EXPERIENCES OF HOMELESS VIETNAM VETERANS IN DECIDING TO ACCESS OR NOT ACCESS HEALTH CARE

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DEDICATION

For my children, Casey, Morgan, Jaime, and Christa; and for Stuart;

You fill my life with joy.

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ABSTRACT

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Homeless Vietnam Veterans (HVV) report their health status as poor, indicating a multitude of health concerns, including physical and psychological problems, post-traumatic stress disorder (PTSD), and alcohol or drug dependencies. Prompt attention to health care may improve the prognosis; however, HVV tend to delay seeking medical attention. The purpose of this study was to explore the process utilized by HVV to make the decision to access or to not access health care services. According to inclusion criteria of the study, all participants served in the US military during the Vietnam War.

Eleven HVV were interviewed to understand the decision-making process about accessing health care services. Using Grounded Theory Methodology with Symbolic Interactionism as the philosophical framework semi-structured interviews were conducted. Data analysis was performed according to Straussian methodology and included open, axial, and selective coding.

Three predominant categories surfaced: military experiences, substance use, and access issues. A lesser category of homelessness with informal communication via the grapevine was also identified. The core category is healthcare decision-making. A

description of processes used by HVV in accessing health care was used to create a preliminary theory.

Based on the data, healthcare decision-making seems to occur within the context of military experiences; substance use; homelessness, where communication occurs via the grapevine, and access issues with difficulty with mobility, convenience, quality, and system inefficiencies. While none of these concepts alone appear to be the primary trigger for healthcare decision-making in HVV, healthcare decision-making certainly occurs within the context of the collective of these concepts.

Therefore, the preliminary HVV Health Care Utilization Theory is that HVV have an alternate view of wellness and health. Rather than health being the absence of disease, it is surviving in the presence of disease. The environment of homelessness enhances diminished or compromised wellness. Camaraderie is important in the homeless environment, where information sharing occurs via informal networks- as through the grapevine. When HVV enter the healthcare environment, especially when using VA facilities, HVV experience more burden than benefit because of access issues.

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INTRODUCTION

Focus of Inquiry

Military veterans have been found to be at an increased risk for homelessness when compared to the general population (Tsai, Mares, & Rosenheck, 2012). According to the 2012 Point-in-time Annual Homeless Assessment Report, veterans are overrepresented among the homeless population (Cortes, Henry, de la Cruz, & Brown, 2012). While veterans account for roughly 10 % of the total adult population in the United States (U.S.), they comprise 16 % of the homeless adult population (Tsai, Kasprow, & Rosenheck, 2013). When compared to non-veteran homeless men, homeless veterans have greater medical and psychiatric health care concerns. To address homelessness in veterans, Veterans Administration (VA) has committed to improve access to and quality of health care services for this population using comprehensive, proven models (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).

For homeless veterans, especially those who are older, there are many challenges that affect health status and quality of life, such as separation from or death of family members and friends; decreased social supports; depression; and becoming dependent on others because of illnesses, such as dementia or cerebrovascular accidents. Medical concerns of homeless veterans include issues with dental health, pulmonary, endocrine, orthopedic, cardiac, oncology, optometry, audiology, and podiatry. Psychiatric needs

include post-traumatic stress disorder (PTSD), anger issues, anxiety, schizophrenia, bipolar disorder, substance use, and sleep disorders. As veterans age, health status becomes more brittle and geriatric issues arise (Molinari, Brown, Frahm, Schinka, & Casey, 2014). Homeless veterans who were involved in combat or who served during the Vietnam have substantial needs, especially those associated with physical injury, psychiatric issues, substance abuse, and medical illnesses (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).

When self-reporting, Homeless Vietnam Veterans (HVV) describe their health status as fair or poor, and indicate they have a multitude of health concerns that include physical and psychological medical problems, PTSD or anxiety, and alcohol or drug dependencies (Virgo, et al., 2004). Malnutrition, skin disorders, and injuries related to violence are major health issues, often untreated (Virgo et al., 2004). In a study by O'Toole et al. (2003), homeless veterans were found to be less likely to utilize community health care clinics even though they had medical and psychiatric health care needs. Homeless veterans were also found to be frustrated and experienced high stress levels with the VA, partly because veterans' benefits are needed to receive VA health care services (O'Toole et al., 2003). For homeless veterans, signing up for VA benefits can be difficult and time-consuming. Though more than half of homeless veterans have a chronic medical condition, and two-thirds have a chronic psychiatric condition, many of these are untreated (O'Toole et al., 2003). Therefore, a qualitative research design will be used to explore the process that is utilized by HVV to make the decision to access or to

not access health care services. The specific aim of this research is to develop a theory grounded in data to explain why HVV do or do not seek health care.

Vietnam Veterans are defined as men and women who served in the military state-side and in foreign countries during the Vietnam War (1959-1975). Homelessness is defined as not having a permanent night-time residence, other than a homeless shelter or homeless camp. Available health care is defined as that provided by VA or community-funded clinics and hospitals. It was anticipated that information gained from this study would offer information for healthcare providers to develop and adapt interventions to better meet needs of HVV.

Statement of Purpose

The proposed study began with recognizing and intending to improve understanding about experiences and challenges of HVV seeking health care services. Several factors may contribute to health problems of HVV, including being part of the "Baby Boomer" generation- Americans born after World War II. This generation is expected to live longer than previous generations because of better understanding of prolonged existences and progressive technology that leads to new and improved medical advancement (Erber, 2005). Additionally, access to quality health care is associated with a care-giving environment and social interaction between health care provider and client (Morey, Peterson, Pieper, Sloane, Crowley, Cowper, & Pearson, 2009). When HVV attempt to access health care, barriers may be great and difficult to overcome. Identifying,

recognizing, correcting, and limiting barriers that fragment health care delivery can improve overall health and well-being of HVV.

The VA's mission is to provide veterans with world-class benefits and services, while at the same time striving to maintain high standards (Department of Veterans Affairs, 2007). Even so, there are many veterans who do not utilize VA health care services. In the last five years, the total number of veterans in the U.S. was approximately 23 million; of that number, less than 8 million, or approximately one-third, were enrolled in VA health care (Department of Veterans Affairs, 2007). Because of VA benefits, homeless veterans are significantly more likely than homeless non-veterans to have health insurance and, conversely, less likely to utilize community health care clinics. Instead, shelter-based clinics or street outreach services are used (O'Toole et al., 2003).

The purpose of this study was to explore the process utilized by HVV to make the decision to access or to not access health care services. The aim of the study was to develop a theory grounded in data to explain why HVV do or do not seek health care. According to inclusion criteria of the study, all participants served in the U.S. military during the Vietnam War. This criterion was significant because the Vietnam War was one of our nation's most taxing wars, presenting continuous threats of violence, injury, or death while in combat, while denying servicemen and women the opportunity to discuss their traumatic experiences once they returned home (Sonnenberg, Blank, & Talbott, 1985). While Vietnam Veterans may have unresolved emotional, physical, and psychosocial needs, most of them are now in their 60s and 70s, which increases needs for

health care for a plethora of issues that come with growing older (Kulka, Schlenger, Fairbanks, Hough, Jordan, Marmar, Weiss, Grady, 1990).

Research Question

Recognizing that HVV may have social problems that affect access to VA and community health care services, it was necessary to understand the decision-making process taken by HVV when health care issues arose. Therefore, the research question was, "What is the process utilized by HVV to make the decision to access or to not access health care services?" The specific aims of the proposed study were: (a) to develop a theory grounded in data that might explain why HVV sought or did not seek health care; (b) to determine specific factors that contributed to and influenced HVV' decision-making process; and (c) to determine if specific behavior patterns were relevant in the decision-making process and what these behavior patterns were.

Rationale for the Study

The researcher's interest in HVV stemmed from experiences as a professional nurse living in a small, rural community with a large percentage of Vietnam Veterans. The researcher became aware that homelessness is a social issue that affects communities across the U.S. Homelessness comprises three essential causative factors that, when combined with other events, create unsafe, unhealthy living (Gottfried, 1999). Essential causative factors are unemployment, or not earning a sufficient wage to support one's self; lack of affordable housing; and a breakdown of family and social support systems,

possibly from divorce, illness or death of a family member, or as an escape from an abusive relationship (Gottfried, 1999).

Access to quality health care is associated with a care-giving environment and social interaction between health care provider and client (Morey et al., 2009). When HVV attempt to access health care, barriers may be difficult to overcome, thus impacting the decision-making process in determining whether or not to access health care services.

The findings from this study will provide methods and rationales for better understanding the needs of this marginalized population. Identifying, recognizing, correcting, and limiting barriers that fragment health care delivery improves overall health and well-being of HVV. If factors and behavior patterns are identified, HVV can be involved accessing health care services and receiving benefits, thus improving overall health care status. Understanding the decision-making process of HVV is important as veterans are disproportionately represented among homeless populations and continue to experience substantial physical and psychiatric health issues.

Philosophical Underpinnings

The philosophical underpinning for this study was Symbolic Interactionism (SI), which utilizes a social psychology approach, adjusting analysis based on how people tend to act and interact in the course of their daily living, focusing on human experiences. Symbolic Interactionism focuses on shared portions of human acts and contact, meaning, and interpretation of meaning (Blumer, 1969). People respond to things based on meaning that those things have for them. Meaning is based on social interactions with

other people, as the person modifies and interprets things he/she comes across (Blumer, 1969).

There are three foundational principles of SI. The first is meaning, or that human behavior is a response to things or symbols. The second is thought which is based on a constant process of determining meaning from things themselves. The third is language, which is thought about, or developed, and used to describe meanings (Blumer, 1969). Even though behavior may be influenced by context, history, and social mores, these symbols do not determine behavior. The essence of SI is how people interpret circumstances, or use thought processes to apply meaning, and select one course of action over another, which was precisely what this research attempted to explain. There is a dynamic relationship among people and society as continuous interpretation and action define each moment and provide a language to better understand actions (Blumer, 1969).

Since meaning is not inherently deduced from symbols, but rather comes from an interaction between person and symbol, people interpret their realities based on an individual awareness of reality, which is a continuous process of creating meaning (Blumer, 1969). In other words, there are three truths to every situation: my interpretation of what happened, your interpretation of what happened, and what really happened. Thus, inter-relatedness between a person and a symbol allows for multiple social interpretations to emerge. As people develop, important individuals and social institutions influence reference groups and acquired roles (Blumer, 1969). Situations are analyzed to determine proper behavior as it applies to understanding of reality. The process of self-reflection

entails “3 me’s”: who the person thinks he/she is, who another person thinks this person is, and who this person really is. This process allows for change as well as stability; as the process continues, actions become more consistent. It is through language that symbolic communication occurs, where meanings are shared, that people become aware of other’s experiences and meanings can be interpreted. Additionally, internal conversations are conducted to attempt to understand reality by defining the current situation a person finds him/herself in and then using that information to determine how to behave (Blumer, 1969).

Research using inductive inquiry and based on SI is thought to be a way to understand human complexity as it allows for an understanding of how people apply meaning to situations where automatic responses are inadequate (Oliver, 2012). For people who have little or no material wealth, other people become very important and those relationships become symbolic (Payne, 1995).

Symbolic Interactionism was used to (a) understand meaning that HVV attached to the health care setting, to health, and to illness; and (b) identify responses Vietnam Veterans applied to things, or symbols, through their interaction with health care providers. Through the use of SI, it was hoped that an understanding would be gained of HVV’s analysis and interpretation of symbols and/or other people’s actions that would lead to interpretations and subsequent behaviors in deciding to access or not access health care services.

For veterans, including those who are homeless, status and rank have meaning. This is found at the group and individual level. Among health care professionals, doctors, nurses, social workers, and therapists may be included and be assigned professional status while delivering diagnoses, treatment, and prognoses. White coats, uniforms, stethoscopes, and name badges may signify knowledge and positions that health care professionals hold, while acknowledgment of military rank, such as sergeant or corporal, are appreciated and may be interpreted automatically, while still influencing and impacting interactive process.

From this interaction, meanings that form our sense of who we are as individuals emerge. These may include such things as dialogues and thought processes. It is important to the individual to be part of a social interaction and be seen as playing a part, or having a role, such as might arise from military experience. An example is being a pilot, attaining the rank of officer, returning home as a hero, or fulfilling a leadership role in a combat squadron or platoon during the war. These self-perceptions motivate behavior. After being in the military, and possibly in a leadership position, being homeless and possibly ill may cause the veteran to feel vulnerable and powerless. Personal connections and interpretations become indicators for mutual interaction and influence decision-making processes. Language also affects interactions as meaning is assigned to symbols, which can affect behavior.

Meanings are modified by interpretation and interaction of shared symbols. As HVV age and become more vulnerable, they have greater health care needs. Social

structure of military life shapes interactions with others, while incorporating a particular language and associated symbols. There is a hierarchy in the military that is carried forward and respected, long after veterans return to the U.S. and leave active military service. To further compound the issue of vulnerability, there is the possibility that HVV with health care issues may be identified by conditions rather than as individuals. It is important for these veterans to be seen as men and women who were initially shaped by society by their military service but then grew and made further contributions to society.

Through the use of SI, individual awareness and interpretation of reality within the HVV allowed for a better understanding of health-related situations to allow him or her to make a decision about whether to access or to not access health care. It was anticipated that a theory explaining behaviors of HVV decisions to access or not access health care services would emerge using philosophical underpinnings of SI.

Summary

A responsibility exists for men and women of previous wars to not be forgotten and for them to have quality, timely health care in various service facilities. By identifying, correcting, and limiting barriers that fragment health care delivery for these aging men and women, it may be possible to improve health care access and health status.

In Chapter 2, the review of literature will be presented.

CHAPTER II

REVIEW OF LITERATURE

A search for literature was conducted of nursing, medical, social work, and public health literature using the databases MEDLINE, CINAHL, and Psych Info. Dissertations and white papers were used to determine gaps, locate recent developments in the field of interest, and provide pertinent support for the study. Key words used were “Vietnam,” “veteran(s),” “homeless,” “homelessness,” “homeless veterans,” “Veterans Health Administration,” “access to health care,” “health services utilization,” “health services accessibility,” “health status,” and “Department of Veterans Administration”. Limiters used were the years 2000-2013, articles in English, and articles in academic and research journals.

The review of literature began using the search term, “Vietnam Veterans,” which returned almost 60,000 results. By adding “homeless” to the search, and limiting the publication time to 2000 through 2013, the results dropped to 590 articles. Restricting the source type to academic journals reduced the results to fewer than 100. Abstracts were read to determine applicability to this proposed research and an annotated bibliography was produced.

The time frame was expanded to include articles published in the 1980s and 1990s as landmark articles on the Vietnam War, which ended in 1973, were likely to be

written during this time. It was necessary to explore research from years following the end of the war to better understand events leading up to homelessness for Vietnam Veterans. Further searches were conducted for authors who were found to have conducted research over an extended period of time on the topic of Vietnam. A search was also conducted for dissertations on "homelessness," "Vietnam Veterans," "Symbolic Interactionism" (SI), and "Grounded Theory Methodology" (GTM). This review of literature will discuss the subtopics of (a) homelessness, (b) health care access, (c) substance use, (d) mental health issues, and will conclude with (e) research gaps.

Homelessness

The Stewart B. McKinney Homeless Assistance Act defined homelessness as "lack of a fixed, regular, and adequate nighttime residence" (Gordon, Haas, Luther, Hilton, & Goldstein, 2010). O'Toole et al. (2003) defined homelessness as living in an unsheltered dwelling, such as an abandoned building, a car, in a park or under a bridge, eating in a public facility, such as a soup kitchen or food bank, sleeping in emergency shelters, and utilizing single-room-occupancy (SRO) dwellings or transitional housing, such as a half-way house. Mares, Kasprow, and Rosenheck (2004) termed "literal homelessness" as a condition that applies to people who sleep in a shelter, public place, or on the street, without benefit of a place to eat. "Marginal homelessness" is when someone who would otherwise be without a place to live uses a motel, transitional housing, or a friend's or relative's house (Kushel, Vittinghoff, & Haas, 2001). The United States Department of Housing and Urban Development (USDHUD) (2012) defined

"chronically homeless" as someone who has no permanent, regular, or satisfactory residence, who has been homeless for over a year, or who has experienced four or more episodes of homelessness during the previous three years.

Historical events have contributed to homelessness in the U.S. In 1963, the Community Mental Health Center Act led to release of mentally ill clients who were not dangerous to themselves or society. Initially, the goal was to assist the mentally ill to find housing in group homes or in single room occupancy (SRO) dwellings and to continue necessary psychiatric therapy and medications on an outpatient basis. Unfortunately, communities rallied against this move, as group homes for mentally ill were unwelcome in most neighborhoods (Gottfried, 1999). The result was that many of the deinstitutionalized persons became homeless. “Modern” homelessness in the 1970s began in response to the faltering economy and led to a reduction in affordable housing (USDHUD, 2012). The incidence of homelessness among Vietnam Veterans became well known; throughout the 1980s, Vietnam Veterans with significant PTSD were at high risk for homelessness. Many Vietnam Veterans became homeless within a few years of returning to the U.S. (Rosenheck, Leda, & Gallup, 1992).

Homelessness is a condition and, ultimately, a social category of people who do not have houses or residences because of three pathways that lead to homelessness: social selection, socioeconomic adversity, and traumatic experiences. Social selection is the inability to live independently because of a mental or physical illness. Socioeconomic adversity includes job loss, low level of educational attainment, inadequate vocational

skills, and scarce resources (Dietz, 2007). Dietz (2007) offered that poverty and social isolation are basic causes of homelessness with substance use a major risk as it is a means to cope with adversity. Traumatic experiences include intimate partner violence, abandonment, and post-traumatic stress disorder (Kim, Ford, Howard, & Bradford, 2010; National Coalition for the Homeless, 2009).

Although veterans comprise 10 % of the total U.S. population, almost 16 %, or approximately 60,000, of the homeless population are veterans and one-third (or about 66,000) is combat veterans (USDHUD, 2012). Dietz (2007) reported that the homeless suffer from malnutrition, experience transportation problems, and face difficulty maintaining hygiene, as living situations are hazardous and finding adequate healthcare is difficult.

When service men and women return home, they may face significant financial, vocational, and individual obstacles, such as reintegrating into family and social realms, which can contribute to homelessness as low military pay places veterans at risk for poverty (Savitsky, Illingworth, & DuLaney, 2009). People struggling with low incomes and barely able to meet financial obligations are one major illness away from being homeless (Tsai et al., 2012).

The Veterans Administration (VA) is committed to ending homelessness among veterans. When compared to the general population, Vietnam Veterans have an increased risk for homelessness, even though the VA created homeless programs specifically for them (O'Toole et al., 2003). Additionally, homeless veterans have more medical

(including mental health) needs than homeless men who were not veterans. They were also less likely to access community health centers and rely on shelters and street outreach services instead (O'Toole et al., 2003).

Homelessness can lead to loitering, criminal acts, and arrests. After incarceration the person has nowhere to go except back on the streets. Additionally, homeless people are required to have no arrests within the preceding 6 months to remain on waiting lists for subsidized housing. Most law-enforcement agencies do not understand the setbacks that result from these arrests. Rounding up large numbers of homeless people and arresting them for loitering or vagrancy, impedes and delays the process of placing them in housing, off the street, for at least another 6 months.

Veterans overwhelmingly identified employment as the single most important goal to attaining self-sufficiency and regaining housing, while expressing a strong desire to overcome their current problems. Their lack of self-esteem destroys their will and determination to escape homelessness (Doolin, 2009). According to veterans, this negativity was the result of multiple setbacks in personal and social interactions (severing of familial ties, loss of peer support, and loss of autonomy and self-sufficiency). Among barriers to seeking employment was lack of a permanent address, a perceived sense of distrust from potential employers of people living in shelters, employer rejection, and need for vocational training opportunities (Garcia-Rea & LePage, 2008).

Health Care Access

In a study by O'Toole et al. (2003), homeless veterans were found to have more medical (including mental health) needs than homeless men and women who were not veterans. They were less likely to access community health centers, and relied on shelters and street outreach services (O'Toole et al., 2003). The approximate cost of one homeless person to health care and legal systems can be as much as $75,000 per year (Garcia-Rea & LePage, 2008), with increases stemming from incarcerations, and associated legal and court costs (Copeland, Miller, Welsh, McCarthy, Zeber, & Kilbourne, 2009). Homeless people may become victims of street crimes because of increased vulnerability and diminished capacity to be able to fight back (Benda, 2006). It is not surprising that transportation, self-care, and access to healthcare become issues.

Personal, situational, and bureaucratic barriers to accessing VA health care services include: high incidence of acute and chronic health issues; limited resources; proximity to clinics; negative public perceptions; insensitive service providers; and dehumanizing policies and procedures (Benda, 2006; Copeland et al., 2009; Greenberg & Rosenheck, 2009). Homeless Vietnam Veterans reported their displeasure with health care service providers who could not communicate effectively and clearly in English when it was the provider's second language.

Fragmentation of services and admission procedures in VA facilities were viewed as obstacles to homeless Vietnam Veterans attempting to access health care or homeless services (Blue-Howells, McGuire, & Nakashima, 2008). Each division has its own

department and separate building, on a common campus, which can be spread out over miles. Appointments for routine check-ups and specialty care referrals require scheduling over spans of weeks or months. Appointments are first scheduled for an intake visit to update information and collect lab samples with a return appointment made for a later date to actually see a health care practitioner for screening, assessment, referral, and prescriptions. Upon arrival at the clinic for subsequent visits, if labs are misplaced or not received by the VA clinic, the veteran is advised to reschedule, furthering delay of receiving necessary health care services. While time and distance seem to be minor inconveniences to most people, to HVV these barriers become insurmountable when coupled with lack of transportation, physical activity limitations or cognitive impairment (Blue-Howells et al., 2008). Public transit systems require purchased tokens or exact fare, and have confusing schedules and transfers. For the HVV who has no money, the bus is not a viable option. If a service is located in another building, the veteran is forced to walk, sometimes great distances, and may be turned away with instructions to come back at a later date. HVV may not have telephones or, if they do have a cellular device, have minimal minutes on their plan, which does not allow them to wait while the receptionist places them on hold.

Some veterans do not qualify for VA benefits while others live too far away to access VA services. It is critical that homeless Vietnam Veterans receive timely help, an early diagnosis, and comprehensive treatment (Doolin, 2009). Veterans were eligible for VA services if they were diagnosed with a covered medical issue within two years of

returning to the U.S., but it often took at least that long to recognize a problem and make a diagnosis ("Alcohol use study," 2008). Vietnam Veterans have long since exceeded this timeframe.

Medical problems commonly associated with homelessness include respiratory illness, obesity, gastrointestinal conditions, and pain disorders (Garcia-Rea & Le Page, 2008). Homeless veterans have more medical and mental health needs than homeless non-veterans (Curran, Stecker, Han, & Booth, 2009; Dietz, 2007). Gelberg, Anderson, and Leake (2000) found that, even though homeless people have poor health, they were not likely to seek health care services until they needed to be hospitalized, the cause of which frequently began as a preventable condition. Provider sensitivity, facility location, access to integrated broad services, time consuming processes, and methods used to ration services may cause homeless people to avoid seeking care as transportation, self-care, and access to health care become an issue. Within community health centers that focus on providing healthcare to underserved and homeless, only half of Vietnam Veterans received services, which may be attributed to lack of mental capacity or to reluctance of homeless people to access services (Gelberg et al., 2000).

Prior to the mid-1990s, in a response to criticism for poor quality of care, the VA struggled with performance and quality issues, which led to a re-evaluation and reorganization to improve quality of health care delivery (Perlin, Kizer, & Dudley, 2003). However, when accepted processes of care were assessed, the VA demonstrated better performance than non-VA comparison groups. The VA, which provides comprehensive

healthcare for military veterans, is the nation's largest system serving a designated population. Veterans who have a service-related disability or who are low-income receive priority status to enroll in the VA (Trivedi, Matula, Miake-Lye, Glassman, Shekelle, & Asch, 2011). However, not all veterans qualify for VA benefits, while others live too far away to access VA systems (Doolin, 2009). It is critical that HVV receive health care services, prevention services, an early diagnosis, and comprehensive treatment, which will be facilitated by understanding the decision-making process that is used to determine whether or not to access care.

Tsai et al. (2012) questioned whether homeless veterans had more severe health problems or had inferior outcomes when community-based supported housing was utilized. Over a one-year period, Tsai et al. (2012) observed a nationally supported housing initiative, comparing 162 chronically homeless veterans to 388 non-veterans. They defined "chronic homelessness" as a condition affecting a single, homeless person who had a disabling condition and had either been homeless for one year or more or who experienced a minimum of four episodes during the preceding three years. Veterans in the study sample tended to be older, from the Vietnam-era, male, and to have completed high school when compared to other chronically homeless participants.

Tsai et al. (2012) reported that once homeless veterans were admitted to a supported housing program, they were at a decreased risk for adverse outcomes, as evidenced by a reduction in use of health services, especially inpatient services. Veterans were found to use outpatient health services more often than non-veterans. Even so, many

veterans either did not qualify for or chose not to access VA services, electing to utilize community-based health care services instead. These results confirmed that veterans often use community-based healthcare services rather than relying on the VA, even when they are entitled to and have earned these benefits (Tsai et al., 2012).

Goldstein, Luther, Jacoby, Haas, and Gordon (2008) compared demographics, homeless situations, and referral recommendations of 2,733 Vietnam Veterans using cluster analyses to create a proposed cluster-solution to plan treatment and predict outcomes for homeless veterans with medical and behavioral health issues. Researchers found that about 30 % of veterans who were homeless had disability-related financial support, while approximately 16 % of homeless veterans had a service-related disability and received health care benefits through the VA. These numbers are low when considering that almost 75 % of homeless veterans reported a serious medical problem and more than 50 % of homeless veterans accessed VA medical services. Of homeless veterans, the majority have at least one medical disorder and frequently report having more than one co-occurring medical, psychiatric, or substance abuse disorder, further justifying need for medical and psychiatric treatment (Goldstein et al., 2008).

The link between the Goldstein (2008) study and this study was that veterans are using non-VA providers for health care even when VA services are available. While the Goldstein (2008) study focused on veterans with PTSD, rather than those who are homeless, many homeless Vietnam Veterans have been found to suffer from PTSD (Goldstein et al., 2008).

Elhai, Reeves, and Frueh (2004) researched top predictors of health service use among combat PTSD patients. As an indirect indicator of service use, numbers of psychiatric medications prescribed were included, along with determining whether racial group status was a significant predictor of PTSD-related service use. The researchers utilized the Behavioral Model of Health, which incorporated a combination of characteristics to determine likelihood and quantity of use of health care services. These included: predisposing factors, such as personal history and demographic characteristics that existed prior to illness; illness/need factors, such as diagnostic and severity characteristics of illness; and enabling factors, such as ability and resources to seek health care services.

Elhai et al. (2004) conducted a quantitative study using a secondary analysis of data. Four linear regression analyses were measured: predisposing factors (i.e., age, educational level, race, and marital status); illness/need factors (i.e., symptom over-reporting, anxiety, and psychosis); and enabling factors (i.e., annual income, distance to VA, employment status, and disability benefits for medical or psychiatric conditions). A chart review of computerized medical records was conducted to determine service use data, such as types of VA health services used and number of visits to PTSD, primary care, and specialty care clinics. Additionally, numbers of psychiatric medication prescriptions were also noted. Clinical-Administered PTSD Scale (CAPS) confirmed diagnosis of PTSD in participants. Minnesota Multiphasic Personality Inventory (MMPI) generated behavioral and clinical data, while Beck Depression Inventory measured

depression. Mississippi Combat PTSD Scale (M-PTSD) was used to measure combat-related PTSD symptoms (Elhai et al., 2004). Archival data was also used, along with full clinical evaluations to examine psychopathology differences and service use based on variables of race and disability-seeking status in combat veterans with PTSD.

The sample for the Elhai (2004) study included 87 PTSD-diagnosed male combat veterans, whose ages ranged from 28-78 years. Of this sample, 79 % served in Vietnam. Mental illness and psychological distress contributed to poor health, increased hospitalizations, and created barriers to seeking health care services for homeless. Only 15 % of Vietnam Veterans who experienced combat had current diagnoses of PTSD, and an additional 11 % had PTSD in the subclinical range (Elhai et al, 2004).

As with the Goldstein (2008) study, the Elhai (2004) study also focused on veterans with PTSD, rather than those who were homeless. The link between this study and the Elhai (2004) study is that veterans were found to be using non-VA providers for health care even when VA services were available.

For health-related conditions, such as chronic conditions that may have long-term effects, homeless people are more likely to seek health care, indicating there is knowledge and concern for potential impact. This may also indicate an ability to cope with conditions that could be managed on their own. For homeless people who access services in shelters, health services are frequently offered on-site, or referrals and transportation are provided to health care facilities.

The Gelberg-Anderson model is a behavioral model that was specialized for use with homeless people. This has been determined to be a valuable model in predicting health care access, suggesting that, in addition to identified predictors of health services utilization, unique needs and characteristics of vulnerable homeless people are also predictors of health services utilization, which may include negative health outcomes (Gelberg et al., 2000).

Predisposing factors, which contribute to decision-making processes regarding health services utilization, include common found problems in homeless populations, including drug and alcohol use, severity of homelessness, health beliefs, and psychological distress. Enabling factors include personal and community resources. Illness is the need factor in vulnerable population's model. People who are homeless for longer periods of time were found to be more apt to access health care than newly homeless people, possibly because of knowledge and awareness of homeless services and having knowledge regarding accessible transportation to health care facilities (Gelberg et al., 2000). This hypothesized, expanded behavioral model might be considered in future studies as it may serve as a predictive tool to assess access or lack of access to health care services in a sample of homeless Vietnam Veterans.

Because of transient and migratory natures of homeless persons, it is difficult to locate and track members of this population for follow-up care. Instead, they often seek medical care in Emergency Departments, where cost of health care services is much higher, but the chief complaint is not necessarily appropriate to that setting (O'Toole et

al., 2003). Active outreach also increases access to VA services to homeless veterans, especially those who suffer from a physical injury, psychiatric illness, alcohol abuse, and/or medical problems (O'Toole et al., 2003). Through this research, and by recognizing those factors that influenced decisions to access health care, appropriate medical care is more likely to be sought.

An exploratory study conducted by Applewhite (1997) examined expressed needs of homeless veterans and obstacles encountered in obtaining health and human services. These veterans reported a high incidence of general health and mental health problems, limited resources, negative public perceptions and treatment, insensitive service providers, dehumanizing policies and procedures, and high levels of stress and frustration with service delivery systems. They encountered personal, situational, and bureaucratic barriers to obtaining services and were highly critical of service providers, an indication that nurses need to be aware of how their attitudes toward victims of homelessness can influence their demeanor in professional practice. Homeless veterans need improved monitoring, interventions and health services with emphasis on advocacy-based case management services, affordable housing, and employment opportunities (Applewhite, 1997). With information and knowledge gained from this research, increased sensitivity in health service delivery systems and greater use of empowerment centered practice is available for nurses to implement in their practice to improve health care delivery to homeless Vietnam Veterans.

Substance Use

Homelessness is not the only issue facing HVV as almost half of them have a diagnosed mental illness, and more than two-thirds have a substance abuse problem (Stewart, 2004). When veterans of foreign wars return to the U.S., they lose unity and camaraderie that existed in combat, where genuine concern for each other is shared (Doolin, 2009). As a result, some veterans turn to drugs and alcohol to overcome loss of support. It is well known that alcohol and illegal drugs were abundant for those servicemen and women involved in combat during the Vietnam War. Young men and women were sent to Vietnam, possibly never having experienced alcohol and/or illegal drugs, yet were introduced and returned to the U.S. experienced in the use of these substances ("Alcohol use study," 2008).

Drug and alcohol misuse is thought to be higher in the homeless population (estimated between 20-80 %) and is considered one of the most important factors leading to the first episode of homelessness (Dietz, 2007). Substance use and treatment services offered through the VA are decreasing with reduced access to VA services. Results of a study performed from 1994-2001 of more than 20,000 men, showed that substance abuse services decreased but the need for these services remained consistently high. Unfortunately, the number of veterans receiving treatment ultimately decreased (Tessler, Rosenheck, & Gamache, 2005).

Drug and alcohol use among homeless influence availability of treatment and decision-making with regard to health care (Goldstein et al., 2008). Surveys from the

Journal of the American Medical Association reveal that the addiction treatment profession acknowledges unmet needs for veterans returning from military combat zones but cannot overcome difficulties dealing with them ("Alcohol use study," 2008). These findings support the need for distinguishing those homeless clients who have veteran status from the non-veteran homeless population to improve monitoring, nursing interventions, and health services as the treatment needs and goals differ.

A study conducted using VA national databases of veterans who received intensive substance use treatment identified participants as male (97 %), with a mean age of 46 years (standard deviation 8 years). Of this group, 42 % were Caucasian and 40 % were African-American; and 43 % were divorced. For those with psychiatric issues, 45 % were diagnosed with co-morbid depression, 23 % with PTSD, and 15 % with bipolar disorder (Curran et al., 2009).

Mental Health Issues

Almost half of HVV have a diagnosed mental illness (Stewart, 2004). Psychosocial issues that affect homeless veterans include post-military psychiatric disorders, social isolation, mental health disabilities, community separation, and low self-esteem (Curran et al., 2009). For this population, access to mental health services is insufficient even though focused outreach and residential treatment services have been extensively promoted to facilitate access to needed psychiatric treatment (Rosenheck, Gallup, & Frisman, 1993).

Combat-related psychosocial and psychiatric problems are commonly found in Vietnam Veterans, who have perceptions of negative self-worth and inabilities to utilize effective coping mechanisms (Mares & Rosenheck, 2006). When these servicemen and women returned from Vietnam, there were reports of dual psychiatric and substance abuse issues, many of which were undiagnosed and untreated.

Additionally, veterans who experienced trauma associated with combat have been diagnosed as having PTSD, in which trauma is re-experienced; the veteran suffers from hyper-arousal; or exhibits avoidance, dissociation, self-mutilation, and suicidal ideation (Ray, 2006). Of male Vietnam Veterans, 15.2 % suffer from PTSD, which is thought to have a strong association with homelessness (Rosenheck et al., 1992). Those veterans who were diagnosed with PTSD were eligible for service connected compensation, which included monthly disability payments, comprehensive medical coverage, and college education for their dependents (Grubaugh, Elhai, Monnier, & Frueh, 2004).

Rodell, Benda, and Rodell (2001) found that PTSD was a factor leading to substance abuse and depression in Vietnam Veterans, which is not surprising when atrocities witnessed and experienced are taken into consideration. A hierarchical logistic regression analysis was conducted on 188 homeless veterans to determine the influence of alcohol abuse, drugs, and combat experiences on rates of depression. Alcohol and drugs were found to more than double the incidence of depression. Further, it was found that these veterans with alcohol and substance abuse-related depression relied on their families for emotional and financial supports until those resources were exhausted, thus

leading to homelessness (Rodell et al., 2001). Nurses need a basis for understanding dynamics of Vietnam Veterans to better identify acceptable methods of monitoring, promoting, and improving delivery of health.

Rosenheck and Fontana (1994) used structural equation modeling to study risk factors of homelessness in 1,460 Vietnam Veterans. They found that post-military social isolation, psychiatric illness, and substance abuse in combination were strong predictors of homelessness as no one factor dominated results. Social isolation, psychiatric illness, and social dysfunction were found to increase an individual's vulnerability to becoming homeless, thus signaling a need for more research that is directed at meeting diverse needs of vulnerable populations, including Vietnam Veterans (Rosenheck & Fontana, 1994).

Homeless veterans may have schizophrenia; along with a variety of physical health problems that are associated with high rates of tropical disease from living in the jungles of Vietnam (Dietz, 2007). These veterans have been found to be significantly more likely than non-veterans to have an anti-social personality disorder, PTSD, an emotional problem, or suffer from anxiety (Virgo et al., 2004). In a study designed to measure impact of behavioral health problems on health care access and utilization, comparing veterans to non-veterans, Virgo et al. (2004) found that veterans were more apt to select VA and non-VA hospital-based outpatient clinics for regular care rather than seek care from a private health care provider. This same study revealed that Vietnam Veterans were found to have more behavioral health issues, traveled greater distances for

health care services, and waited longer periods of time for appointments, further demonstrating the existence of barriers to accessing needed health care services (Virgo et al., 2004).

Accessing psychiatric treatment is sporadic and unpredictable as barriers, such as strained or non-existent family ties, and criminal justice involvement prevent homeless veterans from seeking help (Rosenheck et al., 1993). Zeber, Copeland, McCarthy, Bauer, and Kilbourne (2009) used multivariable logistic regression analyses to assess factors that influenced the decision to seek treatment for mental health conditions. Factors were categorized as predisposing, which includes demographics; enabling, which is homelessness; or need, which is having bipolar symptoms or substance abuse issues. They found that homeless people were more apt to report experiencing barriers to obtaining mental health care; that need and enabling factors were the greatest impediments to accessing care, interfering with treatment and jeopardizing outcome (Zeber et al., 2009). This current study provides insight to remove barriers and improve health status of homeless Vietnam Veterans.

In a study by Wenzel, Bakhtiar, Caskey, Hardie, Redford, Sadler, and Gelberg (1995), logistic regression analysis was conducted on 429 homeless veterans who were willing to accept VA health care to determine whether self-reported need or evaluated need were important determinants in the veteran's decision to seek health care. Self-reported needs included such things as serious psychiatric symptoms, and combat-related stress, while evaluated need included evidence of organ dysfunction. Results of this study

found that homeless veterans who sleep outdoors report a lower probability of utilizing inpatient or VA psychiatric services and that those veterans with less education, who live under harsh conditions and experience residential instability are at risk for not receiving health care and are more alienated from the system. The authors reported that even though social barriers are difficult to change on a short-term basis, interventions, such as outreach, can minimize their impact and possibly lead to new policies (Wenzel et al., 1995).

Research Gaps

Members from a variety of health care disciplines, such as nursing, social work, medicine, and psychiatry, need to be included in planning and implementing health care for HVV to ensure improved services. The current health care system is laden with bureaucratic obstacles that frustrate or disallow veterans of health care services that they are entitled to receive.

With respect to nursing practice, diversity of problems and vulnerability that HVV face is a growing concern to health care practitioners and nurses who attempt to identify health care issues and provide services to promote physical and mental health. While research exists in other health care disciplines, there is limited nursing research regarding homeless Vietnam Veterans and their social problems, needs, and obstacles. Signs of substance abuse, PTSD, and physical and mental health issues must be recognized and included in nursing assessments so that nursing interventions can be properly planned and implemented.

When nursing care is directed to unique needs of homeless people, recognizing each one as unique instead of judging them based on stereotypes, then obstacles are lessened and health promotion can be facilitated. Nurses must be aware of verbal and non-verbal communication that may deter open lines of communication and acceptance of assistance by members of the homeless community. For homeless people who do not have access to bathroom facilities, showers, and who have basic hygiene limitations, judgmental attitudes from health care professionals add to the list of barriers to access.

As for health services-related theory and development, based on gaps in the literature, there is a need for more qualitative research in this area, possibly through case studies or oral histories, to bring the human aspect into research findings. Homelessness is relevant to all health care disciplines; yet, the majority of research and literature are in social work. As a result, nurses and other healthcare professionals may not utilize the information and tools to aid in assisting at-risk HVV in finding quality health care and improving overall health status.

This study provides a foundation for nursing research, with the research question being: "What is the process utilized by HVV to make the decision to access or to not access health care services?" The specific aims of the study were: (a) to develop a theory grounded in data that might explain why HVV do or do not seek health care; (b) to determine specific factors that contribute to and influence homeless Vietnam Veterans' decision-making processes; and (c) to determine if specific behavior patterns are relevant in the decision-making process and what these behavior patterns are.

Participants in the study were homeless Vietnam Veterans. What is known about this sector of the homeless population tends to be based upon small, geographically isolated samples, rather than through nationwide sampling.

There are some veterans who do not qualify for VA services, thus they are forced to turn to public or community-based health programs. It makes sense to develop shared programs between the VA and local, community health care providers, which can possibly increase available health care services to homeless Vietnam Veterans, thereby improving many health outcomes.

Fragmentation of services and admission procedures are obstacles to HVV who are attempting to access health care or homeless services (Blue-Howells, McGuire, & Nakashima, 2008). Appointments are scheduled for intake visits to up-date information and collect lab samples with return appointments made for a later date to actually be seen by health care practitioners for screening, assessment, referral, treatment, and obtain prescriptions. Upon arrival at the clinic for a subsequent visit, if labs are misplaced or not received by the VA clinic, the veteran must reschedule. Additionally, all medications are mailed to the veteran, which poses additional problems for those who are homeless, as they do not have a permanent mailing address with a mailbox. While time and distance issues are minor inconveniences to most people, to HVV these barriers become insurmountable as they face issues with transportation, physical activity limitations or cognitive impairment (Blue-Howells et al., 2008).

Summary

Of homeless veterans, the majority have at least one medical disorder and frequently report having more than one co-occurring medical, psychiatric, or substance abuse disorder, further justifying the need for medical and psychiatric treatment. However, it is speculated that these numbers are low when it is recognized that almost 75 % of homeless veterans report a serious medical problem and approximately 50 % of homeless veterans accessed VA medical services (Goldstein et al., 2008).

The diversity of problems and vulnerability that HVV face is a growing concern to nurses and health care practitioners who attempt to identify issues and provide services to promote physical and mental health to all community members, regardless of living arrangements (Applewhite, 1997). For health care providers, it is necessary to develop a better understanding of experiences and issues facing the homeless population to improve service delivery. Community health services, mental health interventions and social services may provide a workable solution to bring effective rehabilitation, health care and treatment services to homeless Vietnam Veterans. Nurses can strengthen partnerships between government and community health care systems to ensure these veterans get the proper care and attention they need.

Nurses need to provide health care services to veterans who cannot or will not access VA health care. Lack of funding, non-Medicaid qualifications, and a lack of assessment and screening processes specific to veterans may contribute to the problem. Additionally, some veterans do not qualify for VA services while others live too far way

for easy access to utilize the VA system, thus turning to public or community health nurses.

CHAPTER III

METHODOLOGY

Grounded theory methodology (GTM) is an approach to the study of group practices and social organizations. The focus of most GTM research is the growth and developmental progression of experiences that characterize events. The key purpose of GTM is to produce complete accounts of phenomena that are grounded in reality (Polit & Beck, 2012).

In-depth interviews and observation are most commonly used in GTM research to collect data. Grounded theory establishes a technique to use in field research, wherein the problem emerges from the data. One of the central tenets of GTM is that data collection, data analysis, and sampling of participants occur simultaneously. GTM is a non-linear procedure where researchers collect and categorize data, describing phenomenon, and repeating the steps (Polit & Beck, 2012).

Constant comparison develops and refines theoretically pertinent categories, which are drawn and compared with data from previous interviews. Through constant comparison, similarities and differences are recorded. As data collection continues, the analysis becomes focused on evolving theoretical concerns (Polit & Beck, 2012). GTM is important as a research method for studying nursing phenomena, and has led to middle-range theories of particular relevance to nurses.

GTM was used in this study as it emphasizes development of a theory from relationships and interactions of human beings with each other and in social roles (Holloway & Wheeler, 2010). GTM is used when existing theories do not sufficiently address the phenomenon of interest. Therefore, GTM is used to identify concepts and discover a theory that elucidates, justifies, and infers differences (Polit & Beck, 2012).

Using a grounded theory approach, which is a theory building process, and guided by the philosophical theory of Symbolic Interactionism, this research sought to develop a substantive theory to the research question: "What is the process utilized by HVV to make the decision to access or to not access health care services?" The specific aims of the proposed study were: (a) to develop a theory grounded in data that might explain why HVV do or do not seek health care; (b) to determine specific factors that contribute to and influence HVV decision-making process; and (c) to determine if specific behavior patterns are relevant in the decision-making process and what these behavior patterns are. Homeless shelters were the primary location for participant recruitment. The focus of this research was on psychosocial and relational elements that reflected perceptions, descriptions, and evaluation of the decision-making process.

Research Design and Methodology

GTM begins with observations and utilizes inductive reasoning (De Vaus, 2001). The key focus of GTM is to reflectively and concurrently read transcripts and apply codes to generate theoretical ideas. Since these are derived from data, it is imperative that the researcher set aside preconceived ideas (Polit & Beck, 2012).

There are three schools of thought about how to conduct GTM studies. Classic (Glaser & Strauss, 1967), Straussian (Strauss & Corbin, 1990), and Constructivist (Charmaz, 2006). Strauss teamed with Corbin to develop Straussian GTM, which uses a realist approach, is prescriptive, develops categories, and is structured. A feature of this method of GTM is theoretical sampling, where data collection and data analysis phases of research proceed simultaneously, prompting theory discovery and development (Strauss & Corbin, 1990). Straussian, or substantive GTM, was utilized for this study, which began with in-depth interviews of HVV to collect, analyze, and categorize data (Polit & Beck, 2012).

Strauss and Corbin (1990) suggest 3 types of coding: (1) open coding, (2) axial coding, and (3) selective coding. Open coding is a procedure for developing categories of information. Axial coding interconnects the categories. Selective coding is a procedure for connecting the categories to produce a discursive set of theoretical propositions. Constant comparison ensures a close connection between coded information, which is placed into categories. Data saturation occurs when interviews do not provide new insight into categories. When saturation is reached, the category will have robust dimensions and properties, and the relationship among categories will be clear and can be validated (Strauss & Corbin, 1990).

Grounded theory is a cyclical process where theory conforms to data. A systematic process involving repeatedly reviewing data before assigning codes was used to organize and analyze data (Creswell, 2009). This created interplay between probing

and checking as a consequence of beginning with inductive data that led to generation of a theory.

Setting

This study was conducted at a homeless shelter, which serves as a meeting place and support center for the homeless. The building has showers and locker rooms, laundry facilities, a computer room, an art studio, community-support agency offices, and a health clinic. The kitchen and dining room are on the second floor. A 100-bed overnight shelter is located on the third floor in a pavilion-like structure on the roof. There is a conference room with two doors, both are locked, and one wall of windows. The windows face an open outdoor area and are across from the social workers' offices. The interviews were conducted in the conference room, which is private.

Participants

A purposive sample of English-speaking HVV was recruited from a homeless shelter. In purposive sampling, the researcher selects participants for a study based on members who are most representative of the population of interest. This method was the most appropriate sampling method for this study (Polit & Beck, 2012). Inclusion criteria included: homeless, male or female, Vietnam Veterans who self-report they are Vietnam Veterans and who do not have a regular nighttime residence, or are living on the streets, (i.e., abandoned buildings, in parks, and under bridges) or in a place that is considered a shelter. Snowball sampling was also used for recruitment purposes as one participant encouraged someone else to volunteer to participate (Polit & Beck, 2012).

Vietnam-era Veterans with homes, or who did not speak English were excluded. Additionally, during the initial screening, if a participant had become agitated or violent, appeared not to be mentally competent, or used abusive language or threats, he or she would not have been interviewed. To assess whether potential participants were oriented to person, time, and place, initial conversation unrelated to the interview took place.

Procedure

With the consent and approval of the administration of the homeless shelter, flyers were posted for the recruitment of potential research participants (Appendix A) in the mail/hygiene room, at the front desk, on the elevator wall on the first, second, and third floors, and in each of the sleeping rooms on the third floor. These fliers included the date and time for the interview and explained the purpose of the study and the need for volunteers. The participants were recruited on a voluntary basis and could withdraw at any time. No participants withdrew, but if someone had, their data would have been destroyed.

Monetary compensation or transactions in exchange for participating in outside activities, such as research, is not encouraged by the administrators at the homeless shelter. However, backpacks are valued by homeless people as a means to carry their meager belongings with them wherever they go. The participants who completed the interview were given backpacks containing socks, underwear, shampoo, and soap.

In grounded theory research, data saturation is the guiding principle for determining appropriate sample size. Sample size in grounded theory is established not

by a pre-determined number, rather on quality of data collected, and until data and theoretical saturation are reached. Data saturation occurs when new interviews yield no new data. Theoretical saturation occurs when no new data emerges, the paradigm elements, variations and processes are accounted for, and well-established relationships exist between categories (Strauss & Corbin, 1990). Data saturation was achieved when key concepts were repeated and no new data emerged after 11 interviews.

Protection of Human Subjects

Institutional Review Board (IRB) approval was applied for and received from Texas Woman's University in Denton prior to beginning data collection. By obtaining IRB approval, participant privacy, safety, health, and welfare was ensured and protected. The Primary Investigator and Dissertation Chair completed on-line training regarding use of human subjects in research prior to applying for IRB approval.

Throughout the study, anonymity of participants was safe-guarded as each one was referred to only by his or her assigned letter, which was used to protect confidentiality. Participants were assigned a letter by the principal investigator. This letter was used on all documents associated with the participant.

For IRB purposes, diligent electronic and hard copy data storage is required. Therefore, the document that associates letters with the identity of the participant was kept in a locked cabinet in the locked office of the principal investigator. This document was destroyed at the conclusion of the research.

No demographic information or identifiers were used in transcribed notes or audio recordings to decrease possibility of including recognizable information regarding participants. The name of the town where data were collected is not included. Records are accessible to authorized IRB representatives. Data will be retained for at least three years, at which time it will be destroyed in accordance with IRB-approved protocol. Data that has been de-identified may be retained indefinitely.

Data Collection

The researcher recruited and interviewed HVV at a homeless shelter, conducting individual semi-structured interviews. Rather than having participants fill out a demographic survey, the researcher asked participants about demographic information at the beginning of each interview as an ice-breaking process (Appendix B). A list of probing or clarifying questions was created based on the review of the literature. Interviews were audio recorded and transcribed word for word by the researcher, who checked them to ensure exactness. While this is a time-consuming process, the benefit of transcribing the interviews is for the researcher to become well-acquainted with the data (Munhall, 2012). The researcher kept field notes during and immediately after each interview to note pertinent information such as appearance and non-verbal behavior. Observations from field notes were noted in the interview transcript.

The demographic data were analyzed using frequency distribution and measures of central tendency. Responses to the interview questions were analyzed using the constant comparative method and steps recommended by Straus and Corbin (1990). A

description of the sample is provided in this chapter, followed by a presentation of the findings. Themes discovered in the interview data are presented along with a brief description of how data analysis was conducted using the steps recommended for GTM by Strauss and Corbin (1990).

Face-to-face interviews allowed personal experiences to be shared that reflected ideations and accuracy that participants shared regarding their situations (Denzin & Lincoln, 1998). Interviews were semi-structured with a prepared, modifiable list of broad prompts and questions that were altered as the situation warranted, gaining a better understanding of origins and nature of problems experienced, with the researcher posing and modifying additional questions depending on participants' initial responses (Appendix C).

The advantage to this method is that the researcher was free to pursue a line of questioning that added depth to understanding and identification of unanticipated responses (Creswell, 2009). Interpersonal interaction was encouraged and permitted during the interview process and during observations. The participants shared personal and family stories, and revealed narratives and experiences depending on the level of trust and rapport that was gained. Body language, non-verbal behaviors and facial expressions were carefully observed during each interview and recorded by the primary investigator. Possible risks to participants included psychosocial stress. The researcher took field notes while conducting audio recorded sessions to minimize researcher error.

Additional written notes were added after conclusion of the interview as the researcher reflected on the conversation.

Prior to the interview, the researcher utilized the recruitment script to explain the study, clarify, and gain consent (Appendix D). Interviews began by using a questionnaire to collect demographic data, including age; sex; marital status; military history, such as age and year when they joined the military, branch of service, whether they volunteered or were drafted, whether they served in Vietnam and/or saw combat, and their vocation while in the military.

When a potential participant indicated an interest in participating in this study and inclusion criteria was met, the researcher explained the purpose of the study and interview process, including estimated amount of time that would be spent in the interview, steps to maintain confidentiality, and how collected information would be handled. The participant was given an opportunity to ask questions during this time. When the participant indicated he/she had no more questions, the purpose of the study and his/her role in the interview process was understood, the written informed consent form was explained and offered to the participant. An explanation of the purpose of the study and the anticipated length of time for the interview was reiterated and time allowed for additional questions and answers. The participant was assured he/she can change his/her mind at any time and withdraw from the study without fear of repercussion. Only when the consent form was signed did data collection begin.

For purposes of conducting private interviews, conference rooms with tables and chairs were used. There were two doors, which were kept closed, in each conference room. One wall of the conference room is made up of windows that are adjacent to the hallway where the case managers' offices are located. While case managers can see the occupants of the conference room, the conversations could not be heard and the content was private to ensure confidentiality. Interviews, which were audio taped, were completed in one conversation, which sometimes lasted up to an hour.

Data collection methods included direct observation; individual, semi-structured, face-to-face interview; field notes; and audio recordings. Questions from the interview guide were asked and the participant was encouraged to answer in detail (Polit & Beck, 2012). The interview was an active, two-way process, with the researcher asking questions, and encouraging interaction. In GTM, it is important that the researcher adhere to the interview guide and avoid leading questions. The researcher took notes as observed information cannot be reliably remembered, requiring recording during and immediately after each interview. Field diaries recorded observations about body language, theoretical and methodological notes, along with personal perceptions and thoughts. Additional written notes were added as the conversation was reflected upon and the researcher added detail and further description of events that transpired during interviews (Polit & Beck, 2012).

Each interview began with an introduction to establish a relationship between researcher and participant. Then, demographic data were collected. Factual or descriptive

questions, where the participant provided statements about activities, or generative questions were asked. Generative questions allowed participants to respond with long answers while remaining on the central topic. The researcher prompted the participant for more information, while allowing the participant time to think. When the participant was finished speaking, the researcher asked more direct questions to fill gaps and clarify. Audio recordings were transcribed by the researcher soon after interviews to enhance accuracy as the interview was fresh in the researcher's mind. Transcriptions were checked for accuracy by the principal investigator.

Data Storage

Anonymity of participants was ensured by the researcher assigning a letter of the alphabet to each participant with the data stored in a locked file drawer in a separate office filing cabinet. Only the researcher has access to the data, which was destroyed upon completion of the research. Other data will be retained for at least three years, at which time it will be destroyed in accordance with IRB-approved protocol. De-identified data may be retained indefinitely.

Data Analysis

As data began to explain people, places, events, conditions, or settings, the sample was expanded to add more cases and gain additional information. During data analysis, concepts with similar dimensions and properties were grouped into collections of concepts, which were further grouped into categories. The categories were named using theoretical ideas from literature or by using participant's terms, such as family dynamics,

substance use, arrest history, employment, medical issues, meeting basic needs, health care, military history, and benefits. Categories have proportions, are dimensional, can have multiple perspectives, and are presented on a continuum (Strauss & Corbin, 1990). For example, the dimensions of a category may describe frequency of the occurrence.

Data analysis was concurrent with data collection, as themes and patterns developed, leading to new questions. The researcher analyzed data, noting what it did and did not contain, ordering raw data, making note of trends, yet not deriving early conclusions. These early conclusions included such things as the possibility that arrest history or the availability of benefits made a difference in the HVV determination to access healthcare services.

Constant comparison is a way to achieve saturation by comparing the data with other data, looking for instances that represent the categories. Interviews continued until interviews did not provide further categories or insights. Systematic comparisons asked "what if" and explored all dimensions of the phenomena, looking for differences.

During open coding, the researcher examined the text for salient categories, applying codes to and labeling phenomena. Concepts that seemed to relate to the same phenomena were grouped and coded into categories. The transcripts were reviewed line by line, sentence by sentence, which forced the researcher to pay attention to a few words. This process required avoiding mere description. Analyzing word phrases or sentences is conducted by selecting one word that seems significant, listing all of the possible meanings, and then validating the findings against the text.

Axial coding explores the relationship of categories, making connections between them. Causal conditions influence the central phenomena, events, incidences, and happenings. The phenomenon is the central idea, event, incident, which a set of actions or interactions are directed at managing, or handling, or to which the set of action is related. Strategies for addressing the phenomenon are purposeful, and goal oriented (Strauss & Corbin, 1990). The researcher created a concept map to visually display the inter-relationship of the categories. After data saturation, the categories had been examined and adjusted, and some were condensed and renamed, including communication, substance use, system barriers, access issues, homelessness, and military experiences.

Selective coding identifies a single category as the central phenomenon, which forms the basis for the construction of the conceptualization of the core category, which was health care decision-making. Selective coding systematically relates the core category to other categories, filling in categories that need further refinement (Strauss & Corbin, 1990). The refined categories were military experiences, substance use, homelessness with communication via the grapevine, and access issues, including system inefficiencies, quality, convenience, and difficulty with mobility.

Theoretical sensitivity was enhanced through: questioning to expand content and lead to other questions; analyzing words or phrases to validate against text; analyzing through comparisons to compare extremes; systematic comparisons to explore all dimensions of phenomena; and waving the red flag, which is a signal to look closer (Strauss & Corbin, 1990). Commonalities and variations were drawn from comparisons

of information gathered during data collection and data analysis. As this process continued, research became focused and was modified.

Data analysis was concurrent with data collection, as themes and patterns developed, leading to new questions. The researcher analyzed data for what it contained and noted what it did not contain, ordering raw data so it was useful, making note of trends, and not deriving early conclusions. A systematic process involving repeatedly reviewing data before assigning codes was used to organize and analyze data (Creswell, 2009). When the researcher believed that all codes had emerged and had been placed in "like" categories, then the researcher systematically reviewed categories to generate a small number of themes that were representative of findings (Pett, 1997).

Scientific Rigor

Criteria for scientific rigor are used in qualitative research (Munhall, 2012). Most commonly, scientific rigor in qualitative research is measured using Lincoln and Guba's guidelines: credibility, transferability, dependability, and confirmability (as cited in Polit & Beck, 2012).

Accuracy of results from the perspective of the researcher and participants is important, as these establish rigor. Four criteria were used to verify rigor: credibility (i.e., truth or accuracy of data), transferability (i.e., ability to apply findings to other populations in other areas), dependability (i.e., ability of other researchers to replicate the study and derive similar results), and confirmability (i.e., neutral presentation of results, free from researcher bias, or opinion) (Creswell, 2009).

Credibility

Credibility was established beginning with a comprehensive review of the literature, during which the researcher developed intimate familiarity with the topic. During data analysis, systematic comparisons were made between observations and categories; categories spanned a wide range of empirical observations; and logical links existed between data and researcher's analysis. These processes are described in this chapter. Additionally, the researcher assured prolonged engagement with participants and the data. A detailed description of the data analysis process with illustrating quotes was provided to allow the reader to form an assessment and agree with researcher's claims (Munhall, 2012). The primary researcher's dissertation chair reviewed and confirmed consistency of researcher's findings.

Transferability

For transferability, a wide range of experiences was described in detail., Such description allows an opportunity for developing a deeper understanding of experiences of HVV. As often as possible, actual words of participants were used to establish transferability (Polit & Beck, 2012).

Dependability

Dependability refers to the stability of data over time, in various settings, and in other situations (Polit & Beck, 2012). This was assured through maintenance of an audit trail. Specifically, the transcripts, field notes, and coding notes are available for review. Tables depicting the data analysis process as it evolved are provided.

Confirmability

Confirmability was achieved as steps of research were verified through examination of raw data, data reduction products, and process notes (Machin & Campbell, 2005). Transcripts were checked for errors by listening to recordings while reading the transcripts. Field notes were integrated into transcripts for clarity of data analysis. Tables depicting each phase of coding were maintained and are presented here. Researcher biases and beliefs about the HVV were acknowledged to minimize influence on results.

Member checking is a means to validate the credibility of the data through conversations with the participants (Polit & Beck, 2012). Because of the transitory nature of homeless people, the researcher was not able to locate participants after the initial interview; therefore, member checking was not conducted.

Summary

Chapter 3 presented the research design and methodology used in this study. A description of Straussian GTM was offered along with an explanation of open coding, axial coding, and selective coding. The setting was described where participants were recruited and interviews were conducted. Procedures, which include recruitment strategies and interview methods, were discussed.

Purposive sampling was used to recruit participants most representative of HVVs. Snowball sampling was also used as one participant encouraged someone else to

participate. Inclusion criteria were provided, followed by a discussion regarding the provision for the protection of human subjects.

Data collection methods included direct observation; individual, semi-structured, face-to-face interviews; field notes; and audio recordings. A demographic questionnaire and an interview guide were used. Steps used for data storage were discussed followed by a discussion of data analysis. During open coding, the categories were named family dynamics, substance use, arrest history, employment, medical issues, meeting basic needs, health care, military history, and benefits. In axial coding, a concept map was created to visually display the categories, which were condensed and renamed: communication, substance use, system barriers, access issues, homelessness, and military experiences. During selective coding, the core category was identified as health care decision-making. The refined categories were military experiences, substance use, homelessness with communication via the grapevine, and access issues, including system inefficiencies, quality, convenience, and difficulty with mobility. This chapter concluded with a discussion about scientific rigor, including credibility, transferability, dependability and conformability.

Chapter 4 will present the results, beginning with a description of the sample.

CHAPTER IV

RESULTS

Recognizing that homeless Vietnam Veterans (HVV) may have issues that prevent them from accessing healthcare services, it is necessary to understand how they make decisions about seeking health care. The research question for this study was: "What is the process utilized by HVV to make the decision to access or to not access healthcare services?"

Grounded theory methodology (GTM) allows for inductive interpretation of data that is grounded in research (Polit & Beck, 2012). It was used in this study to develop a preliminary theory inductively derived from relationships and interactions of human beings with each other and in social roles (Holloway & Wheeler, 2010). It is considered the research method of choice for problems about which little is known (Munhall, 2012) or there are no explanatory theories, as is the case with HVV and their healthcare decision-making processes. GTM is considered an important research technique for studying nursing phenomena, and is recognized as offering middle-range theories that are pertinent to the nursing profession (Polit & Beck, 2012).

Originally formulated by Glaser and Strauss, GTM was used in a study regarding patients who were dying in hospitals. The goal of Glaser and Strauss' method is to use data to find the *core category*, which is the main concern, and the associated *basic social*

process, or conceptual category, that explains how participants resolve the main concern. Conceptual categories and their properties are generated to *fit* categories to form a substantive theory grounded in data. Glaser stressed that behavior is categorized rather than people (Polit & Beck, 2012).

The main difference between the two methods is the way data are analyzed. Glaser began data analysis by breaking down and conceptualizing data, comparing incidents to see the emergence of patterns. He used three types of coding- open, selective and theoretical- and used 18 coding families to connect categories. The outcome with this method is discovery of an emergent theory (Polit & Beck, 2012). Strauss and Corbin's GTM, which is the substantive type of grounded theory, was utilized as this study began with in-depth interviews of HVV to collect, analyze, and categorize data to discover emerging phenomenon (Polit & Beck, 2012). The initial data analysis began with breaking down and conceptualizing data by taking apart each sentence or observation from the interview transcripts. Open, axial, and selective coding were employed to identify connections between categories to arrive at a verified conceptual description. Rigorous procedures were used to systematically detect related conceptual categories, leading to the identification of a theory (Strauss & Corbin, 1990).

Description of the Sample

Sampling for this research was purposive as the researcher sought participants, in this case HVV, who possessed the requisite characteristics to answer the research

question. Participants were selected from the accessible population of HVV who received services at Austin Resource Center for the Homeless (ARCH).

Demographic Data

Even though the inclusion criteria indicated men and women, there were no women who were identified as possible participants for this research. Eleven men participated in this study (*n=11*). All of them reported they were Vietnam-era Veterans who qualify as homeless and receive services at ARCH. They self-reported they could read English. The youngest was 55 years of age and the oldest was 66 years of age (*M= 61.36* years). Nine men were Caucasian, one was African-American, and one was Hispanic. Eight participants were divorced, two were widowed, and one was separated from his wife. All of the participants volunteered for military services rather than being drafted, enlisting during a twelve-year period from 1965 to 1977. Four of the participants enlisted at 17 years of age, four enlisted at 18 years of age, two enlisted at 19 years of age, and one enlisted at 27 years of age (*M=18.64* years). The parents of the four who enlisted at 17 years of age signed waivers for their under-age sons to join the military. Eight participants were sent to Basic Training immediately upon graduating from high school. Of those eight, five were sent to Vietnam and into combat; three were not sent to Vietnam. For the five who went to Vietnam, their length of stay ranged from 8 to 18 months (*M= 13.6* months). Of the two who enlisted at 19 years of age, one attended a year of seminary before he was sent to Vietnam, while the other, who was not sent to Vietnam, worked in an oil field prior to enlisting. Seven of the men served in the Army,

one in the Navy, two in the Marines, and one in the Air Force. In total, six of the participants served in Vietnam and each reported being involved in combat, while the other five, who were Vietnam-era Veterans, did not serve in Vietnam. For those who served in Vietnam, duties included operating heavy equipment, driving tanks, cooking, operating field radio communications, working as a communication specialist, fighting on foot in the infantry, using long-range weapons in the artillery, being part of a small mobile force using guerilla warfare, and serving on an insurgency team and in the military police. The participants left the military between the years of 1970 and 1992. All of the participants were honorably discharged. One participant with a history of gastric ulcers reported that his discharge was for medical reasons. One participant reported that he was honorably discharged the first time he enlisted, but dishonorably discharged after he re-enlisted. Three of the participants slept at the shelter at night. The remaining eight slept outside or found other temporary accommodations, such as one participant who slept in a self-storage facility. Table 4:1 provides a summary of the demographic information for these participants.

Interviews

The interviews were conducted in a conference room on the second floor at ARCH. The room allowed for privacy by closing the door and because there were no rooms connected to it. Access to the room was via a hallway with a keyed-entry, accessible only by personnel of the facility. A wall of windows faced the cubicles of the social workers but was distant enough so that conversations could not be overheard. One

interview was briefly interrupted when an employee came into the conference room thinking it was empty; she immediately left.

Data Management

Participants were randomly labeled with letters from A to K. This provided a means to identify the speaker when direct quotes were used from the transcripts, while maintaining confidentiality.

Data Analysis Procedures

Data analysis was performed according to Strauss and Corbin's method of GT. Three stages of coding were conducted: (1) open coding, to develop categories of information, (2) axial coding, to interconnect the categories, and (3) selective coding, to produce a discursive set of theoretical propositions by connecting the categories (Strauss & Corbin, 1990). An essential component of GTM data analysis is constant comparison, in which the researcher continually reviews the data, in this case beginning with the first interview and continuing until data analysis was complete. In constant comparison, the researcher looks for similarities, differences, and connections, to gain awareness and better understanding of the phenomenon of interest. Through this process of constant comparison, themes and categories appear and are recognized, allowing interview questions to be amended as new information comes to light (Strauss & Corbin, 1990). Constant comparison was employed during the course of this study to associate data found in one interview with data found in other interviews, continuing until all of the interviews were compared. The semi-structured interviews were modified based on

constant comparison to determine similarities between participant's responses. As the data collection and analysis proceeded, the interviews focused on emerging concerns.

The initial step in GTM data analysis is open coding, which employs a systematic technique to inductively identify applicable themes (Polit & Beck, 2004). The objective is to find as many conceptual codes as needed to appropriately describe the data, thus leading to the development of categories (Strauss & Corbin, 1990). During open coding, properties, which are attributes and characteristics of a phenomenon, were identified to support categories. The experiences of the participants as they served in the military were categorized as these related to healthcare decision-making processes. Properties were dimensionalized to explain connections in the emerging data. Properties included unrealistic expectations, unpleasant experiences, inability to work, affordability of housing, not questioning treatment, exposure to Agent Orange, limited mobility issues, condition of facility, ease of use, wait time, and unfulfilled promises. General properties of categories are important because, regardless of the situation, the full range of dimensions for that category can be measured each time a specific property appears in a category. The ability to locate a specific property along a dimensional continuum gives each categorical occurrence a distinct dimensional profile. When several of these profiles are grouped together, a pattern forms. The dimensional profile represents the specific properties, such as frequency, duration, performance involvement or occurrence, of the phenomenon of interest (Strauss & Corbin, 1990). Concepts were derived from the data during open coding and placed into categories. For example, "rousting folks", and

"quality of life issues" were placed in the category of "arrests", "Agent Orange exposure" and injuries were placed in the "medical" category.

Theoretical sensitivity is also part of open coding and refers to when the researcher is open, or sensitive, to the emerging theory as elements of the theory begin to surface and become apparent. Questioning or delving into terms or phrases used by participants are tools used by the researcher to enhance theoretical sensitivity (Strauss & Corbin, 1990).

Axial coding, the second step in Straussian data analysis, occurs along with open coding. In GTM, the researcher begins with open coding, moves to axial coding, conducts subsequent interviews, revisits the transcripts, open coding and axial coding looking for additional relevant information, and revises interview questions for up-coming interviews (Strauss & Corbin, 1990). In axial coding, data are analyzed and condensed to form new connections between categories and subcategories. Coding paradigms can be created to allow the researcher to methodically consider the data and relate categories and subcategories. This confirms the presence of density and accuracy in the analyses (Strauss & Corbin, 1990).

During the third step of data analysis, selective coding, the researcher assimilates and enhances the emerging theory by adjusting and modifying categories to develop theoretical themes (Strauss & Corbin, 1990). This step begins with identifying the core category and eliminating categories that no longer relate. Through data saturation in selective coding a category is identified as the central phenomenon, or core category. The

relationship of the core category is carefully considered as it relates to the other categories, validating relationships, and supplementing categories that need to be clarified or strengthened (Strauss & Corbin, 1990).

Open Coding

Open coding began after the first interview and continued with each subsequent interview. To begin, data were broken down using one-word terms or brief phrases. Transcripts were analyzed line by line to identify key concepts, and categories. Each transcript was further analyzed in its entirety to gain contextual understanding. The transcripts were compared for similar concepts, noting differences and parallels, while using the same concept name for those phenomena that were thought to be alike. Related data were grouped and began to fall into various categories. After completing open coding and using constant comparison with the first three interviews, preliminary categories were identified and included: family dynamics, substance use, arrest history, employment, medical, meeting basic needs, health care, military history, and benefits. Table 4:2 presents the initial broad themes after the completion and analysis of the first three interviews. These were later condensed into the categories substance use, meeting basic needs, medical issues, and health care.

Substance use. The category of substance use was created based on participants' discussion regarding illegal drugs and/or alcohol. Every participant in this study spoke about drugs and/or alcohol use, leading to early saturation of the category. Properties that were found to support this category developed from *unrealistic expectations* of what

military life would be like contrasted with *unpleasant experiences* encountered. Participant B said he began "smoking pot in Vietnam. I didn't know what it (pot) was before I went. It was all over the place. Everyone smoked- it was the only way to get through that time." Participant K said Vietnam was "something else". He added, "That's when I started using drugs. You didn't care … you could have been on a beach at home somewhere. You'd take something to make it all go away, then come down and have to start the cycle all over again."

Meeting basic needs. The category of meeting basic needs was derived from discussions about participants' experiences. As a condition of participating in this study, all of the participants were homeless and were able to offer depth and breadth to this category. Properties used to support this category were *inability to work* and *affordability of housing*.

Ten participants talked about the desire and inability to work, either because of age and disability or because of the lack of available jobs. Participant K said, "I can't- I wish I could." Participant H had a job as a painter but said he "lost focus" and quit. Participant A said that after moving to Austin "not having a residence" led to his inability to "get work." Participant B said he was "trying to find work for over a month". He added that he would "keep trying" to find day labor work. Participant J said that he had a job working day labor. After a few months he said, "I've got to get out of here." He went on to add, "At my age now, there is no way I can work day labor." Participant C

explained he can no longer work, as “I got disabled. My arm on the right side is messed up and my hip on the left side is messed up.”

Four participants discussed affordability of housing. Participant B said that he has been homeless since his wife died 5 years ago. He added that as long as she was alive, they had a house. He said, “I couldn’t afford to live in Austin on my salary, and I was making decent money.” Participant A said his income is $823 per month and that is not enough for an apartment. Participant F said he could not afford an apartment after his divorce. Participant B reported that minimum wage “didn’t cut it.”

Medical issues. The category of medical issues was created from participants’ discussions regarding illnesses or injuries. All of the participants spoke of illnesses and/or injuries leading to saturation when no new information was collected. Properties that supported this category were *not questioning treatment*, *exposure to Agent Orange*, and *limited mobility issues*.

The property of not questioning treatment, even illogical and uncomfortable treatments, is exemplified by Participant D who reported that he was put in an ice bath when he had pneumonia in Boot Camp and, again when he had a blocked intestine that required surgery.

For the property of exposure to Agent Orange, Participant A, who was diagnosed with lung cancer related to Agent Orange exposure, said he was told he could possibly receive monetary compensation but added, “Nothing’s ever been done about it.” Participant J told about the time he and a friend “had that Agent Orange- that cancerous

stuff. We went to the VA hospital because we were told to. We sat there for six hours before they took him in. Three days later he died."

For the property of limited mobility issues, four of the participants walked with a limp, using assistive devices, such as walkers or canes, to ambulate. Participant A had hip replacement surgery twice, while Participant K had knee replacement surgery. Three participants were in motor vehicle accidents, to which they attributed their difficulty walking and standing.

Healthcare. The category of healthcare was developed from discussions about experiences of HVV when they are going to healthcare facilities. Properties that support this category include *condition of facility*, *ease of use*, *wait time*, and *unfulfilled promises*.

For the property of condition of facility, participants had differing opinions. Participant J said the VA was "okay." Participant A described going to the VA soon after leaving the service. He said, "The VA sucked. It used to be an old prisoner of war camp. The place was filthy."

For the property ease of use, participants spoke about such things as difficulty making appointments and ease of access to clinics. To be seen in a VA clinic, veterans must show their identification cards. Participant K said he had not applied for his cards until he recently became homeless. He stated that he sent the request three times and when he tried to find where his cards were, he was told they had been sent "everywhere but here" and that his cards would arrive "in a couple of weeks." He added that he could not seek health care services at VA facilities until his cards arrived. Participant I said he

did not know where the clinic is located. Participant B said that even though he has not needed health care services, he had to go to the clinic to apply to receive services. Participant F stated that the clinics are not open daily and that making and keeping an appointment is difficult since he does not have a telephone or dependable means of transportation. Participant E stated that it is 30 miles to the clinic; he depends on getting rides from friends when he needs to go. He went on to say that parking is limited and they usually drive around for an hour waiting for a space to become available. Participant K said that he can go to the VA but it is "pretty far away."

For the property of wait time, two participants spoke about making appointments three weeks in advance of seeing a doctor. They described arriving early for scheduled appointments and not being seen until much later in the day. Participant D said he waited 4 ½ hours, even though he had an appointment. He added that on a different occasion he arrived 1 ½ hours early for an 8:00 AM appointment but was not seen by a doctor until 3:30 PM. Participant E said he arrives two hours early for appointments. He said that if he has an emergency, such as with asthma, he has to wait three to four hours to be seen at the VA, so he goes to community emergency departments.

Constant comparison was ongoing throughout data collection and data analysis. Theoretical sensitivity was enhanced by analyzing words, phrases, and sentences, and "waving the red flag," which assists the researcher to look beyond the obvious. Strauss and Corbin (1990) suggest that the researcher must be sensitive to certain words and/or phrases and use these as a cue to take a closer look. Participant I who reported "empty

promises," Participant B who said he had "quality of life issues," and Participant D who said he "was lied to" were asked to provide additional information and clarification as to what they meant by these statements, which are examples of "waving the red flag."

Axial Coding

The researcher continually compared the analyzed data with findings from newly acquired data, arranging and rearranging the data into categories and subcategories. Throughout open and axial coding, memos were jotted down and a concept map was constructed as a way to track ideas, reflections, and concepts. Using these tools, the researcher began reassembling codes while looking for code properties and specifying relationships to find the underlying story. As the picture developed, the researcher focused on what was happening in the data and what patterns occurred. Like themes began to appear, and the categories were labeled *military experiences, substance use, trying to make ends meet, communication, access issues and system barriers* (Table 4:3).

For the participants in this study, their military experiences shaped their decision-making abilities and impacted real-world perceptions. This seemed especially common when talking about substance use, post-military employment, health care access, and past illnesses or injuries. This category was originally named *military service,* but as the category developed, the properties were better related to attributes of *military experiences.* The subcategory used to support military experiences was *personal sacrifices,* such as beliefs, values, expectations (joined the military to be successful or to drive a truck), and impressions. All of

the participants volunteered for military service. Eight of the participants joined as soon as they graduated from high school, between the ages of 17 and 18 years of age. Two of the participants joined when they were 19 years of age. Six of the participants said that after Basic Training, they were sent into combat in Vietnam. Participant E reported that he decided to enlist after completing his first year of seminary. He said that, "after going to a year of seminary, having to fight in Vietnam created havoc inside me. It just tore me up- I couldn't do it." Participant I spoke about the soldiers who fought in the Vietnam War, saying, "Men died to ensure we have rights." Participant G said, "I was lucky- I came home." Participant B explained his discharge from the military, which was toward the end of the Vietnam War: "They were switching from the draftees to all volunteers, and they were weeding out all the druggies." He said he "finagled" his discharge by failing his drug test 3 times. Three of the participants spoke about the mistreatment they received upon returning home, including being spit on and called "baby-killers." The participants' statements reflected enlisting in the military at young, formative ages, trusting their military leaders and the U.S. government, and that they expected more of themselves. Instead, they became disillusioned by what they felt were injustices during the war and mistreatment upon returning home.

The category of substance use was further developed as the comments of each participant mentioned illegal drug use and/or alcohol during the course of the

interviews. Ten of the participants began using drugs and/or alcohol while in the military, either in Boot Camp or shortly after getting to Vietnam.

Coping emerged as a subcategory as it appeared that substance use was a means to cope with the expectations of the military and reality shock. Examples of coping included denial (smokes pot but does not use drugs), acceptance (everyone got high), and avoidance (went to rehabilitation to avoid jail). Participant K said, "I began smoking pot in Vietnam. It was all over the place. Everyone smoked- it was the only way to get through that time." He said that he has smoked marijuana almost daily since that time. Participant B shared that he began using drugs "in Basic Training- mostly smoking pot- or whatever," and said he is "still smoking pot." He added, "It's not hard core." Participant B said, "When I come home from Vietnam I had a drug problem just like everybody else." Participant C said, "When you get out and life seems a little harder … I thought drugs could relieve some of the pain and anguish that I was feeling at that moment." Participant E said he was an alcoholic and that his wife complained that he was "absent" even when he was with her. He said he recognized he drank too much but thought he was funny and that everyone liked him that way.

The category of meeting basic needs was further developed as the entire group of participants spoke about being homeless. As this category evolved, it was renamed *trying to make ends meet*. Subcategories include *socioeconomic adversity, stressful experiences, legal issues,* and *camaraderie*.

Socioeconomic adversity properties include inability to find work and scarcity of resources (waiting for check to arrive or begging). The military training of the participants was found to be not particularly useful for finding employment after separating from the service and returning home. The participants indicated that the ability to drive a tank, operate heavy equipment to set up temporary camps or hospitals, or shoot artillery did not readily translate to jobs in civilian life. With the exception of one man, who was trained as a cook and was able to find work, ten of the participants had to develop new vocational skills to find employment. Participant C said that he was able to work for the Salvation Army, with the benefit that he could sleep there at night. He went on to explain, "I've been out of circulation a couple of years. I just quit even looking for work because I didn't have any idea so I just stopped." Two of the participants indicated they were too old and disabled to work. Participant A said that he was told that he could work if he came to Austin. However, once he arrived, he was not able to find a job or afford an apartment. He explained that he rents a storage unit where he sleeps at night and comes to the shelter during the day. He added, "Technically you're not supposed to be sleeping in them but a lot of these like U-Haul, Uncle Bob's, and a few other ones, after the manager leaves, it's up in the air." Two of the participants say they beg or panhandle. Participant B said he cannot beg.

Stressful experiences, such as family dissolution, and legal issues, were recognized as subcategories of homelessness. The breakdown of family and the loss of family support are recognized as causative factors leading to homelessness. All of the

participants had been married and were either divorced or widowed. Participant J said that his girlfriend took everything he had, leaving him homeless. Participant J added that while he was serving court-ordered rehabilitation for driving while intoxicated (DWI), he lost his house, his car, and his job. Participant H simply said, “I lost focus” when discussing how he became homeless. Participant I said that he moved here from California as he was “evading the law”.

Camaraderie refers to being part of a community, having relationships and friendships, and communicating via the grapevine. Four of the participants spoke about being members of camps and of watching out for and taking care of each other. Participant I explained that people are important- that there is closeness among members of homeless communities. Three of the participants spoke about long-term friendships with people they met, traveled with, and continue to share camps with or care for. Seven of the participants shared that when deciding to go to a doctor, they either asked someone they knew for a referral or they searched the Internet for specialists. Participant A said, “A friend of mine told me I should go to him [doctor].” Participant B stated, “I’ve talked to a lot of guys, and they gave me the down low on what’s happening at the VA in Temple and it’s real nice.” Participant C reported that he has, “real bad pains in my joints- I have to go to the doctor and get medication for that.” When asked how he finds doctors, he said, “I ask friends around here that have the same kind of problems that I have. Then I call and make an appointment.”

For the category communication, nine participants reported problems when interacting with healthcare providers. This category was originally simply labeled *healthcare,* but the properties that evolved were better linked to attributes regarding communication with health care providers rather than merely healthcare. This interface seemed to interfere with effective communication, understanding of prescribed treatments, and willingness to seek further health care services. Subcategories included *negative experiences* and *prejudice*.

Negative experiences were described in the interviews ten times by eight of the participants. Participant J described having a friend die after waiting over six hours for treatment. Participant A described how an advocate, who was reviewing his case, was fired after she began to complain about how he was shuttled around from place to place without receiving treatment. Participant A explained the breakdown of communication by saying, “All they (health care providers) want to do is push pills … it’s no cure.”

Prejudice, such as the veterans’ expressions of bias against some healthcare providers, was also identified as a property within the category of communication with health care providers. Participants referred to health care providers as “female doctors,” “Suzy Wong,” and said the doctors were “difficult to understand.” Two participants spoke of this three times during the interviews. Participant E said that on a visit to the VA, the doctor, a woman from India, treated him disrespectfully. He added that she was rude to him, talked down to him, and seemed to be looking at him scornfully. He

concluded, “The doctors at VA clinics are usually foreign and don’t speak English well. Their people skills are lacking- they’re rude.”

For the category of system barriers, it appeared that for many of the participants there were hurdles to overcome when accessing health care services. This was predominant with regard to VA health care services. This category was originally labeled *decision-making*, but as transcripts were analyzed, some properties of health care were found to better mesh with the attributes of system barriers. Subcategories that developed were *convenience*, and *quality*.

Many participants commented that it takes a long time to get an appointment at VA facilities. Participant J said he rarely gets sick, but “Yeah- I’ve been to the VA for stuff but it takes too long.” Participant E said that he reports two hours before his appointment for lab work and then travels 15 miles to the clinic to see the doctor. If he has a non-service related injuries or illness, it is not treated at VA facilities. He added that recently he did not receive his prescription, and “was really worried and got some from a buddy. I think when the government shut down, my prescriptions stopped.” When asked why he goes to the VA in San Antonio, he explained that moving to a closer facility is a problem as the computer networks are not linked. He added that “You have to physically go there for physical identification and prove who you are and get put in their system before they will make you an appointment.”

Six of the participants were willing to use VA health care services and seemed to be generally happy with the quality of the care they received, offering

suggestions for improvement. Participant H said he was treated at the VA "with the utmost respect." Two participants said they would never use the VA again under any circumstances. Three participants spoke about not getting "strong enough medications," saying health care providers will not give them narcotics because of previous substance addictions. Two participants commented that they never see the same doctor and there is a lot of repetitive testing. When the situation warranted more immediate health care services, participants opted for community facilities. It seemed that the length of time it took to be seen was a determinant in deciding which facility to use. Participant E shared that "there aren't enough clinics to serve everyone who needs help. I have to find a ride to the closest clinic. Once I'm there, they're nice and cordial, but the clinic is crowded." For some of the participants, it appeared that dissatisfaction with the VA healthcare system was great enough to warrant refusing to go to the VA for any future health care, regardless of the illness or injury. Participant A said that the VA is "not getting any better." Three participants who went to rehabilitation said it was not effective.

The category of access issues began as *medical issues* then was renamed *physical problems*, and *barriers to access,* before finally being labeled *access issues.* Time and distance may be minor inconveniences to some people, but to HVV, these often become insurmountable when combined with transportation issues and physical activity limitations. Subcategories included *limited mobility* and *transportation issues*.

Four of the participants have been in motor vehicle accidents. Participant C said, "I got a bad hip and a bad arm from a bad car accident. I messed up my joints and I can't stand like I could." Participant A said, "I had a real bad truck wreck- uh- 20 years ago- 25 years ago- really screwed up my back, and legs...my spine's all screwed up." Participant K had knee replacement surgery and used a walker. He shared that his arthritis has advanced and he needs another knee replacement. Participant I used a cane and a walker.

Ten of the participants discussed transportation issues during the interviews. They reported they were able to ride the bus, walk, or get rides from friends for wherever they needed or wanted to go. The disadvantage to riding the bus for two of the participants was that it took a long time to get to their destination. Participant E asked friends to take him to the VA in San Antonio as he thought that was easier for him than transferring his records to the Austin VA clinic. Four of them said they paid reduced bus fares. Participant C reported he has a lifetime mobility impaired card, which he got from his doctor. With this, he pays half of the usual fare, adding, "It didn't used to be that way. It used to be free but not no more."

Based upon the data analysis, the storyline was developed to contextualize the data through modeling the health care decision making action and interaction strategies of HVV. Strauss and Corbin (1990) recommend using a coding strategy made up of causal conditions, the phenomenon, situational or contextual conditions, intervening conditions, action/interaction strategies, and consequences. The causal conditions, those events or incidents that lead to the

development of the phenomenon are military experiences, homelessness, and access issues. The central event, or phenomenon, was identified as health care decision-making. The situation or context is beliefs, values, expectations, inability to find work, scarce resources, family dissolution, legal issues, negative experiences, prejudice, coping, communicating via the grapevine, friendships/community, length of time needed to see the HCP, distance, limited mobility and transportation. Intervening conditions include young, impressionable, and inexperienced when volunteered for military service, unrealistic expectations, reality shock, racism/bias, denial, acceptance, and avoidance. The action/interaction strategies are information from friends, quality and convenience, communication with HCP, substance use, personal sacrifices, socioeconomic adversity, stressful experiences, and camaraderie.

Selective Coding

To begin the selective analysis step, a concept map was created to identify the core category, or central phenomenon, which led to the identification of the story line. The story that appeared is about how impressionable, and inexperienced young men had expectations of war and Vietnam, which were much different than reality. This led to substance use as a way to deal with unexpected realities of military experiences, which began in Basic Training or upon landing in Vietnam and continued after returning home. The substance use ultimately contributed to difficulty trying to make ends meet and, eventually, homelessness. Among the properties of homelessness are camaraderie and

using informal lines of communication. Military experiences also influenced communication with healthcare providers as these Vietnam Veterans followed orders, trusting military leaders and government officials. Healthcare services were not questioned by participants, even when repetitive tests or illogical treatments like ice baths were ordered, or instructions were given to go to multiple facilities while seeking treatment. Communication with health care providers was influenced by HVV prejudices against foreign and/or female doctors. Access issues, such as physical limited mobility and convenience, along with system inefficiencies, consisting of long wait times for appointments or needing to travel long distances to be seen, impacted the decision about whether health care services were necessary. Each of these contributed to the Vietnam Veteran demonstrating healthcare decision-making as information from friends about convenience is valued more than quality. Using healthcare decision-making processes, which are influenced by convenience more than quality, Vietnam Veterans determine whether or not to access healthcare services. Table 4:4 presents concepts with illustrating quotes. Figure 4:1 presents the preliminary concept map.

Upon completion of the storyline, each category was reviewed to determine one that was most abstract, while preserving details of the story. For this situation, the data seemed to collapse and merge around three central concepts: military experiences, substance use, and access issues.

Identification of the core category. Using a conceptual viewpoint, military experiences seemed to have strong influences on behavior, either becoming submissive or

trusting while they were young or not questioning procedures, such as surgery or being shuttled from place to place. However, substance use seemed significant because all of the participants began using illegal drugs or alcohol soon after joining the military. This may have been a means to cope with discomfort of unexpected experiences and the harsh reality of war. Many of the participants reported that they went through detoxification and rehabilitation programs both while still in the service and, afterwards, through the VA. The selection and renaming of the core category, healthcare decision-making, was made based on three properties that are in the storyline about choosing healthcare: whether it is selected more for convenience or quality.

Summary of Results

The purpose of this study was to explore the process utilized by homeless Vietnam Veterans in making decisions about whether or not to access healthcare services. The specific aims of the study were: (a) to develop a theory grounded in data that might explain why homeless Vietnam-era Veterans do or do not seek health care; (b) to determine specific factors that contribute to and influence homeless Vietnam-era Veterans' decision-making process; and (c) to determine if specific behavior patterns are relevant in the decision-making process and what these behavior patterns are.

Results of this study indicate there are specific factors that contribute to and influence Vietnam Veterans in their decision-making regarding accessing health care. In a study involving HVV, using the category of military experiences may seem redundant. However, HVV were the population of interest and the researcher did not assume that

being a Vietnam Veteran would definitively impact the decision-making process regarding healthcare.

A primary factor includes military experience. Except for one participant who joined when he was 27 years old, these participants volunteered for military service at very young ages, when they were inexperienced, naïve, forming beliefs and values, following orders without question and having decisions made for them. Personal sacrifice came from trusting leaders and government officials, ending with disillusionment. Being treated badly, being verbally and physically attacked and being called “baby-killers” added to feelings of injustice upon returning home.

Another factor that influences healthcare decision-making is substance use, which began soon after joining the service and, in some cases, continued to the present. All of the participants in this study had histories of using illegal drugs and/or alcohol. Many participants indicated this was a way to deal with unexpected experiences and harsh realities of being in the military and/or combat in Vietnam.

Specific behavior patterns were found to be relevant in the healthcare decision-making process. These behavior patterns include getting information regarding healthcare providers through informal channels, such as talking to friends, and sharing experiences. Participants decided whether or not to use healthcare providers or facilities based on the opinions of friends or members of their camp or community. Participants chose healthcare more for convenience than quality.

Finally, this study found homeless Vietnam Veterans who accept homeless services will seek healthcare through VA or community facilities. Prescriptions were filled by the VA and mailed to participants, or they were filled at nearby community pharmacies. Most often, participants used military-sponsored, or VA, detoxification and/or rehabilitation programs. A preliminary theory based on the core category of healthcare decision-making was developed.

Summary of Findings

Chapter 4 presented the study results, beginning with a description of the sample. Descriptive statistics were used to provide demographic information regarding the participants in the sample. The sample was similar in age, gender, ethnicity, and marital status, age when joined the military, and being discharged from the military under honorable conditions. All members of the sample volunteered for military service, rather than being drafted and received services from a homeless shelter. The sample was diverse in the branch of the military in which they served, with the majority of the sample serving in the Army, but the Navy, Marines, and Air Force were also represented. Diversity was noted as half of the sample served in Vietnam and saw combat while the other half did not. There was an assortment of jobs, including heavy equipment operator, tank driver, artilleryman, infantryman, guerilla, cook, member of the insurgency team, military police, and communications.

Findings from open coding followed the description of the sample. Explanations of preliminary category groupings were presented, along with a discussion of properties

that support these categories. Initial major categories created during open coding were military history, substance use, meeting basic needs, medical issues, and health care. Minor categories were arrest history, employment, family dynamics, and benefits.

Findings from the analysis of axial coding were discussed. Revised categories were presented along with supporting conditions, properties, and dimensional ranges upon which they were based.

This chapter concluded with an analysis of selective coding, which was the last step in GTM data analysis. A concept map was created to pictorially present the storyline along with the core category of health care decision-making. Discussion followed regarding the relation of the identified categories to the core category. Using selective coding, a preliminary theory about homeless Vietnam Veterans decision-making regarding healthcare was constructed. Two key categories that supported this effort were military experiences and substance use.

Chapter 5 will present a discussion of the findings of this study, along with conclusions that were reached and implications for practice. The finalized theory will be presented along with recommendations for future research.

Table 4:1 *Participant Demographic Data (N=11)*

Partipnt	A	B	C	D	E	F	G	H	I	J	K
Age in years	65	58	64	60	65	62	62	59	55	59	66
Marital Status (d) divorced (s) separated (w) widowed	d	w	d	d	d	d	d	d	s	d	w
Age when joined the military and year	17 1965	18 ‘73	27 1976	18 1971	19 1968	18 ‘69	18 1969	19 1973	17 1977	17 1972	17 ‘67
Military branch (a) Army (n)Navy (m)Marines (af) Air Force	n	a	a	m	a	af	a	a	a	m	a
(v) Volunteer (d) Drafted	v	v	v	v	v	v	v	v	v	v	v
Served in Vietnam?	yes	no	no	no	yes	yes	yes	no	no	yes	yes
If, so, how long?	18 mo	N/A	N/A	N/A	1 yr	1 yr	18 mo	N/A	N/A	8 mo	1 yr
Combat? job?	Yes Heavy equip	no tanks	no radio comm & cook	no Comm	yes Comm specialist	yes DNA	yes artillery	no infantry	no guerilla	yes Insurgency team	yes MP
Year left	1971	1976	1981	1992	1972	1990	1975	1976	1978	1976	1970
Honorable Discharge?	Yes	yes	1979-yes 1981-no	yes	yes	yes	yes	yes	Yes medical	yes	yes

Table 4:2
Preliminary Themes

Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Cat 6	Cat 7	Cat 8	Cat 9
Family Dynamics	*Subst Use*	*Arrests*	*Employmnt*	*Medical*	*Meeting Basic Needs*	*Health care*	*Mil History*	*Benefits*
Div	**Drugs**	"Rousting folks"	Home	**Illness**	Cost of Living	**VA**	Young	Retire 401k
Girlfriend	Began in Vietnam &In	Warrants	Advocate	Eye infx	"Can't afford to live in Austin"	Empty Promises	"just out of HS"	SS Disabil $823/mo
Children	Basic Tng	"Quality of life issues"	Trucker	Surgery	Low income	Adv got Fired	waiver	Direct dep
Pays child Support	Thai stick	Felony-drug	Tractor	Cancer-Rem	"$12/hr"	"I'm one of the unlucky ones"	Vol	M/care
Widow	Pot	possession	Day labor	Agent Orange?	"min wage	"sucked"	Joined in peace time	Covers 75%
	Still smokes	Cocaine	Show up	Asbestos?	didn't cut it"	Filthy POW camp	"I loved it"	M/aid
	Hashish	Prison x 2	Pd same day	Exp in Vietnam?	Roommates	Didn't care	Boot camp	MAP card
	Navy	Court martial	Carnivals	Flu	"crackheads"	Shuttled	POW	Sect 8
	Detox and Rehab	Fighting	Picked apples	Allergies	"thieving"	Rep tests	Trng	Housing Voucher
	"flunked drug test 3x"	alcohol	Construction	Colds	Unable to find	Only mil-rel'd Inj/ illnesses	GED	Rent pd by city & HUD
	Cocaine		Cook	"I don't get sick"	Work	Budgt cuts	Combat Assmt	Client pays $25 or 35% of inc. & dep.
	Using & Selling			**Injury**	"Can't work now-disabled"	"I'll never g o back"	Heavy equip	
	After mil D/C			MVA-spine, hip, arm, knee	"I can't beg"	Rec lost	Field hosp	Outreach
	Alc			Broken toe	Possessions Lost	Diff to Replace	Tanks	Social Worker
	3/night			Minor cuts & Bruises	**Transport**	"Not getting better"	Maint.	Molly @ Salv Army (VA)
	Cigs			**Dental**	Greyhound	"Push pills"	Radio	
	Began at 16			Missing teeth	Amtrak	**Pos Exp**	Comm	Assist w/ID
				Pain	City Bus	"it's real nice"" I want rehab"	Tech	Housing
				Abscesses	Bus Pass	**Comm**	Cook	DD-214
				"DDS's are exp"	Lifetime Mobility Impaired	Foreign	Hon D/C	SS card
				Dentures (MAP)	Card- ½ fare	"Suzy Wong"	"non-Adapt to mil life"	VA Med benefits
					"I'm on vacation"	Vanderbilt Surgery free Cancer Center	"Second term-(res) bad conduct D/C"	
					Sleeps outside		"finagled way out of svc"	
					Slept at Salv Army			

Table 4:3
Revised Themes

Category 1 *Communication*	Category 2 *Substance Use*	Category 3 *System Barriers*	Category 4 *Access Issues*	Category 5 *Trying to make ends meet*	Category 6 *Military Experiences*
Foreign drs- lack people skills Female, Indian dr- treated funny, looked at odd- when confronted was nicer Diff to Understand- "Why can't they speak English?" "Suzy Wong" Social Worker "Maybe we can. Maybe we can't (help)" Didn't care "Not getting better" "Push pills" "I do not respond to people telling me what to do" "Treated me with utmost respect" Primary dr Prom'd- kept me People nice & Respectful Ambulance called- taken to hospital- no decision	**Drugs** **Way to deal with experiences?** Began using in Vietnam & In Basic Tng "Everyone got high" Began heroine yrs after d/c "flunked drug test 3x" Cocaine 10 yrs Using & Selling After mil Discharge "I smoke weed but I don't use drugs" Felony- drug possession Cocaine Prison x 2 Heart disease CABG x 3 MI age 34, drug related (?) Vascular disease **Alcohol** 2-3/night DWI- Rehab Alcoholic- cold turkey 18-24	Adv Fired "VA sucked" "Commander screwed me up" Filthy WWII POW camp Only mil-related Inj/illnesses Budget cuts Didn't care Shuttled from place to place Repetitive tests Intake clinic Lost VA card- ID card 2-3 wks for replmnt Emergs- wait 3-4 hrs Nearest VA 30 miles Gets a ride at 6:45 am Doesn't know where VA clinic is Hep C- Tx = 6 months Got worse. VA refused to start new tx- liver dr d/c'd No parking- Can take an hr. No Rxs during Govt shut- dn- shared drugs not enough clinics Crowded VA Centers not linked for	Hep C- non-responder **dog kept warm (future research?)** Osteoarthritis Walker, cane Never see same dr twice **Injury/Mobility** MVA- spine, hip, arm, knee Info from friend- Friends go together	Î Cost of Lvg "Quality of life issues" "Can't afford to live in Austin" Low income "$12/hr" "min wage didn't cut it" Unable to find Work "I'm on vacation" "Can't work now-di sabled" "I can't beg" Panhandles "I lost focus" Divorced, lost job, ETOH, lost house Widow- loss of 2nd inc & home Girlfriend took everything, 8 mo in jail- Court-ordered detox- no job, no car, no $$, no house Sister dying/died, quit job, moved	**Formative years- shaped beliefs and values?** Enlisted at young age "just out of HS" Parent signed Volunteered "5000 men died to ensure we have rights" Joined during peace time "I loved it" Joined to drive a Truck Discipline- reform school **Expectations different than reality?** Boot Camp POW Training GED Yellow footprint – 1st trnig Exercise Blocked Intestine Infx. Ice bath Pneumonia boot camp- ice bath Vietnam Combat "I was lucky- I came home" Agent Orange? Asbestos? Exp in Vietnam? Never exp to Agent Orange Honorable D/c "non- adaptability to military life" Med discharge "Second term- (res) bad conduct D/C" "finagled way out of service" **Did what they were told?** "The recruiter lied to me" Free med & dental with 20 yrs "I do not respond to

beers/day Court martial Fighting alcohol DWI's- 2, rehab to avoid jail	easy sharing of info 3 wks to see dr Arrives 2 hrs early for lab work and travels 15 miles to dr Dental emerg only Pays for services Comm clinics not open daily	Evading law Moved to be with girlfriend, who went into rehab Roommates "crack heads" "thieving" Lost Possessions Prev lived with son Sleeps outside Cold/ Rain Slept at Salv Army while worked as cook for them Lottery system for shelter beds Too old for camps Day Sleep Mat- floor Sardines **Information through the grapevine?** Camaraderie and Friendship On streets Part of community People in comm important Phone book to locate shelter	people telling me what to do." "I'm one of the unlucky ones" "I'll never g o back to the VA" "I will not use VA"- friend died, waited 6 hrs **Trusted leaders and govt** "Empty promises" " I thought I could make a difference" "I thought I would be successful" **Injustice/Disillusionment** Spit on when came home Navy Detox and Rehab Rehab in Japan Depression PTSD- fighting created havoc

Table 4:4
Concepts with Illustrating Quotes

CONCEPT	PROPERTIES	ILLUSTRATING QUOTE
Military experiences (non-modifiable)	Young, naïve	I was young- didn't know no better. Scared to death most of the time.
	Decisions made for them	I was at the airport in Saigon- I was an MP. That wasn't my job originally- they decided to put me as an MP. I had no choice.
	Personal sacrifices	55,000 men we lost in Vietnam. They came home after the war was over and they were spit on like dogs. How can you treat a man this way when he wore his colors and defended your right to be free- calling them "baby killers" and "rapists"?
Substance Abuse	Began in Vietnam	I started out like anybody- smoking weed first and then started doing acid when I was 18-19- while I was in Vietnam. Then I started doing cocaine and heroin- it was the only way to get through that time. You'd take something to make it all go away and then come down and have to start the cycle all over again.
	Continued after war	I liked it. I did it until I was 33.

Communication	Health care providers (racism, negative experiences, not questioning treatment)	When I first went to the VA, the doctor was an Indian- a woman doctor. She treated me funny- I don't know- like she was looking at me funny and talking down to me.. It was hard to understand her- I don't like that. Why can't they speak English?
		VA's not getting any better from what I've seen personally and talking to these guys down here and all they want to do is push the pills and yeah pills help to a certain extent but it's no cure. You know, you can push the pain pills onto people and you're not trying to cure you're just trying to get them to calm down.
		I was really, really sick and they dumped me into the ice. I knew the shock was coming. In boot camp, I got pneumonia and they dumped me in the ice then, too.
	Informal grapevine	I've talked to a lot of guys and they gave me the down low on what's happening at the VA in Temple and it's real nice.

Access Issues	System inefficiencies	One time I had an 8 AM appointment so I got there at 6:30- I sat there and sat there and went up and asked and was told they were running late. I was there until 3:30 in the afternoon.
	Convenience	On the day I have an appointment, I go two hours early to one place for lab work and then go about 15 miles to the clinic where the doctor is. Transportation is tough.
	Limited mobility	I had my knee replaced. I had a lot of arthritis. I can't walk without this (points to his walker).

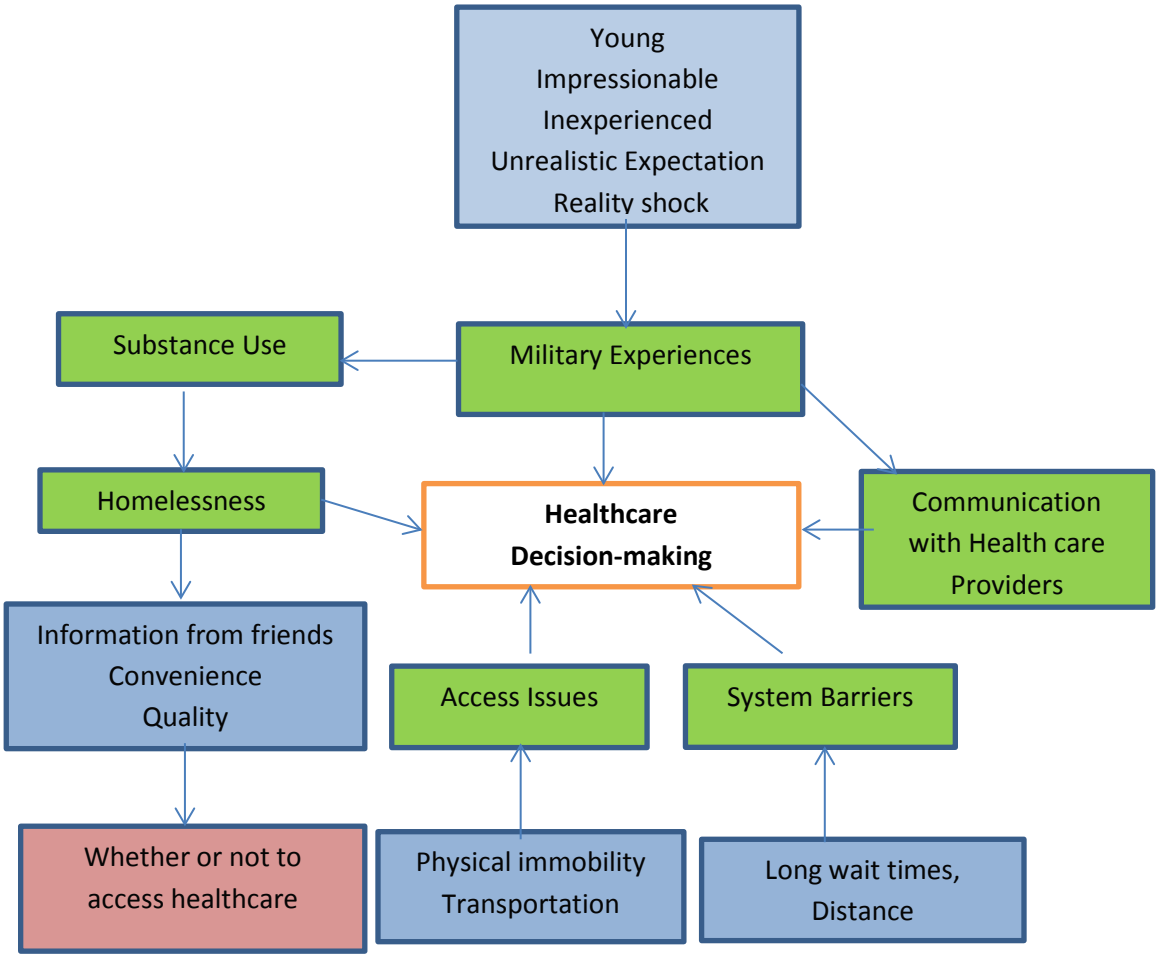

Figure 4:1 HVV Healthcare Decision Making Concept Map

CHAPTER V

PRESENTATION OF THE PRELIMINARY THEORY, SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

Chapter 4 presented data from the demographic data collection form to provide a description of the participants in this research, followed by an explanation of the open analysis of the transcripts of each of the interviews. Concepts derived during open analysis included: military history, substance use, meeting basic needs, medical issues, and healthcare. Minor categories were arrest history, employment, family dynamics, and benefits.

As data analysis continued, these concepts were condensed to military experiences, substance use, trying to make ends meet, communication, and access issues. The properties and dimensions of each of the concepts were presented and discussed. Axial coding was conducted, and the data were concurrently analyzed in a cyclical fashion with open coding as connections were made between concepts. Selective coding followed. The concepts were studied to determine relationships and then categorized to attempt to explain the healthcare decision-making process used by Homeless Vietnam Veterans (HVV) when deciding whether or not to access healthcare services. The core category was identified as healthcare decision-making, which stemmed from several

subcategories. These subcategories were based on events that occurred when healthcare was needed or sought, such as communication with health care providers, communicating via the grapevine, quality, and convenience. Additional subcategories that impacted decision-making were substance use, personal sacrifices, socio-economic adversity, stressful experiences, and camaraderie.

Chapter 5 presents the preliminary theory, which will require testing in later studies. When finalizing the preliminary theory, the researcher studied the theory looking for internal consistency, gaps in logic, and poorly developed categories. The researcher then validated the preliminary theory by determining how well the theory fit with the raw data. By revisiting the raw data, a preliminary theory grounded in data is presented. This preliminary theory provides insight, improves understanding, and provides a meaningful guide to the action that occurred during the development of a decision-making theory related to HVV when healthcare is needed. A discussion of the findings, conclusions, recommendations for future research, and a summary follow.

Discussion

Military Experiences

Military experiences appeared with all of the participants as being a HVV was a condition for inclusion in this study. Properties of military experiences included personal sacrifices, as all of the HVV in this study volunteered for military duty, most of them immediately after completing high school when they were young, impressionable, and inexperienced. These HVV reported having expectations of changing the world, making a

difference, and being successful. They also said that decisions were made for them as they trusted their government leaders and military officials. Instead, they experienced reality shock upon landing in Vietnam and turned to drugs and/or alcohol, to help them cope. Substance use of U.S. soldiers serving in Vietnam and after returning home is well documented. More than two-thirds of HVV continue to have substance abuse problems (Stewart, 2004). Additionally, upon returning home, many HVV reported disillusionment as they were labeled "baby-killers" and spat on.

Substance Use

All of the participants spoke about substance use, which began soon after entering the military and/or being in Vietnam. Most participants indicated this was a coping mechanism for the unforeseen experiences and tough realities of being in the military and/or combat in Vietnam. Substance use continued after returning home, leading to health care issues, or the dissolution of the family and homelessness. HVV who have estranged family relationships and poor coping skills are at risk of increased substance use from boredom and lack of activities (lePage, Garcia-Rea, 2008). Lifestyle behavior has a significant role in continued substance use, which impacts health and decision-making.

Homelessness

Trying to make ends meet was discussed by each of the participants. Recall that many Vietnam Veterans became homeless within a short period of time after returning to the U.S. (Rosenheck, Leda, & Gallup, 1992). Properties of homelessness were

socioeconomic adversity, stressful experiences, camaraderie and using informal avenues of communication, such as the informal grapevine.

According to Dietz (2007), socioeconomic adversity includes job loss, low level of educational attainment, inadequate vocational skills, and scarce resources. All of the participants entered the military soon after graduating from high school, having a 12th grade level of educational achievement. Doolin's study (2009) found veterans recognized that having a job was the best way to regain self-sufficiency and housing. However, in this study, ten participants were unemployed, attributing the inability to work on advanced age and physical disability. Participants discussed the shortage of affordable housing, saying that their retirement or disability income was insufficient to pay for a house or apartment.

Stressful experiences, such as dissolution of the family, either from divorce or the death of the spouse, led or contributed to the HVV struggling with trying to make ends meet and, subsequently, homelessness. Legal issues added to the stresses of HVV. The homeless are at greater risk for experiencing legal problems, both as offenders and victims. Offenses include homelessness, poverty, shop lifting, theft, robbery, substance use, disorderly conduct, criminal mischief, assault, or criminal trespass (Rickards, et al., 2009). One participant explained that homeless people who are on waiting lists for transitional housing cannot be arrested within 6 months of placement. If they are arrested, usually for loitering or public intoxication, the 6-month waiting period begins again. As was the case of two of the participants in this study, court-ordered rehabilitation led to

homelessness as they had houses, cars, and jobs before entering court-ordered rehabilitation but by the time the program ended, those assets were gone and they were left homeless without resources.

Camaraderie and the importance of community within the homeless population appeared many times in conversations about camps, with a close-knit group of friends watching out and taking care of each other. Relationships are reported as important, with closeness and respect demonstrated within communities. Social connectedness is bonding to other people, which provides a sense of security and shared resources (Benda, 2006). HVV in this study spoke about being members of a community, where they watched out for and took care of each other. They were observed sitting together and demonstrated closeness by talking in undertones when strangers came near. When a member of the community is absent, other members share what they have heard. When healthcare is needed, HVV ask group members for referrals. Communication occurs via the grapevine, with one person reporting or recommending a health care professional or facility not necessarily based on actual experiences, but on hearsay.

Healthcare Decision Making

The major finding of this research is that healthcare decision-making was the central phenomenon of the HVV. As decision-making is important for anyone who needs to access healthcare services, the theme of healthcare decision-making highlights the causal conditions of HVV: military experiences, substance use, homelessness, and access issues. The prevalent attitudes are that quality of healthcare is not as important as

convenience of the facility and the healthcare provider. Information is obtained from friends regarding where to go for healthcare services, rather than being referred to the most appropriate provider.

The situations or contexts that contribute to healthcare decision-making in HVV include scarcity of resources, high incidence of family dissolution, legal issues, importance of belonging to a community and having friendships, communicating via the grapevine, limited mobility, distance to health care clinics, long wait time to be seen by a health care professional, negative experiences and poor impressions. Intervening conditions are that HVV were young, impressionable, and inexperienced when they volunteered for military service, having expectations of military life that, in reality, turned out to be much different. They suffered reality shock and turned to coping mechanisms, such as denial of the true situation, acceptance of substance use, and avoidance. Drug and alcohol use greatly influences HVV decision-making with regard to healthcare (Goldstein et al., 2008).

Access Issues

Access issues were present in 10 of the 11 participants. The properties of access issues are limited mobility and system inefficiencies. Most of the HVV had physical activity limitations, such as joint pain associated with arthritis or they walked with a limp from previous motor vehicle accidents. Some of the participants ambulated with an assistive device, such as a cane or walker. Standing or walking for long periods of time or climbing stairs was difficult for many of these participants.

System inefficiencies were described by all of the participants. System inefficiencies included long wait times to be seen by a healthcare provider, inconvenient locations of clinics, convenience, and quality of healthcare. The distance to VA clinics is a problem when transportation means taking the bus, walking, or asking friends for rides. Many participants reported that it takes a long time to get to the clinics when using public transportation, while others ask friends to take them. In 2003, the VA committed to improve access to and quality of healthcare services specifically for HVV (O'Toole, et al., 2003). However, Greenberg and Rosenheck, (2009) found that personal, situational, and bureaucratic barriers to accessing VA healthcare services include: limited resources; proximity to clinics; negative public perceptions; insensitive service providers; and dehumanizing policies and procedures. Six of the participants in the current study, however, reported being happy with the quality of healthcare they received with VA facilities and reported being treated with respect. Even so, participants reported that there is a lengthy delay between making an appointment and seeing a healthcare professional-sometimes as much as three weeks. O'Toole et al. (2003) reported that HVV were less likely to access community health centers, relying on shelters and street outreach services instead. However, in this study, HVV did not qualify for treatment at VA facilities, turning to community healthcare facilities, especially for emergencies. To qualify as a service-related injury or illness, Vietnam Veterans had to be diagnosed within two years of returning to the U.S. ("Alcohol use study", 2008). Many HVV were not identified within this time frame, which has long since passed.

Homeless Vietnam Veterans Health Care Utilization Theory

Theory building depends on facts, observances, evidence, and the researcher's ability to pull the data together to make sense of it. Theories and conceptual models are not proven as they are the researcher's finest attempt to describe and explain the phenomena that appear, which are subsequently studied. With ever changing times and social values, theories and conceptual models are perpetually-evolving and dynamic (Polit & Beck, 2012).

The major categories, which appeared in the responses of the majority of the participants, surfaced from the analysis of the data and include: military service, substance use, homelessness and communicating via the grapevine, and access issues. The minor categories, reported by some but not all of the participants, include family dynamics, arrest history, employment, and benefits.

The phenomenon of interest remains health care decision-making with the recognition that convenience over quality determines how healthcare decisions are made. The causal conditions for HVV in their decision-making processes remain military experiences, substance use, homelessness, and access issues. Figure 5:1 depicts HVV Healthcare Utilization Theory.

Rather than focusing solely on healthcare, the refined version of the preliminary theory of healthcare decision-making used by HVV represents a shift. Based on HVV Healthcare Utilization Theory, the evolving theory seeks to recognize that healthcare professionals need to help HVV make decisions based on convenience over quality.

Context of Health Care Decision Making

Based on the data, healthcare decision-making seems to occur within the context of military experiences; substance use; homelessness, where communication occurs via the grapevine, and access issues with difficulty with mobility, convenience, quality, and system inefficiencies. While none of these concepts alone appear to be the primary trigger for healthcare decision-making in HVV, healthcare decision-making certainly occurs within the context of the collective of these concepts. See Figure 5.1 HVV Health Care Utilization Theory.

Therefore, the preliminary HVV Health Care Utilization Theory is that HVV have an alternate view of wellness and health. Rather than health being the absence of disease, it is surviving in the presence of disease. The environment of homelessness enhances diminished or compromised wellness. Camaraderie is important in the homeless environment, where information sharing occurs via informal networks- as through the grapevine. When HVV enter the healthcare environment, especially when using VA facilities, HVV experience more burden than benefit because of access issues.

Relation of Findings to Philosophical Framework

Symbolic Interactionism (SI), which employs a social psychology approach of modifying analysis subject to the actions and interactions of people in the course of their daily lives, is the philosophical framework used in this study. Symbolic Interactionism concentrates on shared acts and contact, meaning, and interpretation of meaning (Blumer, 1969). People react based on meaning that things have for them, which is centered around

social interactions with other people as things are modified and interpreted (Blumer, 1969). Symbolic Interactionism was selected for this study to (a) understand meaning that HVV attach to the health care setting, to health, and to illness; and (b) identify responses HVV apply to things, or symbols, through their interaction with health care providers. Through the use of SI, an understanding of HVV construal of symbols and/or other people's actions led to interpretations and identification of subsequent behaviors in deciding whether or not to access health care services.

There are three foundational principles of SI: meaning, or that human behavior is a response to things or symbols; thought, which is a perpetual process of determining meaning from things themselves; and language, which is understood and established to describe meanings (Blumer, 1969). Even though behavior may be influenced by context, history, and social mores, these symbols do not determine behavior. The essence of SI is how situations are interpreted or thought processes are used to apply meaning, and how or why a course of action is chosen, which is precisely what this research was able to describe.

For HVV, meaning came from an interaction between trusting the government, having decisions made for them, and being sent to the war in Vietnam. HVV interpreted their realities based on their youthful, inexperienced, and naive awareness of reality, as they continued the process of creating meaning. If we take the example of the three truths that can be applied to every situation, it becomes the HVV interpretation of what happened, society's interpretation of what happened, and what really happened during the

Vietnam War and upon returning home. To further explain this concept, inter-relatedness between a person and a symbol allows for multiple social interpretations to emerge. As Vietnam Veterans continued to serve, military leaders and the disciplined military life influenced them and their families. The three truths need to be evaluated to determine proper behavior as it applies to understanding reality, which then allows for growth. As the process continues to evolve, actions become more consistent. In the case of Vietnam Veterans, many turned to substances when faced with war and being in a strange country. To share meanings, symbolic communication is used, creating an awareness of experiences and interpreting meanings. For Vietnam Veterans, because of the mistreatment and disillusionment upon returning home, many HVV reported they continue to use substances and do not speak of the events related to the Vietnam War, so sharing and interpretation did not occur, thus no meaning was given to these events. See Table 5.1 Relation of Findings to Philosophical Framework.

Using inductive inquiry and basing this research on SI allowed for better understanding of the healthcare decision-making process utilized by HVV in determining whether or not to access health care. For HVV who have few possessions, relationships and friends are very significant and become symbolic. The words, advice, and opinions offered by trusted friends are important.

For those who served in the military, status and rank have meaning. This was particularly noted at the individual level when HVV interacted with health care professionals. The actions/interactions of healthcare professionals influenced and

impacted the process of the HVV receiving healthcare services. As HVV grow older, healthcare issues arise. The social hierarchy of the military continues even after veterans return home and leave military service. It is important for HVV who were shaped by military service to be treated with respect. HVV commented on showing and being treated with respect, using direct eye contact, and the ability to understand when spoken to.

Vietnam Veterans were part of a social interaction and played roles while serving in the military. Examples of roles include driving a tank, cooking, and building hospitals. Unfortunately, when these men returned home, their military roles were not transferable to civilian roles.

Through the use of SI, understanding was gained that HVV defer to people bearing symbols of military hierarchy and of healthcare professions as status and rank have meaning. This was mainly noted when HVV interacted with healthcare professionals. Many of the participants in this study said they felt healthcare providers were insensitive and rude. It is important for HVV who were shaped by military service to be treated with respect. The actions of these healthcare professionals influenced the healthcare decision-making of HVV as five of the participants said they will never seek treatment at VA facilities again, regardless of quality of care. HVV suggested healthcare care professionals should demonstrate respect, using direct eye contact, and speaking clearly, ascertaining HVV understand what they are told. Thus, a preliminary theory

emerged using philosophical underpinnings of SI. See Table 5:2 HVV Symbolic Interactions.

Filling the Gap in Literature

A review of literature was conducted for research regarding HVV. A large portion of the literature was focused on homelessness alone or veterans of any war diagnosed with PTSD. There are many published qualitative and quantitative studies regarding homelessness and veterans in general. There are also studies regarding improving VA healthcare services and various services aimed at helping HVV.

There was limited qualitative research on HVV and their access to healthcare services. While there were some GTM research studies, particularly dissertations, regarding homeless veterans, there were none regarding HVV healthcare decision-making in determining whether or not to access healthcare services. Since HVV are aging and at risk of developing serious health issues, which can be prevented if caught early, additional research needs to be targeted at this population. While this study adds to the gap in the literature with respect to the need for further research, a description of the processes used by HVV in deciding whether or not to access healthcare services was used to create a preliminary theory: HVV healthcare decision-making stems from military experiences, substance use, homelessness and communication via the grapevine, and access issues, including difficulty with mobility, convenience, quality and system inefficiencies. While military experiences are not modifiable, the other categories are. Also, substance use and homelessness are categories the HVV can modify, while access

issues, which impact HVV decision-making processes are modified by outside forces, not controlled by HVV.

Extending Theory

Qualitative research involves gaining knowledge and a better understanding of the participants' needs by looking at the research issue from the perspective of the participant. This study sought to understand what it is like to be a HVV as they determine the need for accessing healthcare services. Listening to the stories and gaining new perspectives about how HVV view their military experiences, including substance use, homelessness with informal communication via the grapevine, and access issues, are important for the researcher to capture.

Nursing theories are used to elucidate various aspects of the profession, upon which evidence-based practice can be founded, furthering the standards of nursing. For a population of veterans who are reluctant to share their Vietnam experiences, this study gave voice to the memories, thoughts, and actions of HVV and established the importance of healthcare decision-making by creating a preliminary theory, and explaining the process used by HVV in determining whether or not to access healthcare services.

The importance of creating a preliminary theory for advancing the care of HVV was to identify and strengthen practices used in the treatment and care of HVV to improve quality of life, decrease untreated health-related consequences, and encourage overall well-being. The creation of nursing theory allows community and public health

nurses to develop new, or amend existing means of service delivery to meet healthcare needs of HVV.

Assumptions

Results from this study differed from the researcher's assumptions. A review of literature was conducted prior to data collection and provided a summary of issues faced by HVV. These issues included mental health disorders, such a schizophrenia and PTSD, substance abuse, issues regarding healthcare access, particularly in the VA system, homelessness, and medical issues. From these issues, initial assumptions were made by the researcher that participants in the current study were likely to report: (a) never accessing any healthcare services, regardless of whether it was from the VA or community, (b) that they had no resources, other than pan-handling or begging, or (c) that PTSD was present in the majority of HVV, contributing to their inability to make effective healthcare decisions.

The first assumption, never accessing any type of healthcare services, was not supported, as all of the participants were amenable to seeking healthcare services if a need was determined. Six of the participants were willing to use VA services, while five were adamant in the refusal to use VA services. All of the participants were willing to use community healthcare facilities. The second assumption was not supported as the participants received a variety of support, including Social Security, disability, Medicaid/Medicare, military retirement, and, in some cases, private insurance. The third assumption was not determined either way as PTSD was not mentioned by the majority

of participants in the natural course of the interviews. Only one of the participants reported a diagnosis and treatment of PSTD. The remaining participants did not address whether or not they had PTSD.

Conclusions and Implications

This section discusses the conclusions and implications of this study for research and practice. There are conclusions from this research, which cross many fields of study. Most important among them is that HVV continue to survive in the face of adversity, forced to develop informal support systems and skills to survive (McMurray-Avila, 2001). However, they require assistance, which can come in informal or institutional forms. As discussed in the results section, a context of healthcare decision-making is dominant in HVV. Assistance can come from healthcare professionals as HVV make healthcare decisions based on convenience more than quality. This assistance will allow HVV to improve their health and overall well-being by gaining timely treatment for illnesses or injuries.

From listening to the stories of the HVV in this study, there was a clear theme of disillusionment: with the government, military leaders, and themselves. Many indicated they had hopes and aspirations to change the world and be successful. Instead, they felt they were lied to and promises, that would later be broken, were made by people they trusted and looked to for well-being. Military officials and the VA contributed to assigning an image of antisocial behavior, substance use as an escape, and a low incidence of combat stress to Vietnam Veterans. The unpopularity of the Vietnam War

contributed to healthcare professionals not recognizing and treating Vietnam Veterans, thus obstructing access to healthcare services (French & Wailer, 1983). Many HVV shared their disappointment in the way they were treated upon returning home, burdened by the knowledge they had no choice but to follow orders and shouldering the blame for the events that occurred in Vietnam.

The specific aims of the study were: (a) to develop a theory grounded in data that might explain why HVV sought or did not seek health care; (b) to determine specific factors that contributed to and influenced HVV' decision-making process; and (c) to determine if specific behavior patterns were relevant in the decision-making process and what these behavior patterns were.

The first aim of this study was met as a preliminary theory grounded in data explains why HVV seek or do not seek healthcare: healthcare decision-making occurs within the context of military experiences; substance use; homelessness, and access issues. The second aim was met as specific factors that contribute to and influence HVV decision-making are: communication via the grapevine, difficulty with mobility, and system inefficiencies. The third aim was met as specific behavior patterns were found to be relevant in the decision-making process. Communicating with friends and members of the shared homeless community played a major role in the healthcare decision-making process. Convenience is a stronger motivator than quality of services, and is important when referrals come through the grapevine. While none of these concepts alone appear to

be the primary trigger for healthcare decision-making in HVV, healthcare decision-making certainly occurs within the context of the collective of these concepts.

Implications for Future Practice

Military experiences shaped how healthcare decisions were made. Past experiences, values, and beliefs thwart effective use of healthcare services (McMurray-Avila, 2001). The past experiences of HVV cannot be changed. Therefore, there are no recommendations for clinical practice, nursing education, or further research with regard to military experiences. Implications for clinical practice and nursing education are discussed here.

Clinical practice. The health-related issues HVV experience is a concern to nurses who provide physical and mental health services to this vulnerable population. Psychiatric disorders and substance use disorders are two to three times more prevalent for homeless veterans than for homeless non-veterans. Additionally, antisocial personality disorder was five to six times higher in this population (McMurray-Avila, 2001). Substance abuse, PTSD, and physical and mental health issues must be recognized quickly and included in nursing assessments so that nursing interventions can be planned and implemented in a timely manner.

The VA and community healthcare systems have barriers in place that discourage HVV from accessing needed healthcare services that they may be eligible to receive. Eligibility to receive VA benefits include honorable discharge, or, because of limited resources, services are targeted to specific vulnerable groups, such as mentally ill or

female veterans. Those HVV who do not fit into either category are unable to access healthcare services through the VA (McMurray-Avila, 2001). Rather than ignoring the needs of HVV, their issues need to be identified so that solutions can be found to offer them healthcare services. In a study by Tsai, Mares, and Rosenheck (2012), veterans were found to frequently use community healthcare services over VA medical, psychiatric, or substance abuse services. To improve access, the VA was encouraged to coordinate with community healthcare providers to improve services to homeless veterans (Tsai, Mares, & Rosenheck, 2012). Participants in this study offered suggestions for ways to improve VA healthcare delivery. More clinics are needed with efficient intake procedures. There needs to be a faster turn-around between making an appointment and being seen by a healthcare professional. More efficiency is needed and less redundancy in ordering lab work. For instance, a frequent comment was that there were too many instances of lab work being repeated even after the HVV reported it was recently done.

Homeless veterans report that VA healthcare is inadequate and inaccessible, describing it as a complex maze of programs with limited resources, coordination issues, and inadequate funding (McMurray-Avila, 2001). The HVV in this study concurred; suggesting a system where HVV have continuity of care, seeing the same healthcare provider when they return for follow-up appointments. The VA has implemented and developed healthcare initiatives to provide specialized services for HVV. Additionally, efforts have been made to connect veterans with appropriate VA services and staff (Tsai,

Mares, & Rosenheck, 2012). It was noted in this study that dental care is sorely lacking as many of the participants had few, if any, teeth and frequently reported severe dental pain. The VA has funded 10 facilities to implement oral healthcare programs for homeless veterans who are in rehabilitation (McMurray-Avila, 2001). Unfortunately, this does not address dental needs of HVV who are not in rehabilitation.

Healthcare disciplines, such as nursing, social work, medicine, and psychiatry, need to be included in planning and implementing healthcare to ensure quality and convenience of services for HVV. Veterans are more likely to use VA healthcare services if they can get priority access to services and if they live near a VA healthcare facility (McMurray-Avila, 2001). Since transportation is an issue and the clinics are not conveniently located for HVV, street nursing and mobile health units could go to HVV on a regular basis, which would decrease the need for transportation and diminish mobility issues. Visiting nurses exist in some areas of the country, but not all. Additionally, clinics could be staffed by volunteer healthcare professionals on a regular basis. Church groups could be recruited to transport HVV to and from free clinics using church vans.

What is known about HVV tends to be based upon small, geographically isolated samples, rather than through nationwide sampling. Since this current study revealed that HVV will use public or community-based health programs, collaborative programs between the VA and local, community healthcare facilities should be developed. The Homeless Providers Grant and Per Diem Program assists public and non-profit

organizations establish service centers for HVV. Unfortunately, these funds can only be applied to supportive housing programs, case management, education, crisis intervention, or counseling (McMurray-Avila, 2001). These collaborations may increase homeless services to HVV, but do not increase healthcare services.

Nursing education. Content about caring for veterans could be included in undergraduate and graduate nursing practicum curricula. Student nurses could assist with vital signs, basic first aid, assessments, and teaching. Nurse Practitioner programs could offer free or low-cost clinics to serve marginalized populations, such as HVV, as part of practicum courses.

Nurses must learn to be aware of verbal and non-verbal communication that may deter open lines of communication and impede access to healthcare by members of the homeless community. In a study by Applewhite (1997), insensitive service providers were described by veterans as being the most important issue when interacting with VA healthcare professionals. This includes lack of respect, apathy, indifference, service-connected labeling, degrading comments, and insults. There is a constant need to ensure healthcare providers are compassionate, well-informed, and culturally competent (McMurray-Avila, 2001). For homeless people who do not have access to bathroom facilities, or showers, and who have basic hygiene limitations, judgmental attitudes from nurses only add to barriers in accessing healthcare.

Recommendations for Further Studies

Nursing Research and Theory Development

While research exists in other healthcare disciplines, there is limited nursing research regarding Vietnam veterans, homeless or otherwise, and their decision making regarding health care access. Specifically, it would be helpful to understand more about how Vietnam veterans who were drafted into the military differ from this sample of veterans who volunteered to serve. Since this was a predominantly white sample, it is important to learn more about Hispanic and African American veterans.

Based on identified gaps in the literature, there is a need for more qualitative research in the area of homelessness, possibly through case studies or oral histories, to bring the human aspect into research findings. This research needs to include all ages and both male and female participants. Homelessness is relevant to all healthcare disciplines; yet, the majority of research and literature are in social work. As a result, nurses may not utilize the information and tools as effectively to assist HVV to obtain quality healthcare and improve overall health status founded in evidence-based practice.

The current study generated a theory of how HVV decide whether or not to access healthcare. A logical future step would be to develop an assessment instrument based on these findings. This assessment tool would be beneficial for use in clinical and educational settings, particularly in VA and community healthcare facilities. While many assessment scales would be the same for HVV as they are for any veteran, items that focus on substance use, homelessness, communicating via the grapevine, healthcare

decision-making, and access issues could give clinicians a more complete picture of the HVV within the present-day context.

A large number HVV had dogs. One of the participants in the current study spoke of the importance of his dog's presence, especially in times of illness. A recommendation for a future study would be the significance of the relationship between the homeless and their dogs, regardless of whether the participant is a veteran or not.

Since the war in Vietnam ended, there have been additional wars, and a new generation of homeless veterans. Future research may be aimed at younger veterans to offer assistance in returning to productive roles in society and maintaining housing.

More women are serving in the military and facing the issues while in the military and upon returning home. Additionally, they may struggle with the dual responsibility of their importance to the family, as mothers, and wives while serving in the military. Further research is needed in the area of women's issues when they serve in the military and have family responsibilities.

Limitations

HVV are a hard-to-reach population, and as such the limitations of this research are best explained by the significance of their marginalized status, rather than weaknesses in the methodological design. Of the 11 participants, all were male. This is not unexpected as there were very few women who served in Vietnam. Therefore, this preliminary theory is more applicable to men than women.

Despite purposive sampling, obtaining a diverse sample of HVV with regard to race and ethnicity was a challenge. The sample was predominantly Caucasian, (n=9). One participant was Hispanic, and one was African American. This is not a racially or ethnically representative sample.

There is a possibility of self-selection bias in this research. HVV in this study volunteered themselves into the group of HVV, meaning that there was no outside criterion or measure of their being homeless or a Vietnam Veteran, other than their own report that they were a HVV. This could potentially confound the results as there was no objective measure of whether or not they were homeless or Vietnam Veterans. The results should be interpreted with caution and future studies should address this concern.

Another limitation was that only HVV who accessed a shelter or social services were included in this study. It is quite possible that those HVV who do not access any type of social services likewise do not access healthcare.

Since this was research for a dissertation, one researcher conducted the interviews and the researcher was a Caucasian, educated female who has never experienced homelessness or the Vietnam War. This could have had an effect on participant responses and the self-selected nature of the study. Therefore, all interview data is from an outsider perspective and all observations were made as a non-participant observer.

Finally, the current research relied on in-depth interview data for each HVV. When the interviews were conducted, the demographic questionnaire was completed by the researcher asking the participants questions and recording their answers. These

responses to the demographic questions were included in the recordings and in the interview transcripts. This was done intentionally as a means of breaking the ice, developing rapport, and gaining trust. However, this reduced the time for discussion in the interview. More information may have been elicited from participants if they completed a written demographics form before beginning the interview.

Summary

This study provided a preliminary theory to explain the healthcare decision making process that is used by HVV in determining whether or not to access healthcare was utilized based more on convenience rather than quality. Specific categories that contribute to and influence HVV healthcare decision-making processes are military experiences, substance use, homelessness, and access issues. The category of military experiences was recognized as not modifiable as these occurred in the past. Substance use, homelessness, and access issues are modifiable and recommendations for clinical practice, nursing education, and future research are directed at these categories. Specific behavior patterns, including communication via the grapevine, are relevant in the healthcare decision-making process as this influenced the decision to seek healthcare based on hearsay and opinions of friends and community members.

Even though military experiences are non-modifiable, they contributed to the healthcare decision making used by HVV in determining whether or not to access healthcare services. Most of the participants volunteered for military service, when they were very young, inexperienced and naïve. Decisions were made for them and they

followed orders without question, trusting leaders and government officials. HVV made personal sacrifices, and suffered from disillusionment as they felt they were lied to, and given empty promises.

Substance use, which included illegal drugs and/or alcohol, was found in all participants and began soon after joining the service and, in some cases, continuing to the present. Substance use contributed to healthcare issues and family dissolution, which may have contributed to homelessness.

Within homelessness, camaraderie and a sense of community are important. Informal communication, such as communicating through the grapevine, is utilized to share experiences and make referrals. HVV decided to use healthcare providers based on the opinions of friends. This was found to impact healthcare decision making based on convenience more than quality of services.

Finally, this study found that access issues, such as long wait times, repetitive procedures, inconvenient locations and difficulty with mobility or transportation contribute to the healthcare decision making process that HVV use in determining whether or not to access healthcare. HVV will seek healthcare through VA or community healthcare facilities based on convenience rather than quality.

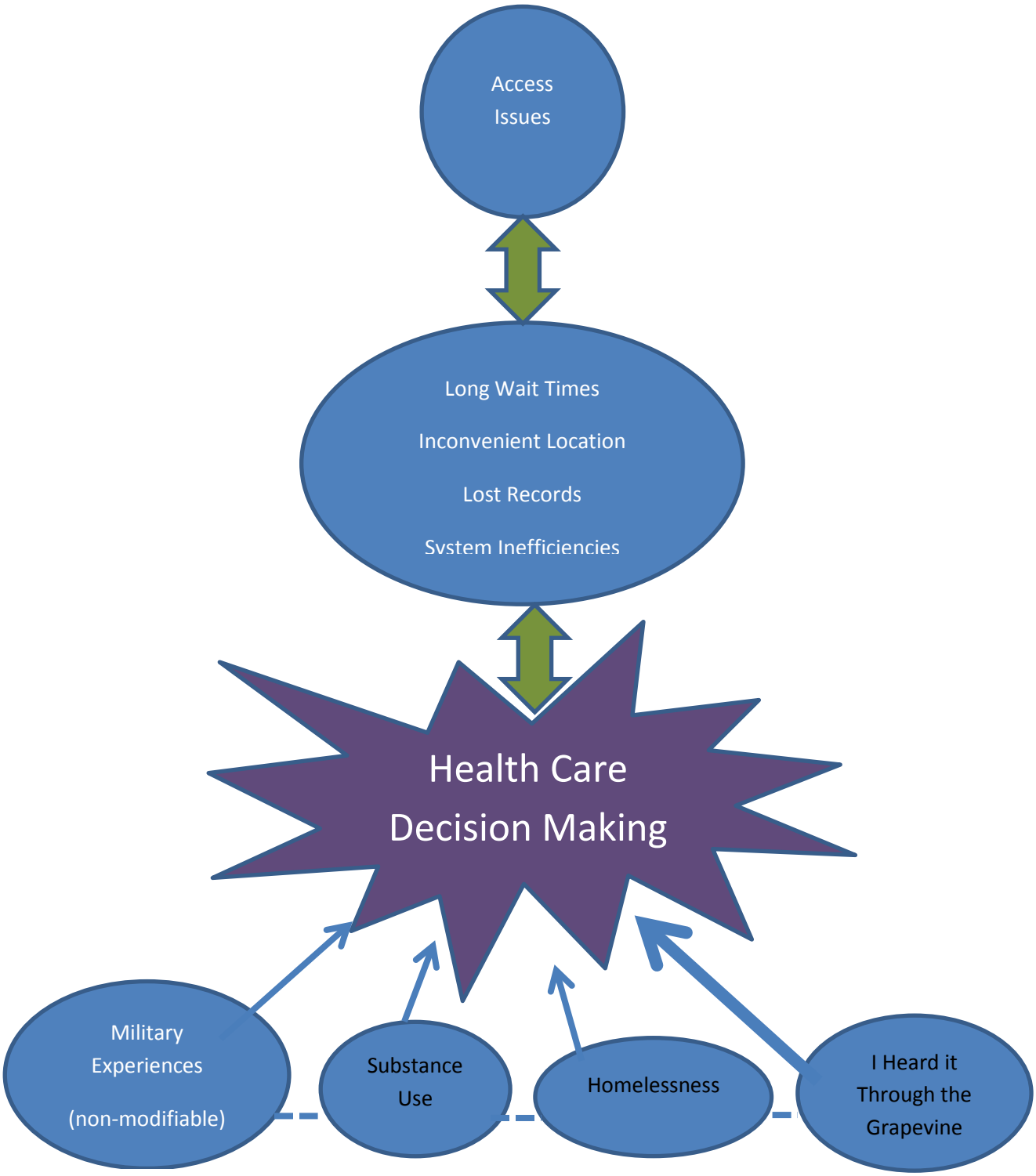

Figure 5.1. HVV Health Care Utilization Theory

Table 5.1

Relation of Findings to Philosophical Framework

Symbolic Interactionism	Findings
Understand meaning that HVV attach to the health care setting	**Based on their experiences in the military (youth, having decisions made for them, obedience)**
- health - illness	Not the absence of illness, living with it Not an issue until it required intense intervention/ hospitalization Not questioning treatments (ice baths)
Identify responses HVV apply to things	**Based on their experiences in the military (youth, having decisions made for them, obedience)**
- symbols	Doctors have authority VA represents military – shouldn't question things
- peoples' actions	Not making eye contact Disrespect Difficult to understand (ESL) Difficult, redundant processes

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Appendix A

Flyer

Research Study Seeks Homeless Vietnam Veteran Volunteers

If you are a Vietnam Veteran, you are invited to participate in a research study conducted by Susan England, MSN, RN, who is a student at Texas Woman's University. This study is part of her dissertation work.

The purpose of this study is to learn about health care choices of homeless Vietnam Veterans.

The study will consist of a one-hour interview
that will be conducted in the conference room
at ARCH.

If you are selected and interviewed, you will receive a backpack at the end of the interview. You can withdraw from the study at any time. Your participation should be voluntary and your information will be kept confidential. If you would like more information about the study or want to participate in an interview, please sign up at the front desk. Susan England will contact you to schedule an interview.

Thank you for your consideration

Appendix B
Demographic Data Collection Form

Participant's number or code name:_____

1. What is your age?

2. Male _____ Female _____

3. What is your marital status?

   Married _____

   Divorced _____

   Separated _____

   Widowed _____

4. Military service history:
   a. When did you join the military? Age_____ Year_____
   b. Which branch did you join?
      Army_____
      Navy_____
      Marines_____
      Air Force_____
   c. Did you volunteer or were you drafted?
      Volunteer_____
      Drafted_____
   d. Which company were you assigned to?
   e. Did you serve in Vietnam? Yes_____ No_____
   f. If so, how long did you serve in Vietnam? _____years
      _____months
   g. Did you see combat? Yes_____ No_____
   h. What was your job? _____
   i. When did you leave the military? _____
   j. Were you honorably discharged? _____

Appendix C

Interview Guide Questions

1. Do you receive disability or social security payments?
2. Do you receive Medicare or Medicaid benefits?
3. What do you do when you need to see a doctor? Share with me your experience of getting medical care when you have needed it.
4. Tell me about your past medical illnesses or injuries.
5. If you use the Veterans Administration (VA) health care services, please tell me about your experiences.
6. If you do not use the VA health care services, please tell me why and where you go for help and your experiences.

Appendix D

Recruitment Script

(To be used after volunteers have agreed to participate and are in a preliminary screening. This will occur prior to the interview)

Preliminary screening:

Before we can begin, I need to make sure you are a Vietnam Veteran, and that you are homeless. Any information you give me will be kept confidential- that is, your name or any information that can identify you will not be used. You will be assigned a number that will be used during the interview, but you need to sign your real name on the consent form. I will keep the consent forms in a locked cabinet in my office.

I will ask you some questions, which should not take more than one hour. As we talk, I will write some notes to myself, but I will also tape record our conversation, so that if I miss something, I can go back and listen to our conversation. At any time, if you change your mind or decide you don't want to participate, please let me know and we will stop. Any information you have given me will be destroyed- I will shred any papers that have your information and erase the tape recording. At any time, if you need a break, tell me.

The information you give me will help me with my dissertation. I may publish the results of this study. If I do, I want to assure you, your identity will be kept confidential.

Do you have any questions for me? Would you like to participate in this study?

If yes, we will proceed to the informed consent form.

If no, thank you for your consideration.

Appendix E

Internal Review Board Approval Letter

TWU
TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378 FAX 940-898-4416
e-mail: IRB@twu.edu

September 6, 2013

Ms. Susan England

Dear Ms. England:

Re: Experiences of Homeless Vietnam Veterans in Deciding to Access or Not Access Healthcare (Protocol #: 17387)

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and appears to meet our requirements for the protection of individuals' rights.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

This approval is valid one year from July 12, 2013. Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any unanticipated incidents. If you have any questions, please contact the TWU IRB.

Sincerely,

Vicki L Zeigler

Dr. Vicki Zeigler, Co-Chair
Institutional Review Board - Denton

cc. Dr. Gayle Roux, College of Nursing
Dr. Donna Sauls, College of Nursing
Graduate School