entire VA health care delivery system and the veterans it serves. These surveys have proved to be critical inputs into the VA Enrollee Health Care Projection Model, the VHA

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Long-Term Care Model, the Secretary's Annual Enrollment Level Decision processes, data on morbidity and reliance that is critical to obtaining accurate projections of VA's ability to serve veterans who are seeking VA services. Projections incorporating this survey data have been used to support VA's Capital Asset Realignment for Enhanced Services (CARES) initiative and have served as the basis for VA's new emphasis on population-based budget formulation, policy scenario testing, and strategic planning.

VHA's qualitative research design will consist of four distinct phases:

**Phase 1. Interviews with Key Informants and Stakeholders**, i.e., interviews with Federal employees, particularly VACO and VHA field staff, who may or may not be veterans: The goal of **Phase 1** is to develop some preliminary hypotheses about how veterans think about VHA for their health care needs and use, and to identify any related VA organizational assumptions about the same.

**Phase 2. In-depth interviews with veterans or small groups of veterans** either enrolled or not enrolled for VA health care: **Phase 2** involves testing the hypotheses developed from the Key Informant/Stakeholder interviews of **Phase 1** with several in-depth interviews with veterans. **Phase 2** will also seek to expand the list of hypotheses and to take into account possible future scenarios. Veterans selected for **Phase 2** interviews might be divided into high, medium, and low reliance or not reliant at all groups, into groups of veterans who have either enrolled or not enrolled for VHA services, or by types of health insurance coverage, access to care, age, gender, and geography (VISN). The outcome of **Phase 2** will be a set of refined hypotheses and potential **key driver metrics** that can be used to determine decision making styles or types on the Reliance Survey and through focus groups, or that can be used to inform VHA policy and budget related decision making.

**Phase 3. Focus Groups of veterans** either enrolled or not enrolled for VA health care: **Phase 3** expands upon the earlier phases but goes deeper, taking into account geographic variation in enrollees' or non-enrolled veterans' population characteristics, and in access, quality, and cost, etc., across health care markets. In **Phase 3**, two Focus Groups in each of at least 2 and up to 5 locations will be conducted for the purposes of further testing, refining, or augmenting the hypotheses developed in the earlier phases.

**Phase 4. Analysis and use of results** of Focus Group activities: In **Phase 4**, key hypotheses developed in the earlier phases will be elucidated, finalized, and documented.

**3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g. permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.**

VHA utilizes the services of contractors to conduct these telephone surveys. VHA provides a stratified random sample and phone numbers to the contractor. The telephone survey is administered using Computer Assisted Telephone Information (CATI) with responses entered directly into an electronic database, making the collection of data very efficient and reliable. This reduction of respondent burden through reliance on CATI meets the spirit of the Government Paperwork Elimination Act (GPEA).

**4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.**

No information on the total health care utilization of services of all VA enrollees, both within VA and in the private community, is available. The term "reliance" means the percentage of a veteran's total care that is obtained within VA. Other surveys have not covered the entire enrollee population and have focused on national, not the necessary network-specific information, needed for the enrollment projection model. VA does consider other pieces of information in the model that help to expand its generalization, e.g., VA and Medicare matched claims data for the Medicare eligible enrollees, VHA's SF-36 surveys (previously approved as a part of 2900-0609) focused on patients in selected settings. But the projection model is not complete or valid without the particular data and information provided in these surveys of enrollees. Thus, there is no duplication of effort in this data collection.

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**5. If the collection of information impacts small businesses or other small entities, describe any methods used to minimize burden.**

No small businesses or other small entities are impacted by this information collection.

**6. Describe the consequences to Federal program or policy activities if the collection is not conducted or is conducted less frequently as well as any technical or legal obstacles to reducing burden.**

VA would not be responsive to the needs of veterans, VA's health care system enrollees, and to the legal requirement of the Health Care Eligibility Reform Act if this information was collected less frequently. Without this information, the analysis upon which the enrollment level decision is made may be faulty or imprecise. The result may be to over- or under-enroll veterans into the VA healthcare system, resulting in hardships and burdens either on the veterans who may be denied care or the system that must manage within its resources to provide needed care.

**7. Explain any special circumstances that would cause an information collection to be conducted more often than quarterly or require respondents to prepare written responses to a collection of information in fewer than 30 days after receipt of it; submit more than an original and two copies of any document; retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years; in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study and require the use of a statistical data classification that has not been reviewed and approved by OMB.**

There are no such special circumstances.

**8. a. If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the sponsor's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the sponsor in responses to these comments. Specifically address comments received on cost and hour burden.**

The notice of Proposed Information Collection Activity was published in the Federal Register on February 27, 2007 Volume 72, Number 38 Page 8838-8839. We received no comments in response to this notice.

**b. Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, clarity of instructions and recordkeeping, disclosure or reporting format, and on the data elements to be recorded, disclosed or reported. Explain any circumstances which preclude consultation every three years with representatives of those from whom information is to be obtained.**

In order to develop the initial Health and Reliance Survey in 1999, a VHA representative attended the consultant panel meeting of internal and external agency participants conducting VA's SF-36V survey, including scientists with the VA Health Services Research and Development Service (HSR&D Service); the Health Care Finance Administration (HCFA), the Communicable Disease Center (CDC), the Foundation for Accountability (FACCT), the Health Institute at the New England Medical Center, the Rand Corporation, the National Center for Health Promotion at Duke University, and the National Committee for Quality Assurance (NCQA) Washington, D.C. Various individuals were consulted over time in the planning and development of the enrollee surveys regarding the availability of data, frequency of collection, clarity of instructions, internal VA record keeping, disclosure, or reporting format, and on the data elements. This included individuals both inside and outside of the agency. These individuals are listed below in item B5. During this survey cycle, VHA will sponsor Focus Groups to obtain their views. Additionally, outside consultation is conducted with the public through the 60- and 30-day Federal Register notices.

**9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.**

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No payment or gift is provided to survey respondents. However, it is expected that subgroups of veterans targeted for focus groups will include many socio-economically disadvantaged veterans from both urban and rural settings, who largely would be reluctant or unable to participate if not reimbursed or compensated for their time and travel. Thus, it is anticipated that veterans recruited for focus groups will be remunerated the nominal amount of \$50 in appreciation for their participation in and contributions to the survey effort, as well as to help defray the costs of their time and travel.

**10. Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.**

An assurance is made that answers provided are strictly confidential and will be used for general management policy decisions and statistical purposes only. The information collected will become part of the system of records identified as 97VA105, Consolidated Data Information System-VA” as set forth in the Compilation of Privacy Act Issuances via online GPO access at <http://www.gpoaccess.gov/privacyact/index.html>

**11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private; include specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.**

There are no questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private on the Survey on Health and Reliance.

**12. Estimate of the hour burden of the collection of information:**

**a. Estimated burden hour.**

No printed forms are used in these telephone surveys, as they are directly input into a computer. Form numbers are used for clarification purposes only. Additionally, no Form Numbers are used for the four phases of the Focus Group Activities. The estimated hourly burden is shown below:

	Respondents	# of Focus Groups	No. of Participants	Minutes	Equals	Divided by 60	Burden Hours
10-21034g	42,000		42,000	15	630,000	60	10,500
Phase 1	20	2	40	120	4,800	60	80
Phase 2	20	3	60	120	7,200	60	120
Phase 3	20	2	40	120	4,800	60	80
Phase 4	20	3	60	120	7,200	60	120
<b>Total</b>	<b>42,080</b>		<b>42,200</b>	<b>Avg. 15.5</b>	<b>654,000</b>		<b>10,900</b>

**b. If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13 of OMB 83-I.**

See the separate burden hour estimates detail in the preceding subparagraph.

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c. **Provide estimates of annual cost to respondents for the hour burdens for collections of information. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.**

The estimated cost to the respondents for taking the time to respond to the survey is \$163,500 (10,900 hours x \$15 per hour). We do not require any additional record keeping.

13. **Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 and 14).**

- a. There are no capital, start-up, operation or maintenance costs.
- b. Cost estimates are not expected to vary widely.
- c. There is no anticipated recordkeeping burden.

14. **Provide estimates of annual cost to the Federal Government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operation expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.**

- a. The total cost to the Federal Government is estimated at \$819,000.

b. It is estimated that the amount paid to the contractor for the Focus Group Activities and the Health and Reliance Survey will be approximately \$819,000. Costs include the cost of remunerating participating veterans, travel costs, minor survey improvements, programming of the questionnaire for CRT administration, questionnaire pretest, interviewing, validation, data processing, providing a clean data file, and project management, staff education, and supervision. This estimate includes additional enhancements to the coding of case level outcomes to better understand reasons for nonresponse and research testing strategies for identifying and handling veterans in institutions, etc, as required by OMB. Estimated costs were obtained via market research with companies that do CATI surveys. The total estimated cost is an average of estimated costs obtained from several companies.

15. **Explain the reason for any changes reported in Items 13 or 14 above.**

We do not anticipate any changes.

16. **For collections of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.**

The primary purpose of this data collection is not for publication. Data is aggregated and provided to the actuary who prepares projections for the enrollment level decision by the Under Secretary for Health and the Secretary of VA. Data will also be used for general descriptive information and analyses on enrollees. The aggregated information will be disseminated nationally primarily in VA reports, but the aggregate results may be published. Data will also be used for VA internal policy and budget scenario development and related analyses.

Results of the qualitative research will be used to supplement and enhance enrollee survey based quantitative inputs into VA Enrollee Health Care Projection Model and VHA Long-Term Care Model projections, such as through the development of questions to be included on the reliance survey and the resulting data and analyses, or through the identification of emergent issues that else wise need to be addressed in VHA modeling, policy, budget, and strategic planning related efforts.

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**17. If seeking [approval to omit the expiration date](#) for OMB approval of the information collection, explain the reasons that display would be inappropriate.**

We request approval to omit the expiration date for the OMB approval from this telephone survey. The more information presented at the beginning of the survey, the greater the possibility for a respondent to either refuse or become confused.

**18. Explain each [exception to the certification statement](#) identified in Item 19, “Certification for Paperwork Reduction Act Submissions,” of OMB 83-I.**

There are no exceptions.