
**RESULTS OF THE TAKE 10 SURVEY
CONDUCTED BY THE
OKLAHOMA VETERANS PILOT PROGRAM**



UNIVERSITY OF CENTRAL OKLAHOMA

Prepared by:

Tracy L. Morris
Kent Morgan

October 1, 2017

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SAMPLE DEMOGRAPHICS

In total, 4,170 individuals responded to the Take 10 survey. Ten responses were identified by Qualtrics to be spam, and 69 responses were submitted by individuals from outside of Oklahoma and bordering counties. Additionally, 915 responses were completely empty, and another 278 responses were submitted by individuals who clicked-through less than 50% of the survey. All of these responses were removed from the sample. This resulted in a final sample size of 2,898 responses, or 0.9% of the total veteran population in Oklahoma. Table 1 presents the raw demographics of the final sample compared to those of the population of veterans living in Oklahoma.

Table 1. Raw sample demographics

		Sample		Population*
Sex	Male	2,191	88.0%	91.0%
	Female	300	12.0%	9.0%
Age	< 30 years	115	4.1%	5.8%
	30-39 years	299	10.6%	11.2%
	40-49 years	501	17.7%	12.7%
	50-59 years	532	18.8%	16.1%
	60-69 years	796	28.1%	24.2%
	> 69 years	587	20.7%	30.0%
Race	Caucasian/White only	2,260	83.6%	81.8%
	African American/Black only	96	3.6%	7.3%
	Native American/Alaska Native only	171	6.3%	4.7%
	Other/Two or More	175	6.5%	6.2%
Ethnicity	Hispanic	86	3.1%	3.2%
	Not Hispanic	2,675	96.9%	96.8%
Annual Income	< \$25,000	586	21.4%	
	\$25,000-\$49,999	952	34.8%	
	\$50,000-\$74,999	642	23.5%	
	> \$74,999	555	20.3%	
Marital Status	Married	2,039	72.4%	
	Divorced	316	11.2%	
	Separated	42	1.5%	
	Engaged	63	2.2%	
	Single	271	9.6%	
	In a committed relationship	85	3.0%	

		Sample		Population*
Location of Residence†	Urban	443	16.0%	16.8%
	Rural	413	15.0%	17.5%
	Mixed	1,905	69.0%	65.7%
War Era	World War II	20	0.8%	3.7%
	Korea	85	3.3%	7.8%
	Vietnam	1,062	41.2%	36.1%
	Post-Vietnam	443	17.2%	12.6%
	Gulf War	1,389	53.9%	36.6%
Branch	Army	1,353	47.6%	
	Navy	488	17.2%	
	Air Force	664	23.4%	
	Marines	267	9.4%	
	National Guard	459	16.2%	
	Air National Guard	99	3.5%	
	Reservist	162	5.7%	
	Coast Guard	22	0.8%	
	Merchant Marine	4	0.1%	
Combat Zone	Yes	1,577	55.7%	
	No	1,253	44.3%	
Service-Connected Disability	Yes	1,885	66.5%	
	Pending	190	6.7%	
	No	760	26.8%	

* Population percentages for sex, age, race, ethnicity and war era collected from the U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, 2016 Veteran Population, https://www.va.gov/vetdata/veteran_population.asp. Population percentages for residence collected from the U.S. Census Bureau, 2015 5 yr. American Community Survey, <https://www.census.gov/programs-surveys/acs/>.

† Residence classification collected from the U.S. Census Bureau, 2010 Census, <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

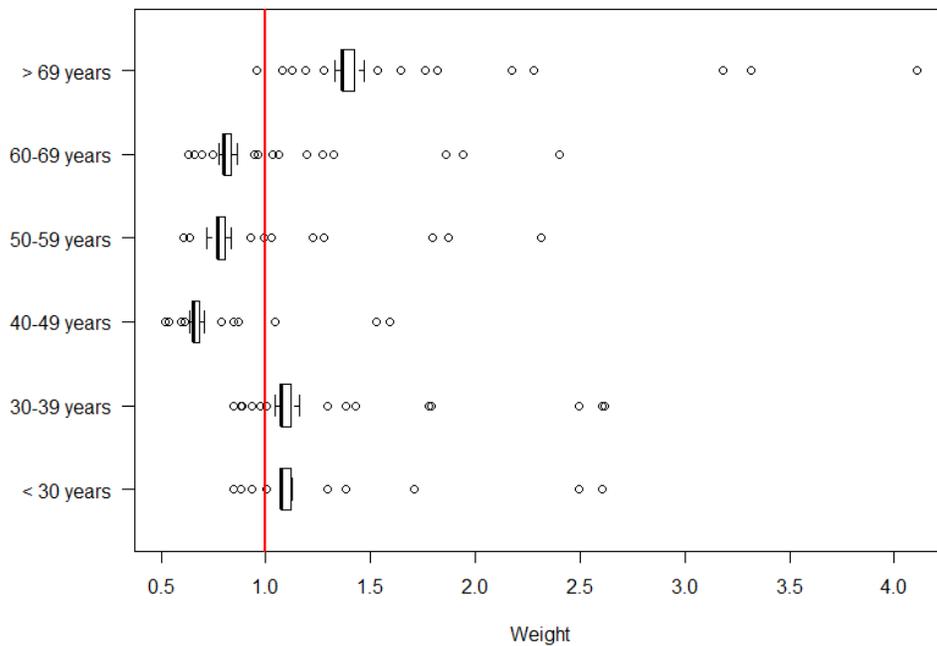
The Take 10 sample is significantly different from the population with respect to sex, age, race, location of residence, and war era ($p < 0.001$), but is not significantly different with respect to ethnicity ($p = 0.754$). Specifically, females, Vietnam veterans, post-Vietnam veterans, Gulf War veterans, Native Americans, and those aged 40-69 years old are significantly over-represented in the sample; whereas WWII veterans, Korean War veterans, African Americans, those from rural residences, and those aged 18-29 or 70 years and older are significantly under-represented. These cells are highlighted in Table 1.

Due to these differences, the sample was weighted with respect to age, race, and location of residence. War era was not used in the weighting process as it is highly correlated with age and

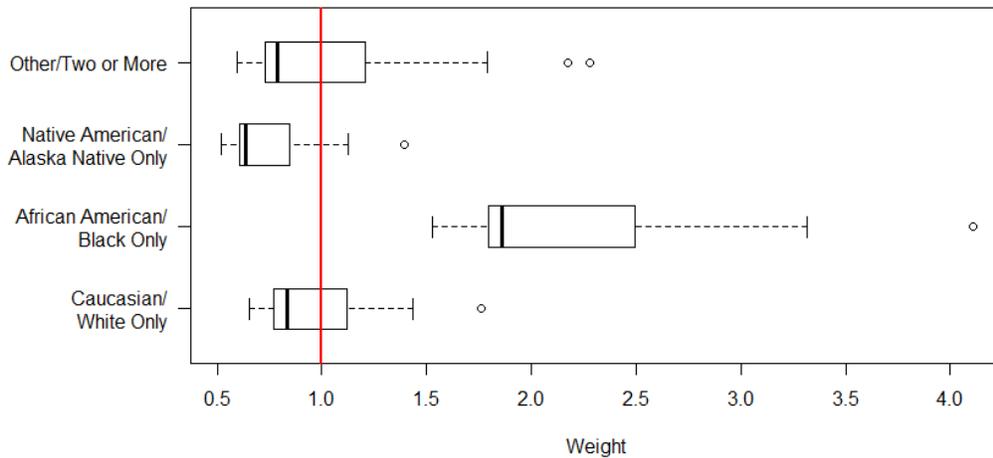
there is some overlap between the war eras, meaning a veteran may have served in more than one war. Sex was also eliminated from the weighting process since there are 407 (14%) missing responses to this item. Also, after analyzing text responses it was discovered that a potentially large number of surveys may have been completed by spouses of veterans rather than the veterans themselves. This could explain the large number of missing responses as the individuals may have been confused as to whether the question was asking for the veteran's or the spouse's sex. It could also explain why females are significantly over-represented in the sample. Figure 1 displays boxplots of the weights by age, race, and location of residence.

Figure 1. Boxplots of weights by age, race, and location of residence.

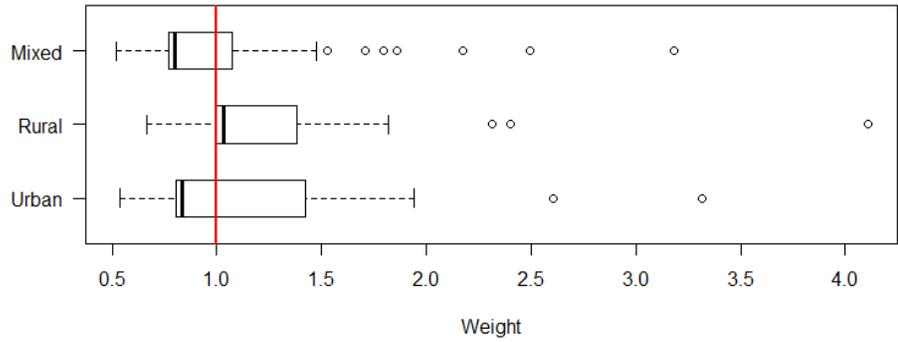
a. Age



b. Race



c. Location of residence

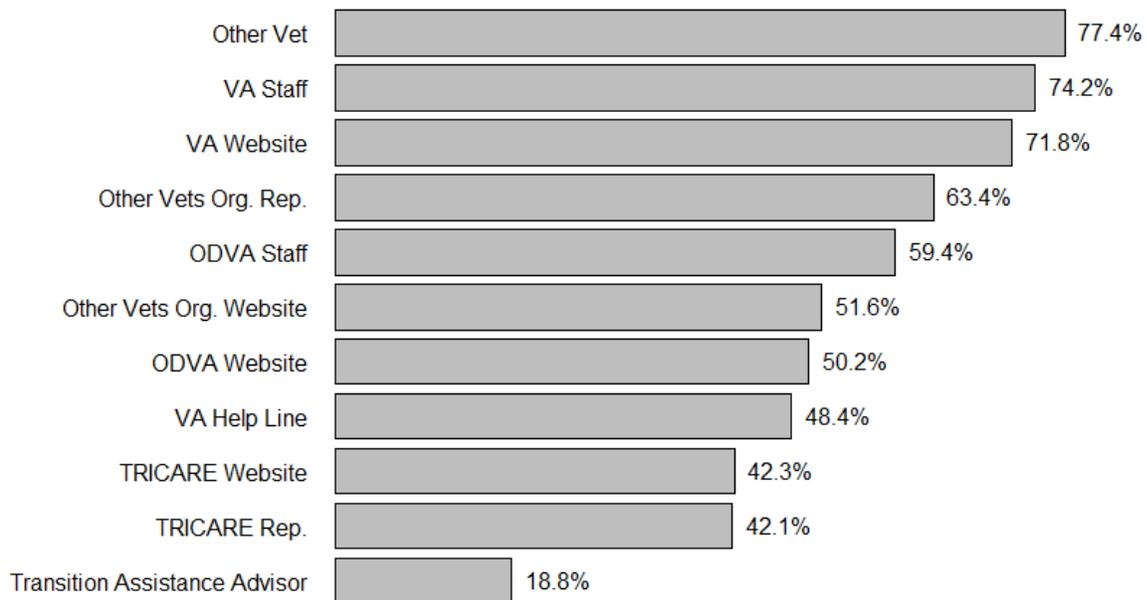


In the following analysis, weighted numbers are reported along with the weighted results of any statistical tests, unless indicated otherwise.

HEALTH CARE RESOURCES

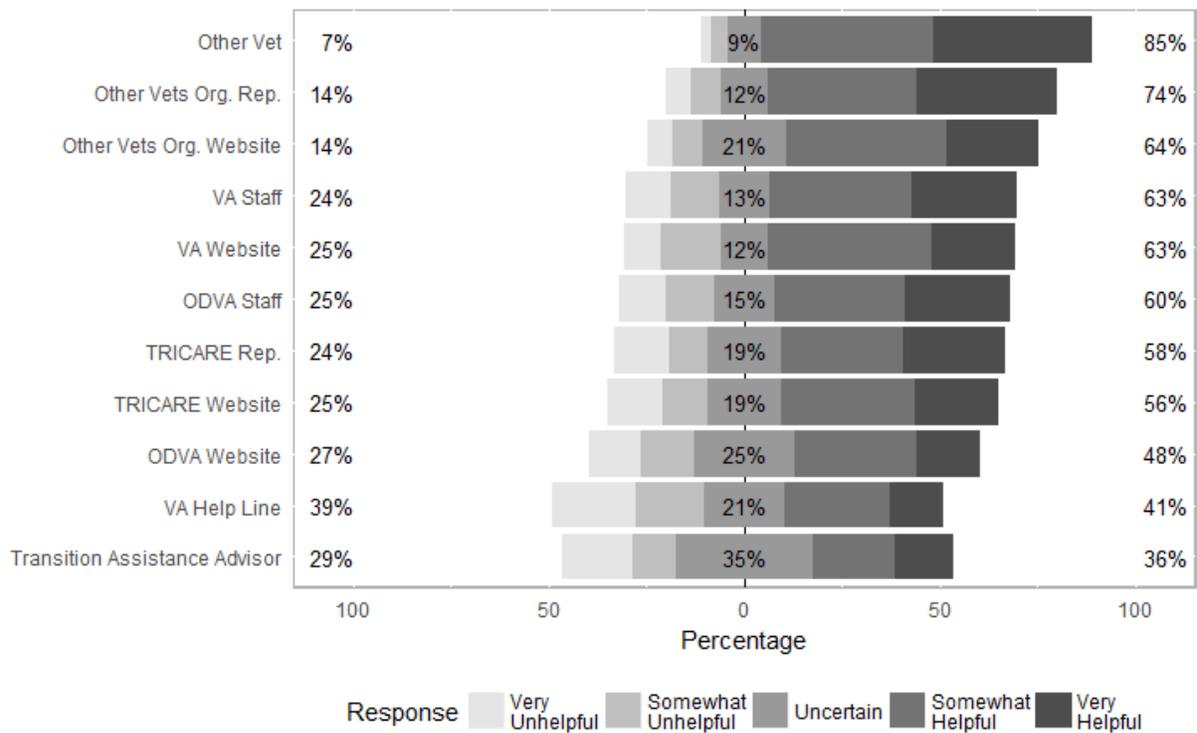
According to respondents, the most used resources for learning about Veterans health care are other veterans (77%), VA staff (76%), and the VA website (73%). The least used resources are Transition Assistance Advisors (19%), TRICARE representatives (42%), and the TRICARE website (42%). Figure 2 displays the reported usage of all resources.

Figure 2. Reported usage of resources for learning about veterans health care ($n = 2,828$)



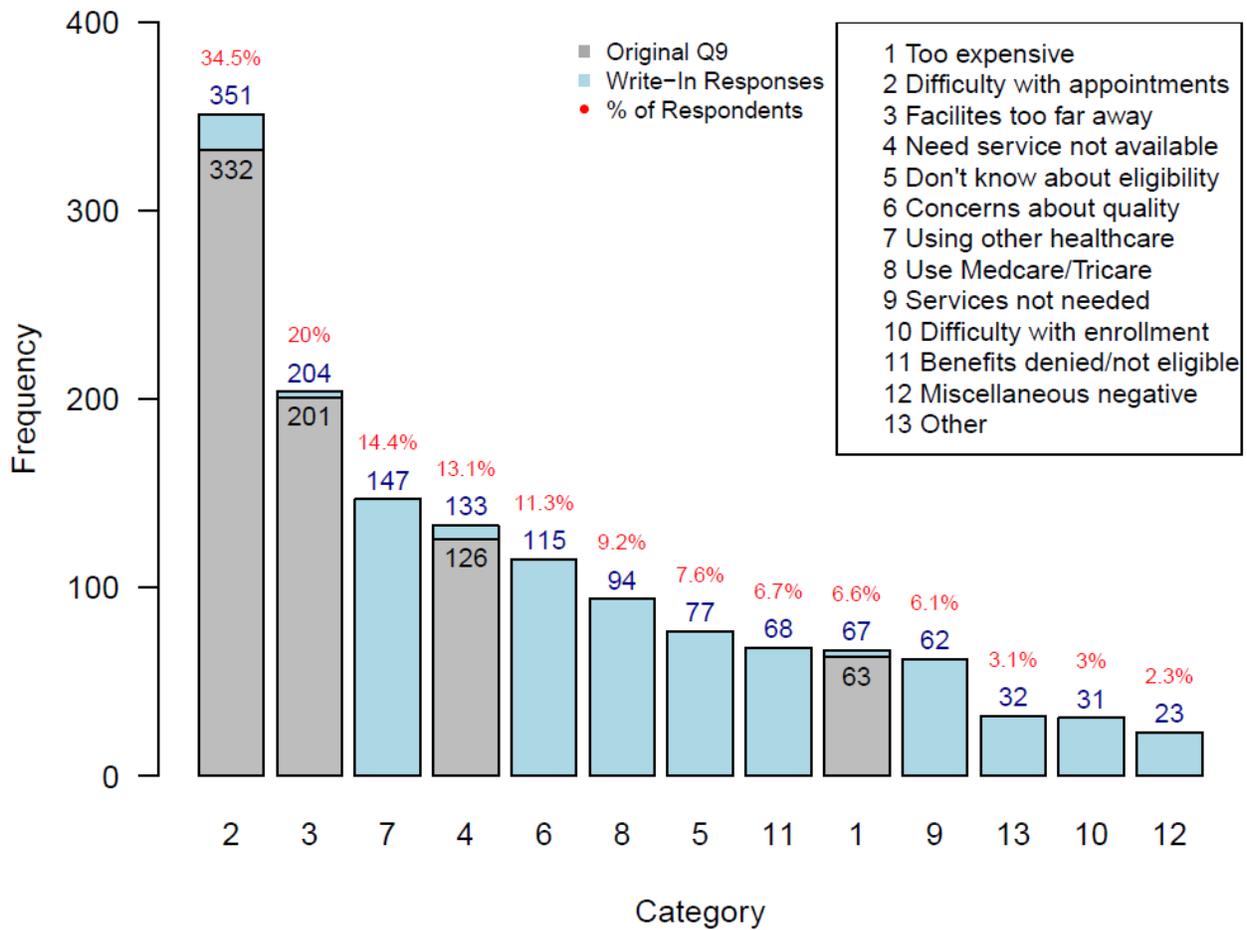
Respondents reported other veterans (85% somewhat helpful to very helpful), other veterans organization representatives (74% somewhat helpful to very helpful), and other veterans organization websites (64% somewhat helpful to very helpful) as the most helpful resources; and transition assistance advisors (36% somewhat helpful to very helpful), the VA help line (41% somewhat helpful to very helpful), and the ODVA website (48% somewhat helpful to very helpful) as the least helpful resources. Figure 3 displays the reported helpfulness of all resources.

Figure 3. Reported helpfulness of resources for learning about veterans health care ($n = 2,828$)



Sixty-four percent of respondents reported using VA health services benefits. Of those who reported not using these benefits, “difficulty getting appointments” was cited as the number one reason (35%), followed by “facilities too far away” (20%), and “using other health care” (14%). Figure 4 displays all reasons given for not using VA health services benefits. Bars shaded in gray represent the original choices on the Take 10 Survey for not using VA benefits. Bars shaded in blue represent the other responses written in by the respondents.

Figure 4. Reasons for not using VA health services benefits (unweighted) ($n = 1,063$)



FACTORS WHEN CHOOSING HEALTH CARE

The most important type of health care was reported to be primary care (60%) and the least important was mental health care (7%). Figure 5 displays the most important type of health care with respect to sex, age, combat status, disability status, and whether or not VA benefits are used. In each plot, significant differences are circled.

There are differences between males and females with respect to the most important type of health care. Both males and females reported primary care as being the most important (61% and 55%, respectively). Males reported mental health care as the least important (7%); whereas females reported urgent/hospital/home care as the least important (6%). Females are significantly more likely than males to report mental health care as most important ($p < 0.001$).

There are differences between those aged 18-39 years and those 40 years and older with respect to the most important type of health care. Both age groups reported primary care as being the most important (57% and 60%, respectively). The younger age group reported access to prescriptions as the least important (2%); whereas the older age group reported mental health care as the least important (5%). The older age group is significantly more likely than the younger age group to report access to prescriptions as most important; and the younger age group is significantly more likely than the older age group to report mental health care as most important ($p < 0.001$).

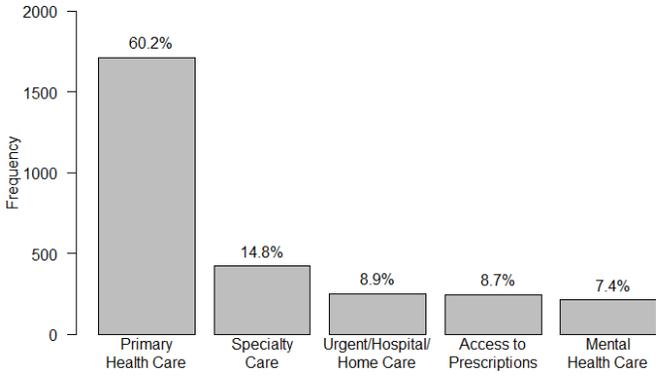
There are differences between combat and non-combat veterans with respect to the most important type of health care. Both groups reported primary care as being the most important (60% and 60%, respectively). Combat veterans reported access to prescriptions as the least important (7%); whereas, non-combat veterans reported mental health care as the least important (4%). Non-combat veterans are significantly more likely than combat veterans to report access to prescriptions as most important; and combat veterans are significantly more likely than non-combat veterans to report mental health care as most important ($p < 0.001$).

There are differences between veterans with a service-connected disability or pending disability and those without a service-connected disability with respect to the most important type of health care. Both groups reported primary care as being the most important (58% and 64%, respectively). Veterans with a disability or pending disability reported urgent/hospital/home care as least important (8%); whereas those without a disability reported mental health care as least important (4%). Veterans with a disability or pending disability are significantly more likely than veterans with no disability to report specialty care and mental health care as most important. Veterans with no disability are significantly more likely than veterans with a disability or pending disability to report urgent/hospital/home care as most important ($p < 0.001$).

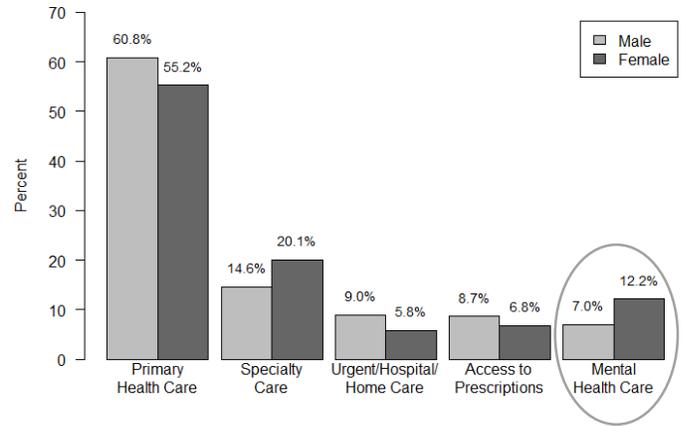
There are differences between veterans who use VA benefits and those who do not use VA benefits with respect to the most important type of health care. Both groups reported primary care as being the most important (58% and 64%, respectively). Veterans who use VA benefits reported urgent/hospital/home care as the least important (7%); and veterans who do not use VA benefits reported mental health care as the least important (6%). Veterans who use VA benefits are significantly more likely than veterans who do not use VA benefits to report specialty care as most important. Veterans who do not use VA benefits are significantly more likely than veterans who do use VA benefits to report urgent/hospital/home care as most important ($p < 0.001$).

Figure 5. Most important type of health care

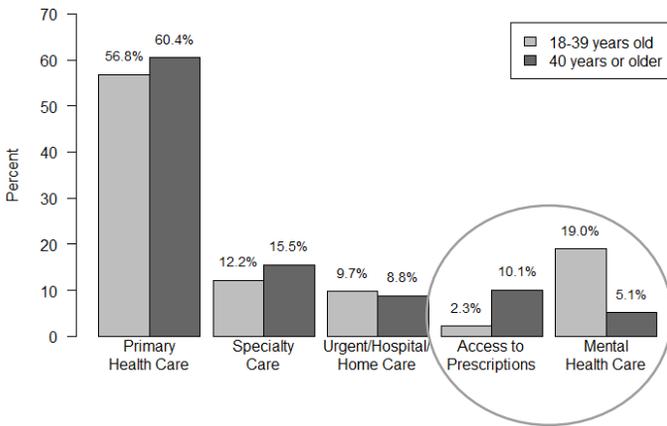
a. Overall ($n = 2,848$)



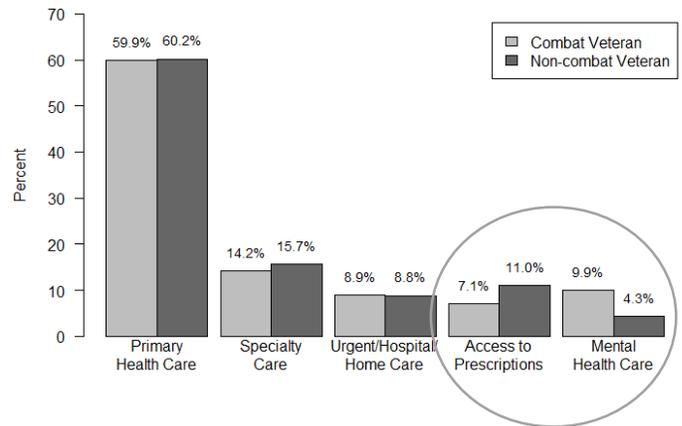
b. By sex ($n = 2,464$)



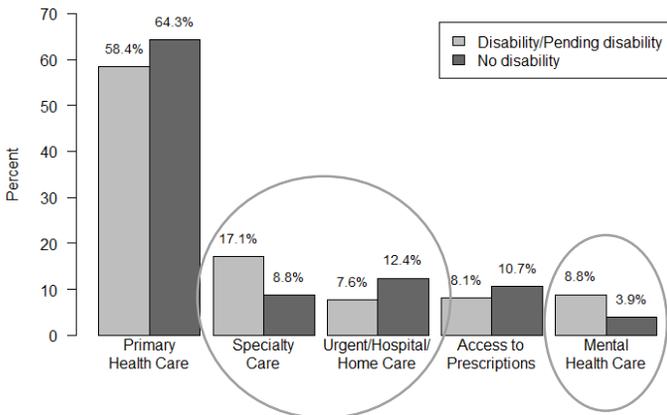
c. By age ($n = 2,786$)



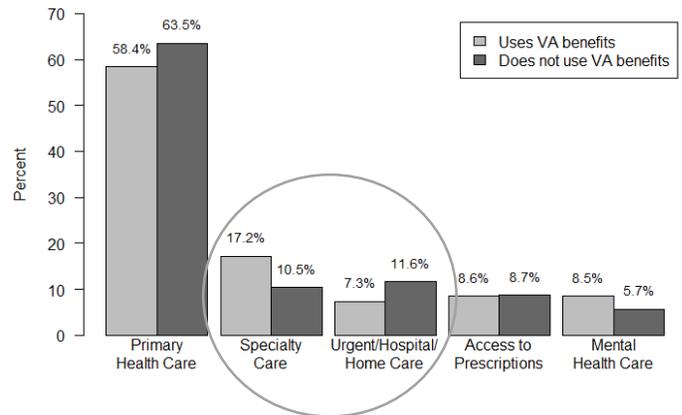
d. By combat status ($n = 2,791$)



e. By disability status ($n = 2,797$)



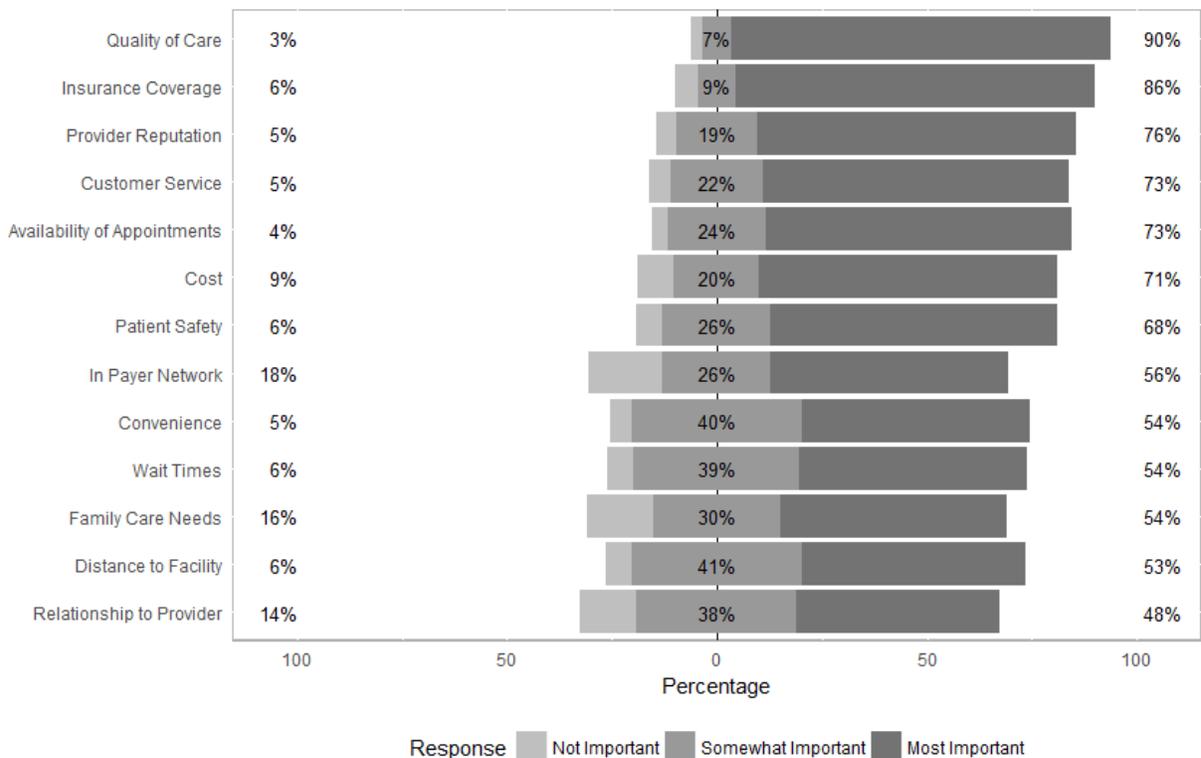
e. By VA benefits ($n = 2,825$)



The most important type of health care is also significantly related to race ($p < 0.001$) and income ($p < 0.001$). Specifically, Caucasian respondents are significantly more likely to report access to prescriptions as most important and significantly less likely to report mental health care as most important. African American respondents are significantly more likely to report primary health care as most important, and significantly less likely to report urgent/hospital/home care as most important. Those making more than \$75,000 per year are significantly less likely to report mental health care as most important. The most important type of health care is not significantly related to ethnicity ($p = 0.327$) or location of residence ($p = 0.437$).

Figure 6 displays the most important factors when choosing a health care provider. The factors receiving the highest ratings are quality of care (90% rated most important), insurance coverage (86% rated most important), and provider reputation (76% most important). The factors receiving the lowest ratings are relationship to provider (48% most important), distance to facility (53% most important), and family care needs (54% most important).

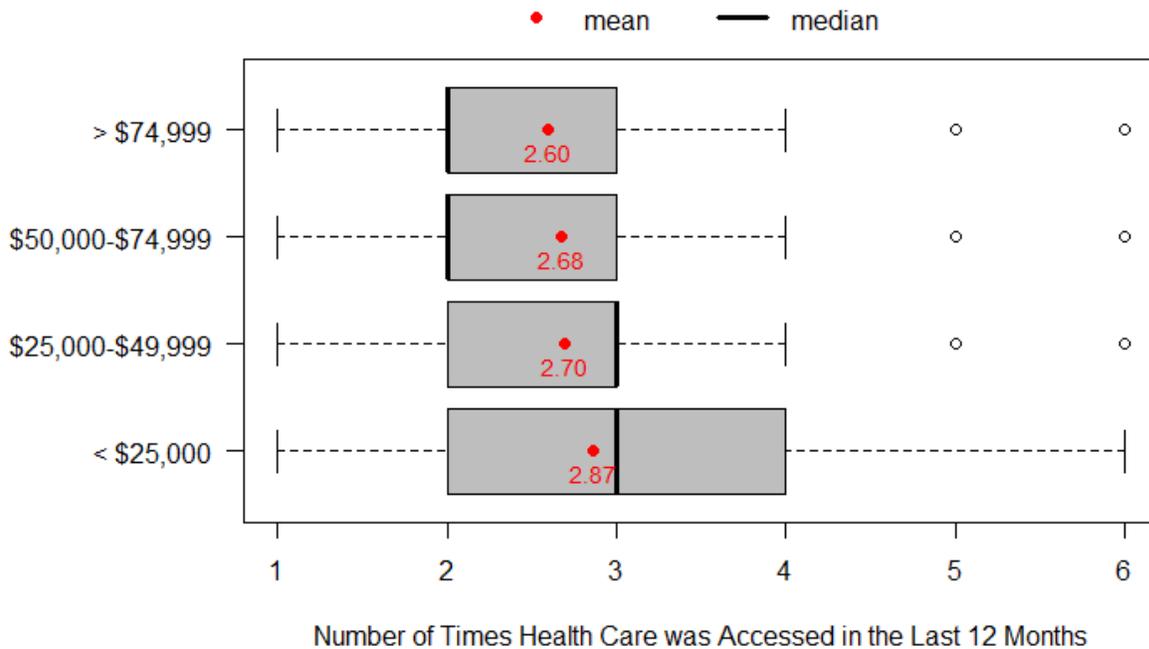
Figure 6. Most important factors when choosing a health care provider ($n = 2,867$).



FREQUENCY OF HEALTH CARE

Individuals reported accessing health care an average of 2.7 (± 1.3 s.d.) times in the last 12 months. There are no significant differences in the mean frequencies of accessing health care with respect to sex ($p = 0.289$), age ($p = 0.173$), race ($p = 0.058$), ethnicity ($p = 0.204$), location of residence ($p = 0.552$), combat status ($p = 0.402$), or disability status ($p = 0.122$). There is, however, a significant difference in the mean frequencies of accessing health care with respect to annual income ($p = 0.006$). Specifically, those making less than \$25,000 per year reported accessing health care an average of 2.9 (± 1.5 s.d.) times in the last year, which is significantly greater than the average of 2.6 (± 1.2 s.d.) times reported by those making more than \$75,000 per year. Although this difference is statistically significant, it may not be practically significant. However, it is interesting that the mean number of times health care was accessed decreases as annual income increases. Figure 7 displays boxplots for the number of times health care was accessed in the last 12 months.

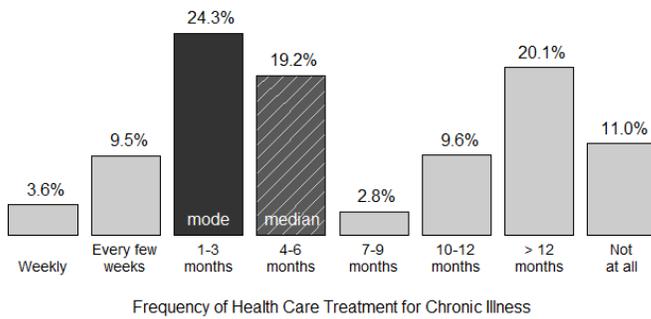
Figure 7. Number of times health care was accessed in the last 12 months ($n = 2,723$)



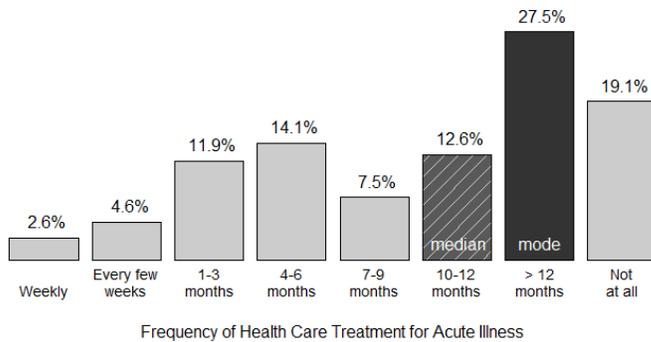
The reported frequencies of various types of health care are displayed in Figure 8. Sixty-nine percent of respondents reported seeking treatment for a chronic illness at least once a year; whereas only 32% reported seeking treatment for mental health at least once a year. These were the most and least sought treatments of the five categories on the Take 10 survey.

Figure 8. Frequency of health care treatment for various purposes ($n = 2,814$)

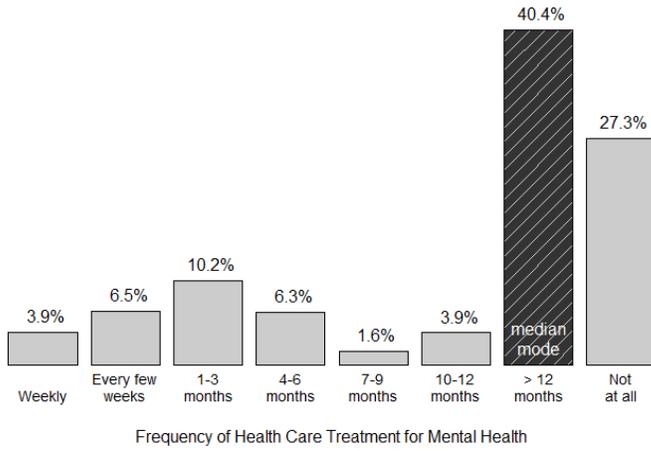
a. Chronic illness



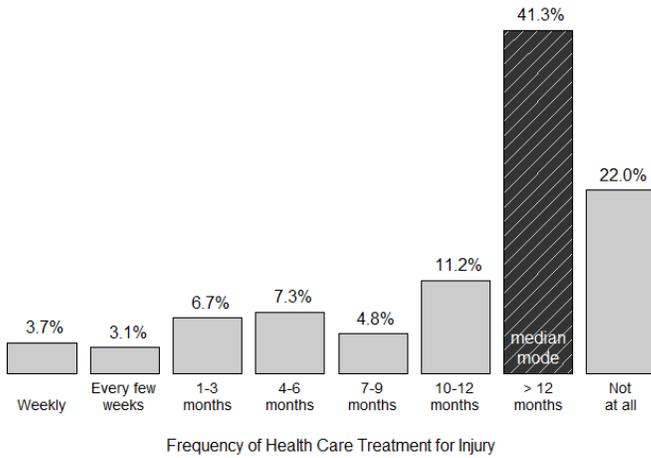
b. Acute illness



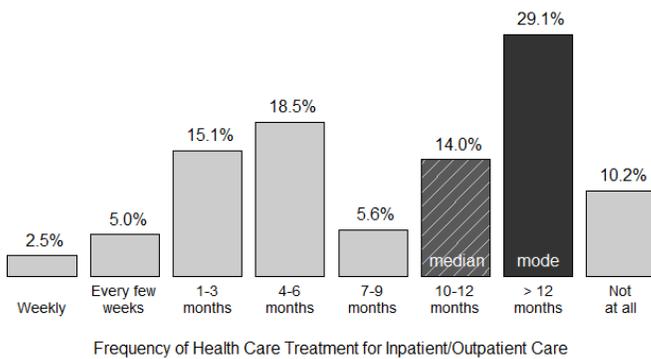
c. Mental Health



d. Injury



e. Inpatient/Outpatient care



LOCATION OF HEALTH CARE

According to respondents, the most accessed locations for receiving health care in the last 12 months were a VA hospital (49%), a physician through private insurance (35%), or a physician through Medicare/Medicaid (26%). The least accessed locations were the Oklahoma Department of Mental Health (1%), Indian Health Services (3%), or the individual's own home (3%). Figure 9 displays the reported locations of receiving health care.

Figure 9. Locations for receiving health care in the last 12 months ($n = 2,675$)

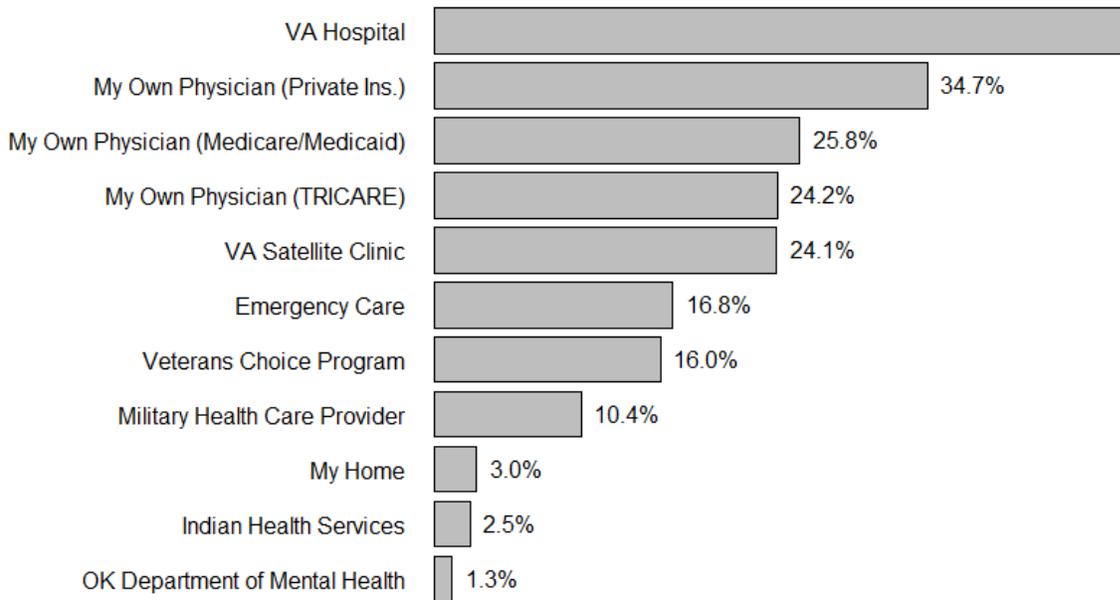
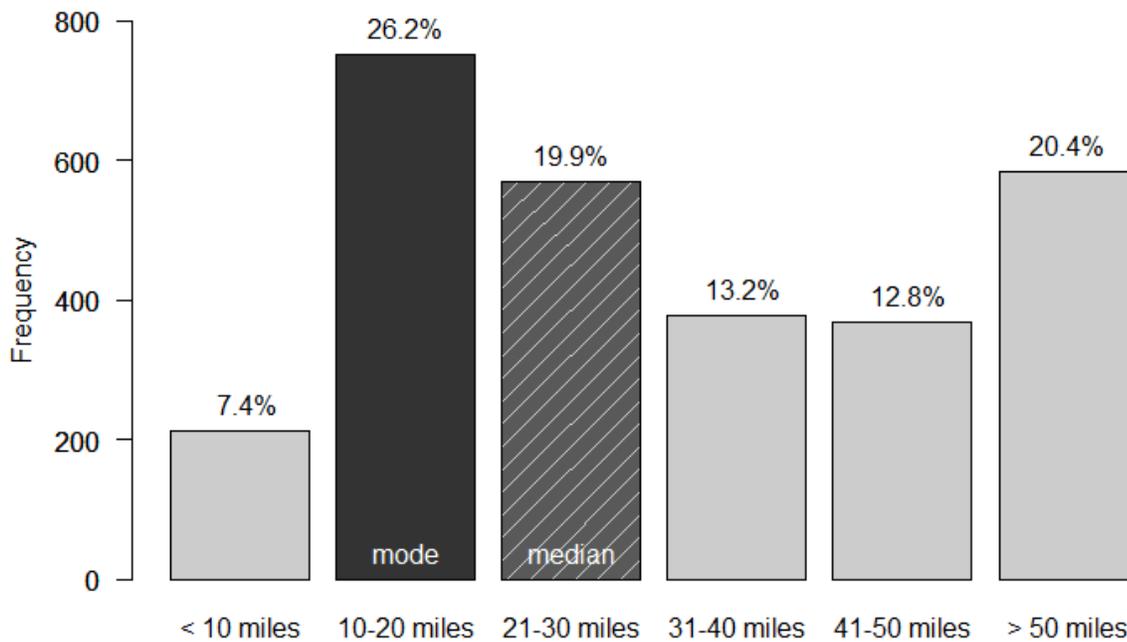


Figure 10 displays the distance respondents are willing to drive to receive health care. The median acceptable distance was 21-30 miles and the most reported acceptable distance was 10-20 miles.

Figure 10. Acceptable driving distance to receive health care ($n = 2,867$)

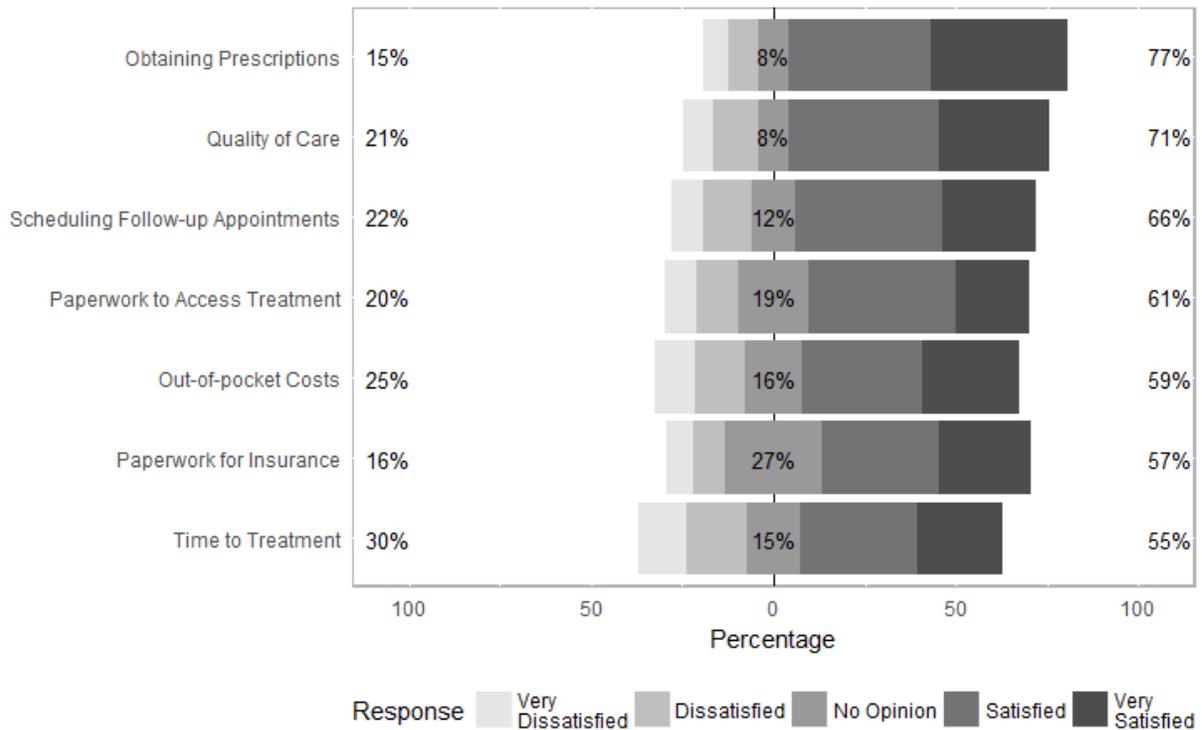


There are significant differences in the median acceptable driving distance for health care with respect to whether VA benefits are used ($p < 0.001$), disability status ($p = 0.002$), age ($p = 0.013$), and race ($p < 0.001$). Specifically, those who use VA benefits are willing to drive further for health care than those who do not use VA benefits. Those with a disability or pending disability are willing to drive further for health care than those with no disability. Those 70 years and older are willing to drive further for health care than those under 70 years old. And, Native Americans are willing to drive further for health care than non-Native Americans. There were no significant differences in the median acceptable driving distance for health care with respect to sex ($p = 0.314$), combat status ($p = 0.928$), and annual income ($p = 0.192$).

SATISFACTION WITH ACCESS TO HEALTH CARE

Figure 11 displays the respondents' satisfaction with various aspects of health care. Overall, the respondents seem to be satisfied with their access to health care, with more than 50% of respondents reporting being either satisfied or very satisfied with each aspect of health care. Respondents are most satisfied with obtaining prescriptions (77% satisfied or very satisfied) and least satisfied with time to treatment (55% satisfied or very satisfied).

Figure 11. Satisfaction with various aspects of health care ($n = 2,720$)



ADDITIONAL COMMENTS

In all, 1,091 respondents provided additional comments at the end of the Take 10 survey. Those comments were tabulated according to key words and phrases resulting in the graph displayed in Figure 12.

Figure 12. Additional Comments (unweighted) ($n = 1,091$)

