SUPPORTING STATEMENT FOR:
NATIONAL SURVEY OF WOMEN VETERANS
COMPUTER-ASSISTED TELEPHONE INTERVIEW
VA FORM 10-21086(NR)
2900-XXXX

A. Justification

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

Women veterans have unique health care needs. Compared with male veterans, a lower proportion of women veterans use Department of Veterans Affairs (VA) health care services.[1,2] Regional studies of women veterans have identified gender-related barriers to VA use.[3,4] However, these regional studies are not designed to account for geographic variation in the organization and availability of VA and non-VA healthcare, and therefore cannot fully inform national VA Women Veterans Health Strategic Health Group planning and policy. Conversely, national VA patient ratings of care (in Survey of Healthcare Experiences of Patients, SHEPs) while assessing patient satisfaction, do not assess gender-specific needs identified in other studies as being important to women. While the National Survey of Veterans, a periodic population-based survey of veterans conducted for planning purposes, focuses on VA users and non-users and modestly over samples women,[5] the survey content is too broad to support evidence-based strategic planning for the Women Veterans Health Strategic Healthcare Group. In addition, the most recent National Survey of Veterans was conducted in 2001, and therefore does not reflect the health care needs, health care delivery preferences, or attitudes toward VA care of the most recent group of women veterans.

Conducting a national survey of women veterans is a recommendation of the Advisory Committee on Women Veterans. Specifically, their 2004 biennial report's recommendation 9 is: Commission a follow-up study to the study entitled "Survey of Female Veterans: A study of the needs, attitudes and experiences of women veterans" published by Louis Harris and Associates in August 1985, to examine the current status, demographics, needs, and experience of women veterans of the U.S. Armed Forces.[6-7] This prior study on the needs, attitudes and experiences of women veterans, though designed to provide detailed gender-specific national data, was conducted in 1985 and is outdated.[8] Since that time, the percent of women serving in the military has increased by over 80% (from 8.3% of the 1980 military, to 15% of the current military) and their roles have changed dramatically.[9,10] With increases in the number of military women have come a growth in the number of women veteran VA healthcare users and their proportion in the total VA population.[11] Among Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) women veterans, 37.5% have used VA health care. A survey of VA-eligible women veterans will assist the VA in identifying the changing health care needs of this growing women veteran population, and the barriers they experience to VA healthcare use.

This research builds on the previously approved *Women Veterans Ambulatory Care Use: Patterns, Barriers, and Influences* project (VA HSR&D #GEN-00-082; conducted in 2004 under OMB #2900-0643, which is no longer an active collection), that identified patterns of

ambulatory care use, and barriers and influences on VA use, among a population-based sample of women veterans in the southern California and southern Nevada region (corresponding to Veterans Integrated Service Network (VISN) 22).[4] In that study we identified barriers to VA use that led some women veterans to go outside the VA for selected healthcare services (fragmentation of care) or to forego needed care (unmet healthcare needs), and led others to rely solely on non-VA sources of healthcare.[3] For many of these women veterans, lack of knowledge of their eligibility for VA services, perceptions of limited availability of gender-appropriate services or of poor VA quality of care, and inconvenience of VA care, are deterrents to VA use.[4] Surprisingly, having a knowledge gap about VA benefits was the strongest predictor of both nonuse of care and of non-VA use, even among women veterans in the highest VA priority groups. This means that many women veterans are failing to capitalize on services for which they are eligible. Unfortunately, first noted in the 1982 GAO studies, this information gap has persisted over time and may require greater attention and resources than was previously afforded targeted outreach and education efforts.[12-14] While the original study answered key questions about patterns and determinants of women veterans VA use, it also raised new questions about how women veterans obtain VA information, the impact of fragmentation of women's health care services on access, coordination, and communication of care, and variations by military cohort and geographic region – areas that will be informed by this national survey.

Specific aims of the current research are therefore to:

Specific Aim 1: Identify in a national sample the current demographics, health care needs, and VA experiences of women veterans of the U.S. Armed Forces.

Specific Aim 2: Determine how health care needs and barriers to VA health care use differ among women veterans of different periods of military service.

Specific Aim 3: Assess women veterans' preference for and the potential impact of prospective interventions to improve VA health care access and quality.

Research questions corresponding to each specific aim are as follows:

Research Questions for each Specific Aim
Describe characteristics and needs of women veterans • RQ1A: What are the patterns of VA and non-VA utilization (i.e., VA-only, dual VA/non-VA, non-VA-only, nonuse of healthcare in the prior 12 months) of general medical, women's health, and mental health care for women veterans? • RQ1B: What are the socio-demographic, military service-related, and health-related predictors of VA ambulatory care use for women veterans? • RQ1C: Is there regional variation in patterns of ambulatory care use? • RQ1D: Is there regional variation in predictors of VA ambulatory care use? • RQ1E: How does fragmentation of care within and across VA and non-VA healthcare delivery sites influence access, communication, and coordination of care?
Assess period of military service differences • RQ2A: How does system of care (VA-only, dual VA/non-VA, non-VA-only, none) and service used (women's health, other primary care, mental health) differ by period of military

service? • RQ2B: What are the determinants of VA use by period of military service?
Inform intervention development • RQ3A: What are the perceived barriers to VA ambulatory care use by women veterans? • RQ3B: Is access to and perceived quality of women's health care a determinant of VA ambulatory care use? • RQ3C: For VA healthcare users, what is the association between use of VA sites that do not have on-site women's healthcare and systems of care used (VA-only, dual VA/non-VA) in the prior 12 months? • RQ3D: Are gender-related military experiences such as sexual harassment and assault determinants of subsequent use of VA health care services? Does presence of a VA women's health clinic mediate this association? What are the facilitators to receipt of VA care for military sexual trauma?

2. Indicate how, by whom, and for what purpose the information is to be used.

This national survey is being conducted on behalf of the VA Women Veterans Healthcare Strategic Health Group (WVHSHG), which is responsible for national program planning and VA health care delivery to women veterans. The audience for this research is also comprised of clinicians, administrators and policymakers at VA sites who are responsible for the delivery and quality of VA ambulatory care and women's health care. The planned research will provide this audience with data on patterns and determinants of women veterans' VA ambulatory care use, and it will also allow investigators to better define components of potential interventions to improve access and quality of VA women's healthcare. Collection of this data will allow these groups to identify prevalence rates of common medical and mental health conditions (including conditions of special interest to the VA such as post-traumatic stress disorder and military sexual trauma), unmet need for healthcare (based on diagnosed conditions and serious symptom), barriers to VA use, and healthcare delivery preferences (i.e., the features of current VA women's health delivery models that facilitate versus hinder access to VA care). Because the VA Advisory Committee on Women Veterans, which advises the Secretary of Veterans Affairs on women veterans' issues, recommended that this survey be conducted, the survey results will be of interest to VA administrative managers and policymakers.

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.

The survey will be administered over the phone by highly trained, professional interviewers, employing computer-assisted telephone interviewing (CATI) software – CFMC Survent.

Use of this technology will significantly reduce interviewing time because very little time is lost between respondents' answers and the recording of the same. By doing so, this state-of-the-art technology significantly reduces respondent burden and inconvenience. The CATI system

allows a computer to perform a number of functions prone to error when done manually by interviewers, including:

- Providing correct question sequence;
- Automatically executing skip patterns based on prior question answers (which decreases overall burden on respondents);
- Recalling answers to prior questions and displaying the information in the text of later questions;
- Providing random rotation of specified questions or response categories (to avoid bias);
- Ensuring that questions cannot be skipped; and
- Rejecting invalid responses or data entries.

Survey responses from the CATI database will be converted into a SAS file and analyzed using SAS on a VA computer. To ensure data quality, SAS programs will be written to perform data checks. Range and internal consistency edit checks will be performed to determine the reasonableness of the data.

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.

We have conducted a thorough search and literature review of the research concerning women veterans and have concluded there are no other surveys of this type specifically aimed at national variations in women veterans' health and health care use across all military cohorts.[15,16] Currently funded VA research on women veterans targets specific health conditions or selected cohorts only.[17]

Previous studies of female veterans' use of health services have examined several potential explanatory factors for their disproportionate underuse of VA ambulatory care. The 1985 Survey of Female Veterans was the first systematic survey of female veterans' use of health care services.[7-8] VA use was contrasted with use of non-VA services, and health status and demographic predictors were identified.[8] In that study, the largest single predictor of both outpatient contact and hospitalization was pregnancy. However, the VA did not offer obstetrical services prior to fiscal year 1999. That study was also conducted prior to the implementation of the Veterans' Health Care Amendment of 1986 (PL 99-272), or VA means test. In addition, in the ensuing years, the scope of VA primary care services has broadened. Thus the current influences on decisions to seek VA ambulatory care may differ. The 2001 National Survey of Veterans, the most recent of a series of periodic surveys designed to describe the use of VA health and other benefits, did not specifically examine women's health care.[5]

There has been no previous collection of this information and thus the information is not available for use for the purposes describe in Item 2.

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

Because this is a telephone survey of individual women veterans, no small businesses or other small entities are impacted by this information collection.

6. Describe the consequence 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.

Women veterans' access to VA healthcare may be adversely affected because there is currently a lack of adequate data required to shape the current and future VHA policies concerning women veterans.

VA health care for women is being developed simultaneously with other major changes in the organization and delivery of VA health care. To implement these changes successfully, VA administrators must be cognizant of the needs of the veterans they serve. Collection of this data will allow key stakeholders to identify prevalence rates of common medical and mental health conditions (including conditions of special interest to the VA such as post-traumatic stress disorder and military sexual trauma), unmet need for healthcare (based on diagnosed conditions and serious symptom), barriers to VA use, and healthcare delivery preferences (i.e., the features of current VA women's health delivery models that facilitate versus hinder access to VA care).

By examining the attitudes, experiences, and needs of women veterans across the spectrum of patterns of VA ambulatory care use, the VA may better understand the impact of its policies and programs on women veteran VA use. By over-sampling OIF/OEF veterans (e.g., to compare physical and mental health care needs of this group with that of others), it will allow the VA WVHSHG to project how health care needs of women veterans may change in the near future.

7. Explain any special circumstances that would cause an information collection to be conducted in a manner: requiring respondents to report information to the agency more often than quarterly, or prepare a written response to a collection of information in fewer than 30 days after receipt of it, or submit more than an original and two copies of any document, or 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; requiring the use of a statistical data classification that has not been reviewed and approved by OMB; that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or requiring respondents to submit proprietary trade secrets, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

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 agency'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 agency in response 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 January 7, 2008, Volume 73, Number 4, Page 1265-1266. 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, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported. Explain any circumstances that preclude consultation every three years with representatives of those from whom information is to be obtained.

This project's investigators are in regular consultation with outside (non-VA) personnel from the RAND Corporation, schools and departments within the University of California, Los Angeles (UCLA) representing a diversity of research and clinical backgrounds, including medicine, public health, social welfare, psychology, anthropology, nursing and gerontology, and community and veteran representatives.

Because this interview is part of a project with a December 31, 2008 end date, it is unlikely that investigators will consult with outside personnel after completion of reports and scientific papers that stem from this project.

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

No payment or gift is provided to respondents.

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

There are two assurances. We will send out a letter to every participant stating: "The research team will make every possible effort to keep your personal information confidential. Your survey responses will be separated from your name and other information that identifies you. Your information will be combined with that of other participants and reported only as totals, averages, and other statistics. The results of this survey may be published, but your name or identity will not be revealed, and your responses will remain confidential unless disclosure of such is required by law. The link between your identity and your participation in this survey will be destroyed as soon as the survey part of this study is completed."

Furthermore, during the consent process over the phone, we will inform each woman veteran of the following: "The VA complies with the requirements of HIPAA, the Health Insurance Portability and Accountability Act of 1996, and its privacy regulations and all other applicable laws that protect your privacy. We will protect your information according to these laws. Despite these protections, there is a possibility that your information could be used or disclosed

in a way that it will no longer be protected. Our Notice of Privacy Practices provides more information on how we protect your information."

The basis for these assurances is that the information will become part of a system of records that complies with the Privacy Act of 1974. This system is identified as "Veteran, Patient, Employee and Volunteer Research and Development Project Records-VA (34VA11)" as set forth in the 1999 Compilation of Privacy Act Issuances via online GPO access at http://www.access.gpo.gov/su_docs/aces/1999_pa.html

Additionally, the Health Insurance Portability and Accountability Act of 1996 can be accessed at http://www.hhs.gov/ocr/hipaa/

The VA Notice of Privacy Practices can be accessed at: http://www1.va.gov/vhapublications/viewpublication.asp?pub_id=1089

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. This justification should include the reasons why the agency considers the questions necessary, the 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.

The following are question areas we plan to address in our survey that may be of a sensitive nature, and therefore will be disclosed herein.

Questions about depression, post-traumatic stress disorder, military sexual assault or harassment, and alcohol dependence are necessary because studies that examined the military experiences of women VA users found that they are often characterized by sexual abuse, harassment, and assault, with prevalence ranging from 23% to 90% depending on the population studied.[18-23] A history of sexual assault while in the military was associated with a significantly greater number of current physical symptoms and medical conditions in respondents to a survey of women VA ambulatory care users.[23-25] Screening prevalence for symptoms of current depression was 3 times higher and for current alcohol abuse was 2 times higher among those who reported experiencing military-related sexual assault.[26] In another study, sexual stress was found to be almost four times as influential in the development of posttraumatic stress disorder as duty-related stress.[20]

To address these issues, the Veterans Health Care Act of 1992 (P.L. 102-585), mandated the establishment of VA sexual trauma screening and counseling services. However, it is unknown the extent to which a military sexual trauma experience deters subsequent VA healthcare use, and therefore what the unmet need for military sexual trauma counseling, and associated PTSD, and alcohol treatment are among women veteran non-VA users. Collection of this information will provide the first estimates of unmet need among non-VA healthcare users for these issues, and may inform outreach planning and non-VA based screening and treatment efforts. Questions about veterans' racial/ethnic backgrounds are necessary because current research on veterans has failed to adequately sample traditionally underrepresented veteran groups, thus precluding collection of meaningful data on their needs and risk factors. These data include health behaviors, health status, functional impairment, and subjective and objective barriers to

health care use, among others. Data on racial/ethnic backgrounds will also help us ascertain whether disparities in access to needed health care services exist for racial/ethnic minority women veteran groups.

Items about health conditions and health status provide objective baseline data on subjects' current health conditions, and whether disparities in health exist by military service period cohort. Self-rated health status will also be asked of subjects to determine if subjective health assessment is correlated to the diagnosed medical conditions and to health services utilization. These data will also help ascertain whether veterans' functional disabilities serve as significant obstacles to access and utilization of health care services.

Items about income and family household size are included to determine if lower income (in absolute value and relative to household size) is a risk factor for poorer health status and increased health care service utilization, and whether these differ by military service period cohort.

Obtaining consent. We will verbally consent all respondents, complying fully with all human subject protection requirements of the Institutional Review Boards of the Department of Veterans Affairs. The consent explains to all prospective subjects that there will be no use or record of any information that can be used to later identify them. The consent also explains that participation in this study is completely voluntary and that any decision to participate or not participate has no effect whatsoever on any other benefits to which the participant may be entitled or on military status. The consent script includes the statement, "In addition, your participation will involve being asked possibly sensitive questions about emotional, physical and sexual trauma. You can refuse to answer any questions of your choosing." It is also explained by the screener that subjects may terminate the interview at any time and that any government benefits and rights will not be affected by participating or not participating in this survey.

Additionally, before the questions concerning trauma in the military are posed, we again consent our participants and provide them an opportunity to opt out with this question: "The next questions are about traumatic or upsetting events that may have happened to you while you were in the military. Before we begin with these questions, I want to confirm that it is okay for me to ask you questions regarding any physical or sexual abuse that you may have experienced."

12. Provide estimates of the hour burden of the collection of information. The statement should:

a. Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. *Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable.* If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance.

(3500 respondents) x (1-time 45-minute survey) x (1 hour/60minutes) = 2625 burden hours. Our time estimate for the survey was derived from pre-testing the survey in 9 respondents.

The entire interview process, including screening, consenting and completing the telephone interview may range between 20 and 60 minutes (conservative estimates), depending on the respondent's answers, with nonusers of healthcare having the smallest respondent burden, and dual VA/non-VA users having a greater respondent burden. The range in our limited pretest was 35 minutes (VA-only user) to 43 minutes (dual user). To reduce the burden on respondents, only highly trained and experienced interviewers will obtain consent and conduct the interview. All interviewers will have prior training and experience in general computer-assisted telephone-interviewing techniques.

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 Form 83-I.

This request covers only one form.

c. Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. 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 13.

2625 hours x $15/hr = $39,375.00

13. Provide an estimate for 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).

There are no capital, start-up, operation, or maintenance costs for respondents. Cost estimates are not expected to vary widely. The only cost is that for the time of the respondent. There are no anticipated capital start-up cost components or requests to provide information.

14. Provide estimates of annualized costs to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational 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 may also aggregate cost estimates from Items 12, 13, and 14 in a single table.

This project is funded by the VA Office of Public Health and Environmental Hazards. We have summarized the FY 07 budget in the table below.

FY07 Budget for research project

Description	**Amount**
Personnel & support staff	$ 197,900
Supplies	$ 5,500
All other expenses	$ 217,100
Average Annual Cost	$ 420,500

15. Explain the reasons for any program changes or adjustments reported in Items 13 or 14 of the OMB Form 83-I.

This is a new data collection; all hours are considered a program increase.

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.

We will publish materials from the data collected in this study to benefit veterans, the VA health care delivery system, the intellectual/academic community, and the community at large. Published materials may include, but are not limited to, research reports, book chapters, and professional journal articles. Complex analytical techniques are described in Section B below.

We estimate that the collection of data will begin June 2008 and conclude September 2008. The completion of reports and publication date is estimated for December 2009.

17. If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

Not applicable to telephone survey instrument.

18. Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

There are no exceptions.