OMB Control Number: 0990-0281
ODPHP Generic Information Collection Request: Prevention Communication and Formative Research

Office on Women's Health Active Duty/Veteran Women's Health Research

Audience: Active Duty and Veteran Women

Supporting Statement — Section A

May 30, 2019

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Section A — Justification

1. Circumstances Making the Collection of Information Necessary

The Office on Women's Health (OWH) requests to conduct additional research under the ODPHP/OWH Generic Information Collection Request: Prevention Communication and Formative Research (OMB No. 0990-0281). The requested research will inform communications at the community level to address active duty and veteran women's health.

Background

Women are the fastest-growing subpopulation of the military and veteran communities, representing more than 16 percent (1.3 million) of the active duty force in 2018 (U.S. Department of Defense, 2018) and over 9 percent (2 million) of all U.S. veterans in 2015 (National Center for Veterans Analysis and Statistics, 2017). By 2020, the number of veteran women is projected to increase to 10.5 percent of the total veteran population (National Center for Veterans Analysis and Statistics, 2017). From 1973 to 2010, the number of active-duty women in the military has increased seven-fold, from 2% to 14% (Patten and Parker, 2011).

Active duty and veteran women have unique health care needs, conditions, and disease symptoms, compared to active duty and veteran men. For example, active duty and veteran women have unique needs related to obstetric and gynecologic care, domestic violence screening, family planning, pregnancy, postpartum depression, chronic pelvic pain, and menopause (American College of Obstetricians and Gyn., 2012; Washington et al., 2006). Compared with their civilian counterparts, active duty and veteran women have higher rates of some mental health disorders, increased rates of lifetime exposure to interpersonal violence (e.g., sexual assault and intimate partner violence) (Wilson, 2018; National Academies of Sciences, Engineering, and Medicine, 2018), and higher prevalence of post-traumatic stress disorder (PTSD) (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006; Haskell et al., 2011; ACOG, 2012; Harvard Medical School, 2007, Lehavot et al., 2017). Factors such as deployment, combat exposure, and military-specific environmental exposures may also create barriers for seeking and accessing health care. Therefore, it is important for health care providers (HCPs) to understand active duty and veteran women's distinct experiences and health care needs.

The administration of health care for active duty and veteran women is complex, primarily due to a mix of insurance coverage (e.g., TRICARE, U.S. Department of Veterans Affairs (VA), employer-sponsored or private insurance, Medicare, and Medicaid) and care settings. Active duty and veteran women may seek primary and reproductive health care through any one of the following settings or a combination thereof:

- U.S. Department of Defense (DoD) Military Health System (MHS) facilities
    - MHS is a system of 55 hospitals and more than 370 clinics, in addition to the care provided in combat situations and at bases and on ships overseas.
- U.S. Department of Veterans Affairs (VA) Veterans Health Administration (VHA) facilities

    - The VHA is a system of approximately 1,250 medical centers and outpatient clinics that provides care to about 9 million veterans annually.
- Civilian sector (non-military) or other facilities within the community

The number of veteran women using the VA health care system has increased 46 percent over the past decade (National Center for Veterans Analysis and Statistics, 2017). Despite this increase, the majority of veteran women (83 percent) get their health care outside of the VA, at academic centers and private community practices (U.S. Department of Veterans Affairs, 2017). This could be due to a number of reasons, including eligibility to receive care through private insurance, unfamiliarity with the application process for how to receive care through the VA, and inconvenience of VA facility locations (National Center for Veterans Analysis and Statistics, 2017). Researchers have also found that a high proportion of veteran women report receiving dual care, or care obtained from the VA and the private health system (U.S. Department of Veterans Affairs, 2015; Nayar et al., 2013; Schell et al., 2011).

In 2014, Congress passed the Veterans Access, Choice, and Accountability Act ("Choice Act") to allow veterans facing extensive wait times or living more than 40 miles from the nearest VA to seek care in the private sector. In 2017, Congress extended the Choice Act to authorize the VA to cover co-pays and deductibles directly for private care rather than reimbursing veterans afterward and ensure that private sector providers have access to medical records for veterans to enhance the continuity of care.

Given the significant numbers of active duty and veteran women who use non-VHA/MHS sources of care and the broad-ranging health impacts of military service, the research proposed in this plan aims to understand active duty and veteran women's experiences receiving health care in civilian settings, including the facilitators and barriers.

This research builds upon previous work with the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to address health needs for women in the military and improve care delivery to both populations of women. A corresponding data collection request has also been submitted to collect data from health providers regarding care and treatment for active duty and veteran women.

2. Purpose and Use of the Information Collection

Active Duty Women

The number of active duty women in the military has risen dramatically since the beginning of the all-volunteer force. Compared to 2000, both the percentage of active duty enlisted members and the percentage of active duty officers who are women has increased (from 14.7% and 14.4%, respectively, in 2000 to 15.6% and 17.3%, respectively, in 2016) (U.S. Department of Defense, 2016). As of 2016, the Army had the highest number of active duty women

(68,965), while the Marine Corps had the lowest number of active duty women (14,854) (U.S. Department of Defense, 2016).

Veteran Women

Veteran women have gaps in their knowledge about services provided by DoD, gaps in knowledge about VA eligibility, and assumptions that VA does not provide unique gender-specific health care services required for women (Washington et al., 2007; U.S. Department of Veterans Affairs, 2015). Only one in six veteran women (15.7 percent) understands their VA health care benefits (Westat, 2010). Among veteran women who do not use VA services, other barriers to VA care include: perceptions of inadequate women's services or provider quality for primary care, perceived stigma when seeking mental health care services, and the location and operating hours of health care facilities (U.S. Department of Veterans Affairs, 2015).

Moreover, researchers have found that some veteran women question their veteran identity and will not readily identify themselves as being veteran. When women talk about their military service, a large number will report that they feel invisible, that their "non-combat" role was less valued than those of the men who served and that they do not identify themselves as veterans (Disabled American Veterans, 2014; American College of Obstetricians and Gyn., 2012). The misperception that a woman who seeks services at the VA is not a veteran herself, but a male veteran's wife, mother, or daughter, also makes it difficult for providers to identify and tailor care based on veteran status (Disabled American Veterans, 2014; American College of Obstetricians and Gyn., 2012).

To address these gaps, we will conduct several focus groups to:

- Understand veteran and active duty women's experiences, facilitators for, and barriers to receiving health care from providers outside of VHA/MHS.
- Determine the health information, online tools, and resources that are most needed to support the physical and mental health of active duty and veteran women.

3. Use of Improved Information Technology and Burden Reduction

To reduce participant burden, limit the screening to 3 minutes in length and the focus groups will be 10 minutes in length.

4. Efforts to Identify Duplication and Use of Similar Information

OWH is collaborating with the Department of Veteran Affairs and the Department of Defense and to our knowledge, there is no information of a similar nature that is currently being collected. Similar research exists for active duty and veteran women using the Military Healthcare System but to our knowledge, no federal research is being conducted for active duty and veteran women that receive health care in a community (non-military) settings.

on the data collection and there are no reports of duplicative efforts.

5. Impact on Small Businesses or Other Small Entities

No small businesses will be impacted or involved in this data collection.

6. Consequences of Collecting the Information Less Frequently

This request is for one-time data collection. These data have not previously been collected elsewhere.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

This data collection is being conducted using the Generic Information Collection mechanism through ODPHP/OWH — OMB No. 0990-0281.

9. Explanation of Any Payment or Gift to Respondents

Participants will be offered an honorarium of $75 for completing a 90-minute focus group to reimburse them for their time.

10. Assurance of Confidentiality Provided to Respondents

The Privacy Act does not apply to this data collection. The proposed data collection will have little or no effect on participants' privacy. OWH will not collect any personally identifiable information from survey participants. OWH will use only comments, quotes, and quantitative responses from participants to inform the development of future communication materials.

11. Justification for Sensitive Questions

OWH does not anticipate that research participants will perceive questions as sensitive in nature. OWH will focus on collecting information that can inform health communication and educational materials on improving care for active duty and veteran women. In the screening, we inform participants that they can stop participating at any time. The forms also indicates that if participants have questions or feel they have been harmed by the project, they can contact the project team.

12. Estimates of Annualized Burden Hours and Costs

We estimate that each prospective consumer participant will spend a total of 3 minutes answering screening questions (see **Attachment B: Screening Instrument)** and 60 minutes participating in the focus group. (see **Attachment C: Discussion Guide**).

Table A-12 shows estimated burden and cost information.

Table A-12: Estimated Annualized Burden Hours and Costs to Participants

Type of Respondents	Form Name	Number of Respondents	Average Burden per Response (in hours)	Total Burden (in hours)
Active Duty Women	Recruitment Form	32	3/60 (.05)	1.6
	Focus Group Guide	32	1.5	48
Veteran Women	Recruitment Form	96	3/60 (.05)	4.8
	Focus Group Guide	96	1.5	144
Total		**256**		**198 .4**

13.Estimates of Annualized Burden Hours and Costs

OWH expects that participants will incur no costs beyond the burden hours required to answer screening questions and participate in the focus group.

14. Annualized Cost to the Government

Table A-14: Estimated Annualized Cost to the Federal Government
Estimated Annualized Cost to the Federal Government

Expense	Number/ Amount	Cost/Hourly Wage Rate	Average Cost

Project Director II labor	240	$263.56	$63,254.40
Project Director II labor	160	$280.03	$44,804.80
Account Supervisor labor	180	$177.35	$31,923.00
Health care provider interviews, other direct costs (recruitment, incentives, recordings, transcripts, qualitative analysis software)	-	-	$12,500
Focus groups, other direct costs (facilities, recruitment, incentives, recordings, transcripts, qualitative analysis software)	-	-	$60,000
Travel for focus groups	-	-	$6,200
Estimated Total Cost of Data Collection			**$218,682.20**

The estimated annual cost to the Federal government is ___$218,682.20____

15. Explanation for Program Changes or Adjustments

This is new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

After the data collection, OWH will conduct an analysis of the data and create a summary report highlighting key findings and recommendations. The results of the research will be used for internal purposes only as research to inform the development of communication and educational tools for health professionals to improve care and treatment for active duty and veteran women. No names or other personal information will be reported in the summaries. We will share the data with the VA and DoD as this data collection will be a pilot and will inform the planning of a larger data collection in the future. The future data collections will also involve collaborations with HRSA's Bureau of Primary Care and the Office of the Surgeon General.

Proposed Timeline

Completion Date	Major Tasks/Milestones
5/17/19	• Finalize logistics, recruitment, and scheduling for interviews and focus groups
6/14/19	• Complete interviews and focus groups
7/19/19	• Qualitative analysis
8/2/19	• Final report

17. Reason(s) Display of OMB Expiration Data is Inappropriate

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

Section A — List of Attachments

[IN SEPARATE FILES]

- **Supporting Statement B: Data Collection Procedures**
- **Attachment A: Screening Instrument** (Research Instrument)
- **Attachment B: Discussion Guide** (Research Instrument)