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Push-Pull Tensions:  
A Grounded Theory on Social Experience  
of Use of Healthcare Services  
Among Homeless Veterans

A dissertation submitted in partial satisfaction of the  
requirements for the degree Doctor of Philosophy  
in Nursing

by

Romanitchiko Samiley

2016

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## **ABSTRACT OF THE DISSERTATION**

Push-Pull Tensions:  
A Grounded Theory on Social Experience  
of Use of Healthcare Services  
Among Homeless Veterans

A dissertation submitted in partial satisfaction of the  
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by

Romanitchiko Samiley

Doctor of Philosophy in Nursing, 2016

Professor Linda Phillips, Chair

The purpose of the study was to develop, from the perspective of the user, a better understanding of the factors that influence use of healthcare services by homeless veterans in the U.S. The study employed the Grounded Theory (GT) methodology and was guided by Critical Social Theory (CST) and Symbolic Interactionism (SI) as the philosophical underpinnings. There is a scant but growing number of studies on the social experience of homeless veterans in accessing care at the Department of Veteran Affairs (VA). Understanding these issues is important

because of the myriad health, psychiatric, and substance abuse problems they encounter. As many VA programs have implemented programs for homeless veterans, an investigation of the current social experience is imperative for homeless veterans. CST, or critical theory, was useful in understanding the sociopolitical and historical contexts of health and healthcare and important in understanding the power relations between the U.S. government and the homeless veterans within the healthcare setting. This approach enabled the development of knowledge from the subjective perspective. CST was useful in exploring injustices related to homeless veterans' access to VA healthcare because this approach exposes the hidden relations of domination and powers inherent in society's fundamental structures and ideologies. SI provided a tool to understand the social interaction of veterans acquiring healthcare. Eighteen homeless veterans were recruited and interviewed at one homeless shelter and two transitional housing programs in the Skid Row area of Los Angeles and the Westside. The qualitative methodology of GT was employed to understand the perspective of the participant or agent, which is in line with the emancipatory aims of CST. The GT developed from these data led to the focus of the theory, which is on the tensions involved in push and pull forces and the outcomes that arise as a result. Hence the theory has two major concepts: Push/pull tensions and outcomes.

The dissertation of Romanitchiko Samiley is approved.

Sally Maliski

Adey Nyamathi

Donald E. Morisky

Linda R. Phillips, Committee Chair

University of California, Los Angeles

2016

## **DEDICATION PAGE**

This dissertation is dedicated to my family, for you only have one:

To my wife, Charlene Mae Querubin Samiley, and our children, Calista “Cali” Mae Samiley and Chloe “Coco” Gwen Samiley. Thank you for your sacrifices to help me complete this degree.

This dissertation is also dedicated to my mother Juanita Mangasi Samiley, and my late father, Romeo Samiley, for the sacrifices they made for my siblings and me, and instilling the importance of education and hard-work.

A special thanks to my sister, Rowena Juliet Abarro, for stepping in for me during this undertaking when I could not be around for my wife and children, especially before she had her own family. Thanks to her family, Randel Abarro, Chance, and Everly for the hope and joy they brought to our family.

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- The Mangasi Family
- The Querubin Family
- The Samiley Family.

## **BIOGRAPHICAL SKETCH**

Romanitchiko Mangasi Samiley attended Loyola High School in Los Angeles, and enlisted in the United States Army Reserve during his junior year of high school. Through the split option program, he completed Basic Training at Fort Sill, Oklahoma, and then served 6 years in the Army reserve after his senior year.

He completed his undergraduate program at the University of California Berkeley and received a Bachelor of Arts in Integrative Biology. While working at Contra Costa County Public Health Department, he developed an interest in becoming a Nurse Practitioner when he worked for the Director of Public Health Clinics, who was a Nurse Practitioner.

He went back to get his nursing degree at Mount Saint Mary's College and then attended the University of California Los Angeles (UCLA) combined Bachelor of Science in Nursing and Master of Science in Nursing program to become a Nurse Practitioner. During his studies and training at UCLA, he developed an interest in working with vulnerable populations.

He subsequently worked at the Department of Veteran Affairs (VA) in the Homeless program for 10 years, and returned to UCLA to work on a doctoral program related to his work with homeless veterans. He plans to continue working at the VA after graduation, with the hopes of eventually working in research and/or academia in the future.

## CHAPTER 1: INTRODUCTION

This study focused on developing, from the perspective of the user, a better understanding of the factors that influence use of healthcare services by homeless veterans in the United States (U.S.). The study employed the grounded theory methodology and was guided by critical social theory and symbolic interactionism as the philosophical underpinnings.

In 2010, veterans were overrepresented among the homeless population, accounting for 16% of homeless adults but only 10.5% of the total adult population (U.S. Department of Housing and Urban Development, *Profile of Sheltered Homeless Veterans for Fiscal Years 2009 and 2010*, 2012). Since 2009, homelessness among veterans has declined by 35% according to the 2015 Annual Homeless Assessment Report (AHAR) to Congress. Presently, on a single night in the U.S. in January 2015, 47,725 homeless adults were veterans, or 11% of 436,921 homeless adults, which is lower than the 16% reported in 2010. Although the decrease demonstrates the impact of increased federal and local resources to house homeless veterans ("2015 Results Los Angeles Continuum of Care," 2015), a sizable number of veterans are still represented in the homeless population.

In general, homeless persons have serious medical problems (Gelberg, Andersen, & Leake, 2000; Goldstein, Luther, Jacoby, Haas, & Gordon, 2008; O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003) and health challenges (Nickasch & Marnocha, 2009). As a result of these medical problems, homeless veterans should require high utilization of primary care services, which are defined by the Institute of Medicine as "accessible medical care that meets the majority of their healthcare needs" (McGuire, Gelberg, Blue-Howells, & Rosenheck, 2009, p. 255). Studies have shown that many homeless adults have low utilization of healthcare services compared to the severity of their needs (Stein, Andersen, & Gelberg, 2007). Although many homeless persons have few healthcare services available, which likely explains their low

healthcare utilization, homeless veterans should have the advantage of access to healthcare resources through the Department of Veterans Affairs (VA).

In fact, the VA is committed to providing care for homeless veterans and has developed some of the most comprehensive successful models of care for homeless persons. However, despite the efforts of the VA to provide such care, studies have found that only one-fifth of homeless veterans (18-19%) reported receiving veterans' benefits and fewer than half reported having veterans' insurance (Goldstein et al., 2008; Nyamathi et al., 2004). A more recent study found that the number of homeless veterans using VA healthcare services, although substantial, is not optimal, given the large number of persons in this population with serious medical problems and the large number of services available (Goldstein et al., 2008).

Among veterans who reported any homelessness in their adult life, only 17.2% reported using VA homeless services (Tsai, Link, Rosenheck, & Pietrzak, 2016). In addition, unsheltered homeless veterans were found to infrequently use VHA outpatient services (Byrne, Montgomery, & Fargo, 2016). In an older study, only 15% of a homeless sample of 83 veterans from Skid Row in Los Angeles and a coastal community reported that the VA hospital was a regular source of care (Robertson & Cousineau, 1986). Another study found that 74% of a sample of 3,595 homeless veterans from the Veterans Integrated Services Network 4 (VISN 4), which includes all of Pennsylvania and Delaware and parts of West Virginia, New York, and Ohio, reported having serious medical problems; however, only 57% had used VA healthcare facilities for medical or psychiatric reasons in the previous 6 months (Goldstein et al., 2008). These studies suggest that homeless veterans are underutilizing resources available to them through the VA. The factors that contribute to resource underutilization have not been clearly explicated. Understanding the factors that influence the healthcare utilization of an underserved group who typically has

healthcare access is particularly important as national healthcare becomes available to the traditionally uninsured.

### **Description of the Population**

Homeless veterans meet the definition of being both homeless and veterans. Various definitions of homelessness exist (Nickasch & Marnocha, 2009) and have been used in several studies. For example, some define homelessness in its most extreme form as “living on the streets” (Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009). Individuals who “live on the streets” have historically stayed in missions and flophouses in the center of U.S. cities, often known as Skid Row (Morris & Strong, 2004). Literal homelessness has been defined as living in shelters, cars, bus stations, abandoned buildings, or outdoors (Buchholz et al., 2010). Based on the McKinney Act (1999), a homeless individual is defined as one who lacks fixed, regular, and adequate nighttime residence, or an individual who has a night time residence in a supervised public or privately operated shelter, an institution that provides a temporary residence for individuals intended to be institutionalized, or a public or private place not designed for regular sleeping accommodations for human beings. An individual with a disability who has been homeless for more than one year or has experienced four or more episodes of homeless within the last three years is defined as being in a state of chronic homelessness (*2007 Greater Los Angeles Homeless Count, 2007*). Studies on homeless veterans often define homelessness as being temporarily doubled up with a friend or family member or living in an outdoor location (e.g., street, car, abandoned building), an emergency homeless shelter, a hotel or motel, in a jail or prison, or a homeless residential care program that they entered within the prior 30 days (Buchholz et al., 2010; McGuire, Gelberg, Blue-Howells, & Rosenheck, 2009).

According to the VA, a veteran is an individual who has served in the active military,

naval, or air service (Balshem, Christensen, & Tuepker, 2011). Active duty is defined as serving for 24 continuous months or the full period for when the individual was called to active duty ("Federal Benefits for Veterans," 2008). Individuals who have been discharged for hardship or disability incurred or aggravated in the line of duty may be exempt from serving the minimum duty requirement and are also considered to be veterans ("Federal Benefits for Veterans," 2008). In research, veteran status is rarely verified through VA administrative data, and studies on homeless veterans have included any participant who reported having served in the military, without regard to active duty or discharge status (Balshem et al., 2011).

In 2015, the total number of homeless veterans in Metro Los Angeles was 4,016 ("2015 Results Los Angeles Continuum of Care," 2015), with Skid Row having the highest concentration of homeless persons in the county (*2007 Greater Los Angeles Homeless Count*, 2007). According to the 2007 Greater Los Angeles Homeless Count, 12% of the general homeless population indicated they served in the regular military (Army, Navy, Marines, or Air Force), and 1% had served in the National Guard and Military Reserve. Among homeless veterans, almost half (46%) were involved in combat (*2007 Greater Los Angeles Homeless Count*, 2007).

### ***Demographic Characteristics of Homeless Veterans***

The demographic characteristics of homeless veterans and their service utilization and comorbidities have been captured recently in a study on the prevalence of homelessness among a nationally representative sample of U.S. veterans (Tsai et al., 2016). In this sample, identified through a research panel of more than 50,000 households, 1,533 U.S. veterans were surveyed from July to August 2015. Of those, 8.5% reported being homeless for a cumulative 2 years in their lifetime. Only 17.2% reported having used VA homeless and social services for veterans.

In comparison to veterans with no lifetime homelessness, veterans with lifetime homelessness were younger, less highly educated, and served a shorter period of time in the military. In addition, they were likely to be non-white, unemployed, low income, and living in a rural area, and to have served in the Persian Gulf War and enlisted (instead of being drafted in the military).

The demographic characteristics of homeless veterans have been captured also in an AHAR to Congress of all sheltered and unsheltered individuals on one single night in January 2010, and during a 12-month period (October 2009 to September 2010). Data from this enumeration were presented in a 2012 research brief entitled *Profile of Sheltered Homeless Veterans for Fiscal Years 2009 and 2010* (2012) by the National Center for Veterans Analysis and Statistics. The brief described the demographic characteristics of homeless veterans as mostly male; White, non-Hispanic; between the ages of 31-50 years old, and disabled. Homeless veterans had a higher percentage of males (93%) than the general population (68.2%). Homeless veterans were older than homeless nonveterans, and most were over 31 years old. The largest groups were between 51-61 years of age. In terms of racial distribution, White, non-Hispanics accounted for 52.6%, African Americans, 34.9%, and Hispanic/Latinos, 8.3%.

Although the U.S. Department of Housing and Urban Development (HUD) requires the Continuum of Care (CoC) Program to conduct a thorough enumeration of all sheltered and unsheltered homeless persons, little is known about the unsheltered homeless population, as collecting information for unsheltered adults is optional (*Veteran Homelessness: A Supplemental Report to the 2010 Annual Homelessness Report to Congress*, 2010). A study on unsheltered homelessness among veterans identified a distinct profile. The study found that correlates of unsheltered homelessness were similar to the findings of the *Profile of Sheltered Homeless Veterans for Fiscal Years 2009 and 2010*, which included being mostly male, White,

and of older age. This study also found that homeless veterans had lower levels of VA eligibility, higher levels of substance abuse disorders, and more frequent use of VA inpatient and infrequent use of VA outpatient services than sheltered homeless veterans.

### ***Morbidity and Mortality in the Homeless Population***

The literature suggests that being homeless is associated with higher rates of morbidity (Schanzer, Dominguez, Shrout, & Caton, 2007) and mortality (Hwang et al., 2009). The higher mortality and morbidity rates among the homeless are associated with poverty, unemployment, social isolation, substance abuse, and chronic mental illness. These problems decrease this population's ability to access care.

With regard to morbidity, Schanzer and colleagues (2007) found newly homeless individuals in their study had higher rates of medical illness; psychopathology, including major depression and anxiety; and substance use disorders in comparison to similarly aged individuals in the general population, as described in the National Health Interview Survey (2007). Moreover, homeless individuals are exposed to increased risks of communicable diseases, injuries, hypothermia, and malnutrition, which may exacerbate existing conditions. However, these data should be interpreted cautiously because identifying and measuring the rates of morbidity and mental health problems in the homeless population is difficult because homelessness is not a variable indexed in most epidemiological studies (Strehlow & Amos-Jones, 1999). Morbidity and mortality rates of the homeless are often inferred from those of minority groups such as African Americans or Hispanics (Strehlow & Amos-Jones, 1999) who are represented at higher percentage than they represent in the population. The prevalence of mental illness, substance abuse, or chronic illness in homeless veterans is rarely directly assessed in any studies of this population (Balshem et al., 2011). Most studies on the homeless veteran



population sample individuals seeking treatment; therefore, results may not accurately represent overall prevalence.

Homelessness also increases the risk of death from a variety of causes. As with morbidity, the mortality rates in the homeless population are difficult to measure because homelessness is not categorized separately in studies of the population as a whole (Strehlow & Amos-Jones, 1999). Sometimes high mortality is assumed because of the association between high rates of poverty and higher rates of morbidity (Wright & Weber, 1987) and a majority of the homeless population consists of minorities groups who have higher mortality rates in the general population (Strehlow & Amos-Jones, 1999). In addition, the high rates of alcohol and drug use in the homeless population are thought to contribute to higher mortality rates (Morrison, 2009; Strehlow & Amos-Jones, 1999). One study attempted to determine whether previous assumptions about the increased risk of mortality among the homeless population were true and whether the increase risk was related to (1) a higher prevalence of morbidity, (2) similarities with other socioeconomically deprived populations, or (3) an independent risk factor (Morrison, 2009). In this study, the homeless population was found to have life-spans 10-20 years shorter than the general population (Morrison, 2009) and the average age at death for homeless adults was found to be 41 years of age. The Morrison study found that after adjustment for age, sex, and morbidity, homelessness was an independent risk factor for death. Compared with non-homeless individuals in deprived areas, and based on a validated instrument using the variables of car ownership, male unemployment, occupational social classes, and overcrowding to measure socioeconomic status, the homeless subgroup had a higher hazard ratio of 3.2 for mortality. Finally, increased mortality due to the higher prevalence of morbidity was found to be significant in some conditions, such as hospitalization for drug misuse, and circulatory and respiratory

disorders. In fact, hospital admissions for drug use doubled the mortality rate for the homeless cohort.

### ***Morbidity and Mortality in Homeless Veterans***

Homeless veterans share the same health and social problems that afflict the general homeless population. Like the general homeless population, homeless veterans encounter a myriad of health, psychiatric, and substance abuse problems (Applewhite, 1997), including alcohol and substance abuse. In addition, they experience military-related health problems, eye problems, hypertension, heart and cardiovascular problems, COPD/emphysema, tuberculosis, gastrointestinal problems, liver disease, seizures, skin problems, orthopedic problems, and significant trauma (Goldstein, Luther, Haas, Appelt, & Gordon, 2010; Goldstein, Luther, Haas, Gordon, & Appelt, 2009; Goldstein et al., 2008). Their psychiatric problems include substance abuse, psychosis, mood disorders, personality disorders, and combat-related post-traumatic stress disorder (PTSD) and adjustment disorders (Goldstein et al., 2009).

### ***Alcohol and Substance Abuse Among Homeless Veterans***

Severe mental and physical illness, as well as alcohol and other substance abuse are the major health problems of homeless veterans ((Applewhite, 1997; Dunne, Burrell, Diggins, Whitehead, & Latimer, 2015). Studies comparing use of drugs and alcohol between the veteran and general homeless populations have had mixed findings. The most recent study found that homeless veterans had six times the odds of reporting current addiction problems when compared to nonveterans (Dunne et al., 2015). In addition, homeless veterans reported a higher percentage of needs related to addiction treatment compared to nonveterans (Dunne et al., 2015). This contradicts past studies that showed no significant difference between the two groups, although substance use was notably high in both groups (Nyamathi et al., 2004; O'Toole et al.,

2003). Seventy to eighty percent from both groups smoked crack cocaine and used alcohol (Nyamathi et al., 2004; O'Toole et al., 2003). A study on comorbidity of psychiatric and physical health among homeless veterans also found high rates of addiction (71.7%) (Goldstein et al., 2009). In a study to identify sociodemographic and homelessness-related variables within five subgroup patterns identified in homeless veterans (cardiac, mood, stress, addiction, and psychosis factors), the addiction cluster (a subgroup with a profile high in addictive behavior, mood adjunct and orthopedic disorders) was highly associated with being employed in the previous three years, being non-African American, and having used the VA medical system in the previous six months (Goldstein et al., 2010). Goldstein and colleagues (2010) also found that married homeless veterans scored lower on the addiction factor than those who were not married, although the percentage of married homeless veterans in the study was low.

### ***Military-Related Health Problems Among Homeless Veterans***

Homeless veterans are considered to have special needs in comparison to their nonveteran homeless counterparts (Nyamathi et al., 2004). Data from a two-city, community-based survey of homeless adults in Pittsburgh and Philadelphia confirmed that homeless veterans have more medical and mental health needs than nonveteran homeless men (O'Toole et al., 2003), such as significantly higher reports of chronic illness (66.1% vs. 55.4%); two or more mental health conditions (33.1% vs. 22.2%); higher rates of hepatitis/cirrhosis (18.9% vs. 7.0%), and higher rates of PTSD (18.1% vs. 0.1%).

Nyamathi and colleagues (2004) found that homeless veterans were affected by post-military mental illness, in addition to other factors that affect the general homeless population, such as poverty, social isolation, childhood physical and/or sexual abuse, and lack of support from family and friends. In addition, veterans who had been exposed to combat, particularly

during the Vietnam era, were particularly affected by physical injury, psychiatric illness, alcohol abuse, and medical problems (Applewhite, 1997; O'Toole et al., 2003). The rates of PTSD, comorbid psychiatric conditions, and severely impaired occupational and social functioning are high among homeless veterans. With these myriad problems, the need for healthcare and use of healthcare services for the homeless veteran is critical.

### ***Commodity of Medical and Psychiatric Illness Among Homeless Veterans***

The medical problems of homeless veterans are better understood as a result of surveys conducted of homeless veterans by the VISN 4 (Goldstein et al., 2010; Goldstein et al., 2009; Goldstein et al., 2008). Through cluster analysis, the general health and behavioral problems of homeless veterans were divided into four subgroups: addiction, psychosis, vascular disorders, and generalized medical and psychiatric illness (Goldstein et al., 2009). For the addiction cluster, a positive relationship was found between substance use and depression, with only a small link to physical health comorbidity, namely elevated liver enzymes and orthopedic problems. The psychosis cluster related to little physical health comorbidity. On the other hand, the vascular cluster had a significant association with the addiction cluster, and with mood and adjustment disorders. Goldstein and colleagues examined the factor structure of health status of homeless veterans within the clusters and found that there was a clear structure combining components of both psychiatric and medical health problems (2010). The clear and distinct structures identified were “Cardiac” without significant psychiatric disorder; “Mood” disorders associated with orthopedic, eye, and gastrointestinal health problems; “Stress”-related disorders; and “Addiction” and “Psychosis” factors.

Odds ratio analysis was applied to these factors and a number of sociodemographic and homelessness-related variables. It was concluded that health status of homeless veterans is

complex and associated with historical and sociodemographic considerations, such as age, ethnicity, and employment status (Goldstein et al., 2009). Age had a significantly positive association with cardiac problems in the older veterans and high association with substance abuse in the younger veterans. No age difference was found to be significant for the psychosis cluster. In terms of employment status, physical illness (Cardiac) and serious mental illness (Psychosis) appeared to be associated with lower rates of employment. On the other hand, addiction without medical or mental illness was associated with being employed. Understanding the impact of the sociodemographic characteristics of homeless veterans on health care utilization is helpful, as age and employment are predisposing variables in health care utilization (Gelberg et al., 2000; Stein et al., 2007).

### ***Mortality Among Homeless Veterans***

Few studies of veterans who are homeless suggest that homelessness is associated with early mortality. In an analysis of all-cause mortality for fiscal years (FYs) 2000–2009 among VA patients with severe mental illness, homelessness was found to be a stronger contributor than diagnosis to years of potential life lost among veterans with a diagnosis of severe mental illness. A letter to the editor reported that among veterans who die from suicide, homeless veterans die at younger ages than other veterans (Birgenheir, Lai, & Kilbourne, 2013). Homeless veterans were found to have higher all-cause mortality rates and rates of use for almost all resources after controlling for chronic disease burden (using the Charlson Comorbidity Index), psychiatric illnesses, substance use disorders, and demographic variables (LePage, Bradshaw, Ciper, Crawford, & Hoosyhar, 2014). Excess mortality was also found to be higher in older homeless veterans (Schinka, Bossarte, Curtiss, Lapcevic, & Casey, 2016)

### *Utilization of Health Services by Homeless Individuals*

In general, homeless persons use medical, psychiatric, and substances services at low rates (Buchholz et al., 2010; McGuire et al., 2009). Perceived barriers to care expressed by the general homeless population in the Skid Row area in Los Angeles included lack of finances, insurance, transportation, and knowledge of the healthcare system, and health problems that were not considered serious enough for medical attention (Robertson & Cousineau, 1986). A possible barrier to care for homeless veterans could be the problems with the scheduling practices described at the U.S. VA facilities in Phoenix, Arizona (McCarthy, 2014). Investigations found that the VA staff kept multiple secret waiting lists that made it appear that the patients were getting primary care appointments within 24 days. The waiting, on average, was 115 days, and there were allegations that 40 veterans had died while waiting for appointments. Similar practices have been reported at other VA facilities (McCarthy, 2014). These long wait times could be a barrier to care for homeless veterans, but it has yet to be described in studies from the perspective of those seeking care.

To better understand other barriers to services use, the personal experience of the general homeless population in seeking health services was examined in two recent qualitative studies (Martins, 2008; Nickasch & Marnocha, 2009). In both studies, participants were recruited from free clinics. Although the authors used different qualitative techniques (phenomenology and grounded theory), both studies had similar findings. In both studies, a lack of financial resources or income limited the ability of the homeless individuals to seek care. Similarly, in both studies, a lack of resources, especially health insurance, was a common theme that compromised seeking services. Both studies also found that the homeless participants experienced negative interactions with healthcare providers and the themes of health providers lacking compassion or

patients' feeling invisible to healthcare providers were identified.

Although informative, some of the findings from qualitative studies on the personal experience of homeless individuals within the healthcare system may not be generalizable to the homeless veteran population. For example, one theme found in the qualitative studies of homeless nonveterans that is not applicable to homeless veterans is the lack of healthcare insurance because veterans are eligible for healthcare benefits through the VA. The proposed study explored the experience of the homeless veterans with the VA healthcare system to understand what other factors influence the use of available services.

### ***Utilization of Health Services by Homeless Veterans***

Despite service availability, veterans use services at a fairly low rate (Byrne et al., 2016; Tsai et al., 2016). This fact has received more research attention in the past few years. New studies have emerged on the healthcare utilization among homeless veterans (J. Chrystal et al., 2015; McGuire et al., 2009; O'Toole, Johnson, Aiello, Kane, & Pape, 2016; O'Toole, Johnson, Borgia, & Rose, 2015; O'Toole, Johnson, Redihan, Borgia, & Rose, 2015). All of these studies have used quantitative methodologies. Only one investigated the factors that explained low utilization of healthcare services by homeless veterans (O'Toole, Johnson, Redihan, et al., 2015). Through a multisite community-based survey, one quantitative study identified three distinct domains as reasons homeless veterans delayed or deferred care: (1) trust; (2) stigma; and (3) care processes. As this study used survey instruments, the factors being explored had been pre-selected and did not allow for new factors to be identified or participants to describe their experiences using their own words.

The other quantitative studies were interventional studies that evaluated different types of clinical settings with additional services to help increase service utilization in homeless veterans

(J. Chrystal et al., 2015; McGuire et al., 2009; O'Toole et al., 2016; O'Toole, Johnson, Borgia, et al., 2015). Researchers in one observational study investigated the impact of the VA's homeless medical home model, also known as homeless patient aligned care teams (H-PACT), on improving clinical and social outcomes for homeless veterans (O'Toole et al., 2016). The HPACT program was designed to increase service use through open access with walk-in capacity, co-location of primary and mental health services, intensive case management intertwined with the community, ongoing staff training on homeless care skills, and data driven processes. In this study, patient health outcomes were correlated with characteristics of high-performing sites, which were defined as high rates of ambulatory care and reduced use of acute care services. Sites that were associated with high performance had 3 distinct features: (1) higher staffing ratios than other sites, (2) integration of social support and social services into clinical care, and (3) outreach to and integration with community agencies.

Another interventional study focused on the experience of homeless veterans at three mainstream primary care clinics of the VA: one homeless-tailored VA clinic, one tailored non-VA healthcare program, and a mainstream primary care facility (J. Chrystal et al., 2015). The most tailored environments had dedicated program staff, specialized training of staff, heavy emphasis on walk-in availability, the capacity to respond to tangible or competing needs (such as food, washing, or clothing), integrated mental health care, and inclusion of homeless individuals in organizational processes. The study found an interaction effect between sites and severe psychiatric symptoms. Participants with severe mental illness had more favorable experiences with the site that had a homeless-tailored service design.

Another interventional study investigated whether an outreach intervention that included a personal health assessment and brief intervention, and a clinic/health system orientation



separately or in combination would increase health-seeking behavior and receipt of healthcare among homeless veterans (O'Toole, Johnson, Borgia, et al., 2015). In the personal health assessment/brief intervention arm, a research nurse interviewed participants and provided feedback and a brief intervention using the motivational interviewing style. In the Clinic Orientation arm, participants were transported to the clinic by a research assistant after having received either the first intervention or usual care, and then introduced to the clinic team. In the usual care arm, a social worker assessed homeless history and social needs of the participants and provided information about clinical services and homeless programs and services. The findings suggest that the combination of personal health assessment/brief intervention coupled with the clinic orientation was most effective, followed by the clinic orientation alone. Both interventions alone were more effective than usual care.

Another study focusing on homeless veterans was designed to explore the effect of one major institutional barrier of the VA system—system fragmentation, which was described as services provided without systematic coordination at different locations with separate admission procedures (McGuire et al., 2009). McGuire et al. (2009) sought to evaluate the effectiveness of having Primary Care and Homeless Social Services located in the same area (co-location), and determined that co-location increased access to primary care and preventive services and reduced emergency room visits. Findings revealed that although there were no decreases in inpatient service use, physical health status improved.

In summary, there is growing research on the factors that influence use of healthcare services by homeless veterans in the U.S. (J. Chrystal et al., 2015; McGuire et al., 2009; O'Toole et al., 2016; O'Toole, Johnson, Borgia, et al., 2015; O'Toole, Johnson, Redihan, et al., 2015). Although many of the new studies have been published on the use of healthcare services among

homeless veterans, these studies were designed to test best practices to improve their use of VA healthcare services. However, the best practices have not been widely distributed to other VA sites. Until that happens, there is a pressing need to give voice to the participants in “usual” VA locations. In addition, many of the studies were also in unique locations, which means veterans only benefitted if they were located where the programs were.

Only one qualitative study was identified (Applewhite, 1997), conducted more than 15 years ago. This study revealed a number of barriers to healthcare service use among veterans, including insensitive service providers, negative policies and procedures, and an unwieldy, inadequate, and inaccessible social service delivery system (Applewhite, 1997). In that study, veterans revealed there was a need for better information regarding available services, how one qualified for services, how to access benefits, what benefits were deserved, and ways to overcome welfare stigma. All of these may be critical in promoting use of services.

Understanding use of healthcare services in vulnerable populations such as homeless individuals is of concern because of their great illness burden and need for healthcare services. Although part of the general homeless community, homeless veterans also have unique healthcare needs, unique resources, and unique barriers to using healthcare services that are important to understand. This study focused on the unique aspects of services utilization experiences from the perspective of the veterans who receive the care.

### **Statement of Purpose**

The amount of research on the use of healthcare services by homeless veterans has grown over the past few years. Much of the research on the homeless population has focused on clinical interventions in the health delivery system or setting, or barriers to care and lack of resources when accessing care, using homeless surveys with pre-determined factors. No studies

have focused on the social experience of homeless veterans and its relationship to use of healthcare services. This study focused on the social experience of homeless veterans with medical coverage. Using critical social theory as the theoretical underpinning for the study, the perspective of the homeless veteran with healthcare coverage was investigated to identify facilitators and barriers to using healthcare services. Therefore, the purpose of this study was to develop a grounded theory (GT) to explain the process used by homeless veterans in deciding if and when to use VA healthcare services. GT was selected to understand the decision to use VA healthcare services among homeless veterans because very little is known about the topic and it “allows the researcher to uncover the inner meaning of a particular life event” (Nickasch & Marnocha, 2009, p. 45). Critical social theory and symbolic interactionism were the theoretical lenses used to understand the data. From the data, a GT was developed to explain the factors influencing decisions about use of VA health services among homeless veterans who had medical coverage through the VA. The specific aims of the study were as follows:

- 1) Elicit homeless veterans’ experiences with use of the VA health system,
- 2) identify factors perceived to impede or enable (barriers and facilitators) use of VA healthcare services,
- 3) describe the health factors that influenced service use,
- 4) identify the influence of veterans’ health beliefs on service use, and
- 5) develop a GT of the social experience of using VA medical care.

## **CHAPTER 2: THEORETICAL BACKGROUND AND PHILOSOPHICAL UNDERPINNINGS**

The theoretical framework guiding this grounded theory study stemmed from Critical Social Theory (CST) and symbolic interactionism. CST provided a useful conceptual lens that allowed for an exploration of unique sociopolitical and historical factors that impeded or facilitated healthcare utilization by homeless veterans. Symbolic interactionism (SI) was utilized as a mechanism for understanding how a person's environment, perceptions, and beliefs influence his/her healthcare utilization. SI also guided the development of the GT.

### **Critical Social Theory**

CST, also called critical theory, is the philosophical underpinning that is most influential in studies of vulnerable populations such as homeless veterans. As a philosophical tradition, CST addresses the sociopolitical and historical context of health and healthcare (Browne, 2000). Because use of CST allows analysts to challenge the status quo (Kinchenloe & McLaren, 1994), the knowledge that CST produces "dangerous," as it is upsetting to institutions and increases the risk of overthrowing the "sovereign regimes of truth" ("Critical Theory and Management - The Return to Rationalism and the Promise of Progress? (2000).", 2000). A study on homeless veterans' decisions not to use healthcare services at the VA has the potential to be upsetting and controversial because it may suggest that the government is not taking care of the people who enlisted in the military to serve and protect the country. However, the potential to be upsetting and controversial is the driving force to understanding the importance of healthcare utilization of homeless veterans, particularly barriers that they face in the process.

Basic assumptions of CST include power relations, social processes, and language (Rodgers, 2005). Many of the elements of CST were useful in this study. Power relations were

important assumptions of CST relevant to this study, which in this case were between the U.S. government and the homeless veterans. The relationship between the government and the veteran has the potential for domination and oppression—concepts that critical theorists adopted from Marxism (Browne, 2000).

Critical theory introduced the subjective form of knowledge into traditional Marxism so that scientific value was placed on the perceptions, experiences, and observations of human beings (Campbell & Bunting, 1991). Through individual interviews, this study enabled homeless veterans to discuss their perceptions of the barriers that limited their use of healthcare services.

Because CST is deeply rooted in Marxist tradition, it was designed to develop knowledge with emancipatory aims (Campbell & Bunting, 1991). Research using CST must be connected to an attempt to confront injustices of a particular society (Kinchenloe & McLaren, 1994). Decreased access to use of healthcare services among homeless veterans who have greater healthcare needs than the general population would be considered an injustice. An aim of this study was to expose the injustices associated with decreased or lack of access to VA healthcare from the perspective of homeless veterans. The researcher's hope is that identification of the barriers will lead to solutions that address the problems. The struggle of veterans to obtain benefits is marked with political and historical undertones that can be revealed using CST.

The concept of ideologies was another useful element of CST for this study. Knowledge is developed through critique of the ideologies (Browne, 2000) of a particular society. Ideologies are belief systems that are developed and presented as facts by the ruling class in order to control workers (Campbell & Bunting, 1991). Ideologies are used to prevent individuals

in the working class from understanding or perceiving their actual situations or real interests (Campbell & Bunting, 1991). Critical theory exposes the hidden relation between domination and power inherent in society's fundamental structures and ideologies (Browne, 2000).

Understanding these hidden power relations has the potential to free or emancipate a society from ideological delusions (Browne, 2000) and allow the agents to evaluate their true situation (Campbell & Bunting, 1991).

As part of the ruling class, the U.S. government espouses ideologies that influence and determine the eligibility criteria for veterans to obtain healthcare through the VA. One indication of the government's ideologies can be represented in the legislation that they enact. As an example, the government appears to be committed to taking care of the healthcare needs of the veterans through the Veteran Eligibility Reform Act of 1996, which opened VA enrollment to all veterans. However, a memo dated July 18, 2002 from the Deputy Under Secretary for Health for Operations and Management ordered VA regional directors not to market activities to enroll new veterans, citing that the "demand for healthcare that exceeds our resources" and the "very conservative OMB [Office of Management and Budget] budget guidelines" (Himmelstein et al., 2007, p. 2199). The prohibition of advertising VA health benefits limits access of healthcare to veterans who are not aware of their benefits, and consequently, influences use of healthcare service.

### **Symbolic Interactionism**

Symbolic Interactionism (SI) is another important perspective that was central in the present study of healthcare utilization of homeless veterans. As an interpretivist perspective in research, it guides the analysis and development of grounded theory. In this study, utilizing a symbolic interactionist framework helped in understanding and identifying the factors that

influenced homeless veterans' experiences with use of healthcare services. The goal of this tradition is to understand the experience from the perspective of those who live it. SI was important in the aims of this study, which sought to understand the interaction of homeless veterans with the healthcare system and healthcare providers and to develop a theoretical model to inform nursing practice and education

### **Historical Background of SI**

SI originated from the work of George Herbert Mead, a professor of philosophy from the University of Chicago (Charon, 2007). Three major perspectives that have influenced and inspired SI are pragmatism, Darwinism, and behaviorism (Charon, 2007). SI was actually named by a student of Mead, Herber Blumer (Jeon, 2004). In addition, Blumer built upon the work of Mead and established SI as a sociological theory and research approach (Jeon, 2004).

#### ***Pragmatism***

Pragmatism, particularly the views of John Dewey (1859-1952), had a major influence on Mead and thus on SI (Jeon, 2004). The pragmatist school of philosophy provides a framework for understanding the nature of truth (Charon, 2007). Pragmatism explains that the mind enables human beings continually to adapt to a constantly changing social world through contemplation of the situation (Jeon, 2004). Four ideas of pragmatism are essential to Mead's SI perspective: (1) humans interpret their environment, instead of responding to it, (2) human beings learn, remember, or believe something that has been useful and helpful to them in situations they encounter, (3) humans define objects in their environment according to their usefulness to them, and (4) a focus on human action is central in understanding human beings, rather than on personality, past events, traits, or qualities (Charon, 2007). These pragmatist principles are essential to Mead's SI in understanding and making sense of meaning behind human behavior

and various social processes.

### ***Darwinism***

The Darwinian perspective, as developed by Charles Darwin, also had an impact on Mead and the SI perspective (Charon, 2007). According to the Darwinian paradigm, human beings should be studied in naturalistic terms, instead of relying on supernatural explanations, spiritual beliefs, or metaphysical terms. Applying Darwin's theory of evolution, Mead believed that human beings developed qualities through physical evolution and as part of the evolutionary process. Meade identified unique human qualities that differentiate humans from animals and found that humans are best understood through the combination of unique qualities that developed through evolution, such as a highly developed brain, reliance on society and socialization due to helplessness in childhood, and vocal chords and facial muscles developed to create subtle and distinct sounds.

In the Darwinian paradigm, evolution is a passive process, which Mead accepted. Mead asserted that evolutionary qualities enable human beings to become active participants who can adjust to their environments through language and the ability to reason. Finally, Mead adapted the Darwinian belief that nature is constantly changing, instead of being static, as a result of humans constantly thinking, adaptating, defining, and redefining their self-based interactions with other human beings.

### ***Behaviorism***

Behaviorism is a school in psychology that has also contributed its perspective to SI. As a behaviorist, Mead believed that humans are best understood through their actions, in terms of what they do, instead of who they are (Charon, 2007), their personality, or their attitudes. Unlike traditional behaviorists, Mead believed that action was not simply physical, but it included action



within the actor, in other words thinking or “minded action” (Charon, 2007). Mead called himself a social behaviorist, who believed that interpretation of action is essential in understanding the human being (Charon, 2007). Understanding the mind, symbols, and self is central to elucidating human behavior. Thus understanding the “meaning” behind both physical and nonphysical action is the basis of understanding human behavior (Jeon, 2004).

American pragmatism, Darwinism, and Behaviorism have been adopted and adapted in the development of Mead’s SI perspective. From pragmatism, the importance of the interaction of the human with his/her environment was incorporated into SI. Darwinism introduced into SI the idea that human beings are dynamic and constantly changing. In addition, Mead added that humans are active in their natural environment, and even in their own evolution. Borrowing from the behaviorist perspective, SI places import on the action of human beings, including both physical and, even more importantly, “mind action.” Applying principles from these three different perspectives to the SI perspective, human beings are active in their environment, interact with others and self, and constantly define immediate situations using symbols based on their ongoing social interactions. The study of utilization of healthcare services by homeless veterans is consistent with the SI perspective as the study aimed to understand veterans’ health seeking behavior as an active process of interacting with both the external environment and the internal environment, or the “self,” and how veterans adapt and change as dynamic organisms in their decision to use healthcare services.

### **Major Principles of Symbolic Interactionism**

According to Herbert Blumer, SI is based on three simple premises. The first premise asserts that human beings act toward objects based on the meanings that the objects have for them. The second premise suggests that the meaning of objects is developed from social

interactions between human beings. The third premise is that meanings are developed through an interpretative process by the person interacting with the object.

Charon (2007) identified the following five central ideas essential for understanding how the human being is viewed using the SI perspective:

- 1) Human beings must be understood as social persons, and lifelong social interaction is central to what they do;
- 2) human beings must be understood as thinking beings, and interactions within the individual or the conversation within the individual is central to understanding cause;
- 3) human beings do not sense their environment directly; instead, they define the situation they are in from ongoing social interaction and thinking;
- 4) the cause of human action is a result of the present situation, including present social interaction, present thinking, and present definition; and
- 5) human beings are viewed as active beings in relation to their environment.

Blumer (1969) described important basic ideas or “root images” in SI, including human groups or societies, social interactions, objects, human beings as active organisms, human action, and the interconnection of lines of action. These basic ideas form the framework of any study or analysis using SI.

### ***Nature of Human Group Life***

The first basic concept of SI views human society or groups of human beings as communities that are engaging in action (Blumer, 1969). The action in human society/groups comprises the myriad of activities in which individuals engage in their daily lives as they interact with one another and deal with situations that confront them. Action can be performed by individuals or by collective groups on behalf of, or as representatives of, some organization or

group of others. Human groups/society exist in action and must be seen in terms of action.

Thus, analyzing human behaviors empirically has to begin with understanding human society as engaged in action.

### ***Nature of Social Interaction***

The second basic concept of SI recognizes that social interaction is a central component in its own right as a process that is the cause of human action (Blumer, 1969). Social interaction is defined as individuals communicating with one another with symbols and interpreting each other's actions (Charon, 2007). Through social interaction, human beings must take into account what other individuals are doing and how to direct their own actions or handle their situations. Two forms or levels of social interaction were described by Meade as "the conversation of gestures" and "the use of significant symbols" (Blumer, 1969, p. 8). Blumer (1969) referred to Meade's two levels of social interaction respectively as "non-symbolic interaction" and "symbolic interaction" (p. 65). "Non-symbolic interaction" is a response to the action of the other without any interpretation of the action; whereas, "symbolic interaction" involves interpretation of the action.

Throughout life, social interaction is responsible for the formation of basic human qualities, identities, and society (Charon, 2007). "Self" as a social object, "mind" as an ability, and "role taking" are all important human qualities that develop through social interaction and active use of social objects to understand, define, and manipulate the environment. From the SI perspective, the environment does not cause human action, but rather persons are active in the environment as they act based on their interpretation of the actions of others. Finally, social interaction is necessary for the formation of one's identity. In interactions, identities form as a result of a negotiating process between a person's presentation of his/her perceived identity

based on his/her interpreting the identity of others, perceiving the way other people label him/her, and other people revealing their perceived identity to him/her. Our actions are influenced by a other people's identity or who they think they are.

“Taking the role of others” during social interaction is an essential concept in SI. In taking the role of the other, one assumes the perspective of someone else in order to better predict how the other might act (Blumer, 1969). The someone else or the “other” can be an individual or a collective group. The process of “taking the role of others” involves the SI concepts of “symbols,” “self,” and “mind.” In “taking the role of others,” one uses covert “mind action” directed toward the “self” to understand the perspective of others by trying to imagine what they are thinking and by using their symbolic framework to understand the “symbols” that they use (Charon, 2007). In addition, Meade believed that the development of self occurred through “taking the role of others” because it is through this process that the individual experienced himself or herself (Charon, 2007). “Taking the role of others” is important for the success of a group, organization, and society. Role taking is essential to achieving individual goals in relation to other people and understanding that the perspective of the other is different for each individual. In this study, data were explored to identify participants' descriptions of “taking the role of others” during the social process of healthcare utilization to reveal and understand perceptions of the healthcare institution, its employees, or other patients.

### ***Nature of Object***

The third basic concept of SI is “objects.” In SI, the environment or “worlds” of human beings and groups are composed of objects, and these objects are products of symbolic interaction. Objects are anything that can be indicated, pointed to, or referred to. There are three categories of objects: (1) physical objects, such as furniture, plants, or vehicles; (2) social

objects, such as teachers, parents, and friends, and (3) abstract objects, such as concepts, peace, and freedom. The meaning of an object can be different for different people. The meaning of an object is formed, changed, and transmitted through the process of indication, which occurs through social process. The meaning of objects is not fixed. Meaning is sustained or can undergo change through indication.

Charon (2007) expounds on the concept of objects through the concept of symbols. Symbols are a central concept in SI and have four key elements (Charon, 2007). First, symbols are considered social objects, but not all social objects are symbols. Social objects become symbols when they are socially established and understood. Second, symbols are meaningful to the person using them and the person receiving them. Symbols are not simply responses. Third, symbols are used to represent and communicate to others and self. Finally, symbols are intentional acts of communication.

According to SI, symbols differentiate humans from animals in their behavior or interaction with their environment. Humans learn behavior through imitation, experience and instinct (Charon, 2007). Instinctive behavior can be developed through stimuli or conditioned responses, which were popular theories in psychological schools of thought on conditioning at the time that SI was being formed (Maliski, 2009). Conditioning is a form of learning in which a conditioned stimulus triggers an unconditioned response. Nonhuman animals are believed to have a passive relationship to their environment (Charon, 2007). On the other hand, humans do not simply respond to their environment. Through the use of symbols, humans act on their environment. The SI perspective views humans as unique in nature because of their use of symbols.

In the SI perspective, symbols have several functions. They provide a lens through which

humans see reality. Symbols allow for socialization. Through symbols, humans learn their roles, rules, and language of their culture, community, and society. From symbols, objects in the environment can be identified and named. Naming is a strategy that is employed in grounded theory during the data analysis process to develop midrange theory (Maliski, 2009).

Symbols include words, objects, and acts. For the present study, healthcare was viewed as a social object used for the purpose of treating a disease or disorder or improving health. Healthcare was also a symbol that represented a benefit earned from military experience.

### ***Human Being as an Acting Organism***

The fourth basic concept of SI recognizes human beings as action. Human beings do not simply respond to others on a nonsymbolic level during social interaction. Human beings are active in their environment, making indications to others and interpreting their indications. Social interaction is made possible in human beings through the “self.”

The “self” enables human beings to be acting organisms in their environments. The “self” can be considered an object. As such, human beings can be objects to themselves, can act on themselves and guide their actions toward others based on how they view themselves. To become an object to themselves, human beings must take the role of others. As an object, the self is defined through social interaction.

Through the “self,” human beings are able to interact socially and communicate with themselves. Self-communication allows human beings to make indications to themselves and directs their action. This is a different view from other social and psychological sciences, which consider human behavior to be the result of a diverse array of factors, such as stimuli, organic drives, need-dispositions, conscious motives, unconscious motives, emotions, attitudes, ideas, cultural prescriptions, norms, values, status demands, social roles, reference group affiliations,

and institutional pressures.

The self develops, changes, or remains the same through interaction (Charon, 2007). The self also undergoes three developmental stages: the play stage, the game stage, and the reference group stage. In the play stage, the beginnings of the self are formed in childhood through symbolic interaction with significant others. In the game stage, the child develops a mature self through interaction with a generalized other. Finally, in the reference group stage, the view of self changes during adulthood based on the reference group or situation. From the SI perspective, self is considered the actor and also an object or social object. As an object, actors can act back on the self, or talk to themselves, through thinking. When acting back on self, the actor is involved in self-analysis and self-awareness.

From the SI perspective, the self can be labeled “I” or “me,” depending on the type of interaction with the external environment (Charon, 2007). The self is referred to as “I” when it is the subject. As the “self” receiving the action, it becomes an object and is called “me.” The meaning of “self” in SI is not defined in today’s popular terms, such as a “real person,” the “productive person,” the “total person,” the “personality,” the “identity,” or the “actor.” Instead, self is an object of the actor’s own action. Using the concept of self, the same individual can define “self” as being a veteran after service from the military, a patient when in a healthcare facility, or a homeless person when living on the streets or shelters.

### ***Nature of Human Action***

The fifth basic concept of SI, “making indications to the self,” is a distinctive character of human action in SI. Essential to this premise is that human beings act on the environment instead of simply responding to it. Behavior is directed on the basis of indication and interpretation.

Charon (2007) uses the concept of “Mind” to describe the process of “making indications to the self.” In SI, the Mind is involved in an active process of thinking, which is a covert action toward oneself or a silent conversation with oneself (Charon, 2007). The Mind is not the brain or an object, nor is it the unconscious in SI. It involves intentionality and is covert or internal. Mind is action involving self and symbols. Mind Action includes making indications toward the self, and the ability to control overt action to problem solve, and to be part of all social interaction (Charon, 2007). In making indications toward the self, the self indicates and labels the importance in the situation. Mind Action also includes the ability to control overt action, acting toward the environment, instead of simply responding to a stimulus. Mind action is also the ability to problem solve as a person plans, rehearses, or tries to overcome obstacles. Finally, mind action is a part of all social interaction as people become objects, take account of others, make indications about them, define and redefine what they are doing, and then evaluate what they are going to do (Charon, 2007). In this study of homeless veterans utilizing healthcare services, Mind Action was very important as they describe interactions with the healthcare system.

### ***Interlinkage of Action***

Finally, interlinkage of action is an important concept in SI. The existence of human group life is based on the lines of action toward other group members (Blumer, 1969). Lines of action make up “joint action,” which is the societal organization of conduct. Joint action is not simply an aggregation of the same lines of action of each diverse component, but it can also be separate and different lines of action between actors in a group.

There are three observations on the importance of the interlinkage that constitute joint action. The first observation is joint action in human society is usually repetitive and stable,



particularly in settled society. However, not all of life in human society is an expression of pre-established forms of joint action. New situations and problems arise and call for members of society to engage in discussion to work out new ways of acting. In both cases, lines of action are accomplished through the dual process of designation and interpretation. Thus, meanings are important and not just the joint action itself.

The second observation on the interlinkage of joint action is a connection of actions that make up human group life. The concept of division of labor exemplifies the interdependence of diverse action of diverse people; for example, the process of building a home involves lumbermen cutting down trees for materials to be used, architects drawing plans, and contractors erecting the building. Again, it is the set of meanings that lead participants to act.

The third important observation is joint action, whether newly formed or long established, stems from previous actions of participants. Each participant brings a world of objects, and the set of meanings and schemes of interpretation that they already possess to joint action. Thus, understanding joint action involves consideration of the linkage with preceding forms of actions.

### ***The Utilization of Symbolic Interactionism in Research***

SI has been used in a few studies of homeless populations (Alvarado-Chacon, Silva, Guzman-Facundo, Serrano-Cazorla, & Bencomo, 2011; Morris & Butt, 2003; Morris & Strong, 2004). These studies, however, did not address decisions about healthcare utilization. Instead, Alvarado-Chacon et al. (2011) studied the meaning of drug use for adolescents living in the streets. Morris and Strong (2004) investigated parents' perspectives of homelessness and its effects on the educational development of their children in their study on the impact of homelessness on the health of families.

SI has been used in healthcare to understand the meaning of accessibility in health information technology (HIT) planning (Nilsson, Hofflander, Eriksen, & Borg, 2012). In the Nilsson study, nurses working in multidisciplinary groups were interviewed regarding their perspective on HIT. Findings revealed that HIT accessibility depended on working routines, social structures, and social support of patient. relationship. Understanding the importance of the meaning of words such as accessibility is facilitated through the SI perspective.

Both CST and SI were the theoretical and philosophical frameworks that were compatible philosophical underpinnings for examining the aims of this study. Both SI and CST are frameworks that focus on understanding social interactions. While SI focuses on general social interaction, CST specifically focuses on power relations, social processes, and language. Both theoretical underpinnings value the subjective form of knowledge or knowledge developed from the perspective of the individual.

### **Summary**

This chapter presented a review of the theoretical backgrounds and philosophical principles that were the lenses through which data were accessed and viewed. CST, or critical theory, was useful in understanding the sociopolitical and historical contexts of health and healthcare (Ray, 1992), which were particularly important in a study of homeless veterans' experiences with using healthcare services at the VA. CST was also important in understanding the power relations between the U.S. government and the homeless veterans within the healthcare setting. It enabled the development of knowledge from the subjective perspective. CST was useful in exploring injustices related access to VA healthcare because it exposes the hidden relations of domination and power inherent in society's fundamental structures and ideologies. SI provided a tool to understand the decision-making practices of homeless veterans

acquiring healthcare services. SI and CST were integrated, as both were tools to understand the social experience of homeless veterans, with CST specifically allowing examination of power relations.

## **CHAPTER 3: REVIEW OF THE LITERATURE**

Access to healthcare is an important issue that has been studied both by the VA and the greater medical community (Kehle, Greer, Rutks, & Wilt, 2011). In the early 2000s, the Behavioral Model for Vulnerable Populations was presented for understanding the factors that predict health services utilization and physical health outcomes in vulnerable groups such as the homeless population. In this chapter, the Behavioral Model for Vulnerable Populations, which is based on the Andersen and Aday framework (1978), will be used as the conceptual orientation for organizing studies about use of healthcare services in the homeless population. Studies on use of healthcare services by the general homeless population reveal that they often do not have access to a regular source of care. Many studies have also been done on accessibility to VA healthcare with the focus on the general veteran population, but not specifically on homeless veterans. Understanding the facilitators and barriers to homeless veterans' use of healthcare services is important because homeless veterans have access to medical care through the VA, unlike their nonveteran counterparts; however, healthcare service utilization among homeless veterans with medical coverage remains low and has not been studied. Familiarity with previous studies in the general homeless and general veteran populations was useful in generating the data-eliciting questions.

### **Behavioral Model**

The Behavioral Model for Vulnerable Populations is a revision of the Behavioral Model that was used to explain the health and health seeking behaviors of vulnerable populations. The original Behavioral Model was developed by Andersen and Aday (1974) as a framework to explain that use of medical services is dependent on the predispositions of people to use health services, the factors that enable or impede use, and the person's need for care. Predisposing

variables include beliefs about health services, and personal characteristics determined by demographics and social structure, such as residential history, prison history, mental illness, and substance abuse. The “enabling” domain consist of factors that facilitate or impede health service utilization, which include personal/family resources and community resources. Under the needs domain, perceived health and evaluated health also influence persons’ propensities to use services. The variables in the Behavioral Model were selected because they were expected to play a significant role in understanding the process of obtaining services according to previous research, and/or depict policy options that promote equitable access to medical care (Andersen & Aday, 1978).

Gelberg et al. (2000) described that the original Behavioral Model underwent two additional phases of revision and update. In the 1970s, Phase 2 added measures to the use of the health services “domain” related to particular conditions and episodes and to consumer satisfaction. In the 1990s, in Phase 3, the model was revised to consider use of healthcare services as a health behavior and to include the “outcomes” domain to measure impact of health service use on health practices, health status, and satisfaction with care. A feedback loop was added from the outcomes “domain” to predisposition, enabling, need, and health behavior.

The Behavioral Model was also revised and expanded to better understand how vulnerable groups such as the homeless population use health services (Gelberg et al., 2000). The domains of the Behavioral Model (predisposing, enabling, and need) were broadened to include vulnerability factors, and these added determinants were distinguished from the original factors, the latter of which became known as traditional factors. The “vulnerable” determinants of use took social structure and enabling resources of vulnerable populations into consideration. The Behavioral Model for Vulnerable Populations takes into consideration the influence of

vulnerability on the ability or opportunity of a person to use healthcare services.

### **Predisposing Characteristics**

Predisposing characteristics represent the factors that impede or enable use of healthcare services. Predisposing characteristics include demographic factors prior to the onset of illness (Gelberg et al., 2000). In the Gelberg-Andersen model, predisposing factors that are especially relevant to the homeless population include problems with drug and alcohol use, severity of homelessness, and psychological distress (Stein et al., 2007). In addition, severity of homelessness and competing needs are social structures that pose significant barriers to obtaining healthcare (Kushel, Gupta, Gee, & Haas, 2006; Lewis, Andersen, & Gelberg, 2003). Gelberg and colleagues (2000) defined severity of homelessness by two measures: the number of episodes of being homeless and the percentage of life spent being homeless.

### ***Race***

Homeless veterans seem to fall in demographic categories that traditionally are associated with difficulty in using healthcare services. Although White veterans account for a majority of the homeless veteran population, minority groups constitute a larger percentage of the veteran homeless population than their counterparts in the general veteran population. According to the 2015 AHAR, Blacks (African Americans) accounted for 34.4 % of the homeless veteran population, yet they only represent 11% of the overall veteran population. Likewise, Hispanics also had a greater percentage of homeless veterans (10.8%) in 2015, although they only account for 5% of the veteran population. American Indian and Alaska Natives were the other minority groups that were over-represented among homeless veterans (2.6%) in comparison to the general veteran percentage (<1%).

In a nationally representative sample of U.S. veterans, veterans with lifetime

homelessness were also likely to be nonwhite in comparison to nonhomeless veterans. (Tsai et al., 2016). Tsai and colleagues found that Black veterans had a higher percentage of lifetime homelessness than Black veterans with no reported history of homelessness in their lifetime (20.6% vs. 9.3%). Similarly, the percentage of Hispanic veterans with lifetime homelessness was higher than Hispanic veterans with no lifetime homelessness (14.3% vs. 8.2%). In the Tsai and colleagues study, only 17.2% of veterans with lifetime homelessness used VA homeless services. However, prevalence of homelessness and VA homeless services use did not vary significantly by race/ethnic groups. The lower utilization rate of primary care services was found in the unsheltered homeless veteran population (Byrne et al., 2016), although most of the homeless veterans were White, and the findings demonstrated no association between healthcare utilization and race.

Interestingly, in a study on homeless female veterans, African Americans were more likely to have a regular source of care than White female veterans. The investigators suggested that homelessness among the sample of White female veterans was related to being older and having a higher prevalence of mental illness and substance abuse in comparison to African-American and Hispanic women whose homelessness was related to loss of affordable housing, lack of family support, and extreme poverty (Stein et al., 2007). Buccholz and colleagues (2010) conducted a study on perceived access to general medical and psychiatric care among veterans with bipolar disorder. About 12% of the sample were homeless and 13% were African Americans. African Americans experienced better self-reported access and shorter lags between medical visits than their White counterparts (Zeber, Copeland, McCarthy, Bauer, & Kilbourne, 2009).

## ***Education***

Padgett, Struening, and Andrews (1990) found that higher levels of education predicted healthcare utilization in both the general and the homeless populations, including perceived access to general medical and psychiatric care among veterans with bipolar disorder. Female veterans with higher education were found to use health services higher than female veterans with lower education; however, less education was not shown to be factor in accessing care in this population. A low education level is usually a pre-eminent predisposing variable in the Behavioral Model for the general population (Stein et al., 2007). In comparison to veterans with no lifetime homelessness, veterans with lifetime homelessness were found to be less highly educated and used VA homeless services less, but the relationship between homelessness and service use was not established (Tsai et al., 2016).

## ***Alcohol and Substance Abuse and Psychiatric Problems***

Alcohol and substance abuse are specific vulnerabilities of the homeless population that affect use of healthcare services, and these were added to the predisposing domain in the Behavioral Model of Vulnerable Population. Several studies have shown that severe mental and physical illness, and alcohol and other substance abuse are major health problems of the homeless (Applewhite, 1997; Buchholz et al., 2010; Goldstein et al., 2008; Nyamathi et al., 2004; Stein et al., 2007), all of which may be barriers to healthcare utilization. In the study by Stein and colleagues (2007), recreational drug use in female homeless veterans had a positive association with hospitalizations. Substance use problems among jailed veterans, who also had high rates of homelessness, were considered serious although lower in the jailed veteran group than homeless veterans in the community (McGuire, Rosenheck, & Kaspro, 2003). Incarcerated veterans were found to be less likely to use medical services than the community



homeless veteran group (McGuire et al., 2003). In the study by Zeber and colleagues (2009), 12% of the veterans sampled had recently been homeless and had a high prevalence of substance abuse, with 28% of patients reporting drug use in the past year and 21% recently engaged in binge drinking. In the Zeber study, substance abuse had a positive association with lag between appointments and ability to locate convenient treatment sites. Buccholz and colleagues (2010) found that consistently homeless veterans had a higher rate of alcohol use than consistently housed veterans. The homeless veterans in the Buccholz study used more healthcare services and had higher total costs than housed veterans. Veterans who were consistently homeless at baseline and at the final assessment had higher rates of inpatient admissions than veterans who were consistently housed. Psychiatric hospitalization was higher in the consistently homeless group compared to the consistently housed group. The consistently homeless group also used emergency department services more than the consistently housed group. Use of emergency services decreased over time, particularly in the group that was homeless at baseline and housed at the final assessment.

### **Health Beliefs**

Health beliefs of the population are another important variable that affects healthcare utilization in the predisposing component of the Behavioral Model. Health and illness beliefs are the values concerning well-being and disease. Health and illness beliefs also include attitudes toward health services and knowledge about disease. No studies have been done on the health beliefs of homeless veterans. Moreover, few studies have explored the health beliefs of the general homeless population.

In a qualitative study designed to understand the health experiences of Canadian homeless persons in shelters and the strategies they employed to attain, maintain, or regain

health, McCormack and Macintosh (2001) identified the meaning of health from the perspective of the general homeless population in relation to three pathways to health. Six different conceptions, or worldviews, of health were defined. One worldview was “being a whole person.” The second worldview conceptualized health as an integration of physical and mental dimensions. The third worldview was that mental, physical, and emotional health were separate dimensions. The fourth worldview was that physical, mental, and spiritual dimensions were separate. The fifth worldview included only physical and mental health as separate dimensions. Lastly, the sixth worldview view of health focused only on the physical dimension.

The first pathway to health involved participants choosing to promote health through the mediating factors of lifestyle behaviors, which potentially included using informal strategies such as blocking dental pain through imagery when unable to access services. The second pathway to health involved use of sector services when health was compromised and when the condition could not be managed by self-initiated interventions, as in a heart attack. The third pathway to health involved using both mediating factors to health, such as accessing medical follow-up with the lifestyle behavior of being more active. In the study by McCormack and MacIntosh (2001), the worldview of health influenced the choice of health behaviors and the types of sector services utilized for care, although it was not clear how a particular worldview of health influenced the choice of health behaviors.

Some studies on health beliefs of homeless people have been disease specific. Fogg and Mawn (2010) explored beliefs and intentions of homeless persons related to HIV (Human Immunodeficiency Virus) screening. Tarzian, Neal, and O'Neil (2005) conducted a study on attitudes, experiences, and beliefs affecting end-of-life decision-making among homeless individuals (2005). The relationship between healthcare beliefs and healthcare utilization in

either study was not identified.

### **Attitudes Toward the Healthcare System**

Under the category of health beliefs that affect healthcare utilization are the attitudes of a population toward healthcare services. Homeless veterans' healthcare beliefs have yet to be explored in studies. However, the attitudes toward the healthcare system, specifically the VA, have been studied through focus groups, secondary analysis of data from 1994 National Survey of Veterans, and a telephone survey (Damron-Rodriguez et al, 2004). Damron-Rodriguez and colleagues (2004) identified five themes regarding the perceptions and expectations of veterans about the healthcare experience. The first theme was the need for improved information regarding available services and eligibility. The second theme was veterans' perception that VA healthcare is a deserved benefit. The third theme was concern that VA healthcare services were stigmatized because they were forms of welfare. The fourth theme was the expectation of physicians being attentive to the patient. Finally, the fifth theme was the expectation that staff respect patients as veterans (Damron-Rodriguez et al., 2004). Of the themes identified, the first three were factors that influenced healthcare utilization; the last two were veterans' concerns related to acceptability of VA services.

The first three will be discussed more fully below. The first theme, knowledge of the eligibility criterion for VA benefits was an important factor that prevented veterans in the study from using VA healthcare services. Many veterans said they lacked information about benefits. In addition, the lack of a central location and lack of a VA employee to provide information on eligibility were identified as problems in obtaining care at the VA. Veterans wanted more education about benefits to enable them to use VA services (Damron-Rodriguez et al., 2004).

The second theme involved the perception that VA healthcare was a deserved benefit.

Veterans expressed that they were entitled to VA healthcare due to their service in the military. Most veterans in the study believed that benefits should be commensurate to their service. For example, those who had been in combat or had a disability in the service should have full benefits. However, those who were not in combat did not feel they were entitled to the same or any benefits.

The third theme identified was the fear of the welfare stigma. Although veterans expressed the belief that they were entitled to VA benefits, some considered VA care to be a form of charity from the government. Veterans who viewed the VA as a form of welfare were less likely to use its health services (Damron-Rodriguez et al., 2004). The welfare stigma may not apply to homeless veterans, as they are apt to be accustomed to using public services.

The sampling and the design of the Damron-Rodriguez and colleagues (2004) study of accessibility and acceptability of VA services limit the interpretation of the findings. The generalizability of the findings is limited due to the single geographical area where the sample was obtained. The sample was also not representative of all veterans because participants were not randomly selected, and the sample did not include women or Native Americans.

### **Enabling Resources**

Enabling resources, the second component of the Behavioral Model that predicts healthcare use in a population, has been studied in the homeless population. Personal/family and community resources are factors that predispose individuals to use health services. Enabling factors facilitate the ability of an individual to secure services and address a health need, for example insurance and income (Gelberg et al., 2000). Limited resource availability is a factor that contributes to the vulnerability of a population. Healthcare utilization is affected by financial and environmental resources. Research has shown that a lack of resources in vulnerable

populations has a greater influence on illness and premature death than the presence of risk factors (Nyamathi, Koniak-Griffin, & Greengold, 2007). Use of healthcare services is an important indicator of resource availability.

In the vulnerability model proposed by Aday, resources are described in three forms: human capital (e.g. income, jobs, education, housing), social status (e.g. prestige and power, social connection, integration into society, and social networks), and environmental resources (Nyamathi et al., 2007). The community of homeless veterans has special needs because of their disproportionately limited, or lack of, resources in the form of human capital, social status, and environmental resources. Homeless veterans may also lack social support and may not be connected to their families. In a comparative study between homeless veterans and nonveterans, a majority of homeless veterans (59.2%) were single, while 5.8% reported being married and 18.6% reported being divorced (Dunne et al., 2015). Moreover, Nyamathi and colleagues (2004) noted that veterans born in 1954 or after were less likely to be married than veterans born before that time. Although decreased resources should contribute to lower healthcare utilization, studies have yet to show a connection between low service utilization and social connection in this population.

Extreme poverty from a lack of resources is an underlying cause of homelessness and can also influence use of health services. For homeless veterans, lack of resources such as housing or shelter is a primary stressor, which is one of the basic needs according to Maslow's hierarchy of needs (Nyamathi et al., 2007). Homeless veterans also face economic hardship, which contributes to further decrease in human capital. Many studies have shown that homeless veterans have limited financial resources. Almost three quarters of a sample of homeless veterans in one study reported having no income or less than \$500/month (usually in disability/pension

payments) (O'Toole, Johnson, Redihan, et al., 2015). The lack of monetary resources threatens the health status of members of the community, and prevents them from seeking healthcare.

In addition to the traditional “enabling” domain of the Behavioral Model, such as a lack of resources, the vulnerable “enabling” domain includes homeless-specific barriers to care, such as receipt of public benefits, competing needs, and availability and use of informational sources (Gelberg et al., 2000). Gelberg and colleagues identified receipt of public benefits as a nonfinancial “enabler,” and three-fifths of the homeless population reported receiving public benefits. Through a cross-sectional community survey of homeless adults in Pittsburgh and Philadelphia, O'Toole and colleagues (2003) found that homeless veterans lacked VA benefits, which limited use of healthcare services. Findings showed that more than half of the homeless men in these two cities needed VA benefits. Despite presumed eligibility for free care, homeless veterans reported in one study (O'Toole, Johnson, Redihan, et al., 2015) that affordability was one of the reasons for delaying care, suggesting they continue to lack knowledge of the healthcare system, as described in one of the earlier studies on barriers to care in homeless (Robertson & Cousineau, 1986).

Several studies on the homeless population have added to knowledge about barriers to care. Barriers to accessing available primary care and seeking healthcare when needed were identified in a multicenter community based survey of homeless veterans (O'Toole, Johnson, Redihan, et al., 2015). The participants in this study were homeless veterans eligible for care but not receiving primary care either with the VA or through another provider. This study collected survey data in face-to-face interviews using survey instruments such as the Basic Shelter Inventory (modified) and the Motivation for Healthcare Summary (adapted from National Institute of Drug Abuse-funded Clinical Research to Engage in Substance Abuse Treatment

Study), and ratings of intrinsic and extrinsic motivating factors for wanting primary care, reasons for not seeking care, and perceived role/importance of having primary care provider for their care needs. This quantitative study identified three distinct domains of reasons for delaying or deferring care: (1) trust; (2) stigma; and (3) care processes. Under the category of trust, veterans identified the main reasons for avoiding or delaying care at the VA from a list of options were “I don’t trust the VA” (84.9%), “I don’t trust the doctors” (75.8%), and “I’m afraid” (72.6%). The specific examples of stigma included “I’m not sober” (79.0%), “They treat me poorly when I go there” (78.5%), and “I’m embarrassed about clothes/appearance” (66.7%). Finally, the category of care process for delaying care at the VA included “I can’t smoke” (88.7%), “no identification (82.8%), “I’m always assigned to student doctors” (81.2%), and “They ask too many questions” (81.2%). Because of the use of survey instruments, the factors explored had been chosen from a list of options and did not allow participants to describe their experience using their own words.

Other barriers to accessing available primary care and seeking healthcare when needed were presented in a mixed qualitative and quantitative study on the factors that influence collaboration between the Iowa City Veteran Administration Healthcare System (ICVAHCS) and local community providers (Cretzmeyer, Moeckli, & Liu, 2014). Collaboration between the VA and community providers began in the late 1980s when Congress provided the VA funds that would allow collaboration between the VA and community agencies. In this collaboration, the VA would provide case management and community outreach while the community agencies would provide residential services. In the qualitative part of this study, interviews were conducted with VA and community providers of homeless veterans to understand the process and structure of VA/community collaborations, in particular examining the roles of the primary individuals involved in this process. From these interviews, barriers to collaboration that would

inhibit veteran participation in services provided were identified.

Several barriers were identified, including lack of coordination between community providers and the VA; restrictions in the exchange of information between programs; concentration of institutional authority and expertise in certain individual champions; and limited chronic substance abuse assessment, treatment, and long-term care options for veterans. Under the theme of lack of coordination, the key barriers to collaboration were rigid inclusion criteria for benefits and layers of bureaucracy that were challenging for an unstable population. In addition, information sharing between the VA and community providers was restricted, particularly after hospital discharge. Another barrier of concentration of institutional authority and expertise in certain individual champions was explained as community providers having the tendency to rely on the expertise of one individual at the VA, resulting in problems occurring if that contact person was no longer available. Finally, substance abuse was one of the common major barriers that caused homeless veterans to fail to engage and complete veteran programs and services.

In a qualitative study on experiences of homeless people in a health delivery system, barriers to receiving healthcare were identified, including social triaging, a non-accommodating healthcare system for homeless persons, being labeled and stigmatized, being treated with disrespect, and feeling invisible to healthcare professionals (Martins, 2008) Social triage is the process of limiting access to healthcare based on the homeless person's ability to pay. Nonhomeless veterans also identified problems with the healthcare system in the Damron-Rodriguez and colleagues' study. Nonhomeless veterans complained about waiting times, distance to VA facilities, and excessive paperwork as potential barriers (Damron-Rodriguez et al, 2004). Removal of these barriers to care has the potential to turn the VA into a veritable



resource for homeless veterans and become the “enabler” that it was meant to be.

A research study that addressed beliefs of the homeless veteran population regarding barriers to healthcare service use was done by Applewhite (1997). This study focused on the homeless veterans’ perspectives on social services use, and identified obstacles in obtaining health and human services. The study was qualitative and used the focus group methodology to obtain emic data, which refers to the insider perspectives from the veterans.

The Applewhite study identified the following barriers to VA service use: insensitive service providers, negative policies and procedures, and the complexity of the social service system. The main concern from veterans related to insensitive service providers. Veterans reported that they experienced a “lack of respect for their human dignity, apathy, indifference, callousness, service-connected labeling, degrading comments and put-downs” (Applewhite, 1997, p. 25). Another barrier to service use pertained to negative social policies and practices. Homeless veterans believed the system was designed to delay or prevent veterans from receiving needed services. In addition, homeless veterans described the service delivery system as unwieldy, inadequate, and inaccessible.

### **Need for Care**

Need for care is the third domain of the Behavioral Model for Vulnerable Populations. Illness is the “need” variable in the Behavioral Model, and it includes individuals’ perceptions of illness and healthcare providers’ objective evaluations of health (Gelberg et al., 2000). The “Need” domain includes perceived and evaluated need regarding conditions that are specific to vulnerable populations. Due to multiple and combined risk factors, homeless veterans have an increased relative risk for medical, psychiatric, and substance abuse problems, which may drive their need for care. Medical risk factors that are specific to being homeless include

communicable diseases, injuries, hypothermia, and malnutrition. Another behavioral risk factor of homeless veterans is their exposure to stressful events, abuse, violence, or crime, which should lead to higher service use (Strehlow & Amos-Jones, 1999).

Researchers identified the needs of homeless veterans in a comparison study of the experience of homeless veterans with homeless nonveterans describing reasons for homelessness, current problems, and healthcare utilization (Dunne et al., 2015). The study found that homeless veterans reported a higher percentage of unmet needs related to addiction treatment compared to nonveterans. In addition, homeless veterans had greater than six times the odds of reporting current addiction problems in comparison to nonveterans. On the other hand, homeless veterans reported having lower unmet medical care needs than nonveterans. The investigators suggested that homeless veterans might be having better health outcomes because they have access to healthcare benefits through the VA. However, the homeless veterans in this study were more likely than their nonveteran counterparts to report emergency department visits in the last year. The findings of this study was geographically limited, as all participants were recruited from North Central Florida, so results may not be generalizable.

The unmet needs of homeless veterans were described in another study to identify the reasons homeless veterans engage in low use of primary care (O'Toole, Johnson, Redihan, et al., 2015). Seventy-six percent of the study cohort reported needing healthcare in the previous six months. Homeless veterans who reported alcohol or drug use or post-incarceration as a cause for their homelessness were more likely to need care in comparison to veterans who identified economic reasons (no job or money) for their homelessness. The need for care in the previous six months was also reported for any active medical or mental health condition, specifically hypertension, emphysema, depression, anxiety, and PTSD. Veterans reporting active cocaine use and veterans

who rated their health status as fair or poor also reported having higher need for care.

Another study on the homeless population in the Skid Row area of Los Angeles and West Los Angeles focused on the effects of mental health, substance use, residential history, competing needs, and victimization on healthcare utilization (Gelberg et al., 2000). The study was designed to define and determine predictors of healthcare utilization and physical health outcomes among homeless individuals who had high blood pressure, functional vision impairment, skin/leg/foot problems, or positive TB skin tests. The study found that homeless adults had high rates of vision, skin/leg/foot problems, and TB, but the rate of high blood pressure was the same as the general population. Utilization of healthcare services was high for high blood pressure and TB skin tests, and low for vision impairment and skin/leg/foot problems. The most important finding was that longer periods of homelessness, mental health problems, and substance abuse did not deter the homeless population residing on Skid Row from obtaining care.

Homeless veterans were also four times more likely than homeless nonveterans to report current mental health problems (Dunne et al., 2015). High rates of PTSD and childhood physical and/or sexual abuse (Nyamathi et al., 2004) are specific factors that may affect need for care in the homeless veteran group. Homeless veterans specifically from the Vietnam era also have a higher relative risk for physical injury, psychiatric illness, alcohol abuse, and medical problems compared to veterans from other theaters of war (Applewhite, 1997; O'Toole et al., 2003).

### **Use of Health Services**

According to the Gelberg-Andersen Behavioral Model for Vulnerable Populations, use of health service utilization is predicted by the Predisposing, Enabling, and Need Domains (Gelberg et al., 2000). Healthcare use can be evaluated with objective measures or from the perception of

the individual attempting to use services. In the Behavioral Model, health services include preventative care, ambulatory care, in-patient care, alternative healthcare, or long-term care.

Studies on the use of health services of the homeless who do not have a regular source of care have given some insight into the settings that are frequently used for health services. More than half of a homeless veteran sample from North Central Florida presented to hospital emergency rooms (Dunne et al., 2015). In the Skid Row area in Los Angeles, Robertson and Cousineau (1986) found that the general homeless population used inpatient care more than outpatient services. In a cross-sectional, community survey of homeless adults in Pittsburgh and Philadelphia, O'Toole and colleagues (2003) also found that homeless veterans relied on shelter-based and street outreach services for care and were less likely to use community health centers.

Several quantitative studies of health service use were interventional studies that randomized participants into different research “arms” with varying levels of support and services (J. Chrystal et al., 2015; McGuire et al., 2009; O'Toole et al., 2016; O'Toole, Johnson, Borgia, et al., 2015). From the title of one of these studies, “Experience of Primary Care Among Homeless Individuals with Mental Health Conditions,” it would seem that the purpose was to explore the viewpoint of homeless veterans about their use of primary care; however, the study was actually an interventional study focused on their experience at three primary care clinics: one homeless-tailored VA clinic, one tailored non-VA healthcare program, and a mainstream primary care clinic. The tailored VA site included co-located mental health and primary care with emphasis on access and same-day services. The tailored non-VA site had the most homeless-focused services characteristics: providing outreach care within the community, a homeless-focused medical and nursing staff, and representation of homeless and formerly homeless persons in organizational governance (J. Chrystal et al., 2015). The site also had

dedicated, specially educated program staff, a heavy emphasis on walk-in availability, the capacity to respond to tangible or competing needs (such as food, washing, or clothing), and integrated mental health care. The study found an interaction effect between site and severe psychiatric symptoms. Participants with severe mental illness had more favorable health service use experiences with the site that had a homeless-tailored service design.

An observational study of 33 VA facilities with homeless medical homes, or as known in the VA, patient-aligned care teams (PACT), investigated the role of healthcare systems such as the homeless PACT (H-PACT) program, in improving clinical and social outcomes for homeless veterans (O'Toole et al., 2016). H-PACT has five core elements that differentiate it from traditional primary care: (1) enhanced, open access with walk-in capacity and flexible scheduling; (2) integrative services (co-location of both primary care and mental health services); (3) intensive healthcare management that interacts with community agencies with an emphasis on ongoing, continuous care; (4) ongoing staff training on development of homeless care skills; and (5) data driven, accountable care processes. In this study, patient health outcomes, such as reduction in acute care services, were correlated with characteristics of high-performing sites. High performance was defined as high rates of ambulatory care and reduced use of acute care services. Characteristics of sites associated with high performance included (1) higher staffing ratios than other sites, (2) integration of social support and social services into clinical care, and (3) outreach to and integration with community agencies. In this study, patients who were enrolled in H-PACT showed substantial reduction in acute care use in six months.

To improve use of healthcare services among homeless veterans, an interventional study examined the implementation of an outreach intervention that included Personal Health Assessment/Brief Intervention, and a Clinic Orientation separately or in combination versus

usual care (O'Toole, Johnson, Borgia, et al., 2015). In the Personal Health Assessment/Brief Intervention arm, participants were provided interviews, feedback, and a brief intervention from a nurse using the motivational interviewing style. Participants also underwent cursory examinations including vital signs and height and weight, and had discussions with the nurse about the findings that could indicate possible treated and untreated medical conditions. In the Clinic Orientation arm, after the first intervention or usual care, participants were personally taken to the clinic by a research assistant and introduced to the clinic team (either the PACT or homeless PACT). Finally, in the usual care arm, a social worker assessed participants' homeless histories and social needs and informed participants about homeless programs services and clinical services. The findings suggest that the combination of personal health assessment/brief intervention coupled with the clinic orientation was most effective, followed by the clinic orientation alone. Both interventions alone were more effective than usual care for improving health services use.

One of the studies on use of health services among homeless veterans examined the hypothesis that a demonstration clinic integrating primary care and mental health services for homeless veterans with serious mental illness or substance abuse would improve medical healthcare use and physical health status (McGuire et al., 2009). The study found that homeless veterans who were enrolled in a clinic with integrated services received more prevention services and primary care visits and fewer emergency department visits than veterans who received "usual VA care." However, the integrated clinic did not improve perceived physical health status over 18 months nor did it change inpatient utilization, with approximately ninety percent of veterans in both groups reporting an average of 15 and one-half days of hospital admission.

The authors did acknowledge in the discussion that a lack of improvement in health

status was not surprising because findings about the relationship between access to healthcare and health status have been mixed in studies of low income and poor populations. The study focused on the impact of an intervention of co-locating social, mental, and health services on improving access, based on a belief that one major institutional barrier to use of health services has been service fragmentation and lack of coordination. Consequently, this study was limited to addressing only a single barrier to use of health services, and data were collected from a health service delivery perspective rather than from the perspective of the patient.

Another recent study on veterans' use of health services focused on perceived access to general medical and psychiatric care among veterans with bipolar disorder (Zeber et al., 2009). In the Zeber study (2009), health service utilization was measured using an adapted survey that asked questions about appointment wait times, lags between scheduled visits, and ability to access care when needed for general medical care (including primary care or medical specialists, admissions to the hospital or emergency department visits) and mental health treatment. Fifteen to twenty percent of veterans with bipolar disorders reported having difficulty using different forms of healthcare, when needed (Zeber et al., 2009). Being homeless was considered the most important barrier to use of health services among the homeless veterans, particularly admission into the hospital, when needed.

### **Outcomes: Health Status**

The Outcomes Domain evaluates healthcare use through perception of health status or satisfaction of the individual attempting to use services. Health status of a community is reflected in disease incidence and prevalence, and morbidity and mortality rates (Nyamathi et al., 2007). Nyamathi and colleagues (2004) performed the only study of the health status of homeless veterans, and found that compared to nonveteran homeless individuals, homeless

veterans were less likely to perceive their health as fair/poor (8% versus 19%). Moreover, researchers found that homeless veterans were more likely to report having a regular source of care compared to homeless nonveterans.

### **Summary**

The literature on homeless veterans is scant but growing; however, as yet, there are no studies on access to care that have included homeless veterans' perceptions. Instead, many of the current studies have concentrated on improving use of VA services through changes in the healthcare setting such as co-location of services, from the perspective of the healthcare system (McGuire et al., 2009); tailoring and organizing clinical settings around the needs of homeless people (J. Chrystal et al., 2015); the use of population-based care models such as the medical home, or H-PACT, as known in the VA (O'Toole et al., 2016); and the addition of outreach interventions that include a personal health assessment and brief intervention and/or clinical orientation (O'Toole, Johnson, Borgia, et al., 2015). Another study focused on small subsets of veterans, or specific barriers, such as lag between scheduled visits (Zeber et al., 2009). Focusing on specific barriers precludes the homeless veterans from identifying problems they face from their own lived experience. Moreover, studies on homeless veterans may also focus on general VA services instead of medical services.

The purpose of this study was to fill some of the gaps in literature. The primary aim was to understand decisions about use of health services among homeless veterans who had a regular source of care. Using a qualitative design allowed for the inclusion of the perception of the participant or agent, which is in line with the emancipatory aims of CST, the philosophical tradition that drove this study.



## **CHAPTER 4: DESIGN AND METHODS**

The purpose of this chapter is to describe the research design and methods used to study homeless veterans' experiences with utilizing VA healthcare services. This section includes the process of data collection, participant recruitment, data analysis, research confidentiality measures, and personal safety of both the study participants and researcher. This study employed the qualitative methodology of GT.

### **Research Design and Methods**

Grounded Theory (GT) was the chosen research methodology for understanding the homeless veterans' experiences with the VA healthcare system. GT is suited for this study because it is useful in explaining human behavior in context and capturing social process in a social context (Munhall, 2007). GT is useful in understanding human behavior related to health issues, developmental transitions, and situational challenges (Munhall, 2007). The study of homeless veterans using VA health services was a perfect fit for GT research because it was an investigation on the social process or human behavior of a group using healthcare services and understanding the barriers they may have encountered.

Since the introduction of GT in the 1960s by its proverbial "fathers," Barney Glaser and Anselm Strauss, GT has branched off into three different versions with divergent methodologies, designs, and constructs: Classic GT, Straussian GT, and Constructivist GT. In Classic GT, developed by Glaser and Strauss, theory is generated from the data (Chen & Boore, 2009). Straussian GT, developed by Strauss and Corbin, uses more structured coding, memo-ing, and analysis, and sets of relationships are identified denoting causal conditions, phenomena, context, intervening conditions, action/interaction strategies, and consequences. Finally, in Constructivist GT, from Charmaz and Clarke, theory is grounded in the mutual experiences of the researcher

and participant, and the meaning is constructed by them (Chen & Boore, 2009). This study employed Straussian GT.

GT is particularly useful in exploring a phenomenon that is under-researched (Morse, 2001) and about which little is known because of the strategy of eliciting rich, full, focused, and detailed narratives for development of theory that is grounded in empirical data and in acts of everyday social life (Hunter, Murphy, Grealish, Casey, & Keady, 2011). Little is known about homeless individuals' experiences and their interactions with the healthcare system (Nickasch & Marnocha, 2009), and even less is known about homeless veterans experience with the VA healthcare systems. GT can be used to gain an in-depth understanding of this phenomenon. GT achieves vibrant understandings of a phenomenon because it moves away from description of the system or behavior under study toward a theoretical rendering that identifies key explanatory concepts and the relationships among them (Munhall, 2007). The aim is to discover patterns and processes and understand how a group of people defines, via their social interactions, their reality (Cutcliffe, 2000). GT is an inductive process (Morse, 2001), and the researcher should limit the number of preconceived ideas. Issues of importance emerge from the stories told by participants. The narrative data reveals the participants' views, feelings, intentions, and actions and gives context and insight into the structure of their lives (Charmaz, 2006).

In classic GT (Glaser & Strauss, 1967), the researcher is directly involved with the subjects being studied to help them interpret their social world and meanings (Hunter et al., 2011). In the GT research methodology, conducting interviews, transcribing text, and detailing, storing, and referring to theoretical memos are central and allow for interactions between the researcher and the subjects.

According to Speziale and Carpenter (2003), the main purpose for selecting the GT

approach is to allow the researcher the flexibility and freedom to explore a phenomenon in depth. In the GT research methodology, the researcher begins by asking very broad questions but continually refines the questions throughout the study. The goal of having broad open-ended questions is to allow study participants to define what is important to them, whereas other approaches may begin with assumptions that have been hypothesized as important by the researcher. As topics emerge, the researcher refines the questions and continues to gather data until the point of saturation is reached.

Another important advantage of GT is it lends itself to the use of critical theory, which is the lens that guided this study. One important aspect of critical theory in conducting research on a vulnerable population such as homeless veterans is self-conscious criticism by the nurse scientist. Self-conscious criticism can help the nurse researcher understand the power relationships between the researcher and the subject. Nurse scientists must promote equality in the development of knowledge and include the perceptions of the participants or agents for the research to be emancipatory. The participation of the “researched” in the research process helps to ensure that the research informs practice and practice research (Mill, Allen, & Morrow, 2001). Research in the critical tradition takes the form of self-conscious criticism (Kinchenloe & McLaren, 1994). The nurse scientist should, at a minimum, critique the ideological assumptions that drive research, theory, and practice, as required by the praxis (Browne, 2000). By unraveling the ideologies that influence nursing praxis, the nurse scientist identifies the constraints he/she has over the future emancipatory potential (Browne, 2000).

### **Research Question**

In the GT methodology, the study begins with a broad research question. In this study, the broad question asked was what social or structural factors influenced homeless veterans’ use

of VA healthcare services. Answers to this question can help explain not only reasons for underutilization of the available healthcare services but, more important, some of the barriers homeless veterans may face.

### **Target Population**

The target population was homeless veterans who were eligible for VA healthcare benefits. The rationale for the population and sample was that homeless veterans are underutilizing resources available to them through the VA (Nyamathi et al., 2004; Robertson & Cousineau, 1986) despite having serious medical problems (Byrne et al., 2016; Gelberg et al., 2000; Nickasch & Marnocha, 2009; O'Toole et al., 2003; Tsai et al., 2016).

The inclusion criteria were homeless veterans who (1) served for 24 continuous months, or were called up to active duty and served the full period after September 7, 1980, or who entered active duty after October 16, 1981; (2) had been homeless for more than 30 consecutive days; (3) were male and 18 years old or older; and (4) have had a perceived need of medical care in last year. Participants who were interested in participating in the study were screened using a form that asked them about their age, length of homelessness, and time of service in the military. Women were excluded because their healthcare needs are different from male homeless veterans. The homeless female perspective is also important but beyond the scope of this study.

### **Operational Key Terms**

A veteran has been defined as an individual who has been in the armed forces (<http://en.wikipedia.org/wiki/Veteran>). Eligibility for VA services is open to individuals who have served in the military, naval, or air services and were released or discharged from the military with a condition other than a dishonorable discharge (Federal Benefits for Veterans and Dependents, 2008 ed.). The minimum duty requirement was defined as 24 continuous months or

the full period for which they were called to active duty if an individual enlisted after September 7, 1980, or who entered active duty after October 16, 1981 (Federal Benefits for Veterans and Dependents, 2008 ed.). In addition, veterans are also eligible for VA benefits if they “were discharged for hardship or disability incurred or aggravated in the line of duty may be exempt from serving the minimum duty requirement” (Federal Benefits for Veterans and Dependents, 2008 ed., p.1).

Homelessness was defined as a state of having no stable residence to sleep or receive mail in the previous 30 days, as defined in previous studies of the homeless. The researcher chose thirty days of homelessness as the minimum in order to exclude individuals who were recently homeless who may have been more concerned about shelter than healthcare or VA healthcare services.

### **Sampling**

In GT, selection of participants is determined through purposive and theoretical sampling, both of which were used in this study. Purposive sampling is a process used at the beginning of the study when the researcher does not have adequate information about informants (Munhall, 2007). Purposive sampling is a research method used in qualitative studies to select a sample based on three criteria: experiential fit, qualities of a good informant (Munhall, 2007), and theoretical relevance. The experiential fit criterion ensures selection of research participants who have either lived through the experience, are presently undergoing the experience, or have observed someone else going through the experience (Munhall, 2007). The second criterion, qualities of a good informant, is essential in obtaining quality data. Research participants should have the motivation, willingness, and personal qualities that enable them to talk, reflect on, describe, and share their experience with the researcher (Munhall, 2007). The theoretical

relevance criterion involves identifying participants who can contribute information that will expand and/or enhance the evolving conceptualization.

Theoretical sampling is a method of data source selection based on concepts/themes derived from data during analysis (Corbin & Strauss, 2008). Theoretical sampling is guided by the ongoing theory development, is responsive to data collected, and seeks to answer questions or hypotheses that arise during analysis (Munhall, 2007). Theoretical sampling involves interviewing new participants, going back to participants to ask new questions (which would have been challenging in homeless participants), conducting participant observation, consulting policies or documents, and looking at literature to answer questions that arise during data analysis.

In GT, quantifying sample size and identifying a sample plan is difficult at the beginning of the study because of theoretical sampling (Munhall, 2007). This study considered the range of people who may have offered insight into the domain of healthcare utilization of homeless veterans with access to healthcare.

In this study, the snowball technique was employed, in which a local informant (an employee of the facility) was identified and asked to identify homeless veterans potentially interested in discussing their experiences interacting with the VA healthcare system. Through the inclusion criteria, purposive sampling ensured identification of participants with extensive experience as homeless veterans using VA healthcare. Interviewing participants was the first stage of theoretical sampling. Participants were recruited until saturation. In purposive theoretical sampling, saturation is reached when no new data are appearing (Corbin & Strauss, 2008). Another part of conducting theoretical sampling is collecting participant observations. Finally, the researcher employed the theoretical sampling technique of looking at literature to

answer questions as they arose in analysis in this study.

### **Recruitment and Data Collection**

The participants were recruited from three recruitment sites, which included one homeless shelter and two veteran transitional housing sites in the Skid Row area of Los Angeles. These places were chosen because they were congregational sites for homeless veterans.

Gathering participant observations as a data collection technique implies an active engagement with individuals in their natural setting. For this study, the researcher had previous direct experience with homeless individuals as a student volunteer at a tuberculosis (TB) screening clinic at the Union Rescue Mission (URM), and later while attending residential community meetings for veterans at the Weingart Center and Russ Hotel.

The researcher worked closely with the coordinator of TB Testing at URM. In exchange for helping with TB screening, the coordinator helped identify some veterans for potential study participation. TB screening was done weekly on Tuesday mornings, and occasionally on Wednesdays in the main congregation area. The activity of volunteering at the TB screening clinic allowed the researcher to observe, interface, and recruit potential participants. A recruitment flyer was posted at the table. The TB coordinator also made an announcement asking for veterans to meet with the researcher if they were interested in talking about their experiences with healthcare. Recruitment fliers were also posted by the elevators on every floor at this site to engage participants.

Due to low recruitment activity at the URM, the researcher also recruited participants from nearby veteran transitional housing, specifically the Weingart and Russ Hotel. The researcher attended residential community meetings for veterans at these sites, and the local informant introduced the researcher to the attendees at the meetings and asked them to meet with

the researcher after the meeting if they were interested in talking about their experiences with healthcare.

After the TB screenings or community meetings, the researcher confirmed eligibility of interested participants based on self-report of using the VA for medical services. If the interested participants met the inclusion criteria, the researcher obtained complete informed consent and their permission to audio record interviews. Effective listening skills such as reflection, clarification, request for examples, and silence were used to create a comfortable setting. Data collection occurred at the URM, Weingart Center, and Russ Hotel.

### **Data Collection Procedure**

GT provides a systematic inductive guideline for collecting and analyzing empirical data and for building theoretical frameworks that explain collected empirical materials (Lincoln & Guba, 1985). Data collection occurred within a five-month period from October 2014 to March 2015. The PI conducted all interviews in a private room at the respective sites. Data were elicited from 18 participants at homeless shelters or veteran transitional housing using a semistructured interview guide with open-ended questions focusing on their social experiences of healthcare utilization.

The semistructured interview format allowed participants to provide information and insights in their own words. The interview guide included broad categorical open-ended, nonleading, and probing questions to ensure that major topical areas of interest were captured in each interview with enough depth to develop concepts and theories. The researcher developed the interview protocol with the guidance of the dissertation chair, who is an accomplished researcher with extensive experience in qualitative research. Homeless veterans were not involved in the interview development process.



**Question 1:** “Mr. (insert participant’s last name), I’m interested in understanding your experiences with health and healthcare. Tell me about your health and healthcare.” This question was a broad introductory probe.

**Question 2:** “Describe where you go for routine check-ups or follow-up on medical conditions when you are not sick.” This question sought to elicit data about how perceived health status influenced use of services (*Specific Aim #2*). The focus was on primary care, as homeless veterans have access to primary care services through the VA and there has been low utilization of these services. Probing questions were asked about their health/medical conditions and use of healthcare services to maintain health:

2a. “Tell me about your health medical conditions.”

2b. “Tell me about how you use healthcare services to take care of your health.”

**Question 3:** “Please tell me about a positive health experience with the VA that stands out in your mind. What has your experience been when trying to get healthcare services from the VA?” This question was designed to place the veteran in the social world of using healthcare services and to situate a sense of self within that world. Each homeless veteran’s experience with healthcare utilization varies, and there might have been a tendency to focus on negative experiences unless asked about a positive example. This question was designed to elucidate perceived facilitators to healthcare services (*Specific Aim #1*).

The researcher asked probing questions meant to prompt participants to describe the effects of veteran status, homelessness, and attitudes about the VA on their healthcare utilization:

**3a:** “Many homeless persons are not veterans. Tell me about how your veteran status has helped you obtain healthcare?”

SI in GT assumes that human beings have the capacity to reflect upon the “self.”

Participants' responses to this question elucidated how the veterans interpreted their self-identities and role as veterans within the context of their interactions in the VA system.

**Question 4:** "Please tell me about a time when you were sick and needed healthcare and attempted to go to get healthcare from the VA but did not receive care."

This question explored perceived factors (barriers) that impeded healthcare within the VA system (*Specific Aim #2*). SI in GT assume that human beings must be understood as thinking beings and that interactions within the individual are central to understanding causes. Responses to this question elucidated the strategies homeless veterans used to navigate the healthcare system.

Probing questions were also asked to more fully describe strategies homeless veterans used to navigate the healthcare system:

4a: "Where do you go for healthcare when you are not able to receive care at the VA?"

4b: "Can you describe a time when you thought about going to the VA for medical care but could not go or did not want to go?"

**Question 5:** "Tell me about how your health beliefs determine how you seek care. Tell me about how your attitudes about the VA healthcare system enable you to obtain healthcare services." These questions were designed to identify health beliefs of homeless veterans, particularly attitudes toward the system and its relationship to use of healthcare services (*Specific Aim #4*). In SI, symbols are a central concept and are meaningful to the person using them and the person receiving them. Healthcare from the VA can be viewed as a symbol to represent a benefit earned from military experience.

Interviews lasted between 1 to 1.5 hours. Each participant had one semistructured interview. The interviews were recorded on a digital recorder and transcripts of the recordings

were completed.

### ***Field Notes and Memo Writing***

The researcher completed field notes and memo writing after the interviews. Field notes focused on description of observed activities and on the process and reflections on activities. Memos focused on an action process and “Aha” moments. Memo writing promoted ongoing dialogue for the researcher to ask what is happening in the field and what is explicit and implicit in the data. Memos enabled the researcher to start data analysis and identify codes and categories, such as ideas, events, or process, in the data (Ghezeljeh & Emami, 2009).

### **Process of Data Analysis**

The purpose of this section is to summarize the process of data analysis using GT, the findings or results leading to a GT, and the integration of key elements of GT with SI and situational analysis. The process of data analysis, based on GT principles, involves constant interaction between sampling, data collection, and analysis. Like other qualitative methods, GT involves constant comparative methods throughout the entire research process.

The researcher reviewed the transcripts and listened to the digitally recorded interviews to gain an overall understanding of the data. The data were coded and analyzed to develop themes, with the help of ATLAS.ti software. The Dissertation Chair, one of the expert qualitative researchers on the dissertation committee, was asked to take a representative portion of the coding to review identified themes in veterans’ descriptions of obtaining VA healthcare services.

### **Line-by-Line Coding**

The narrative texts collected during the interviews were loaded into ATLAS.ti software. The guidelines for coding using the GT approach (Charmaz, 2006) were followed during data analysis of the narrative texts. In GT, coding involved two phases: line-by-line coding and

focused coding. Coding is an exercise that involves principles of SI because it focuses on the action from the data and is consistent with SI principles, which focus on social interaction of human beings, who are thinking beings acting directly on the environment.

The first phase is line-by-line coding, also referred to as open coding. In this phase, the researcher highlighted a section of the transcript in Atlas.ti software and coded each word, line, or segment of data using “gerunds.” Gerunds are used to describe the action code in the data and are action words that end in “-ing,” for example, “coding.” The researcher used gerunds when coding to identify social processes occurring in the data, using the lens of Critical Social Theory (CST). During the analysis, the researcher is constantly asking two questions: “What is happening?” and “What is the meaning?” Through line-by-line coding, the researcher becomes immersed in the data, thinking about the meaning of the data, questioning the data, and identifying gaps in the data (Charmaz, 2006). From these action codes, the researcher can make constant comparisons between people, data, incidents, and categories (Glaser & Strauss, 1967).

### **Focused Coding**

After a few interviews were analyzed, the researcher started focused coding, a process of identifying frequent and recurring codes. From the focused codes, the researcher identified categories and described their properties and dimensions. Focus codes are useful in sorting large amounts of data. Focused coding is more directed and conceptual than line-by-line coding and precisely accounts for most of the data. The identification of clusters of meanings from significant statements were refined and transformed to themes through iterative cycles of comparisons with the original interviews.

During the coding session, the narrative experience of participants provided rich and full data because it was based on his experience. In contrast, data provided about general problems

could be considered thin because it does not reflect the actual experience, but rather a composite experience.

The aim of GT is to develop theory that is grounded in the data. There is disagreement about the meaning of theory within the social sciences (Charmaz, 2006). The more common meaning of theory comes from the positivist perspective, and it is defined as the relationship between abstract concepts that cover a wide range of empirical observations (Charmaz, 2006). In the positivist perspective, theoretical concepts are viewed as variables, and operational definitions are constructed from hypothesis testing through accurate, replicable empirical measurements (Charmaz, 2006). On the other hand, the interpretive perspective views theory as an understanding of the studied phenomenon (Charmaz, 2006). Interpretive theory is compatible with George Herbert Mead's SI because of the shared assumptions of "emergent, multiple realities; indeterminacy; facts and values as inextricably linked; truth as provisional; and social life as processual" (Charmaz, 2006, p. 126-127). GT includes both the positivist and interpretivist perspective.

The researcher used Strauss and Corbin's systematic process in the data analysis to explain the social process occurring within homeless veteran's social context when using healthcare services. In this study, structured focused coding, field notes, memo-ing, and development of GT were elements of the Straussian systematic process used to understand the social experience of homeless veterans when using VA healthcare services.

### **Credibility, Dependability, Transferability, and Conformability**

In qualitative studies, the issues of credibility, dependability, transferability, and conformability should be addressed to describe the scientific rigor of the study. Credibility is the qualitative equivalent to validity in quantitative studies. Strategies for assuring credibility focus

on ensuring that the phenomenon identified was adequately reflected in the data (Marshall & Rossman, 2005). Threats to credibility are minimized through an “in-depth description of the complexities of processes and interactions that are embedded with data derived from the setting” (Marshall & Rossman, 2005, p. 201). In this study, the researcher used iterative cycles of comparing and contrasting of the data, and maintaining availability of transcripts for audits. A discussion of the study design limitations is another strategy that can be used to increase the credibility of the study (Marshall & Rossman, 2005).

Dependability is similar to a measure of reliability in quantitative studies. Unlike reliability, however, dependability attempts to account for changing conditions in the phenomenon (Marshall & Rossman, 2005). In this study, dependability was assured through collection of data until saturation occurred and through describing the specific ways of approaching data gathering, analysis, and interpretation. Thick description of methods provides information on replication of the study or demonstrates the unique situation of the study.

Transferability is similar to the generalizability or applicability of the findings to similar situations with similar research questions (Marshall & Rossman, 2005). Transferability is achieved by providing a thick description necessary to allow a researcher interested in making a transfer of the findings to judge the possibility of success (Lincoln & Guba, 1985).

Finally, confirmability involves maintaining neutrality or objectivity (Marshall & Rossman, 2005). The researcher identifying his/her presumptions is essential in upholding confirmability and understanding the phenomenon. Some of the presumptions about homeless veterans' healthcare utilization have been discussed in the literature review section. Memos can be used to identify presumptions that were identified at the beginning of a study. Memos and field notes also create and maintain an audit trail.

As important as these qualitative techniques are in ensuring rigor, Sandelowski (1993) cautions that researchers cannot become too preoccupied with rigor as the measure of scientific merit, at the expense of “creating the evocative, true-to-life, and meaningful portraits, stories, and landscapes of human experience that constitute the best of rigor in qualitative work” (pg. 1). To ensure that rigor was maintained without compromising the evocative meaningful stories or portraits of the social experience of veterans using VA healthcare services, a semistructured interview guide was used to provide structure, but the questions were broad and open-ended enough to allow thick descriptions of their social experiences.

### **Ethical Conduct of Research**

This study was submitted to and approved by the UCLA Institutional Review Board for conducting research with human subjects (Appendix B). The principal investigator and consultants had all been certified in human subjects protocols from their respective institutions. Human subjects protocols require that confidentiality and privacy are maintained, informed consent is obtained, and risks and benefits are explained.

#### ***Confidentiality***

Confidentiality was maintained for this research study to ensure that data collected from the study participants were kept private. Every study participant was assigned an identification code number when consent to participate was obtained. The researcher used the identification code number on all study documents, including transcripts, field notes, memos, and data collection forms. In addition, proper names were removed from transcripts to ensure privacy and confidentiality.

Data storage procedures also ensured confidentiality. The identification code numbers assigned to study participants were stored on a master list on a computer that was password

protected. Only the research investigator and the dissertation committee chair had access to the research. Audio recordings were erased after they had been transcribed and reviewed.

Transcriptions and analysis of the interview data were also stored on the same password protected computer. Other research-related materials such as memos and field notes were kept in a secured, locked file cabinet. Finally, research study materials with personal identifying information will be destroyed three years after study completion.

### ***Informed Consent***

A local informant identified potential participants for the research study. The researcher obtained consent from participants who met eligibility criteria. All participants had the capacity to give informed consent. A quick assessment of the capacity to consent, which has been used in geriatric populations, is to have the individual explain their understanding of the study. Because the participants in this study were at high risk for substance abuse and mental illness, they were assessed for active drug use and unstable mental illness, and were excluded if they appear intoxicated or self-reported actively using drugs or having unstable mental illness. As part of the consenting process, the research investigator discussed the study purpose, strategies for ensuring confidentiality and privacy, and risks and benefits. One copy of the consent form was given to the research participant and another copy was retained by the researcher. Study participants were made aware that they could discontinue their participation in the research study at any time. The statement of the right of the participant to withdraw from the study at any time was repeated and included in the informed consent to ensure each participant's understanding of it.

### ***Benefits, Risks, and Safeguards***

All appropriate steps were taken to protect subjects from harm and minimize risks. The probability and magnitude of harm or discomfort anticipated in the research were not greater in



and of themselves than those ordinarily encountered in daily life. Possible risks included discomfort from engaging in an in-depth interview about painful or stressful memories related to healthcare utilization. The subject could withdraw from the research study or refuse to answer questions if he felt that disclosure was too painful/stressful. Another potential threat to the subject was the possibility of the information gathered from this study being divulged to the VA. The measures taken to maintain confidentiality prevented this from occurring.

Research participants did not receive any direct benefit from participation in this study. A potential benefit for the participants was the opportunity to voice their personal stories on healthcare utilization. One potential future benefit is that data obtained from this study were used to understand factors for underutilization of available medical services to them and may influence healthcare policy to improve access for homeless veterans.

### **Summary**

There is a paucity of research on the specific population of homeless veterans and their lived experience with access to VA healthcare services. The proposed GT research study was designed to increasing our understanding of service underutilization found in previous studies. This study addressed the priority topic of advancing the science in regard to vulnerable populations and improving access to healthcare, an identified priority in Health People 2010.

GT was selected because of the paucity of literature focusing on this population. GT allows for in-depth understanding of a phenomenon. Another consideration was selection of sampling and site. To increase the eligibility of study participants from this population, the investigator chose to loosely define homelessness to increase the number of eligible participants.

## **CHAPTER 5: RESULTS**

The purpose of this GT study was to develop a substantive theory that described and explained the social experience of using VA medical care by homeless veterans who, unlike their homeless nonveteran counterparts, are eligible for medical coverage but may have chosen not to use them. The specific aims of this study were to (1) elicit homeless veterans' experiences using the VA health system, (2) identify factors perceived to impede or enable (barriers and facilitators) use of VA healthcare services, (3) describe the health factors that influenced service use, (4) identify the influence of veterans' health beliefs on service use, and (5) develop a GT of homeless veterans' social experiences of using VA medical care. The empirical findings that emerged from the 18 interviews are described in this chapter. First the sample will be described. Then findings will be presented according to the study's specific aims.

### **Description of Sample**

The sociodemographic profiles of the 18 participants are presented in Tables 1 and 2. Participants' ages ranged from 28 to 77 years; 72% were over 50 years of age, and 50% were >60 years of age. One third of participants were African American, 22% were White, and 33% were Mexican/American, Hispanic, and Puerto Rican (Table 1).

Eighty-nine percent of the participants met the inclusion criteria of serving at least 24 continuous months or 2 years in the military. Although two served less than 2 years, they were both eligible for VA care. In fact, one of them had been using VA medical services and the other had recently learned of his eligibility. All participants reported being homeless for more than 30 consecutive days, 33% had been homeless for < 1 year and 50% had been homeless for more than 2 years (Table 2).

## **Experiences of Participants with the VA Health System**

Fifteen of eighteen participants had experiences with the VA health system; three did not. One veteran did not use VA medical services because he considered himself healthy, despite having Hepatitis C, and was not sure if he was eligible for care. The second veteran had not used VA services yet because he was recently discharged from the military and did not have his DD214, an official document that lists military service and whether the veteran was discharged honorably. On attempting to establish care with an initial visit to the VA facility, this individual had already started to develop a negative impression of the VA based on his observations of the veterans outside the buildings who seemed to have significant mental illnesses and appeared not to be receiving care. The third veteran had not yet used VA services, but he had recently learned that he was eligible (Participant 16).

The experiences of participants with use of the VA health system, as described by the veterans, were categorized by the researcher as neutral, positive, and/or negative based on their initial descriptions. Only one participant felt neutral or indifferent about VA medical services, saying “There are positive aspects to it (VA) such as social services, which are important for homeless veterans” (Participant 14). However, he also complained about the bureaucracy and seeing his primary care physician infrequently (every 3-4 months) and having to wait three months for an eye appointment.

### ***Positive Experiences***

The experiences of 12 of the 18 participants with the VA healthcare system were categorized as mostly positive (Table 3a). Five of the 12 reported a purely positive experience without any negativity. One participant described the VA staff as “helpful,” “comforting,” and “problem solvers.” Two had positive experiences with the VA because they learned about an

unknown and undiagnosed medical condition through use of VA medical care. Another participant credited the VA with saving his life, and he also had a positive encounter with the VA police who did not harass him when he slept overnight in the waiting room. The fifth participant described the care he had received as excellent, citing examples of getting an MRI on the spot and receiving calls from a physician assistant (PA) during the weekend when she was not working.

A few themes emerged from the participants who described elements of an overwhelmingly positive VA healthcare experience. One major theme was based on the interaction with staff. Another theme was unexpected care/treatment for a longstanding problem or unknown medical problem. Lastly, the theme of prompt care was also an important element in a positive healthcare experience

### ***Positive Healthcare Experience is Dependent on Interaction with Staff***

An overwhelmingly positive healthcare experience was shaped from the interactions with VA staff. The interactions with the staff occurred on an individual or collective level and personal or professional level. Interactions occurred with collective groups such as the entire staff (all the people), specific professional group (all nurses), or specific departments (radiology, neurology, and pulmonary). Participants described the entire staff as “all the people [being] pleasant,” and “all nurses [being] nice” (Table 3a, Participant 8). VA staff were also described as “helpful” and “comforting” (Table 3a, Participant 16). The entire medical team (PA, nurse, radiology, neurology, and pulmonary) was also very involved in the care of patients and knowledgeable about the participants’ medical problems. On a professional level, even if the VA staff were not able to provide help within their scope of practice, they would ensure that the participant was given other options or referred to the appropriate medical personnel. The staff

members displayed qualities of a consummate professional as they would work closely with the participants and call them after business hours and on the weekends (Table 3a, Participant 13). Finally, participants seemed surprised that the VA police were accommodating and allowed them to sleep in the VA facility to wait for their appointments. Positive interactions of the staff seemed to be the prevalent indicator of a positive experience with the VA.

### ***Positive Healthcare Experience is Unexpected Medical Care***

Participants also had an overwhelmingly positive healthcare experience from unexpected treatment of unknown or longstanding medical problems. Unexpected treatment of a longstanding medical problem such as a hemangioma on the eyelid was a positive experience because a hemangioma is a visible skin condition on the face that can lead to alteration in body image. Prior to coming to the VA, if the participant had sought removal of it, the procedure would have been denied, as it would likely be considered a cosmetic or elective surgery. As a result, the care and treatment recommendations from the VA would have been unexpected to the patient, and the perfunctory manner of identification of the hemangioma on exam and the treatment with ease and without complication made it seem like it was appropriate care to expect.

Another theme of unexpected care for an overwhelmingly positive healthcare experience was for treatment of a life-threatening condition. One participant had a grave feeling of impending death because of unusual symptoms prior to his stroke. The participant believed that the comprehensive care provided by the VA saved his life. The participant felt like all that can be done for him was done, as he was given “all medications” and multiple medical supplies/devices to relieve acute symptoms. Comprehensive care not only included medical care, but also social services to provide patient with homeless services. Participant received housing assistance much quicker through this VA service than through the community process.

### ***Positive Healthcare Experience is Prompt/Immediate Care***

Positive healthcare experience was also marked by promptness of services. For example, one participant, on his initial visit to the VA, was immediately assigned to a primary care provider/team and started receiving care immediately: “They started giving me...a primary care physician, and they started giving me the prescribed drugs, and I started feeling better right away” (Table 3a, Participant 8). Another participant described getting immediate care when he went to the radiology department to set an appointment:

I had another incident. I can't remember what x-ray they were asking for this time. Oh, it was when I went for my first hip x-ray. I went in to check on the date, and they said, “Oh, well, we can do that right now.” (Participant 13)

Even though another veteran did not have the same experience of getting immediate care for a radiological procedure, he did not think that the waiting time for his appointment was different from what it would have been had he gone to a non-VA healthcare facility:

Now, they have me scheduled for April to have a MRI on my neck because the nerve ending – here it is three months later and I'm still having – my left arm is still numb. That might be considered a long time for some situations. However, I'm not sure whether private insurance would have done any better. (Participant 16)

### ***Mixed, Mostly Positive Group***

The other seven participants who reported overall positive experiences with the VA healthcare system also reported some negative experiences (Table 3b). Two participants complained about not getting benefits/care for PTSD. However, despite his complaint, one saw his primary care provider on a monthly basis. The other had moved from one state to another because he believed the VA healthcare facility in this state offered better services.

A third participant recalled not getting care for a laceration, as too much time had passed and it could not be treated. Participant 4 thought the timeliness of appointments was an issue, while the fifth participant, who had a positive experience during his hospitalization for a stroke,

complained about the length of time before getting appointments for speech therapy.

A sixth participant was currently satisfied, but he admitted he had a negative impression of the VA many years ago. Finally, the seventh participant reported confusion and frustration when he was sent to the emergency room by his primary care provider, thinking that he would be admitted and, instead, he was treated and released after a few hours.

The elements of a mostly positive group included the themes of “no complaints,” and “access.” Even though these themes were elements of a positive experience, the participants actually did complain about the care they received at the VA.

“No complaints” seemed to be a recurring theme for patients who described their experience with the VA as a positive experience. These participants described their overall experience at the VA as “outstanding” and “great.” Yet, a participant who had a positive rating for the VA left a VA facility at one location and moved across the country to another VA location (Table 3b, Participant 2). Participants who rated the VA favorably also shared prior disappointments with the VA due to not receiving adequate care for mental health problems related to war (Table 3b, Participant 5).

Access was another theme that emerged in the participants’ accounts of positive experiences. Access was described in the general sense as not being denied medical care in contrast to previously not having it. For example, Participant 6 explained, “A good experience [with healthcare] is not being denied—that I’m not eligible.” Having access to healthcare was important for this same individual because he was concerned about his health after many years of not having medical care: “I was very worried about it [prostate CA] and concerned due to the fact that I didn’t see a doctor for more than 10 years.” Access was also described in terms of consistently receiving care when needed. For example, “Every time I’ve ever become sick,

injured, or needed care, they [the VA] were always there for me” (Participant 9). Similarly, “I always got help from the VA. They never turned me down. Never. No, no, they’ve been very nice all the time” ( Participant 12).

### *Negative Experiences*

Only two of the 18 participants reported having overall negative experiences with the VA (Table 4). One participant had a negative experience because he developed a post-biopsy infection. In addition, he had problems obtaining service-connected disability benefits for a facial fracture. Furthermore, he had negative encounters with VA staff and police. The second participant who reported negative experiences also had problems with the VA staff, and thought that all veterans were subjected to forced psychosocial evaluations, which he thought was unnecessary: “The VA is primarily in conjunction with the psychosocial services of the veteran and the consideration of the impact of the veteran in conjunction to the civilian community” (Participant 10).

Several themes about the healthcare of participants also developed from the two participants who gave overall negative ratings and from those with positive experiences yet complaints. The themes for negative experiences included inadequate medical care, staff exploiting the system, uncaring providers, and perception of deception.

One theme was about receiving inadequate medical care. For example, one participant, who had sustained a back injury from a mortar falling on him, went to the VA clinic and felt he was misdiagnosed with a pulled muscle and undertreated. When he went to a non-VA chiropractor, he was shown an x-ray that evidenced his vertebrae was out alignment:

Anyway, I go to a chiropractor, and he takes an x-ray - body scan you know, full skeleton. And he pulls the damned thing up and he shows me - he says, “This is what's happening to your . . . I can see the vertebrae actually pushed halfway out of its alignment. No wonder it hurts. . . .” It took him two months, but he pushed that sucker



back into place, took the pressure off, and now, that's about the strongest part of my back. (Participant 13)

Similarly, another participant with uncontrolled diabetes mellitus was sent from a VA clinic to the VA hospital for treatment. He expected to be admitted and possibly started on insulin, but was instead kept in the emergency room where he was hydrated and discharged shortly after:

The doctor that had seen me at the downtown VA wanted me to be admitted and for them to start me on injected insulin. But the doctors at the other VA hospital, they said, "No," they couldn't do that without the consent of the doctor that had seen me. That's what I was told. This was late at night when I showed up. The only thing they did was - what did they do? They just gave me water. They told me to drink water, "lay down, and we'll check you in a couple hours." (Participant 18)

Another example of inadequate care was shared by a veteran who complained about receiving medications without a thorough examination:

But, what I'm saying is, he give me three little packets and it had about four or five pills, each one of them told me how to take it. "You'll be all right, Mr. W. Just take this." Come on, man. I done had - you didn't even give me no examination. You didn't even check me out, do nothing - you know. (Participant 5)

Another theme of negative experience was poor treatment from VA personnel. Some participants had negative impressions of VA employees. Some viewed the VA as benefiting the civilians employees rather than veterans they served:

The VA is a civilian organization that's run by civilians and for the benefit of civilians. As far as I can tell, you know, the veterans I talk to get very little help from the VA, and you don't go to the VA expecting to be helped. You go to the VA expecting to get jerked around, and that's what seems to be their method. (Participant 3)

Along these same lines, some participants indicated VA employees appeared to be exploiting the system: "Unfortunately, you got people who's working for the system who's dogging the system more than people who's trying to get the benefits out of the system" (Participant 11).

Some participants complained about uncaring treatment by healthcare staff. For one participant, uncaring treatment was associated with medical professionals acting like they were in the military:

Military doctors are the same way. "Oh, well, you can still walk. I'm not going to help you." They have this impunitive reverberation of psychology that is berating to the general facility of individuals and their psychologies. We're not in the military anymore. You're not punishing anything. As a matter of fact, shut your mouth or I'm going to send you to jail for abuse. (Participant 10)

One doctor made an uncaring statement to the participant that he could not forget, and he mentioned it throughout the interview: "Well, we're not here to take care of you from cradle to grave" (Participant 3).

Other complaints were about VA personnel other than healthcare providers. For example, one participant complained about the VA police. He was confronted by VA police while shaving and cleaning up in the VA bathroom to get ready for his medical appointment:

The VA police comes into the men's room and he's got - he's sneaking into the restroom like this, and he's got his hand on his gun like this, and he goes, "What are you doing?" So, I stopped, and I looked around, and I said, "What does it look like I'm doing? I'm shaving. Anything wrong with that?" "Well, yeah, you're not allowed to shave in the bathroom." I said, "Who said so?" "Well, that's the VA policy." I said, "What are you doing with your hand on your gun? Are you scared? Are you afraid of me?" (Participant 3)

The same participant had sought help from the patient advocate, and the patient advocate called the VA police on him:

The person who is paid to take care of this problem, says, "I'm going to call the police. I'll get the VA police over here." And I said, "Well, I asked you to help me get my medication straightened out. That's your job. You're paid to do this. Go ahead, get the VA police down here, because maybe the VA police is finally going to get me some help. You're no good to me. Go away." (Participant 3)

Another theme of negative experience was deception. A few participants complained about feeling deceived by VA employees. For example, one felt deceived when he was sent to a

local hospital instead of being transferred to another VA facility:

The nurse - we were sitting in a room like you and I are, and I'm listening to the nurse call (another VA facility) asking them do they have a bed available in B. They told the nurse "Yes." I heard this with my own ears. And then, the clerk outside - she changed it and sent me to a local hospital. (Participant 2)

Another participant felt he was deceived because he was given a psychosocial evaluation: "Instead of being upfront and saying, we're doing this to you, they're putting people through psychological evaluation processes with a different label. I highly disagree with it" (Participant 10).

Still another participant felt he was deceived because providers claimed he had consented to a treatment when he had not. "And they wrote on the paper, which I went and got a record of, that I agreed to go to outpatient stuff, which I never agreed to" (Participant 2).

Although each participant had his own unique experiences with the VA, the individual experiences had collective similarities that influenced the participants' use of VA medical services. Positive experiences were marked by positive perception of staff, unexpected treatment for identification of newly diagnosed medical problems, prompt and more importantly, lifesaving medical care. Most of the healthcare experiences participants described were positive, and although some participants reported experiences of denial of benefits, denial of treatment, length of time between appointments, and poor communication between staff, these problems did not seem to influence their positive perception of their experience. Negative experiences occurred from inadequate care, uncaring and confrontational staff, and deception.

### **Factors that Impeded or Enabled Use of VA Healthcare Services (Barriers & Facilitators)**

Barriers to VA care were difficult to identify from the interviews. Typically, barriers are factors that prevent a healthcare user from obtaining care. However, most of participants used VA services. Thus, barriers were factors that prevented initial engagement with the VA in the

past, or factors that delayed participants from returning for follow-up care.

### ***Barriers to Initial Use***

Barriers to initially using VA care were participants' *negative perceptions* and *the poor reputation* of the VA healthcare system. One negative perception was that the VA provided preferential treatment to patients with high acuity health problems. As one veteran put it,

I'm pretty much convinced that they go after the big fish. You know, if a guy goes in and he's lost a leg, or he's lost a limb or whatever, obviously they're going to get preferential treatment over everybody. You know, if a guy goes in and he has chest pains, and he's a heart patient, or he's a cancer patient or whatever, they seem to do much, much more for these people, because these people are severely ill...But, if you're moderately healthy, which I am, and you go in, you say, "I have this allergy or I have these headaches. I have these sinus headaches. I've had two surgeries already." And they say, "Okay, fine. Take your medication. Take a number and have a seat." (Participant 3)

Another negative perception was that the VA was a training school for doctors, and diagnosis or treatment may be made for training purposes rather than sound medical care:

I would have said, "Be careful when you go to VA because the rumor was that it's a school for training doctors." And, you know, a doctor might say, "Oh, okay, you've got an infection. We got to cut off a limb," when that's not necessarily the case. That was the rumor that they would, you know, too quick in training doctors. Now VA has gotten a lot better reputation. (16)

The VA also had a reputation for being a large bureaucratic system that made it difficult for it to provide care to veterans with non-life-threatening disease. "They're just overwhelmed. The system is too large, and they really don't have the time to spend with you and try to find out what's wrong with you and what's the reason for the headaches, and why do you have this nasal discharge?" (Participant 3). Another participant stated that improvements needed to be made to the VA administrative structure:

I think there are some positive aspects to it. I think it's a federal bureaucracy that needs a lot of work, just like any other federal agency that needs a lot of work. It's top-heavy. You know, I don't think Obama knows what I'm going through right now. And frankly, I don't think he should, you know. It's just the way it is. (Participant 14)

Another negative perception expressed was that the VA was only concerned with making money: “I think they get paid for every patient they work [on]. So, I don't know, man. I'm just saying that” (Participant 5). The statement implied that the higher the number of patients seen the higher the amount paid.

Another negative perception was that the VA was small enough that confidentiality would not be maintained. One participant believed that VA employees could ruin his reputation because it was so small. “That town in Florida is a little small town, so if one person don't like it, they know everybody else around the hospital. And I believe they would spread the word” (Participant 2).

Negative perceptions and a bad reputation were described by this story of poor medical care resulting in the death of a veteran:

It can be so bad, it can be dangerous. Like the guy who sat in the waiting room at the VA and actually passed away in the waiting room, in emergency, waiting to see a doctor. And when they came out, the guy was sitting in the chair - he was dead. (Participant 3)

Some participants had resisted using VA services initially because they had *health insurance through work and a preference for private care*. One participant did not use the VA for many years when he had a job with health insurance:

Well, see, that's a little difficult to answer, because I've never used any of my veterans benefits ever since 1978 when I was in the military - when I was discharged. Not until recently, like 34 years later, I started using benefits due to the fact that - I used to work for a company at one time that offered medical health benefits. (Participant 6)

Another veteran added “I stayed with the union insurance all the way until I wasn't able to work anymore and keep up with the rest of the crew” (Participant 13). One homeless veteran did not use VA services because he wanted to take advantage of health benefits from his job before he lost them: “You know, but I didn't because – and I just wanted to use it because I had

Kaiser and I might – I figured the job might be ending soon, so I better go check my toes out or whatever, you know. That was the only thing” (Participant 7).

Another participant used VA healthcare services until he obtained medical coverage: “My first option was the VA, but then, I qualified for LA Care, and I also used them as well” (Participant 6). Some participants went back and forth between the VA and another healthcare provider depending on whether they were working and whether they had coverage:

So, over the years, I've just been going back and forth to the VA, and then, you know, when I'm working and I have my healthcare, I go to my civilian doctors, and I seem to get better results from the civilian doctors than I have with the VA. (Participant 3)

### ***Barriers to Follow-Up Care***

*Long wait times for appointments* were barriers to follow-up care described by many participants. Long waits could occur when the patient scheduled an initial appointment:

Getting first appointment is most difficult part in scheduling: Like physical therapy and speech therapy - for what I need right now and what I'm going through as a follow-up for the stroke. And so, I think the initial part when you start therapy, that initial interview is far out. I almost had to go somewhere else for my speech pathology appointment, but I wanted to keep it all under one roof. So, I went ahead and dealt with the long delay in getting that started. (Participant 15)

Long waits also occurred between visits: “And then, it took so long in between visits” (Participant 2). Long waits could occur when the individual did not have an appointment:

Last year I was having real bad back pain and I went to the - I went to the clinic. And since I didn't have an appointment, I was put on standby. I waited almost five hours and I wasn't able to see a doctor so I left. I walked out. (Participant 18)

Responses to long wait were mixed. As a result of the long wait, one participant said, “So, I would imagine if most veterans are like me, the VA is a last resort” (Participant 3).

Another expressed understanding of long waits due to large volume of patients served:

Now, the one drawback I will say is based upon the volume of individuals that they have to see, when they set up an appointment, some appointments can be 30 days down the road or longer sometimes. And for certain situations, that might be considered a long

time. However, when you look at the volume that they deal with and the price, two thumbs up. (Participant 18)

Still others expressed disappointment with the care received after the wait:

I did get waited on - the VA doctor. All he'd give me a handful of pills, told me to come back tomorrow. And I asked myself, I said, that's all you can do for me? I spilled my blood, and you going to give me a handful of pills? I said, "The hell with y'all," and I walked out. I walked out. Haven't been back since. (Participant 5)

Other responses to long waits were also evident. For example, one participant opted for self-care in order to avoid long waits:

If it needs a prescription, let's just say, I'll address a doctor. If it's something I can go to the pharmacy at CVS or somewhere, you could talk to a pharmacist and they can recommend certain things for you, as well as a doctor can, and save you a lot of time of signing in, waiting, you know, that kind of thing. (Participant 16)

Another chose private care over the VA because of the waits. "I found I was getting better help, faster help, more comprehensive treatment at the health center than I was at the VA" (Participant 3).

*Feeling vulnerable and disappointed* was another barrier to follow-up care expressed in these three examples:

You know, you go there when you don't have healthcare insurance. And you go there, and you wait all day, and you hope you can come away with some solution, you know, after waiting. (Participant 3)

So, why should I come back to you and ask you for some help, and I know damn well you're not going to give me the help that I need? If you want to put this pressure on me, I know where to come to you for this. So, I didn't have no really emotion to go running to the VA say like I'm fixing to kill somebody. You know, because it's a lot of things the VA could be doing for veterans, and they're not doing it. They're pushing guys aside - certain things - so, I don't need to talk about that neither. (Participant 5)

When I came out of the army, you know, and something was wrong. And during that time, they didn't even speak of PTSD, and the Vietnam vets, they wouldn't even acknowledge us, you know, with that. But, a few years after, we were all out. But anyway, when I did complain, they said there was nothing wrong with me. And so, you know, we just had to live with that. (Participant 2)

Another veteran (Participant 18) avoided the VA for 2 years because he felt helpless and didn't think his health would improve much even though he tried to follow recommendations:

Well, that period - that period for two years where I didn't go. I didn't go because - because I was kind of like - I had kind of like given up. I felt like...it was useless, you know. I'm taking the medication but it doesn't seem to be helping. But then, again, I wasn't doing my part. I had - I had gone to different classes with a nutritionist. I had gone to see the doctor numerous times. And the doctor kept telling me I needed to watch the intake, the portions. (Participant 18)

Other competing social factors were barriers to VA care for one veteran who lacked employment and had a pregnant wife. A homeless veteran explained that he had other priorities that caused him to neglect his health and avoid the VA: “Currently, there's some stuff that I probably should do at the VA. Dental's one of them. A few other things that I should probably do - I'm unemployed. I have a pregnant fiancée who just lost her job. So, my first priority is finding work” (Participant 14).

In summary, even though the typical factors of barriers to care such as bureaucracy, insensitive providers, and long waiting times were also identified in this study, the barriers did not completely prevent the participants from use of the VA for medical services. For this study, the most prevalent barriers included factors that temporarily kept the participants from going to the VA. These barriers included negative perceptions of the VA, poor reputation of the VA, and long waits.

### ***Facilitators of VA Care***

Facilitators were factors that enabled participants to use VA care. *Veteran status and eligibility* were major facilitators to the use of VA healthcare services. Veteran status was determined from military service, and it granted them eligibility for care. Most participants acknowledged that being a veteran was an enabling factor to use VA medical services. One veteran said, “If I wasn't a veteran, I wouldn't have any healthcare at all” (Participant 8).



Being a veteran had other advantages because when homeless veterans were identified while incarcerated, they were released from jail and sent to the VA for the residential treatment program: “Well, it was actually the healthcare that got me over here, because I was in the halfway house. I was considered not homeless” (Participant 13). Some participants expressed gratitude for having served in the military and being eligible for services. One veteran said, “And so, I was glad that I put some time in to serve my country and I'm able to benefit now at a time when I really need it” (Participant 15). In addition to feeling grateful about being a veteran and having benefits, some participants grappled with feelings of guilt about having benefits:

But, I just really - I don't mention it (being a veteran), but I'm grateful that I do have - you know, secretly inside. I'm grateful that I do have that. I just try not to mention it to other people, unless I'm being asked by a professional or something if I'm a veteran.  
(Participant 15)

Veteran status helped give participants a sense of security of having medical access. One veteran said, “Well, just the - knowing that you have access to it helps out” (Participant 7). Another added, “Having assurance of access to the VA as a homeless veteran” (Participant 3). Eligibility for VA healthcare services enabled homeless veterans to have access to medical care after not having it for many years: “I was very worried about it and concerned due to the fact that I didn't see a doctor for more than 10 years prior to that. So that was one of the main issues” (Participant 6). Being eligible for VA care enabled veterans to have healthcare after becoming unemployed.

Although eligibility was a major facilitator to service use, it is important to note that eligibility was also confusing to these participants, and at times the system seemed capricious in its decisions about who was eligible. One veteran thought that he was eligible for VA healthcare benefits on account of the Affordable Care Act, or Obamacare, rather than his veteran status:

Well, because I am a vet, I have healthcare. . . .It's probably more due to the Affordable Healthcare Act, which I was not a big supporter of and still am not. But, it did force federal government to do a little bit more as far as taking care of their vets, and I think we should take care of our vets. I think vets, depending on their level of service, require more attention. Someone like me who has only done three years of service - I'm fairly young compared to, you know, most of the guys you talk to. (Participant 14)

Another participant described his frustration and confusion about losing benefits and regaining some of it back:

Yeah, but anyway, they reduced me down to zero for whatever reason. And but, anyway, I finally - they finally gave me 40 percent - was for something. But anyway, down from 100 to 40, and I had a lot of issues, you know, dealing with that, even though they say it's not true. (Participant 2)

*Being homeless* also facilitated use of VA healthcare services. Being unemployed and homelessness led some participants to turn to the VA. One man stated, “You know, you just happen to be homeless, and you just happen to wander in the VA because you can't go to your own private doctor anymore because you don't have a job” ( Participant 3). Another veteran said, “It [being homeless] hasn't really helped me other than the VA hospital being available to me, you know” (Participant 11). Living in a shelter was an enabling factor to seeking care: “Since I did suffer the circumstances that led to my homeless, being here in the program has enabled me to not struggle for a roof over my head while I'm seeking care” (Participant 15).

Location of shelter and arriving to appointments at an earlier time of the day were identified as other factors that enabled veterans to obtain medical care. Proximity of a shelter to VA services was an important factor to using VA medical services. One veteran who was housed near the VA clinic said, “I don't know that it's (homelessness) helped me. I know I'm a lot closer to the clinic. I'm walking distance from here. At this time, which is convenient” (Participant 18). Another veteran implied that going to the VA earlier in the day was helpful in obtaining care when he stated that he found parking challenging when going later for

appointments: “If you wait too late to go, parking is hell. That's the only bad thing I see” (Participant 7).

The facilitating factors that enabled participants to use VA care were based on their veteran status and homeless status. Through their veteran status, they were eligible for VA care, although the awarding of eligibility seemed to be arbitrary. Homeless status also seemed to help the participants if they were connected to a homeless program with ties to the VA.

### **Health Factors Influencing VA Service Use**

Most participants (15/18) had multiple medical problems (Table 5). The medical problems determined the healthcare factors that influenced VA service use. Approximately 17% (3/18) of participants had a single medical diagnosis, which included Hepatitis C Virus (HCV), diabetes mellitus, and a cystic mass on the back. Interestingly, 39% (7/18) of participants reported having good health despite having diagnoses of HCV, suspected glaucoma, alternating foot pain, a cystic mass on the back, scabies, pneumonia, eye drainage, a sinus condition, and coccyx removal.

One of the six participants who considered himself to be healthy had multiple medical problems, which included diabetes, high cholesterol, and high blood pressure. He also noted that he had a “new onset pinched nerve in my neck that creates numbness all the way down my left arm” secondary to a motor vehicle accident. One participant actually had no medical diagnoses but was concerned about his risk for prostate cancer due to his family history. Twenty-eight percent (5/18) had dual diagnoses (PTSD and substance abuse; alcohol abuse and depression; drug use and PTSD; depressive disorder and drug use; depression and methamphetamine use). Twenty-two percent (4/18) of the participants had diabetes. Eleven percent (2/18) had cardiac problems. Thirty-nine percent (7/18) had musculoskeletal problems, including facial fracture;

knee and hip pain; multiple gunshot wounds to elbow, right leg, left leg, stomach, and back of head; right wrist fracture secondary to military accident; back pain; pinched nerve in the neck secondary to a motor vehicle accident; and back pain.

### **Influence of Health Beliefs on VA Service Use**

Participants commonly defined health as the absence of physical stress and the ability to work:

It shows - what you call stress - physical stress - when you – you: know, physical health - if you're not in good physical health, you can't perform that well on the job, so it affects everything, the same way mental health. (Participant 3)

Another definition of health was as follows:

For me, being healthy - I can take a little bit of experience that I learned and share it with somebody else. That's what it means to be healthy, because I want to leave a mark on this world. (Participant 5 )

Health was seen as a balance between the physical and the mental, and lack of balance affected the ability to perform like a soldier: “If you don't have both in a balance there, it shows. You know, you're not going to be a soldier that you were when you got out of basic training” (Participant 4). Health was seen as important because it led to being independent: “I believe if my health improves or if I keep my health steady, or good, or whatever, I'm less dependent” (Participant 15).

Participants viewed taking care of self as an important aspect of health: “Well, I view health as important. It's important to take early steps to maintain your health. I see that now” (Participant 15). Taking care of self included lifestyle behaviors that promoted health:

Well, sure, to do a little follow up, you know, stay, you know, on top of my health. And the issues with it. And to, you know, eat right, you know. Sleep right, you know. You take your shower, you know, regularly and all that. And, you know, that definitely, you know, makes you or helps your health, you know. (Participant 17)

A desire to be healthy was also necessary for taking care of one's health: “As long as you

have the desire to be healthy, you'll do the things that keep you healthy” (Participant 2). One participant believed health became more valued as he became “older and “cleaner” (Participant 1).

Utilizing medical care was also important for taking care of self: “No, I know it's for my benefit, so I get up and go. Because the only person that's going to benefit from it is me, and it's kind of common sense” (Participant 15) Preventative care and health maintenance were components of taking care of one’s health and enabled the use of services. For one participant, going to medical appointments was important in prevention of diabetes complications:

But my beliefs are that I need - I need to be seeing a doctor or different doctors at one time in order to keep living without going blind, without losing my toes. A lot of things that I've been told comes along with being diabetic. (Participant 18)

Having medical conditions controlled was a sign of receiving proper medical care: “I feel, you know, except for the conditions that I have, as long as they're under control - meaning I'm receiving the proper care” (Participant 2).

However, health beliefs could also serve as a barrier to use of health services. Some participants did not go for services if they didn’t feel sick. One participant stated: “I got to be ready to die to go” (Participant 12). Another participant also stated that he did not seek medical care if he was not sick: “Well, when I'm not sick, I don't go - I don't need to go to the doctor. So. And I don't have a primary care” (Participant 17). Another (Participant 10) said he avoided medical care to avoid unnecessary cost: “I don't concern myself with a facilitated extracurricular cost if I don't need it” (Participant 12). “When I'm not sick? I don't go anywhere” (Participant 12 ). One participant avoided the VA when he was sick because he didn’t want to spread disease: “Part of the reason I didn't want to go to VA was because I thought as sick as I was harking and barking and sneezing and runny nose, I would probably infect more people than - you know”

(Participant 16).

Health beliefs about use of medications inhibited some participants from seeking services. Some participants disliked medications due to side effects:

I don't like taking the pills. I was taking the pills, and I was tying my shoe, and I woke up with a knot over my head. . . . I don't like the medications that - some of the medications they give me, they have me feeling loopy, dizzy, nauseous, I can't sleep, I can't go - I'm constipated. (Participant 11)

One participant was so unhappy about getting medications that he tried to stay healthy in order to avoid going to the doctor:

Just them giving me all this medication and, you know, I kind of frown. I kind of think twice maybe about - that's like today, I'd rather - I do try to take care of myself as best I can so I don't have to go to the doctor, because I have this idea that they're just going to give me medicine. (Participant 11)

Lack of alternatives to medications bothered one participant: “I have an issue with the pharmaceutical part of the system, you know, that they should find alternatives in medicine - maybe some acupuncture, some herb therapy, you know, or medicinal marijuana” (Participant 11).

In summary, participants held diverse health beliefs that affected use of healthcare services. The definition of health varied, and it included use of medical care services, through the VA or not, in order to sustain it. Participants also believed in self-care for minor conditions, and self-care usually led to avoidance of VA care. Finally, a few participants believed in choices for alternative therapies, and although they expressed disappointment about the lack of options, it did not affect their use of VA services.

### **Push-Pull Tensions: A Grounded Theory of the Social Experience of Using VA Medical Care**

The GT developed from these data describes the social experience of using VA medical

care from the perspectives of the participants and explains outcomes of the experience. It is important to acknowledge prior to explaining the theory that the options for healthcare available to homeless veterans are very limited. Admittedly, they can access VA services, but, in fact, VA services are virtually their only choice. In essence, they are trapped in the situation and in the end, their choices are to use the VA or to use nothing. This observation led to the focus of the theory, which is on the tensions involved in push and pull forces and the outcomes that arise as a result. Hence the theory has two major concepts: Push/pull tensions and outcomes (see Figure).

The push force was actually described in one of the participant's statement on feeling vulnerable and disappointed with the VA: "They're [VA] pushing guys [veterans] around. . ." (Participant 5). The concept of push and pull factors has two dimensions that explain the experiences of participants in using VA services. The concept behind the push and pull dimensions is that participants used VA services because they were pulled by the external forces related to the attributes of the VA and their own internal pride in being eligible. Moreover, they are simultaneously pushed away by their own internal forces and experiences.

### ***Pull Factors***

The pull factors that motivated participants to use the VA were driven by internal and external factors. Participants used VA services because the services fulfilled intrinsic desires and needs, and at the same time, their motivation to use VA services was based on the positive attributes of the VA. The internal pull factors to use VA services included the positive feelings about the military, their feelings of deserved benefits, and their perceptions or actual physiological need for care.

The external factors that pulled participants toward the VA are what made the VA services attractive to veterans. These factors included tangible resources and participants'

perceptions and expectations, such as a perception that the VA provides quality medical care and that it takes care of veterans, as well as tangible resources such as the VA connecting homeless veterans with social programs. Individually or collectively, these attributes drew or attracted the participants toward the VA for medical care.

The initial and major internal factor that pulled the participants into the VA system was related to their veteran status, and having a positive perception of their military service. The participants who had a favorable experience in the military expressed feelings of pride and gratitude for their military service. Although the participants were no longer in the military, going to the VA kept them connected to other veterans who also served in the military.

The internal pull factor seemed stronger for participants who felt veterans deserved medical care for their military service to their country. Participants were in agreement that veterans who had engaged in combat were most deserving of greater benefits. However, higher levels of benefits or eligibility for care did not necessarily result in higher use of VA medical services. It seemed that participants with fewer or lost benefits, regardless of whether it was general benefits or healthcare, seemed to be pulled into the VA system more in order to increase and re-establish their benefits. For participants with fewer benefits, the use of medical services seemed to be a means of increasing their benefits rather than for strictly medical purposes.

Perception of health was another internal factor that determined the level of pull toward the VA for medical use. Participants determined a need to use VA services based on their assessment of their health status or medical problems. The pull to VA care based on perception of their health status was greater in participants who had major illnesses and in those who believed in maintaining their health.

Participants were also pulled to the VA system through external factors of social



programs for homeless veterans connected to the VA, such as transitional housing or drug treatment programs. Through these programs, participants learned about their VA benefits and were connected to the VA system. Participants in transitional housing near a VA facility were pulled even more.

The participants were also drawn to the VA because of its availability as a healthcare resource to them and because of its positive attributes. The participants counted on the VA as a resource available to them because of their service in the military for their country. In addition, they expected the best medical staff because of their training is from the best academic institutions. They expected not only to receive care when they needed it, but to receive the best care.

Once engaged with the VA system for medical care, there were several factors that pulled participants toward the VA. Positive experiences maintained the pull into the VA. The majority of participants' description of their experiences with the VA system could be categorized as positive. The positive experiences were a result of encounters with VA staff who were described as helpful, comforting, and problem solvers. Participants appreciated VA staff who worked and called them outside of regular business hours. Participants also considered detection of medical problems that were not previously diagnosed as positive experiences. Finally, getting appointments in a timely manner was a positive experience that pulled participants into the system.

From these strong pull forces, participants developed high expectations for medical care. The participants not only expected medical care because of their service in the military for their country, but they expected the best medical care from the best medical staff. The expectations for medical care were also revealed in their health beliefs. Many participants were not satisfied

with medications as the only form of treatment, and expected other options such as alternative therapies. They also expected to receive a thorough examination before providers rendered treatment.

### ***Push Factors***

The push factors also had both internal and external driving forces. Participants avoided VA services because of intrinsic fears or negative feelings or memories related to the military and the VA, because of access to other personal resources, and because of their own positive assessment of their health. At the same time, the lack of motivation to use VA services was based on the negative attributes of the VA. The external factors were the participants' perception of the VA having a negative/bad reputation, and their own negative experience with and perception of the VA system and staff. Examples of negative feelings about the VA included problems with timeliness, long waits, and length of time between appointments. Any one of these push forces could deter participants from the VA or make use difficult or uncomfortable.

Secondary insurance was a major internal factor that pushed participants away from the VA system. Participants usually possessed secondary insurance prior to becoming homeless when they were gainfully employed. Participants felt compelled to use secondary insurance primarily for non-VA medical services as they were paying for it through work. Losing employment and secondary insurance would pull the participants toward the VA system. Participants also obtained secondary insurance through social security due to their age, which pushed them to use non-VA services, but also pulled them into the VA system for dual and specialty care.

Negative military experience was an internal push factor that prevented participants from coming into the VA system. Participants who had negative military experiences, such as one of

the Vietnam veterans, avoided the VA system because it was a painful reminder of war.

Perception of health was also an internal factor that pushed the participants away from the VA for medical use. However, the participants' assessment of their health may have been different from their actual or evaluated medical status. Many considered themselves healthy despite having chronic medical problems, especially if there were no acute symptoms that were currently affecting them, or medical problems were stable. For participants who believed they were healthy or had minor illnesses, the pull to the VA for medical services was blunted or weakened as it was for participants who provided care for self. In some ways, self-care was defensive. Participants decided not to go to the VA for minor medical illness because they believed that they would not likely get care based on previous experience. As a result, participants avoided going to the VA and provided care for themselves. In addition, participants who believed they were healthy also did not seek medical care for primary or preventative care.

The VA's negative reputation was a major external factor that pushed participants away from the VA prior to engagement with the system. Participants who heard about the negative or bad reputation of the VA were hesitant to come to the VA for medical care. Participants feared coming to the VA because they thought that it was a teaching institution, where decisions were made in the interest of teaching students rather than taking care of patients. Participants also had second thoughts about using the VA as they believed that they would not receive adequate care from the VA because it was a large bureaucratic system that did not allow the healthcare providers to spend sufficient time with the patients. Fears about the VA being interested in profit and providing preferential care were also very strong forces that kept participants away from the system.

Several external factors pushed the participants away from the VA after engagement with

the system. Negative experiences were a major factor that pushed participants away from the VA. Long waits for an appointment was one of the main push factors, as participants considered going to non-VA facilities for medical care after they had to wait for a long time to get an appointment at the VA. Due to the anticipation of these long waits, some participants decided to go to the VA only as a last resort.

Participants were also pushed away from the VA system by negative experiences with the staff, such as staff who made uncaring comments. Another push factor was being confronted by VA staff who called the VA police to remove them from the area. Sometimes VA police also harassed participants when they were preparing or waiting for their appointments. Perceptions of VA staff could serve both as a push and pull factor for homeless veterans. The VA police, who would harass homeless veterans while they were in the bathroom was a major push factor. Homeless veterans felt they could not depend on the VA police to be impartial, as they'd experienced the VA police siding with VA employees. There was an expectation that the VA police would confront them when they were resting and waiting for appointments. Homeless veterans did not feel that they could depend on VA staff because advocates for the veterans also called the police on them. Some of the healthcare providers were seen as insensitive, for example, by telling patients that they were not to care for the homeless veterans from the "cradle to the grave."

The veteran status of the VA staff was not a pull factor, as might be expected. Not surprisingly, VA staff who were considered to be civilians were seen as employees simply collecting paychecks. Surprisingly, doctors who acted as if they were in the military were found to be offensive and hostile, and also pushed the participants away from the VA.

### *Push/pull tensions*

Push/pull tensions are defined as a strains or pressures that occur when opposing push and pull forces interact upon an individual seeking care at the VA. Push/pull tensions arose from conditions that could both draw homeless veterans toward the VA and drive them away. Pull factors attracted homeless veterans to the VA. In contrast, push factors drove them away from the VA or made use difficult or uncomfortable. Tensions could arise because the same condition could have elements that gave rise to both push and pull forces. Tension could arise because of the competing nature of two different conditions.

Tension could develop between the push force of negative perceptions and poor reputation of the VA and the pull force of veterans' negative perception of their own health. The participants avoided the VA due to the push force of negative perception and poor reputation of the VA. The reputation of the VA as a bureaucratic and teaching institution and the perception of the VA as being interested in profit and providing preferential care were very strong forces that pushed participants away from the system. These push forces were weakened by the stronger pull forces of perception of one's poor health that required acute medical treatment. As one participant stated it,

Because usually, like I say, I got to be ready to die to go. . . . And I was - I felt like I was going to die. I said, "This is it. I'm all swollen, my legs are swollen from the knees down - all swollen, and I've had that a long time." And I said, "Now, I'm really sick," and I said, "You got to go to the veterans' hospital." (Participant 12)

Tension could occur with the pull factor of deserved benefits and the push factors of secondary insurance and positive perception of health. Participants are drawn to the VA because they believe that they have earned and deserved benefits due to their military service. The pull force of deserved benefits was strongly opposed by the push force of secondary insurance. Participants usually received secondary insurance from employment they had prior to becoming

homeless. The force of secondary insurance was a lot greater than the force of deserved veterans benefits. As a result, those participants used non-VA services almost exclusively when they had secondary insurance. They could be pushed and pulled back and forth between the VA and non-VA facilities as dual care patients, using the VA for specialty services and the non-VA clinic for primary care

High expectations for the level of care/services provided by the VA and the reality of dealing with a bureaucracy were pull and push factors that clashed with each other. Participants were pulled to the VA because they believed that they were entitled to medical care because of their military benefits and as a result had high expectations. However, the bureaucracy of the VA was a factor that pushed some of them away. The large size of the VA was seen as a hindrance to providing care, especially for non-life-threatening medical conditions. Because of the bureaucracy of the VA, homeless veterans developed a belief that the VA provided care for veterans with medical problems that were considered “major,” “severe,” or life threatening. Participants with “minor” or non-life-threatening conditions felt they were left to provide care for themselves.

Tension also arose between the pull force of high expectation for quality VA medical care and the push factor of negative perception of staff. Homeless veterans expected the “best” medical care and the “best” medical staff. These expectations were challenged when they faced VA staff who were confrontational, undependable, uncaring, and hostile. VA staff with these negative qualities drove the participants away from the VA.

Tension also developed between the pull factor of need for care due to major illness and the push factor of perception of provision of inadequate care. Homeless veterans tended to wait to seek medical care until they perceived that they had a major or life-threatening illness. When

they finally presented to the VA, they had to come to grips with the feelings of receiving inadequate care due to misdiagnosis, treatment without examination, and undertreatment. As a result of this negative perception, they thought about seeking care from non-VA providers. Participants also felt they received inadequate care due to providers not presenting the option of alternative therapies and lack of communication between various providers, but that perception did not push the veterans away.

The push and pull tensions led to feelings of unfulfilled expectations. Perceptions about the level of care that the VA provided could change due to the experience of receiving inadequate care. Examples of inadequate care included misdiagnosis, undertreatment, lack of alternative therapies, lack of communication, and treatment without examination. One veteran felt that he did not receive adequate care when he went to a VA doctor to get treatment for a back injury. The VA doctor had underdiagnosed the back injury as a strain, but a chiropractor showed the patient that his spine was misaligned and treated him accordingly, which relieved the problem. Another veteran complained about inadequate treatment from the VA for PTSD because he was only offered pills by the VA provider, and believed he did not receive proper treatment until he got advice from doctors who worked with his wife. Poor communication between providers of the VA also led to inadequate care. As an example, a homeless veteran was sent from his primary care provider to the ER with the expectation of being admitted for poorly controlled diabetes; instead, he was hydrated and discharged because there was no communication between the VA providers. Finally, participants also experienced inadequate care when they received medications without any examination.

Expectations of the quality of care of the VA medical services could change after engagement with the system. The changes in expectation could either push or pull the veterans

away. For example, some veterans do not expect care for “minor” or “non-life-threatening” illnesses based on their past experiences. They expected that they would not be satisfied with the care provided, and ended up treating themselves. The participants tried to avoid the push and pull tension exerted on them by the VA system. Their avoidance of the tension was a form of adaptation and resulted in outcomes including negative emotions, avoidance, and satisficing. On the other hand, a lack of tension did not require adaptation from the participants and it led to an unexpected outcome of altruism.

The push-pull tension produced the outcome of negative emotions, notably disappointment, disillusionment, and anger. Disappointment came from expectations of not getting care: “I was disappointed in the VA at that time. . . . So, why should I come back to you and ask you for some help, and I know damn well you're not going to give me the help that I need?” (Participant 5). Disappointment also came from not getting help from individuals who are supposed to provide help, and getting in trouble with the VA police: “I don't know what happened. All I know is that you go over there to get help from the VA, and there are people like that over there who their first response is call the cops.” (Participant 3).

Anger was an outcome of the push-pull tensions. For example one participant was angry about a system that subjected him to unnecessary psychological testing and was disillusioned about not getting care for a cyst on his back because he believed that the VA doctors held a wartime mentality like his mother. He commented about his mother who was a nurse who grew up in Holland during the Hitler occupation: “She always had this mentality about her – ‘oh, well, you're not bleeding to death. You're not injured enough. Shut your mouth and get back to work...’” (Participant 10). The built up anger of another participant was expressed when he told his story of being denied care. He stated: “We're not in the military anymore. You're not



punishing anything. As a matter of fact, shut your mouth or I'm going to send you to jail for abuse” (Participant 10).

Another negative emotion that developed from the pull-push tension was disillusionment, or the feeling of disappointment resulting from the discovery that something is not as good as one believed it to be. As one participant stated, “They [the VA] say we [the VA] give the best healthcare in the country. Well, if they provided the best healthcare in the country, then why do they still provide eyeglasses instead of laser eye surgery as a mandated principle?” (Participant 10). In addition, the participant complained about the expensive radiological work-up for him only to be denied surgery:

When I had my cyst. I went to the doctors at the VA for 18 months. They put me through MRIs, MRIs injected with radioactivity, CT scans with radioactivity - they put me through, I'm not kidding you, like, 25,000 dollars' worth of tests on my body and then refused to do the surgery. (Participant 10)

Participants also developed a sense of disillusionment from their observations of veterans outside the facility who appeared not to be receiving the care they needed: “A lot of the people outside the VA look like they have very, very bad mental problems. And I don't - it seemed like they weren't getting the care, you know, that they need” (Participant 4). Disillusionment also occurred when participants' medical conditions were misdiagnosed and as a result undertreated.

Avoiding the VA for care was an outcome that arose from pull-push tensions. Participants avoided the VA because of the perception that they would not receive care, especially for minor problems. This outcome stemmed from the negative perception of the VA going only after the “big fish” or veterans with major health problems and not providing care for veterans who were not “bleeding to death..., not injured enough,” and “can still walk.” Instead, participants felt like they were being admonished and felt like they were being told, “Shut your mouth and get back to work.” Avoidance of the VA was so extreme that many participants

considered going to the VA only as a last resort: “The only time I'm going to seek help with the VA is as a last resort, because I know that I'm in for a problem” (Participant 3).

Satisficing was another significant outcome that resulted from the tension between pull and push forces. By definition, to satisfice is “to act in such a way as to satisfy the minimum requirements for achieving a particular result” (“Collins English Dictionary - Complete & Unabridged,” 2016). In other words, the participants did the best they could and drew on their own resources. For example, they opted for self-care when they assessed that their illness was minor, as they expected that the VA would instruct them to provide care for themselves. They also sought advice on over-the-counter medications from pharmacists or obtained medical advice from non-VA physicians through family members who had a connection to healthcare. Another example of satisficing is shown when the participants show understanding for the shortcomings of the VA: “When you look at the volume that they deal with and the price, two thumbs up” (Participant 18).

Ambivalence was another outcome of the push-pull tension: “I'm ambivalent about the VA because you never know what you're going to get. You know, you hope that because of who they are, that the VA would be consistently - the quality of care at the VA would be consistently high standards” (Participant 3).

Tension did not occur when there was no opposing pull and push factors. The cumulative pull of forces of veteran status, need for care, and positive experience with the staff kept some veterans engaged in the VA. These veterans described the care provided by the VA as excellent and dependable, as they did not recall “ever being turned down.” Good experiences came from prompt and immediate care.

Altruism seemed to be an outcome of having a good experience. After participants

received good care from the VA, it was important to them that they help their fellow veterans get VA care. Being able to help another veteran was a sign of having good health for the veteran providing the help.

Participants developed a sense of altruism from positive experiences and were pulled back to the VA not only to get help for themselves, but to allow them to help other veterans.

### **Summary**

An underlying assumption of this study was that homeless veterans have a choice about whether or not to use VA services. However, study findings suggest that the participants did not really have a choice, as there is no choice for poor people. The participants got what they could get. Hence, the participants were exposed to tensions created by push and pull factors. The tension between push and pull factors could cause considerable distress and enhanced vulnerability in an already vulnerable group. Despite having benefits from the VA, they still had to draw on their own resources. In the end, the participants had to continue using the VA because it was the only choice available to them and they could obtain the care or services that they needed even though it caused tension.

In summary, these data suggest the following hypotheses:

1. Homeless veterans are pulled toward the VA by intrinsic desires and needs and perceived positive attributes of the VA.
  - a. The more pride a homeless veteran has in his/her military service, the stronger the pull to the VA and the higher the expectations for care.
  - b. The desire of a homeless veteran for more benefits and a sense of entitlement increases the pull of the VA and also increases expectations.

- c. If a homeless veteran perceives his/her health status to be poor, the greater the perception of need and the greater the pull of the VA.
  - d. Social programs pull homeless veterans into VA care.
  - e. Homeless veterans' high expectations of VA care pull them into the VA.
  - f. Positive experiences with the staff maintain the pull of homeless veterans into the VA.
2. Homeless veterans are pushed away from VA services by internal forces and negative attributes and experiences with the VA. The following push veterans away from the VA:
- a. Secondary insurance providing other care options.
  - b. Negative views or experiences with the military.
  - c. Perceived lack of medical need (i.e., perceived good health).
  - d. Negative reputation of the VA.
  - e. Long waits and a perception of the VA being a large bureaucracy.
  - f. Experiences with uncaring and confrontational staff are a strong push.
3. Strong push/pull tensions produce various outcomes.
- a. Lack of tension results in perception of good care and keeps the veteran engaged and satisfied with VA medical care.
  - b. The veteran has no choice except to use the VA and has high expectations. The higher the expectations, the more tension created by the push/pull and the more likely outcomes of encounters will be negative (e.g., anger, disillusionment, disappointment).

- c. All other things being equal (e.g., no strongly negative encounters), if the veteran has no choice except to use the VA and has a strong perceived medical need (perceived poor health), satisfying is a likely outcome.
- d. If the veteran has relatively low perceived medical need (perceived good health) and experiences or perceives the VA as a bureaucracy or as having a negative reputation, the likely outcome is avoidance.
- e. High expectations of VA care and negative perceptions of staff lead to negative outcomes (e.g., anger, disillusionment, disappointment).
- f. High perceived need and perceptions of inadequate care lead to negative outcomes (e.g., anger, disillusionment, disappointment).

These hypotheses are based on the GT categories and are identified as push, pull, push-pull tensions and outcomes.

## CHAPTER 6: DISCUSSION

The objectives of this GT study were to understand homeless veterans' social experience of using VA healthcare services. This population, unlike the general homeless population, is eligible for medical benefits. Further, the researcher sought to construct a substantive GT that described and explained their experiences. The findings indicate that most participants had used the VA for medical services and most used the VA services as the only or main source of care, as generally there is no choice for poor people. This reasoning, however, contradicts the underlying assumption of this study, that homeless veterans have a choice about whether or not to use VA services. The conceptual themes of "pull," "push," "push-pull tension," and "outcomes" emerged from the analysis of the data to explain homeless veterans' experiences of using VA healthcare services. Although the findings are generally compatible with previous studies on the general homeless population, there are several areas in which they differ. In addition, the findings are limited and restricted to homeless veterans in Skid Row. This chapter describes the findings of this study and its fit with the literature on use of VA services and extant theories about healthcare use, the limitations of the study, and the implications for practice, policy, and future research.

### **Fit of the Findings with Extant Literature**

#### ***Factors That Pull Homeless Veterans to the VA***

In this study, the factors that pulled participants to the VA include the following:

- positive feelings about the military
- self-entitlement or feelings of deserved benefits
- need for care due to poor perception of health
- perception of VA providing quality medical care

- VA connection through social programs for the homeless.

The pull factor to the VA of feelings of self-entitlement or deserved benefits is consistent with findings from literature on the general veteran population. Perception or actual physiological need for care as a pull factor to the VA did not fit in the current literature. Some of the unique pull factors identified in this study and not in literature include expectation of the VA providing high-quality medical care and feelings of pride about the military.

Feelings of deserved benefits as pull factors to the VA has been discussed in a study by Damron-Rodriguez et al. (2004) on the perceptions and expectations of veterans about the VA healthcare experience. One of the themes identified in the current study was the perception that VA healthcare is a deserved benefit resulting from participants' service in the military. The veterans believed that benefits should be commensurate to their service. This was not found with the Damron-Rodriguez and colleagues (2004) study, but the qualitative methodology used in that study was focus groups and the present study used individual interviews. Although all the participants were veterans in the Damron-Rodriguez (2004) study, they were not homeless like the participants in the present study. Despite the differences in sampling and design, the expectation of benefits as entitlements earned by their service was expressed by homeless veterans in this study.

Although the need for care has been examined in several studies on homeless veterans (Applewhite, 1997; Nyamathi et al., 2004; O'Toole et al., 2003; O'Toole, Johnson, Redihan, et al., 2015), the finding of the pull, or predictor of use, of the VA services due to the need for care or perception of poor health has not previously been established in the literature about homeless. Several studies have explored homeless veterans' expressed and perceived medical and mental health problems, including chronic health problems, substance abuse, psychosocial challenges,

and clinically diagnosed problems (Applewhite, 1997; Dunne et al., 2015; Gelberg et al., 2000; Nyamathi et al., 2004; O'Toole et al., 2003; O'Toole, Johnson, Redihan, et al., 2015).

Surprisingly, one of these studies found that homeless veteran men were less likely to perceive their health as fair/poor (8%) compared to nonveteran homeless men (19%) (Nyamathi et al., 2004). The only study to find high illness level to be a predictor of VA use was completed in a sample of the general veteran population (Rosenheck & Massari, 1993). The present study showed that homeless veterans' perception of illness level is important in use of medical care.

The present study's findings of a strong pull of the participant to the VA based on his strong pride in the military service is a factor that was not identified or explored in previous studies. The most similar study explored the relationship of military service on outpatient care use among racial/ethnic groups in VA medical centers (Harada et al., 2002). In that study, race-specific military service effects on outpatient care utilization in the VA were examined using data from the 1992 National Survey of Veterans. The investigators found that race and the veteran's wartime military service affected VA outpatient care. Specifically, African Americans were 3.7 times more likely than White veterans to use VA outpatient care. In addition, veterans discharged from the military for medical reasons were less likely to use VA outpatient care (odds ratio = 0.76) in comparison to veterans discharged at the end of their normal terms. Hispanics who were discharged for similar medical reasons as White veterans were 5.3 times more likely to use VA outpatient care. Finally, veterans from the Korean conflict and mixed war period were more likely to use VA outpatient care than World War II veterans. The study population consisted of 4,791 male veterans and differed from this present population because they were not homeless. Unlike the present study, Harada and colleagues (2002) did not explore the variable military pride or positive feelings about the military.



The finding of the present study that homeless veterans who had lost or been denied benefits are pulled to the VA to increase military benefits runs counter to the studies on healthcare service utilization among U.S. veterans who were denied VA service-connected disability compensation (Laffaye, Rosen, Schurr, & Friedman, 2007; Sayer, Spont, DB, Clothier, & Murdoch, 2008; Spont, Sayer, Nelson, & Nugent, 2007). Laffaye and colleagues (2007) reviewed seven studies that examined VA healthcare utilization among veterans seeking VA disability compensation for PTSD. They found that “awarded” veterans were more likely to use VA medical and mental healthcare than “denied” veterans. Another study examined the relationship between VA disability compensation award status and VA healthcare disability compensation claims between 1997 and 1999 (Spont et al., 2007). The investigators found no difference in post-claim use of VA medical care between the “awarded” and “denied” veterans, but found greater pre-claim use of VA mental health services in the awarded group.

Finally, in a study that examined factors that predicted choice of providers among homeless veterans with mental illness (Gamache, Rosenheck, & Tessler, 2000), the main predictors of VA service use were those who received VA benefits that gave them priority access to VA services and those who lived near the VA medical center. The present study shows that desire to increase benefits in veterans who have lost some of their benefits is a factor pulling homeless veterans into VA use.

The findings that social programs for homeless veterans pulled the study participants into VA care is not consistent with findings of a previous study on the impact of VA outreach and residential treatment program for homeless mentally ill veterans on utilization of VA healthcare services (Mares, Kaspro, & Rosenheck, 2004). That study explored the effect of a residential treatment program prior to entry into supportive housing. The VA Supportive Housing Program

provided ongoing case management to homeless veterans placed into transitional and permanent supported housing settings in the community. Unlike the findings of the present study, the study by Mares and colleagues (2004) found that service use did not increase in homeless veterans in supported housing programs.

The pull of the VA based on high expectations of homeless veterans has not yet been evaluated. A recent study on the experience of primary care among homeless individuals with mental health conditions used the Sofaer and Firminger's Patient Perceptions Model that included the variable called "patient expectations" (J. G. Chrystal et al., 2015) However, high expectation was not one of the variables that was studied or found to have a relationship with service use (J. G. Chrystal et al., 2015). The study by J. G. Chrystal et al. (2015) was focused on predictors of a positive experience and identified a site offering tailored service design for the homeless, perceived choice among providers, and current housing as predictors for primary care use. The findings of the present study identified caring staff as an important factor for a positive VA experience.

In summary, this present study identified many unique pull factors that have not been found in previous studies. First, a factor that has never been investigated in homeless veterans that may explain use was military pride or positive feelings about the VA. If the VA is concerned about improving care for homeless veterans, they may need to explore and foster military pride to increase use.

Secondly, this study identified that homeless veterans also viewed healthcare as a deserved benefit, as found in a previous study on the general veteran group, and it was an important factor that pulled them to the VA.

A third factor that this present study also identified was homeless veterans using

healthcare based on self-assessment of their health or need for care. An interesting finding was that many of the participants considered themselves healthy despite having chronic illnesses. Understanding how homeless veterans assess their health may be important in understanding their use of medical care and possible interventions. The pull of decreased or lost benefits is a fourth factor that was identified in this study. This is an area that needs to be explored, as use of VA services may be impacted for non-medical use by homeless veterans who think it will help increase their benefits. The fifth pull factor is connection to the VA through social programs for the homeless. Two of the sites where I recruited participants had a connection to the VA through on-site care-manger/liaison to the VA, a service that seemed to provide the veterans with better access to the VA. The VA may need to make more connections with homeless programs to facilitate access to care for homeless veterans. Lastly, the expectation of homeless veterans for high quality medical care was an important pull factor that was identified because in order to improve care it is important to understand the expectations that need to be met.

### ***Factors That Push Homeless Veterans Away From the VA***

In this study, the factors that pushed participants away from the VA include the following:

- Negative military experience
- Secondary insurance
- Positive self-assessment of health
- Negative reputation of the VA
- Negative experience of with VA
  - Long waits
- Negative perception of the staff

The push factors of secondary insurance, long waits, negative perception of staff, and negative reputation of the VA have all been found in several studies. The finding of secondary insurance as a factor that pushed participants away from use of VA care has been suggested in two studies that showed lack of insurance was a predictor for VA use (Rosenheck & Massari, 1993) and dual use of VA and non-VA services (Borowsky & Cowper, 1999). The study of dual use of VA and non-VA care focused largely on use of Medicare services by VA users, primarily use of inpatient care. Borowsky and Cowper (1999) focused on outpatient care and found that dual use was common among veterans with Medicare, with any type of insurance, and who had previous dissatisfaction with VA care. This present study results are in line with the finding of these studies.

The finding that negative views or experiences with the military push veterans away from the VA has not been studied as a factor predicting use of VA care. Harada and colleagues (2002) conducted the only study that found race and the veteran's wartime military service affected VA outpatient care, and the findings again showed veterans discharged for medical reasons were less likely to use VA outpatient care. Being discharged from the military could be viewed as a negative experience. The present study found that perception of one's military experience can play a role in using VA services.

In the present study, a negative military experience, particularly during wartime, pulled veterans away from the VA. A study using data from a 1987 national survey of veterans examined the relationship between wartime military service and utilization of VA healthcare services (Rosenheck & Massari, 1993). The authors of the study found that veterans with war-related military experience showed a distinct affinity for VA services. Unlike the present study, Rosenheck & Massari (1993) did not distinguish between positive and negative military

experience, or how positive experience increased likelihood of VA use. The subjects in their study were all veterans but not homeless.

The finding that better perceived health status seemed to lower the perception of need and push participants away from the VA has yet to be explored. Several studies in which investigators examined the need for care in homeless veterans who rated their health as poor (Applewhite, 1997; Nyamathi et al., 2004; O'Toole et al., 2003) also provided insight on homeless veterans who perceived their health to be good. The author of one of these studies found that homeless veterans were less likely to perceive their health as fair/poor (8%) compared to nonveteran homeless men (19%) (Nyamathi et al., 2004). Nyamathi and colleagues also found that homeless veterans more often reported having a regular source of care (57%) compared to their counterparts (36%). Although that study showed that homeless veterans are more likely to have a regular source of care, it didn't show a connection between perception of good health and use.

Lower perception of need was also discussed in two studies on homeless veterans (Dunne et al., 2015; O'Toole, Johnson, Borgia, et al., 2015). Dunne and colleagues (2015) found that homeless veterans reported a higher percentage of unmet needs related to addiction treatment compared to nonveterans; however, homeless veterans reported having lower unmet medical care needs than nonveterans. That study showed that veterans whose homelessness was caused by alcohol or drug use or incarceration had higher unmet needs than veterans whose cause for homelessness was economic (no job or money) (O'Toole, Johnson, Borgia, et al., 2015). In addition, veterans who rated their health status as fair or poor and reported cocaine use also reported having a higher need for care (O'Toole, Johnson, Borgia, et al., 2015). A possible reason for lower need for medical care was explained by having access to healthcare benefits

through the VA (Dunne et al., 2015).

The findings that the negative reputation of the VA pushed homeless veterans away from the VA was touched upon in a study on general veterans' perspectives of the accessibility and acceptability of VA healthcare (Damron-Rodriguez et al., 2004). Damron-Rodriguez and colleagues found that veterans considered the VA as a last resort because of the welfare stigma. Veterans feared that the quality of VA care was low because it was a program provided by the government as a charity. The participants in Damron-Rodriguez and colleague studies were all veterans but not homeless.

The finding that long waits push homeless veterans away from the VA has been reported from patient satisfaction research (Sandoval, 1995). In focus groups, veterans complained about long waiting times for appointments and delays in getting follow-up specialty appointments. The complaints of long waiting times seems to have persisted after more than 20 years despite the efforts of the VA to improve the quality of care.

The finding of uncaring and confrontational staff leading to a strong push away from the VA has been identified in a few previous studies (Applewhite, 1997; Damron-Rodriguez et al., 2004; O'Toole, Johnson, Redihan, et al., 2015). The homeless veterans in the Applewhite study identified insensitive service providers as a barrier to service use. Specifically, their experiences included lack of respect for their human dignity, apathy, indifference, callousness, service-connected labeling, degrading comments, and put downs. Similarly, the homeless veterans in the O'Toole and colleagues (2013) study identified lack of trust of VA and doctors and being treated poorly as reasons for avoiding care. An interesting finding in the present study was that staff, who acted like they were in the military were perceived to be abusive.

### ***Push-Pull Tensions and Outcomes***

Although push-pull tensions and their outcomes are not described in the research literature, these tensions are congruent with extant theories that relate to human behavior and healthcare utilization. The following section considers social exchange theory, CST, and the Anderson Behavioral Model for Vulnerable Populations.

Social exchange theory was introduced by prominent sociologist George C. Homans to explain elementary social behavior associated with exchange of goods and rewards. Homans defines elementary social behavior as behavior between two people that is based on rewards (or punishments) for the behavior; the exchange is direct rather than indirect, and it is the actual behavior and not the norm of the behavior (Homans, 1961). In the present study, participants and the VA were involved in an exchange of goods and rewards during interactions involving healthcare. The pull toward the VA and having positive outcomes could be considered rewards, whereas being pushed away from the VA and having negative outcomes could be considered punishment.

Social exchange theory consists of five propositions (Homans, 1961). The first proposition, the success proposition, states that behavior that generates positive consequences is likely to be repeated. The second proposition, the stimulus proposition, states that behavior that has been rewarded on such occasions in the past will be performed in similar situations. The third proposition, value proposition, states that the more valuable the result of an action, the more likely the action is to be performed. The fourth proposition, the deprivation-saturation, states that the more often the person has received a particular reward for an action, the less valuable an additional unit of that reward. Finally the fifth proposition specifies that people react differently to different reward situations. For example, people become angry and aggressive when they do

not receive what they anticipate. When Homan refined these original propositions a few years later with the normative concept of distributive justice, he noted that feelings of anger also occurred when it is perceived that a fair rate of return (i.e., one that is equivalent to the situation) is not provided.

The five propositions of the social exchange theory are useful in understanding some of the findings in the present study. The success proposition can be applied to participants who had positive experiences with the VA, such as being diagnosed with a previously unknown condition and being successfully treated for it. These individuals were likely to keep coming back to the VA (repeated behavior). On the other hand, participants who did not find use of the VA rewarding were less likely to repeat the behavior of seeking VA care. In fact, one of the findings of this study was avoidance of the VA because of participants' perception that they would not receive care, especially for minor health problems, and the negative perception that care was only provided to veterans with major health problems.

In this study, the stimulus proposition was exemplified in participants' choice of self-care for minor ailments. Participants learned that the behavior of using VA services for care often did not meet their expectations. Instead of receiving care at the VA, they were given self-care instructions. As a result, when the similar situation of having another minor ailment arose, self-care was chosen over the use of VA services because self-care was rewarded on other occasions in similar situations.

The value proposition, which states that an action is more likely to be performed if the result of an action is considered valuable, is represented in participants' perceptions about the care they received from use of the VA. Participants were pulled to use VA care because they perceived that they deserved benefits and their expectation of quality medical care imparted



value to the action of using it. However, the value of VA use could be lost when participants' perceptions changed as a result of negative experiences due to long waits for appointments and confrontational and uncaring staff. In such cases, participants minimized their use of the VA.

The deprivation-saturation proposition may explain the reason that participants who had lost VA benefits demonstrated a higher propensity to use VA services. According to the fourth proposition, the more often the person has received a particular reward for an action, the less valuable an additional unit for that reward. When deprivation occurs, the reward becomes more valuable. Participants who lost veteran benefits or had them reduced were an example of deprivation in this study. As a result of the reduction in benefits, use of the VA seemed to gain value and participants used it more in hopes of increasing their benefits.

Finally, the fifth proposition, which specifies that certain emotions are triggered in response to different reward situations, is very apparent in this study. The proposition asserts that people become angry and aggressive when they do not receive what they anticipate. Anger was certainly one of the outcomes in this study when participants attempted to use VA services and did not receive care that was expected. Other negative emotions included disappointment, disillusionment, and ambivalence. Homan's work suggests that when individuals have little choice about continuing the exchange (i.e., are literally trapped), negative outcomes are more likely.

The findings of this study are also consistent with Critical Social Theory (CST), the philosophical underpinning of this study. CST was chosen as the theoretical lens for this study because it was assumed that the vulnerable population of homeless veterans was not receiving care from the government, and CST allows for identification of structural factors that might explain why. Findings of this study showed that a majority of the participants received care from

the VA because they did not have any other options, but the use of VA services actually led to a build-up of tension that resulted from the conflicting factors that participants had to grapple with. Lack of choice in healthcare and tension added up to increased vulnerability in this already vulnerable population. This increased vulnerability widened the divide between the dominant U.S. government and the vulnerable homeless veteran population.

The confrontation with VA Police was one of this study's findings that is consistent with the use of CST to expose hidden relations of domination and power inherent in fundamental social structures, in this case, the VA. The power dynamics between the VA police and the participants was one-sided because the VA police represented a position of power in the VA institution. The VA police would use their position to harass participants for washing up in the bathroom to get ready for an appointment and accuse the participants of violating regulations that may not exist.

To assert his power, one VA police officer made threatening motions of reaching for his weapon when trying to escort the patient out of the facility, even though the participant was elderly and unarmed. In addition, the VA police also seemed to side with the VA staff when there was a dispute between the participants and staff. When the VA police and staff come together collectively, the participant is put in a more vulnerable position simply because he/she is outnumbered. It can be even more distressing to a veteran when the staff who confront him/her with the police are patient advocates, who are supposed to help veterans. The veterans are literally driven out by aggressive VA police and staff.

The VA bureaucracy is another example of a fundamental structure that is exposed in this study, and is consistent with CST. Participants described bureaucracy in the VA as being too heavy and too large to effectively provide care for veterans with minor problems. This

realization is in line with the memo mentioned in the literature section from Deputy Under Secretary for Health for Operation and Management. The memo discouraged marketing activities to enroll veterans in 2002 because “demand for healthcare exceeds our resources.” The participants’ feelings about the VA being too large to provide care goes against the VA’s commitment to taking care of the healthcare needs of its veterans.

The confusion about veteran benefits arises from another fundamental structure that creates an inherent imbalance of power between the participants and the government. The government is the dominant entity that controls and grants the distribution of benefits to the participants. The participants assume the dependent role, accepting what is given to them. The process can be confusing and capricious, as benefits can be granted entirely, or a percentage may be taken away and then later returned in part. An interesting finding in this present study was that the confusion extended to the effect or influence of the Affordable Care Act, or Obamacare, on veteran benefits. The Affordable Care Act was seen as forcing the participants to use VA care, leaving them no option to use services outside the VA, and it was also seen as forcing the government to provide care for the participants.

Another possible CST issue is the recommendation given to participants to provide self-care for themselves for minor illnesses. Self-care recommendation for minor illnesses reflects insensitive disregard for participants’ lack of or limited self-care resources. The participants in this study should have received some accommodations through treatment plans based on their homeless status. However, this was not addressed or mentioned in their personal accounts.

Uncovering these truths from the findings of this study is a useful emancipatory result of employing CST. The aim of this study was to expose the injustices associated with decreased or lack of access to VA healthcare from the perspective of homeless veterans. Instead, it found that

vulnerability could occur even as a result of VA use because of the tension that homeless veterans experienced. This knowledge will hopefully strengthen the commitment of the government to take care of the healthcare needs of the veterans.

This study's findings can also be understood using the Anderson Behavioral Model for Vulnerable Populations, which explains that use of medical services is a function of the participant's predisposition, factors that enable or impede use, and the need for care. In the current study, the findings fit, conflict with, and add to the model to explain use of VA medical services by the participants.

For the Behavioral Model's predisposing variables, beliefs about health services, which were important factors affecting use, were a significant finding in this study. Beliefs about health services included perceptions about VA care. The expectation that the VA would provide a high-level of care was a surprising finding. This is contrary to previous studies that have identified the negative reputation of the VA because of stigma as a welfare program and as a result, expectation of poor care (Damron-Rodriguez et al., 2004).

In this study, the main personal characteristics of the participants that should affect use, as posited by the Behavioral Model, were veteran and homeless status. Even though all the participants were veterans in this study, veteran status in and of itself did not predict use of VA services. However, participants' feelings about their military experiences played a significant role in use of VA. Veterans who took pride in their military service were more likely to use the VA than those who had no military pride. The military granted all the participants benefits. However, the amount of benefits varied and participants found eligibility requirements confusing. The findings of this study seemed to show that for participants, having fewer benefits led to higher use, with the goal of having part or all of the benefits reinstated.

Most participants did not believe that their homeless status influenced their use of healthcare. Although homelessness did not directly lead to use of the VA for medical care, many participants came to the VA or homeless programs associated with the VA for other reasons when they became homeless. Once the connection to the VA was established, it led to use of medical care.

In this study, secondary insurance would fall under the category of enabling characteristic in the Behavioral Model of Vulnerable Populations. Possessing insurance should be considered a major personal resource that predicts use of healthcare. In this study, secondary insurance inhibited use of VA care and dual care. Instead, it usually led to use of non-VA medical care. In some cases, dual care did result from having secondary insurance, with participants using both VA and non-VA medical services. The concept of dual-care can be added to the list of different types of health services specified in the Behavioral Model, such as preventative care, ambulatory care, inpatient care, alternative healthcare, or long-term care.

Under the Behavioral Model, social programs for homeless veterans are an example of community resources that would fall under the enabling characteristic that led to use. The findings of the present study found that service use increased in homeless veterans who utilized supported housing programs. The increased use of VA services is connected to these supported housing programs.

The perception or actual physiological need for care was a very important finding in this study. The participants' perception of illness level was important in their level of use of medical care. The participants who viewed their health as good had a decreased perceived need for care that resulted in lower use of the VA. Higher utilization of VA healthcare services occurred when participants had acute or more serious medical conditions. The findings of this study are

consistent with the pattern of homeless individuals using the ER when acute problems arise. It is important to educate homeless individuals about using healthcare services for preventative care, and it may also be helpful to understand how they rate their health.

There is a paradox in the findings that addressed two of the specific aims of this study. In the findings for Specific Aim 1 (SA 1), the experiences were mostly positive, from my evaluation. However, the GT model that was developed to meet SA 5 described mostly negative experiences. One explanation is that the VA is actually starting to meet its goal to provide good care for veterans. Another more plausible explanation for the contradictory findings is satisficing. From a broad perspective, the participants in the study made excuses for the negative aspects of the VA, and as a result, their initial reports appeared mostly positive. A closer and more critical look at their accounts actually led to identification of numerous problems with the VA.

### **Limitations of the Study**

There are several limitations inherent in the design of this study. First, the researcher's dual role as a clinical provider for the VA and researcher for UCLA may have influenced data collection and analysis. My connection to the VA may have motivated some participants to withhold important information, or to express favorable comments about the VA as a result of social desirability.

In addition, these results cannot be generalized to all homeless veterans. The sample was small and nonrepresentative, as all participants were homeless veterans from a Skid Row area and most were from social programs associated with the VA. In addition, they represented a sample of homeless men who had used VA medical care and were willing to talk about their experiences with the VA medical use. They may differ in important ways from other homeless

veterans who have not used the VA or who are not comfortable discussing their personal experiences. As female veterans were excluded in this study, the findings may not transferable to female homeless veterans.

Another limitation of this present study is the potential bias from the sample selection. A majority of the study sample was selected from two recruitment sites, which are transitional housing programs associated with VA health services. Because of the association of these venues with VA health services, the findings of the themes of access and high satisfaction, or positive experience, from a majority of the sample may have been overestimated. As a result, the findings cannot be generalized to homeless veterans who do not have the same access to VA health services through such programs. A more representative sample should include homeless veterans without access to VA associated programs in order to increase the generalizability of the results of this study.

The findings of the study are also limited due to possible unstable mental illness in the group. Because of the high risk for substance abuse and mental illness in the study participants, the researcher assessed the participants for unstable mental illness or active drug use based on appearance or self-report. If participants appeared or self-reported to be intoxicated or to have active mental illness or intoxication, they were excluded. However, assessments based on appearance and self-report are not always reliable, and the possibility of unstable mental illness had to be considered in the analysis.

The present study is also subject to the limitations of anachronism due to the nature of self-report and open-ended questions. Anachronism is “an error in chronology in which a person, object, event, etc., is assigned a date or period other than the correct one” (“Collins English Dictionary - Complete & Unabridged,” 2016). One of the inclusion criteria was that

participants have a perceived need of medical care in the previous year so that a contemporary account of their healthcare experience could be obtained. However, the open-ended questions did not specify a timeframe for the past year. As a result, some of the accounts of their experiences with use of VA services may have included both current and past experiences, and the identified factors for healthcare use of VA services may not be reflective of the current situation, in other words the factors may be anachronistic. Although the factors identified by participants may be anachronistic if their past experiences continued to affect their current use of healthcare services, they are still relevant and included in the study.

These inherent biases were considered during analysis. Subsequent studies of homeless veterans and their use of VA health services are needed to test the accuracy of the findings and their generalizability to other homeless veteran populations.

### **Implications of the Findings**

The findings of the current study increased the understanding about the nature of the experience of homeless veterans with the VA healthcare system, healthcare providers, and staff. This study demonstrated that use of VA services was very common in this group, which contradicts the underlying assumption that homeless veterans were underutilizing VA services. However, the widespread use of VA services may not be a result of the VA being the provider of choice but rather a result of this population's limited or lack of choice due to a lack of resources. Despite the widespread use of VA services among the participants, the study results indicated that homeless veterans still experienced tension from use of VA services due to tension between pull and push factors that influenced use or no use of VA services. Understanding the pull and push factors that motivate homeless veterans to use VA services, the tension that emerges from interplay of these factors, and the outcomes are important in improving the care of homeless



veterans. Specifically, pull factors, such participants' pride in their military service, desire to affiliate with other veterans and give back, and high expectations for quality care, need to be promoted to improve the experience and care of homeless veterans, while push factors, such as insensitive staff, bureaucracy, and persistent negative perceptions of the VA, need to be minimized.

These findings can also be used to improve policy on healthcare for homeless veterans. Past studies have shown that homeless veterans have complained about insensitive and uncompassionate staff, and the findings of this study revealed that the treatment of homeless veterans may not have improved. Homeless veterans deserve the basic human right of respect when seeking care. Providers and staff may still lack the education and support necessary to understand the unique needs on the population. On an institutional level, the VA needs to continue to provide staff with customer service and sensitivity training that is unique to the homeless veteran population in order to address these longstanding complaints by this population.

The study findings can also raise awareness of homeless individuals' unique problems in effecting self-care for minor problems and chronic conditions. Strategies for equalizing the power disadvantage in an already vulnerable group need to be identified. The VA has to address the policy paradox about how much and what kind of commitment they have for healthcare to homeless veterans if this population's unique circumstances and the VA's limited ability to provide care are not considered.

Even though homeless veterans have access to healthcare, the tension and frustration from use of VA services can lead to increased vulnerability, and these tensions need to be addressed in order to minimize them and thereby decrease vulnerability. The study results can

inform healthcare providers to become more aware of tensions that occur for homeless veterans from their use of the VA healthcare system. Although this study's result cannot be generalized beyond the current sample, the pull-push tensions identified from the data analysis should be considered in the case of veterans with mental health diagnoses who may experience similar pull-push tensions. These tensions may also lead to satisficing, negative emotions, and ultimately, avoidance of healthcare use, thereby increasing vulnerability. It is also possible that such tension may contribute to the high rates of suicide in this population. An awareness and identification of the unique pull-push tensions in veterans with mental illness may be instrumental in mitigating the high rates of suicide in this group.

### **Recommendations for Future Research**

The next step in this research would be to empirically test the hypotheses generated in this qualitative study with a larger sample. A quantitative study of the push-pull tension hypothesis would lead to additional insights to direct policy. Additional future research should focus on interventions that improve the healthcare experience of homeless veterans. Health service research can contribute to improving care for homeless veterans.

Another area of research that can be explored is to get a better understanding of the processes that homeless veterans use in deciding to use self-triage and self-care rather than seek care from a provider. This current study found that homeless veterans avoided healthcare when they assessed that they were healthy. In addition, they would opt for self-care when they believed that their illness was not urgent. As homeless veterans have a high prevalence of medical, mental, and substance abuse problems, understanding this process would be helpful in improving the care of homeless veterans. Such a study could identify healthy and/or unhealthy decisions or behaviors in seeking care or providing self-care. In addition, such research could provide a

better understanding about how individuals with few self-care resources actually implement self-care activities “on the street.” Interventions could be identified and developed to educate or support patients to care for themselves appropriately. Homeless veterans have to be resourceful in order to survive the conditions they face, which includes lacking basic needs such shelter and food. Identifying their survival skill strategies, particularly in healthcare, can empower veterans to have a greater sense of control in their lives.

### **Conclusion**

In summary, GT methodology was useful in guiding the direction of this qualitative research on the social experience of homeless veteran use of VA care. From the findings of this current study, a GT was developed. The theory debunked the assumption that homeless veterans have an advantage over nonveteran homeless populations because of access to healthcare. Instead, the study found that use of healthcare can actually result in greater vulnerability because of the tensions that emerge from opposing pull and push factors that arise during use of VA services. It offers a new and unique perspective derived from the narratives of homeless veterans using VA services. Being aware of these tensions is important in improving the social experience of homeless veterans when using the VA. Homeless veterans who are satisfied with the care are probably more likely to have good continuity of care, leading to improved health for the individual and ultimately the community.

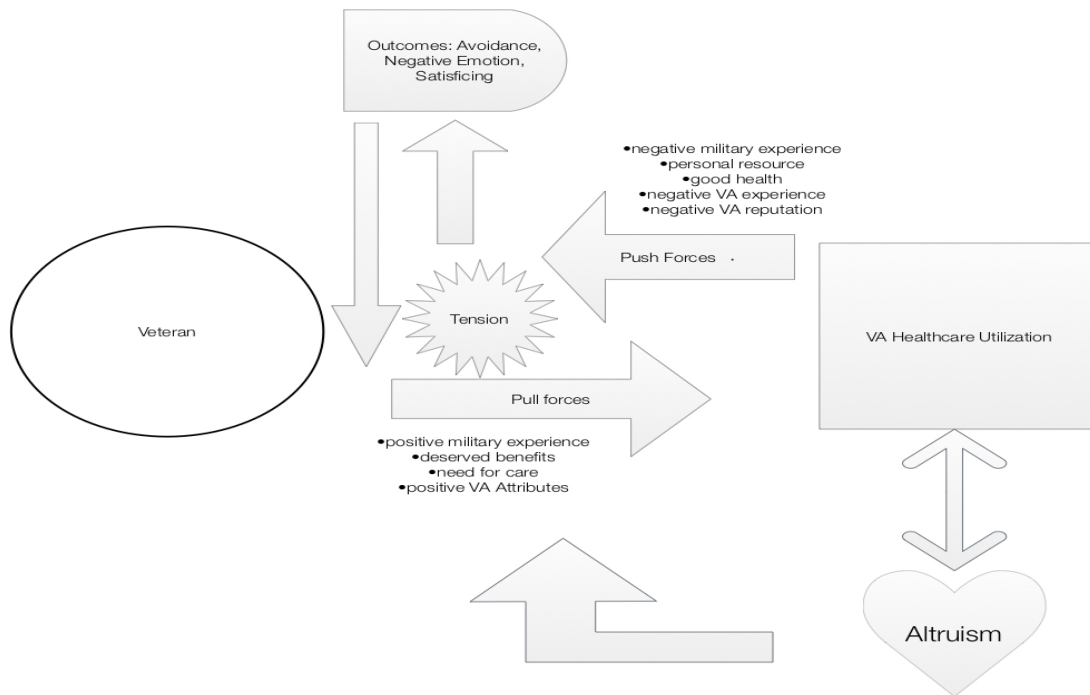


Figure. Push/pull tensions and outcomes.

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Table 1

*Age and Racial/Ethnic Profile of Homeless Veterans*

Age	N	%-age	Race/Ethnicity	N	%-age
20-29	1	6%	African American	6	33%
30-39	0	0%	Caucasian	4	22%
40-49	4	22%	French-Creole	1	6%
50-59	4	22%	Hispanic	1	6%
60-69	7	39%	Italian	1	6%
70-79	2	11%	Mexican-American	3	16%
			Puerto-Rican	2	11%

Table 2

*Length of Homelessness and Years in Homeless Veterans*

Length of Homelessness	%-age	N	Years-in-Service	%-age	N
< 1 year	33%	6	< 1 year	0%	0
1 to 1.9 years	17%	3	1 to 1.9 years	11%	2
2 to 2.9 years	22%	4	2 to 2.9 years	17%	3
3 to 3.9 years	11%	2	3 to 3.9 years	11%	2
4 to 4.9 years	0%	0	4 to 4.9 years	22%	4
>5 years	17%	3	>5 years	39%	7

Table 3a

*Positive ratings of experiences with VA health services*

Description of Experience	Experiences of Homeless Veterans	Participant
Discovery and Treatment of Unknown Medical Problem	“Okay, when I was put in the program, I discovered that I had very high blood pressure, and they [VA] actually wouldn’t let me in until I got my blood pressure lowered so I had to go over to the hospital.”	8
Unexpected Treatment	“A good experience...I had what is called a hemangioma, right on my eye. And I had it removed. They asked me, you know, how long have had that? I said all my life. And they said, well, okay, well take it off...I had no trouble with the surgery. It just happened quickly, and then I woke up in bed. You know, and they held onto me for, I think, two days. I went home from there. And it was all real easy.”	
Pleasant Staff	“All the people were pleasant. All the nurses were nice, actually.”	
Promptness	“They started giving me – they gave me a primary care physician, and they started giving me the prescribed drugs, and I started feeling better right away.”	
Good Personal and Observational Experience	“My experiences with VA has [have] been very good, not only personally, however, as well as from what I've seen.”	16
Improvement in Care	“I'll say if you had asked me this question maybe 10 years ago, I would have said, Be careful when you go to VA because the rumor was that it's a school for training doctors. And, you know, a doctor might say, ‘Oh, okay, you've got an infection.’”	
Eligibility/Access	“A good experience I’ve had obtaining my health service is not being denied - that I’m eligible.”	6
Consummate Professional	“I have a good attitude with the VA and the people in the VA as well, because they're very helpful. They are very comforting. Even if they cannot help you, they're very positive and they give you alternative paths to go to or apply to see some kind of medical attention.”	

Table 3a (continued)

*Positive ratings of experiences with VA health services*

Description of Experience	Experiences of Homeless Veterans	Participant
Unexpected Life-Saving Comprehensive Care	<p>“The VA? I'm very happy they - I had pneumonia, they saved my life. It was raining. I was going to die. They took care of me. They gave me everything. They gave me the medicine, and my legs were all swollen because I had bad water circulation - really bad. They gave me the socks that you put on - three pair of them, the skin-tight. And every - I tell you, I was in bad shape. And then, the woman from the social worker come over and said, go to building 402. We have a program to help homeless veterans get housing. And I already was waiting on San Francisco. They told me I might be a year before we're going to be able to get you a room.”</p>	12
Dependable	<p>“Oh no, I always got help from the VA. They never turned me down. Never. No, no, they've been very nice all the time, even with the Kwell and the Emilite cream for the people that got scabies. Never got turned down from the VA ever. Never. Never.”</p>	
Accommodating VA Police	<p>“And I told them, well, I'm sleeping right here where your building is. And the police know and it's okay.”</p>	
Excellent Care	<p>“So, I'm getting excellent care at [the VA].”</p>	13
Involved Medical Team	<p>“I got - well, all the people I deal with there, they know my medical problems, and my PA - even his nurse does. Everybody in radiology and neurology and pulmonary - all that.”</p>	
Personal Attention	<p>“And she was a great PA. She's not - I guess she's done now. But, she was great for a doctor. She called me up, asked me to take my blood pressure and give it to her, and stuff like that...on weekends.”</p>	
On-the-Spot or Prompt Care	<p>“I can't remember what x-ray they were asking for this time. Oh, it was when I went for my first hip x-ray. I went in to check on the date, and they said, ‘Oh, well, we can do that right now. Come on in.’ That's twice. Radiology over there in Sepulveda is something else. One time, I was scheduled for an MRI, they called me up on the phone because I'm over in building 45 and says, ‘Hey Mr. C, we've had a cancellation, and we know you're scheduled for the MRI. Do you want to - can you come down here?’”</p>	



Table 3b

*Mixed mostly positive ratings of experiences with VA health services*

Description of Experience	Experiences of Homeless Veterans	Participant
Outstanding Care	“Like I said, I have no complaints because you go in, and you're a veteran, and you receive outstanding treatment, you know, once you're there.”	2
No Complaints, Denial of Benefits	“The VA, I have no complaints about, except when I was trying to get my PTSD in the early days here. You know, I started - but the VA, other than that, they have been great here.”	
Location-Dependent VA Care	“So, I felt that I wasn't getting the treatment that I needed in Florida, or cooperation. And so, I decided to come back to California where I know we have good hospitals, and I will receive better treatment - the best treatment.”	
Great Care	“Well, the healthcare was great. My health right now is beginning to get back normal like it should be. But before, I had problems with my knee and my hip, you know. And these are some of the things that my doctor today - he's a real young guy, and he's doing a swell job...I wouldn't want another doctor, you know? And it's the God truth...I goes to the doctor once every four weeks, sometimes twice for the month if something serious happen to me, you know.”	5
Prior Disappointments	“I'll put it this way. I was disappointed in the VA at that time, you know...Come on, man. I need help. I need somebody to lock me up in this place, work on me, run me through some tests, stick some needles in me, give me some medication that I know are going to work...then he give me them pills? [unintelligible] the pills, I throw them right in front of the lawn...At that time, no. At that time, my wife was working at...She was a nurse on the second floor - the head nurse on that whole second floor. She got to talk to doctors there, and she was - they was giving her pills, and it was medicine - well, I don't know they - she come home, she got me - she used to shoot me with stuff, you know, and that helped me out a great deal.”	
Satisfactory	“Well, it's overall okay.”	7
Prompt Care	“Well, if I go early in the morning, you know - very early in the morning, before the time - I sort of, like, get in early, and that's a good thing, because I can do other things in the daytime...whatever I need to do before.”	

Table 3b (continued)

*Mixed mostly positive ratings of experiences with VA health services*

Description of Experience	Experiences of Homeless Veterans	Participant
Denial of Care	“The participant recalled one unsatisfactory event when he did not receive care for a “small cut” on his foot because he did not seek care immediately.	7
Trustworthy	“I just - you know, I trust the system to an extent.  Can't trust everything full heartedly, you know?”	11
Bureaucracy	“I trust it to an extent, and I realize it's a lot of bureaucracy involved - paperwork, and this and that, and they call themselves fixing the system, and the system is not going to fix itself.”	
VA Employees Exploiting the System	“Unfortunately, you got people who's working for the system who's dogging the system more than people who's trying to get the benefits out of the system.”	
Lack of Timeliness	“As far as the healthcare system, it could be a little bit more timely. Sometimes, they give me an appointment, and I show up, and the physician or the individual I have an appointment with is not there.”	
No Alternatives	“What would help me is to find alternatives to medication other than these pharmaceuticals. You know, don't get mad at me. I do think medical marijuana has its medicinal purposes”	
Life-Sustaining	“I'd probably be dead if I wasn't able to rely on the VA for healthcare... Well, I recently need to establish my eligibility because I suffered a stroke on Thanksgiving of last year. And I had another one two	15
Long Wait for Appointments	“I find the appointments are - getting an appointment - excuse me - is kind of slow. Not to get an appointment, but to make it, and then the appointment actually come - you have to make them - it might be three weeks to two months for some appointments. Like physical therapy and speech therapy - for what I need right	
Second-Hand Experience	“My brother's also a veteran, you know. He came home from the military, you know. And when he came home, he was all right for a bit. Then he was in a car accident. He got bad. And it turns	17

Table 3b (continued)

*Mixed mostly positive ratings of experiences with VA health services*

Description of Experience	Experiences of Homeless Veterans	Participant
Second-Hand Experience	<p>out he had gotten cancer, you know, and he was getting his treatment all at the VA. And, you know, they were very good. I used to take him down there all the time, you know. Because he couldn't - he couldn't walk. I had him in a wheelchair, you know. So, I used to take care of him. I came back from New York back then to, you know, take - help my mom with him because she couldn't pick him up or anything. So, you know, I took care of him, you know - or I helped my mom take care of him. And, you know, I was - I was fine with the VA and the treatment of him, you know. I thought the VA, you know, was pretty good, you know."</p>	17
Second Opinion from VA Due to Improper Care	<p>"They don't know - because there's a possibility that I may have to lose this leg - but, you know, I need to - I definitely want a second opinion on that. That's why I want to go to the VA, you know, and have them look at this leg and see, you know, what's really happening with it. And I'm counting on them doing the right thing, you know, and letting me know exactly what's what."</p>	17
Second Opinion from VA Due to Improper Care	<p>"They don't know - because there's a possibility that I may have to lose this leg - but, you know, I need to - I definitely want a second opinion on that. That's why I want to go to the VA, you know, and have them look at this leg and see, you know, what's really happening with it. And I'm counting on them doing the right thing, you know, and letting me know exactly what's what."</p>	17
Satisfactory Experience	<p>"They're [VA appointments] all satisfactory to me."</p> <p>That [initial diabetes mellitus diagnosis] was a scary experience, yeah. Yeah. Because they - because the - I guess the doctor that had seen me at the VA - he wanted me to be admitted and for them to start me on - on insulin. Injected insulin. But the doctors at the VA in..., they said no, they couldn't do that without the consent of the doctor that had seen me. That's what I was told. This was late at night when I showed up. The only thing they did was - what did they do? They just gave me water. They told me to drink water, lay down, and we'll check you in a couple hours</p>	18
No Complaints	<p>"They've [VA] taken care of me so far. I've heard other people complain but I - I don't have any complaints because I've always - I've always received medical attention that I believe was adequate to my - to my condition."</p>	

Table 4

*Negative ratings of experiences with VA health services*

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Negative	Overall negative experience with VA, and believed the VA forced psychosocial evaluations on every patient when it was not necessary.
Mostly Negative	Mostly negative experiences with the VA, stating that going to the VA was the last resort. His reasons were that he had a post-biopsy infection; he had difficulty getting a service connected disability for a facial fracture because the VA was calling it chronic sinusitis or allergies; he had negative encounters with the VA staff and VA police and he had needed to go to a civilian doctor for eye care. He'd had one good experience with treatment of a rash because the VA is accustomed to treating homeless veterans with skin problems.

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Table 5

*Participants' descriptions of health problems*

Perceived Health	Health Problems	Mental Health Problems	Alcohol or Drug Use
"Overall good health"	<ul style="list-style-type: none"> <li>Hepatitis C Virus (HCV)</li> </ul>	Post Traumatic Stress Disorder (PTSD)	
	<ul style="list-style-type: none"> <li>Prostate Cancer (CA) with chemotherapy</li> <li>Heart issues</li> </ul>		Substance abuse
	<ul style="list-style-type: none"> <li>Enlarged prostate</li> <li>Facial fracture</li> <li>Rash</li> </ul>		
		Depression related to divorce	Alcohol abuse
"Getting back to normal"	<ul style="list-style-type: none"> <li>Knee pain secondary to occupational injury</li> <li>Hip pain</li> <li>Heart problem related to drug use</li> <li>Transient ischemic attack</li> </ul>	PTSD	Drug use
"Good health"	<ul style="list-style-type: none"> <li>Concerned about health, especially prostate CA, due to age and family history of CA</li> </ul>		
"Overall good health"	<ul style="list-style-type: none"> <li>Suspected glaucoma</li> <li>Alternating foot pain</li> </ul>		
	<ul style="list-style-type: none"> <li>Newly diagnosed hypertension (HTN)</li> <li>Diabetes Mellitus (DM)</li> </ul>	Depressive disorder	Drug use
"Well rounded"	<ul style="list-style-type: none"> <li>Cyst on back</li> </ul>		
	<ul style="list-style-type: none"> <li>Multiple GSW to elbow, twice in the right leg, three in the left leg, three times in the stomach, one to the back of the head</li> <li>Right wrist fracture from accident during military service</li> </ul>	Anxiety Depression PTSD	

Table 5 (continued)

*Participants' descriptions of health problems*

Perceived Health	Health Problems	Mental Health Problems	Alcohol or Drug Use
“Pretty good health”	<ul style="list-style-type: none"> <li>• Scabies</li> <li>• Pneumonia</li> </ul>		
	<ul style="list-style-type: none"> <li>• Back pain</li> <li>• Pinched nerve</li> <li>• Hip pain</li> <li>• Memory problem</li> <li>• Chronic Obstructive Pulmonary Disease</li> <li>• HTN</li> </ul>	Depression	Meth-amphetamine use
“Pretty normal”	<ul style="list-style-type: none"> <li>• Eye drainage</li> <li>• Sinus</li> <li>• Coccyx removal</li> </ul>		
	<ul style="list-style-type: none"> <li>• New onset cerebrovascular accident</li> <li>• Hypertension</li> </ul>		
“Pretty good health for my age”	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• High cholesterol</li> <li>• High blood pressure</li> <li>• New onset pinched nerve in my neck that creates numbness all the way down my left arm related secondary to motor vehicle accident (MVA)</li> </ul>		

## APPENDIX A

### Interview Guideline

Date of Interview:

Start time/End Time:

Location:

Interviewee's ID#:

Age:

Ethnicity:

Dx:

#### **Broad Question:**

“Mr. (insert participant’s last name), I’m interested in understanding your experiences with health and healthcare. Tell me about your health and healthcare.”

Question 2: Describe where you go for routine check-ups or follow-up on medical conditions when you are not sick (*Specific Aim #2: Describe the health status that influence use of services*).

Prodding questions:

Tell me about your health medical conditions.

Tell me about how you use healthcare services to take care of your health.

**Question 3:** Please tell me about a good experience that you have had when trying to obtain healthcare. (*Specific Aim #1: Predisposing factors that promote use of VA healthcare services.*)

Prodding questions:

Many homeless persons are not veterans. Tell me about how your veteran status has helped you obtain healthcare?

Tell me about how your homelessness has helped you in obtaining healthcare?

Tell me how your attitudes about the VA enable you to obtain healthcare services

**Question 4:** “Please tell me about a time when you were sick and needed healthcare and attempted to go to get healthcare from the VA but did not receive care.”

(*Specific Aim #1 Perceived Factors That Impede (Barriers) to Access to VA healthcare*)

Prodding questions:

“Where do you go for healthcare when you are not able to receive care at the VA?”

Can you describe a time when you thought about going to the VA for medical care but could not go or did not want to go?”

**Question 5:** “Tell me about how your health beliefs determine how you seek care. Tell me about how your attitudes about the VA healthcare system enable you to obtain healthcare services.”

(*Specific Aim #3: Identify health beliefs of homeless veterans and the relationship of health beliefs to use of healthcare services.*)



## APPENDIX B



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### APPROVAL NOTICE New Study

<b>DATE:</b>	8/19/2014
<b>TO:</b>	ROMANITCHIKO SAMILEY SCHOOL OF NURSING
<b>FROM:</b>	ALISON MOORE, MPH, MD Chair, SGIRB
<b>RE:</b>	IRB#14-000717 Utilization of Healthcare Services from Perspective of Homeless Veterans

The UCLA Institutional Review Board (UCLA IRB) has approved the above-referenced study. UCLA's Federalwide Assurance (FWA) with Department of Health and Human Services is FWA00004642 (IRB00004474).

#### Submission and Review Information

Type of Review	Expedited Review
Approval Date	8/19/2014
Expiration Date of the Study	8/18/2017

#### Regulatory Determinations

-- The IRB has determined that this study meets the criteria for a 3 year extended approval. (For reference, please see the OHRPP guidance document "Extended Approval for Minimal Risk Research Not Subject to Federal Oversight" at [http://ora.research.ucla.edu/OHRPP/Documents/Policy/4/Extended\\_Approval.pdf](http://ora.research.ucla.edu/OHRPP/Documents/Policy/4/Extended_Approval.pdf)).

-- **Expedited Review Category(ies)** - The UCLA IRB determined that the research meets the requirements for expedited review per 45 CFR 46.110 categories 6 and 7.

-- **Waiver of Signed Informed Consent** - The UCLA IRB waived the requirement for signed informed consent for screening under 45 CFR 46.117(c)(2).

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