Health-Care Use Survey for Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans
OMB 2900-XXXX
VA Form 10-0478

A. JUSTIFICATION

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

Legal authority for this data collection is found under 38 USC, Part I, Chapter 5, Section 527 that authorizes the collection of data that will allow measurement and evaluation of the Department of Veterans Affairs Programs, the goal of which is improved health care for Veterans.

Findings indicate that many OEF/OIF Veterans are not receiving the health care they need and while previous studies have examined individual factors (e.g., background characteristics) and structural factors (e.g., ease of using VA facilities) as potential barriers to care, few studies have addressed the effects of negative beliefs related to health-care seeking, or stigma, as a potential barrier to VA use. Moreover, studies of barriers to care within prior cohorts are likely to fall short because the current generation of Veterans is very different from the VA's typical clientele, and thus, barriers to care may differ for this population. In addition, although a number of studies have addressed barriers to VA care in female- and male-only samples, no study has explored gender differences in wide array of barriers to care, including stigma-related factors, within a national sample of male and female OEF/OIF Veterans. Therefore, a study of the prevalence and multidimensional nature of barriers to VA care in a population-based sample would fill a critical gap in the literature and complement other HSR&D funded research. The primary objective of the study is to examine the contribution of individual, institutional, and most importantly, stigma-related barriers, to VA health care. A secondary objective is to document unique barriers to VA care for women and men. A third objective is to provide reliable and valid measures of barriers to care that can be used by other researchers to study factors that influence Veterans' health-care behaviors (e.g., use of services, treatment adherence, etc.).

This project is responsive to the call for studies to "determine VA system-wide barriers and facilitate factors that promote early *identification, treatment, and prevention capabilities" identified in the HSR&D request for applications on Deployment Health Services Research. This project also addresses a number of other mandated areas for further research attention outlined in the Deployment Hea*lth solicitation, including the call for studies: (1) examining predisposing, enabling, and need characteristics of the post-deployed population; (2) addressing how female and male deployment health concerns differ; and (3) using mixed quantitative and qualitative research methods for assessing patient factors that influence the outcomes of health-care services. Importantly, this project also supports HSR&D's identified priority areas for Investigator-Initiated Research. Specifically, this project addresses Solicitation B's (Implementation) call for studies that focus on Veterans' self-identified needs and that include veteran participation at various stages of study, including development. This project addresses Solicitation C's (Mental Health) emphasis on evaluating strategies to improve early treatment of PTSD and related mental health disorders and to improve access, quality, and patient satisfaction and decrease cost. This project also addresses Solicitation E's (Women's Health) call for the evaluation of barriers to mental health care and preference for care by women Veterans, and is consistent with the recent identification of gender-specific barriers to access to VA care as an area in need for further work at the first national VA Women's Health Research Agenda-setting conference (Yano et al., 2006). This project is also responsive to the call for additional empirical evidence on barriers to care for returning Veterans issued by the APA Presidential Task

Force on Military Deployment Services for Youth, Families, and Service Members (2007) and a working group jointly commissioned by VA Research and Development, National Institute of Mental Health, and the United States Army Medical Research and Materiel Command to identify major scientific questions that need to be addressed with respect to OEF/OIF Veterans ("Mapping the Landscape of Deployment Related Adjustment and Mental Disorders," 2006).

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.

Study results will have numerous implications for clinical care provided to Veterans by the VHA. For example, the finding that difficulty accessing VHA care is a primary barrier for returning OEF/OIF Veterans would suggest the need for increased attention to efforts to streamline the process of care. Alternatively, the finding that concerns about negative evaluations predict mental health-care use would suggest the need for greater integration of primary and mental health care services, as well as other efforts aimed at maximizing privacy in the health-care setting. Results can also be used to inform VHA outreach efforts. For example, the finding that stereotypes about the types of Veterans who use VHA services are a barrier to care would point to the potential utility of initiatives aimed at educating Veterans and their family members about the increasingly diverse nature of the VHA patient population. Likewise, gender differences in beliefs about Veterans who seek VHA care might suggest the need to tailor these outreach efforts to the gender of the veteran. As Sayer and colleagues (Sayer, N. A., Clothier, B., Spoont, M., & Nelson, D. B., Use of mental health treatment among veterans filing claims for posttraumatic stress disorder, *Journal of Traumatic Stress, 20*(1), 15-25., 2007) noted, VHA could greatly benefit from the use of tailored treatment-promotion strategies. Results may also be used to inform employee education about Veterans and the factors that influence their choice to seek VHA care. As noted by Murdoch and her colleagues, (Murdoch, M., Bradley, A., Mather, S. H., Klein, R. E., Turner, C. L., & Yano, E. M. (2006), Women and war: What physicians should know. *Journal of General Internal Medicine, 21*(Suppl 3), S5-10., 2006), increased knowledge among VHA health-care staff about the patient population they serve can enhance the quality of the health-care interaction. More generally, efforts to educate staff about barriers to care from the perspective of OEF/OIF Veterans can promote empathy and build trust within the doctor-patient relationship.

In addition, the project will provide reliable and valid measures of barriers to care that can be used by other researchers to study factors that influence Veterans' health-care behaviors (e.g., use of services, treatment adherence, etc.). High quality research requires the application of measures with demonstrated reliability, validity, and utility. Too often VHA researchers and clinicians must employ assessment instruments that have not been validated for the Veterans they serve or that are limited with regard to the constructs in which they are most interested. Therefore, the extent to which these measures assess relevant dimensions of Veterans' perspectives and experiences is a recurring, open question. With Veterans now returning from Iraq and Afghanistan and seeking services at VHA, researchers require measures they can use to assess barriers to care within this population of Veterans with confidence. The availability of reliable and valid measures of salient barriers to care, and especially stigma-related barriers to care, can be used to enhance the quality of future research on VHA health-care use.

The information will be used to publish articles that will increase the knowledge base about the healthcare seeking behaviors of OEF/OIF service members, with the focus on barriers to accessing healthcare. The researchers will disseminate the findings to organizations with interest in active duty service members and Veterans. These organizations will include the Department of Defense, the Office of Seamless Transition, Veterans Health Administration (VHA) Quality Enhancement Research Initiative programs, the National Center for Post-Traumatic Stress Disorder, and the VHA Mental Illness, Research, Education and Clinical Care Centers.

The information will be provided through reports, presentations at national conferences, and publications in scientific peer-reviewed journals. It will also be provided to VHA clinical mental health service managers, clinical program leaders, and administrators and policy makers. No use has yet been made of this information because there is no current collection of these data.

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.

This project involves a survey which will be administered in a mailed paper-and-pencil format. No information will be collected through automated, electronic, mechanical, or other technological means. Conducting the survey electronically would mean that Veterans without access to computers or the Internet would be excluded from the study and preclude the ability to randomly sample a representative population of Veterans.

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.

The VHA Office of Research and Development has funded this research study based on its originality in addressing factors that contribute to use of VHA care among Veterans. This decision was based upon merit review and the portfolio manager's examination of other research studies supported by VA and other organizations. This research is unique and addresses a high priority for VA. The survey instruments to be administered for this study are not duplicative of any other surveys with this population.

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.

This data collection activity will occur one time only. Data will be collected on OEF/OIF service members to obtain information about barriers to accessing VHA healthcare services. This activity will allow the VHA to be responsive to a very important population of Veterans and to develop ways of reducing barriers to their accessing services that will meet their needs. VHA would not be able to be as responsive to the needs of this population of patients if the data collection is not conducted.

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 November 4, 2009 page 57221. No comments have been received 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.

To determine the data elements to be developed and collected, the investigators consulted with researchers within the VHA. In addition to conducting a thorough review of all documents, both those distributed by the VHA and Federal Government, as well as those published in the scientific literature, the Principal Investigator and research team have engaged in lengthy discussions with other researchers and experts on what data elements should be addressed in assessing barriers to accessing healthcare and how these data elements should be queried. These data are not available from any other source. Outside consultation will be 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.

All potential study participants will receive a small token of appreciation in the amount of $15 in the first mailing of the survey. The decision to include this token is a response to the finding that response rates are better when incentives are used. High response rates are important to ensure the generalizability of study results.

10. Describe any assurance of privacy to the extent permitted by law provided to respondents and the basis for the assurance in statute, regulation, or agency policy.

Participants will be assured that all data will be kept private to the extent permitted by law and that no identifying information will be used in any dissemination activities. Study participants will review a study fact sheet that contains all the elements of an informed consent form, including this statement of privacy. Participants are not required to complete any portion of the consent page. Completion of the survey implies consent. All data collection procedures have been approved by the Institutional Review Board (IRB) at the VA Boston Healthcare System.

11. Provide additional justification for any questions of a sensitive nature (Information that, with a reasonable degree of medical certainty, is likely to have a serious adverse effect on an individual's mental or physical health if revealed to him or her), 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.

The survey instrument involves questions regarding participants' use of VA and non-VA healthcare services, as well as questions about factors likely to impact their use of healthcare services. As such, the instrument does not include questions that would be likely to have a serious adverse effect on an individual's mental or physical health.

It is possible, however, that participants may experienced distress in response to survey questions, although this is very unlikely given that the questions focus on identifying factors that may influence Veterans' health-care use. In the cover/introductory letter and informed consent fact sheet ("Study Fact Sheet"), participants are informed that they may skip any questions that they do not want to answer. Further, participants are provided with a list of resources and instructions in the event that participation in the study causes them distress or psychological problems. These resources include a phone number for a licensed psychologist on staff at the Boston VA, a phone number for the phone number for VA Boston Healthcare System Operator (as an additional resource for emergencies outside of regular business hours, with instructions regarding how they may request to speak to the on-call Psychiatry Fellow), 911 (if they are having a medical emergency), the National Suicide Hotline (if they are having thoughts of hurting themselves), the phone number for VA Boston Healthcare System Operator (as an additional resource for emergencies outside of regular business hours) and the VA Boston Healthcare System Patient Representatives (for questions about their rights as a research participant). In addition, respondents are provided the opportunity to meet with the clinical contact, Dr. Suzanne Pineles, a licensed and trained Clinical Psychologist who specializes in the treating traumatized veteran populations, if they should become distressed.

A number of safeguards have also been put in place to protect the privacy of participants, including storing identifying information separately from survey responses, transmitting and storing all data securely, using password-protected and encrypted files on networks accessible only to authorized trained study staff, as well as ensuring that the final dataset does not contain any personally identifiable data.

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

All participants will be sent an "opt-out" postcard, which they may return to us if they choose not to participate. The survey will be conducted only with those service members who do not opt out; individuals who choose to return the "opt-out" postcard will have no further contact from us.

The entire survey instrument is expected to take approximately 35 minutes to complete. Thus, the estimated total burden hour is 816.67 hours (that is, 1400 respondents X 35 minutes per respondent).

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.

This request covers only one form.

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 of the OMB 83-I.

Because respondents are reimbursed for their time, there will be no cost to them. The research project manager will keep records of completed questionnaires and payments to participants.

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

There will be no costs to respondents or record keepers.

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.

The estimated total budget for the three years of this study, including all staff time, equipment, and other expenses, is $518,400. This averages $172,800 in each of the three years.

15. Explain the reason for any burden hour changes since the last submission.

This is a new collection and all burden 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.

Prior to hypothesis testing, VHA will examine the psychometric properties of newly developed and updated barriers-to-care stigma measure and refine the measure as needed. VHA will first examine item characteristics to identify the highest quality items for retention in final scales (Aiken, 1994; Anastasi & Urbina, 1996; Nunnally, 1978). For items accompanied by multipoint Likert-type response formats (“strongly disagree” to “strongly agree”), frequency distributions will be computed. Items that tend toward a more symmetric distribution of responses are generally preferred over items with a more skewed distribution. Next, corrected item-total correlations, the correlations of each item’s score with the sum of scores on all other items measuring that construct, will be computed. Item-total correlations are indices of an item’s ability to distinguish among those high and low on the attribute, and thus, are indicative of the item’s precision of measurement. Items with higher item-total correlations take precedence over those with lower item-total correlations. Using judgments of content validity, distributional and endorsement patterns and statistics, and item-total correlations, a final set of approximately 15 to 20 items will be chosen for each construct of interest. VHA will then compute estimates of internal consistency reliability (Cronbach’s alphas) for the final scales.

To familiarize ourselves with the data and detect any problems with the data (e.g., outliers), VHA will examine frequency distributions and descriptive statistics for all study variables and compute bivariate correlations among all variables prior to conducting analyses intended to evaluate study hypotheses. Should non-normality be an issue for any of our variables (e.g., measures of VA health-care use) we will compute necessary transformations (Cohen, Cohen, West, & Aiken, 2003, p. 246). VA will also conduct exploratory and confirmatory factor analyses for each scale in the study instrument to better understand the factor structure underlying these scales.

To evaluate our first hypothesis, which proposes that each of the different barriers categories will be associated with VA health-care use, VHA will first compute bivariate correlations between all barrier measures and indices of VA health-care use. These correlations will be followed by a series of simultaneous regression analyses for each predictor category. That is, each of the health-care use outcomes will, in turn, be regressed on all barriers-to-care item/scales within each of the focal categories (i.e., personal/individual, structural/institutional, and stigma-related factors) that obtain significance in bivariate correlations to identify unique contributors for each factor. For example, a total VA health-care use score would first be regressed on all items/scales within the personal/individual barriers category that were significantly related to use in bivariate correlations. VHA would next regress VA health-care use on all items/scales within the structural/institutional category of barriers to care that obtained significance in bivariate correlations, and so on. Significant partial regression coefficients will indicate support for hypothesized associations, but will also take into account any multicollinearity among predictors.

To evaluate our second hypothesis, which posits that stigma-related factors will contribute unique variance in the prediction of VA health-care use above and beyond personal/individual and structural/institutional factors, VHA will next conduct a hierarchical regression analysis in which all significant personal/individual and structural/institutional factors from the previous set of analyses will be included in a first step and the set of significant stigma-related barriers will be added in a second step and VHA will examine whether the set of stigma-related factors account for a significant amount of variance in VA health-care use after accounting for other barrier categories (Cohen & Cohen, 1983; Cohen, Cohen, West, & Aiken, 2003).

To evaluate our third hypothesis, which posits that stigma-related barriers will be stronger predictors of mental than physical health-care use, VHA will conduct separate regression analyses in which we predict each type of health-care use from the set of stigma-related barriers and VHA will examine and compare the proportion of variance in mental and physical health-care use accounted for by this set of predictors.

To evaluate our fourth and fifth hypotheses, which propose that women will report more structural/institutional barriers and these factors will be stronger predictors of VA health-care use for women than men and men will report more stigma-related barriers and these factors will be stronger predictors of VA health-care use for men than women, VHA will first calculate means separately for women and men on all barriers-to-care scales within these two categories, and independent samples t-tests will be computed to test for significant gender differences. Then, effect sizes in the form of correlation coefficients (Rosenthal, 1984) will be calculated for all contrasts. Next VHA will conduct multiple regression analyses in which each of the VA use outcomes is regressed on the barriers-to-care items/scales within these categories and terms representing the interaction of the barrier and gender. For example, for the category of structural/institutional barriers to care, VHA will conduct a regression analysis that includes the three factors, gender, and three interaction terms. For ease of interpretation, the variables representing the main effects of deployment factors will be centered prior to the calculation of the product terms, as recommended by Jaccard, Turrisi, and Wan (1990), and Cohen et al. (2003). Centering is a procedure that involves subtracting the mean from all scores which is used to facilitate the interpretation of the values of the coefficients and reduce problems with multicollinearity between first-order predictors and predictors that carry their interaction with other predictors (Cohen et al., 2003). A similar procedure will be used to examine the extent to which barriers to care differ for Veterans with physical injuries and racial/ethnic minorities.

Consistent with recommendations (e.g., Wilkinson & The APA Task Force on Statistical Inference, 1999), VHA will attend to both statistical significance and effect sizes for all analyses. The Bonferroni family-wise p value correction will be applied to protect against an inflated Type I error rate associated

with multiple tests, and sample design weights will be employed to ensure that results are generalizable to the population. As noted earlier, women will be oversampled to allow for meaningful comparisons among subgroups, and racial/ethnic minorities and non-minorities will be sampled relative to their proportion in the population. Sample design weights will be used to adjust for oversampling and permit the projection of results to the larger population. Specifically, weights will be used to adjust responses of Veterans so that the sum of the weights for cases in each group equals the number of cases in the reference population. VHA will also account for the stratified sampling design (i.e., 4 strata for gender and minority/non-minority racial/ethnic status) in our analyses. The application of sampling weights, combined with the recognition of stratification in the survey design, will allow for the computation of unbiased estimates and correct standard errors. All analyses will be conducted in STATA, which accommodates weights, and which the authors have used in other research involving complex sampling designs and weighting (Vogt et al., 2006). Finally, if incomplete data rates exceed 5%, VHA will apply a full-information maximum likelihood estimation procedure (Graham et al., 1997; Little & Rubin, 1987) to achieve reduced standard errors and more precise parameter estimates (Arbuckle, 1996; McArdle & Bell, 2000).

Data collection will begin after the sample is obtained from Defense Manpower Data Center (DMDC). Approval has been obtained to draw a sample of OEF/OIF Veterans from DMDC, which maintains automated files of military personnel with the necessary demographic information on gender to support the study. Importantly, this recruitment technique will allow contact with potential participants as private citizens rather than through their units while they are “on-duty.”

This is a three-year project, the first two years of which are already complete. During the first phase of the study, VHA developed measures of mental health beliefs that comprise an important aspect of the survey instrument, and the final survey instrument, was developed and finalized. During the second year of the study, we have been developing a program for tracking mail surveys and a data management system for the project. Once OMB approval is obtained, VHA will begin preparing the mail survey instrument for the large-scale mailing. We then intend to initiate data collection in the third year of the study, after obtaining the sample from Defense Manpower Data Center (DMDC). We have obtained approval to draw a sample of OEF/OIF veterans from DMDC, which maintains automated files of military personnel with the necessary demographic information on gender and Active Duty versus National Guard/Reservist status to support the study.

Activity	Year 1				Year 2				Year 3			
	Sept-Nov 2008	Dec-Feb 2008	Mar-May 2009	Jun-Aug 2009	Sep-Nov 2009	Dec-Feb 2009	Mar-May 2010	Jun-Aug 2010	Sep-Nov 2010	Dec-Feb 2010	Mar-May 2011	Jun-Aug 2011
PHASE I: Focus Groups and Scale Development												
Submit items to project consultants			X									
Identify final item pool				X								
Preparation of presentations and publications					X							
PHASE II: Survey Administration and Hypothesis Testing												
Finalize survey instrument for study				X								
Seek OMB approval for study*				X	X	X	X					
Create mail survey tracking program						X	X					
Develop data management system						X	X					
Prepare mail survey materials						X	X					
Coordinate with DMDC to select sample							X					
Secure veteran list from DMDC								X				
Submit veteran list for IRB address matching								X				
Pre-test survey to 8 OEF/OIF veterans									X	X		
Execute multi-stage mailing to 2,000 OEF/OIF veterans											X	
Data entry											X	
Psychometric analyses											X	
Refine scales as needed											X	
Conduct tests of hypotheses											X	X
Confer with project consultants											X	X
Prepare conference presentations											X	X
Prepare manuscripts for publication											X	X
Prepare final report for funding agency											X	X

17. If seeking approval to omit the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

There are no requests for approval to omit the expiration date for the OMB approval of the information collection.

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.