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Operation Enduring Freedom and Operation Iraqi Freedom Veterans in the Veterans Health Administration

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Abstract

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Abstract

The Veterans' Health Administration (VHA) has faced critical issues regarding the deaths of war veterans, the result of which stakeholders raised questions about the quality of health care given within the VHA. Through patient-centered care standards of health care, the VHA worked diligently to end such horrific events that more than 300,000 veterans may have died while waiting for health care service. This study examined five core concepts of the health care system and whether VHA has utilized its five core concepts of patient-centered care to deliver proper health care to war veterans. This study used qualitative research in the tradition of descriptive phenomenology; ten Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veterans comprised the sample. Qualitative study included standardized and open-ended questions for research interviews. Nine themes emerged in the findings from thematic coding and transcribing data such as systemic action, healthcare production, development of health care staff, hierarchical administration, requirement, unexpected, consistent, proactive, and control. Findings implied tangible implications for positive social change that should involve assigning combat veterans with the five core concepts of patient-centered care.

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Dedication

I dedicated this dissertation to the men and women of the United States Armed Forces and Intelligence Community in protecting and serving the United States every day. I can personally say this from a career that has spanned service as an 0311-infantryman, an E-5 noncommissioned officer in the United States Marine Corps, a veteran of foreign wars with two combat deployments during the Iraqi war. My comrades had done tremendous services in prioritizing to love, protect, and serve the United States of America. It was very upsetting to see many of my brothers and sisters in arms make the ultimate sacrifice due to their excellence of commitments to our country. It was heartbreaking to learn that my fellow veterans were feeling ill when home became the battlefield. I conducted this research to help war veterans live a healthy lifestyle. I wanted to take this opportunity to make a difference to our brave men and women while studying at Walden. I utilized this research as a resource to honor veterans. My military service did not end in active duty. My service continued with non-lasting support to our veterans via writing. It is my hope that the primary value of this dissertation will be that it brings greater awareness to the issue of the quality of veteran's health care.

Acknowledgments

I thank my Lord and Savior Jesus Christ for his never-ending love and peace to my life. His provision has given me incentives to achieve my dreams with this deep inner strength, understanding of the world, and acting optimistically through wisdom. The doctoral degree became valuable to me in gaining new knowledge and skills to use in our society. My wife, Maria Kristina Aranez, and my son, Ezekiel Peter Aranez Jr., provided me the unconditional love and support every day. I am thankful for both each and every day. My wife and son have motivated me to reach my future endeavors. My dissertation team included Chairperson Dr. Marisa Bryant, Second Committee Member Dr. Nikolas Roberts, and University Research Reviewer Dr. Josh Ozymy. They were the backbone of this dissertation in mentoring and guiding me to write my research study in its entirety. I wished more and more partnership and friendship to come with all the people I met at Walden. With God, wife, son, family, friends, and community, I became a better person. The product of hard work and perseverance resulted in inclusiveness to all people around me that this research study is all about.

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Chapter 1: Introduction to the Study

The U.S. Armed Forces operates its large-scale military forces in the United States of America. Currently, there are 1.2 million military personnel on active duty and 800,000 reservists who have volunteered to serve the United States (Crawford, 2018). In the post-9/11 years, there have been approximately 2.5 million people served in the U.S. military and deployed in the wars of Afghanistan and Iraq (Crawford, 2018). Two conflicts were part of the Global War on Terrorism consisting of both, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). OEF was the war that happened in Afghanistan. It started in October 2001 and ended in December 2014 (Viscusi, 2019). OIF began in March 2003 and ended in December 2011 (Viscusi, 2019). These conflicts resulted 7,000 lives of service members. And, it brought about 52,010 service members wounded in war conflicts (Crawford, 2018). Dedicated medical personnel saved many lives in combat of approximately 90.6% wounded service members from OEF/OIF. In comparison and contrast with World War II, OEF/OIF has 80.9% incapacitated service members, and the Vietnam War caused 84% service members to have a disability, leading them to casualty evacuations (Viscusi, 2019). Wounded service members evacuated from combat zones to the Polytraumatic Rehabilitation Center (Armstrong et al., 2020).

Since the wars in Afghanistan and Iraq began, Post-traumatic Stress Disorder has been identified as common injury among those wounded service members served in OEF/OIF (Clausen et al., 2020). Traumatic brain injury and tinnitus were other injuries of a growing population from returning service members in transitioning to civilian life

(Gundlapalli et al., 2020). The Department of Veterans Affairs (VA) outlined the coordination of these injuries from many injured service members who participated in OEF and OIF (Gundlapalli et al., 2020). The VA defined *developments of injured service members* as wounded, ill, and disease from the Global War on Terrorism (Hamilton & Marko, 2019; Hines et al., 2020). War veterans were not required to enroll in the VA health care system of Veterans Health Administration (VHA) to receive medical, surgical, or preventative care (Gundlapalli et al., 2020; Hines et al., 2020). War veterans are reminded when seeking the help of the VA for the VHA that they will receive services not only for their sustaining injuries, contacting diseases, but also looking on their type of statuses for discharge papers from the U.S. military records (Koebli et al., 2020; Kudler, 2019). The VHA directed an outlined structure to definite areas to place veterans inclusive of nursing homes, state veterans homes, living care assistance, psychological counseling, rehabilitating centers, and more transitioning programs (Faurer et al., 2020; Whitworth et al., 2020). All service members of the U.S. Armed Forces had a specific transitional program, for the U.S. Marine Corps provided the Marine Corps Transition Management Program (Linneroot et al., 2017; Melcer, 2020). The programs supported war veterans for benefits, educational options, federal assistance, and employment (Wilkie, 2019).

The VHA's mission continued the late U.S. President Abraham Lincoln in fulfilling a promise to war veterans about health care (Wilkie, 2019). He said "To care for him who shall have borne the battle, and for his widow, and his orphan" (Wilkie, 2019, p. 7). This quote stated the VHA's mission and vision was to serve and honor men and women in the United States uniform. There were VHA facilities were located in the State of Washington. It offered a variety of health care services to war veterans congregating their needs and providing compassionate care of which that instilled hope for recovery (Wilkie, 2019).

Many war veterans wanted to learn new ways to overcome their invisible wounds to accomplish goals and return to a new normalcy. Normalcy was a memory of the tainting minds of war. The veterans returned home with a prewar mentality. As of November 2019, the VA supported more than 970,000 veterans who served in foreign wars in Afghanistan and Iraq (Viscusi, 2019). There were 6,500 inpatient veterans assigned to VHA facilities across the state of Washington (Brown et al., 2015). The VA believed that war veterans would achieve new normalcy of life from coaching, counseling, educating, and rehabilitating (Armstrong et al., 2019).

The VHA of the VA health care system struggled in unquestionable points of health care quality to war veterans. The VHA lacked sufficient training in evidence-based practices (Carlozzi et al., 2020). The VHA with collective medical services delivered an inadequate health care system for more than 2 million veterans returned home to a significant extent from first war disposition did not receive a quality of health care (Koebli et al., 2020). Mostly, the problems are with physicians and medical practitioners accustomed to less training and few ailments that are mentally and psychologically related (Carlozzi et al., 2020). War veterans suffer a high risk of posttraumatic stress disorder (PTSD), TBI, and other invisible wounds (Wolf et al., 2019). Many war veterans returned home but stigmatized because of their mental health illnesses of military trauma in combat deployment (Wolf et al., 2019). War symptoms triggered war veterans to be in survival mode. According to Koven (2017), rigorous research was essential in addressing the challenges that the U.S. war veterans are facing today. It was our task to find a long-term solution (Koven, 2017). The phrase explored concerns on health issues of war veterans for their well-being and their family members.

Closing the gap in health care quality among war veterans was the goal of health care organizations. Several programs were created and designed for implementation, dissemination, and prevention that would justly deliver health care quality (Carlson et al., 2016). Since the deaths of many veterans escalated, VA leaders were fired, increased grants, regulated government funding, and strategized the needs of health care quality (Carlson et al., 2016). However, many health care organizations and families of war veterans looked for other valuable helping hands. The essential information established opportunities to improve the health care quality of war veterans. In particular, the care information about the perceptions of health care participants (Carlson et al., 2016).

Background

A series of *Washington Post* articles published in 2014 revealed the critical findings of Inspector General at the VA office (Hicks, 2014). The Inspector-General affirmed that the VA was inadequacy in providing appropriate health care quality to U.S. veterans (Hicks, 2014). The Office of Inspector General found that VHA medical centers had failed war veterans. In many years, the VHA failed to address the problems of war veterans. The investigation identified resulting health care issues together with fraud hotline office for complaints, unrevealed reports of patient experiences, and lack of access to patient care (Bloche, 2016; Devine, 2015). The VHA facilities provided long wait times, ignored severe infectious diseases, showed signs of potential neglection, and unreported dissatisfactions of many veterans (Hankel, 2014). Hicks (2014) said "I am deeply disappointed not only in the substantiation of allegations raised by whistleblowers but also in the failures within VA to take whistleblower complaints seriously that includes a review of possible criminal misconduct by VA senior hospital leadership" (p. 5). The quote informed by the VA Secretary Sloan Gibson during its investigation demanded attention from the U.S. Senate.

The 44th U.S. President Barack H. Obama vowed to address VHA scandals about providing inappropriate health care quality to the U.S. war veterans (Bloche, 2016; Devi, 2014). The U.S. Congress approved new funding of $16 billion for the VA health care systems. The amount of financial support via funding divided into three parts is counting $10 billion in emergency spending to pay for private doctors and health care professionals, $5 billion in hiring medical staff, and $1.3 billion in opening 27 new VA clinics across the country. In response to better its leadership of an organizational structure and fundamental management, the VA support increased substructure that veterans would transition back to civilian life successfully (Devi, 2014). The VHA developed mental health care practices and health care transitions for many returning war veterans (Robeznieks, 2015). President Obama promised the VA to overhaul the health care systems that provided inadequate quality of health care involving delays of wait time appointments, falsifies waiting lists, and inappropriate spending that causes deaths of many veterans in VHA (Robeznieks, 2015).

The National Academy of Sciences proposed guidance of health care quality to war veterans from OEF/OIF. The war conflict that happened in the Middle East was more than a decade. The returning war veterans were facing challenges with war symptoms of PTSD, TBI, and other invisible wounds (Wolf et al., 2019). While military members were in a survival situation, their families have been increasingly concerned about the health care system of the VA (Bloche, 2016). It was exclusively disturbing when the scandals escalated in mid-2014 through many deaths of war veterans in the VHA (Robeznieks, 2015). Many service members confirmed the need for care for mental health care carried from the conflict zones. To better serve the U.S. war veterans, the VHA followed the quality of health care defined by the National Academy of Sciences. I sought more information to gain new knowledge in learning new opportunities that will improve a gap in health care quality for the VHA. It was necessary to seek more information that determines whether the VHA system of health care demonstrated the five concepts of patient-centered care: collaboration, respect and dignity, participation, information sharing, and decision making.

War Symptoms

The reality of traumatic injuries from combat deployments causes veterans to have severe injuries that cause long-term impairments and functional disabilities. Severe injuries are life-threatening that includes physical, cognitive, psychological, psychological impairments, and functional disability. More than 2 million war veterans suffered from TBI (Wolf et al., 2019). Severely wounded veterans are diagnosed with mental and physical injuries (Wolf et al., 2019). The patient-centered care of veterans needs to prescribed medication for psychiatric and physical problems (Wolf et al., 2019). Many service members are diagnosed with PTSD. They are in medical conditions of depressions, whereas service members with TBI are more likely to have problems of family relationships for their medical conditions (Wolf et al., 2019). The careful assessment developed to take care of these complicated conditions include feeling upset, having nightmares, experiencing emotional cut-off, and feeling numb. Critical issues of war veterans are the following: veterans are upset when reminded of the experience of OEF or OIF, war veterans experience flashbacks and nightmares, war veterans do not get along for the most part with family and friends, and war veterans have no interest in working on the things that they care about in life (Wolf et al., 2019). The physical and mental health are the effects of traumatic war experiences of OEF and OIF combat veterans.

Health Care Quality

In 1919, Dr. Avedis Donabedian advanced a study of health care quality (Sheingold & Hahn, 2014). He conducted medical research that led to an outcome of creating the original health care quality concept called the Donabedian model of health care (Sheingold & Hahn, 2014). Dr. Donabedian described seven pillars as valuable for health care quality. It is useful for patient-centered care. The seven pillars entailed efficacy, efficiency, optimality, acceptability, legitimacy, equity, and cost (Hines et al., 2020). VHA congregated the seven components that were defined by the Donabedian model of health care quality that includes safety, effectiveness, patient-centered care, timely manner, efficiency, and equity (Sheingold & Hahn, 2014). The National Academy of Sciences's landmark wanted to improve the health care system by looking into the description of health care quality (Sheingold & Hahn, 2014). Recently, the health care reform law passed opportunities that offered a disease prevention program and health care promotion (Sheingold & Hahn, 2014). Either individual or family preferences, the cost, and quality of health care were beyond the extent to assure people will receive plans that attempted to achieve health care competency (Sheingold & Hahn, 2014). Health care quality is derived from structures and programs to improve the process of health care delivery systems.

Patient-Centered Care

Patient-centered care is a precondition component of the health care system by ensuring that all patients accessed their chosen care (Brown et al., 2015). In 1998, the Salzburg group from Austria suggested computer-based guidance and communication systems build relationships among clinicians and patients in the health care system (Brown et al., 2015). Community leaders played significant roles in integrating community resources and representing health care in financing processes at the legislative level (Brown et al., 2015). The vision of patient-centered care in 2020 included automatic payments and affordable health insurance to all people (Brown et al., 2015). *Patient-centered care* is defined as health care quality by patients and physicians working together in desiring acceptable health outcomes (Brown et al., 2015). It was a considerable attribute of the primary care health care system defined by patient-centered care (Brown et al., 2015). It included superb access to care, patient engagement in care, clinical care information systems that support high-quality care, care coordination in comprehensive information across the virtual team of providers with patient feedback, and available public details (Brown et al., 2015). Patient-centered care has recommended health care quality concepts to many health care professionals and organizations for more than 25 years (Brown et al., 2015).

Five Core Concepts

Patient-centered care is patient and family engagement care. *Patient-centered care* defined a patient and family engagement care as working together with the health care system to deliver safety, delivery, and health care quality (Brown et al., 2015). Patient-centered care provided five schemas of patient-family engagement care in conjunction with collaboration, respect and dignity, participation, information sharing, and decision making (Brown et al., 2015). The definition of each schema was by the following: (a) Collaboration outlined a partnership between providers, patients, and families to deliver direct care and design successfully; (b) respect and dignity expressed patients and families are valued and treated very well with compassion in the hospitals; (c) participation has a voice to the patients and families in being supported at every level of health care; (d) information and sharing explained patients and families receive information and decide on status and condition; and (e) decision-making marked the patients and families participated in care must decide on the quality of health care (Brown et al., 2015).

Patients Perception

The improvement of health care quality weighted on measurement tools using interviews. The most common assessment tool in conducting qualitative research was using instruments that measure patient perspectives on health care quality. Although many hospitals were currently using patient satisfaction surveys, other researchers partnered with the health care agency to research that used cognitive interviews (Anhang Price et al., 2019). Measures of patient-centered care derived observation methods, focus groups, interviews, and surveys (Anhang Price et al., 2019). Measures identified from the institutional structure from the feedback of several patients and physicians with collaboration on pilot studies (Llardo & Speciale, 2020). Some satisfaction surveys demonstrated a bias toward an increasing performance of scores. Many researchers used research interviews, even though experiences say that surveys from many patients were highly effective measures of patient-centered care (Llardo & Speciale, 2020). Pilot studies in the health care systems were often using measures intended for functions and outcomes (Llardo & Speciale, 2020). The VA used customer experiences of feedback surveys that increased to 2.4 percent satisfaction on perspectives about perspectives of health care quality as patient-centered care from veterans (Anhang Price et al., 2019). The VA Washington Medical Center added 400 veterans to apply for health care systems. Health care providers are satisfied with health care quality. Patient-centered care involved measurement that improves hospitals and physicians to performance proper communications, practice guidelines, and health care quality (Llardo & Speciale, 2020).

Problem Statement

Wars generated human casualties. A by-product of war is the loss of human life. In 2019, the Department of Defense (DOD) estimated that more than 7,000 deaths and more than 50,000 injuries of military personnel from OEF/OIF Viscusi, 2019). Many veterans who returned home from war were facing complexities of health care when seeking help at the VHA (Longman & Gordon, 2017). The VHA encountered health care issues from lacking focus, training, experience, and resources dealing with the needs of post-service military veterans.

The VHA is one of the entities from the Department of Veterans Affairs (VA). In 2014, the U.S. Senate demanded the VA to conduct its investigations of all VHA facilities to collaborate on what solutions must be done who delivered a low quality of care and negative consequences to post-service U.S. veterans (Molina, 2018). According to McCormick et al. (2019), the health care system needs more development and must adopt continuous assessment and treatment that will yield improvement and opportunities.

The problem is that more information is needed to uncover opportunities that exist to improve the VHA health care quality for the OEF/OIF veterans. This means that a researcher must seek more information to gain new knowledge in learning new opportunities that will improve a gap in health care quality for the VHA. This project studied the perceptions of actual patient-centered care participants. Patient-centered care is an essential element of health care quality that overhears the patient's concerns (Anhang Price et al., 2015). The patient's experience, engagement, and feedback are quality measurements that facilitate efforts and improvements in the VHA. Patient-centered care inquires perceptions from medical providers and patients about obtaining health care quality (Anhang Price et al., 2015). It is necessary to seek more information that determines whether the VHA system of health care demonstrates the five concepts of patient-centered care: collaboration, respect and dignity, participation, information sharing, and decision making.

Purpose of the Study

The purpose of this phenomenological study was to explore the perspectives of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

Research Question

RQ1–Qualitative: What were the perceptions of current OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making?

Theoretical Foundation

Maslow's (1943) theory comprises the theoretical framework of this research. Maslow wrote "Also, no need or drive can be treated as if it were isolated or discrete; every drive is related to the state of satisfaction or dissatisfaction of other drives" (Maslow, 1943, p. 17). Maslow developed his theory on the hierarchy of needs based on human motivation. Maslow provided this type of framework in understanding the patient-centered care of self-actualization, esteem, belonging, physiological, and safety for OEF/OIF vets in the VHA. Seeing the OEF/OIF vets have healed of their invisible wounds and achieved self-actualization of patient-centered care are two types of successful delivery by the VHA. Consequently, the qualitative research uses Maslow's theory of human motivation with the hierarchy of needs assessed the VHA health care system for effectiveness in providing adequate care to military veterans. Maslow confirmed “While behavior is almost always motivated, it is also almost always biologically, culturally and situationally determined as well” (p. 25).

Research Design

The methodology that I used in this study was qualitative research, and the research design was descriptive phenomenology. Descriptive phenomenology helped me explore the perceptions of OEF/OIF vets with a particular phenomenon (Giorgi, 2009). It sought the meaning of OEF/OIF vets’ intuition and reflection on conscious experience and understanding (Giorgi, 2009). Qualitative research methods for interviews helped understand the lives of OEF/OIF vets socially and culturally (Patton, 2015). Qualitative research explores phenomena in understanding the perceptions of OEF/OIF vets (Patton, 2015). Snowball sampling identified 10 OEF/OIF vets from the targeted population of war veterans to the VHA (Cosco et al., 2015). Data collection must be concise in understanding the interview protocol of the VHA provides a quality of care (Cosco et al., 2015). A descriptive phenomenological study assessed the implementation of organizational programs with provisions in the behavioral management of care contracts (Giorgi, 2009). The qualitative research method uses the research design of descriptive phenomenology to appropriately analyzed OEF/OIF vets as patient-centered care who were not experiencing a quality of care in the VHA. A qualitative research method uses the design of a phenomenological study to describe and translate the experiences of OEF/OIF vets in the VHA (Patton, 2015). My study offers information on providing a quality of care for OEF/OEF vets.

Amid COVID-19 restrictions, I used snowball sampling of this qualitative study. Snowball sampling is functional in using social media of networking strategy. I conducted a personal network to recruit participants in any current wars from OEF or OIF. A qualitative study examines the experiences of patients in the VHA facilities. The method does not require formal approval from the VA, but I had to follow the confidentiality protocol of each veteran.

Definition

Maslow's (1943) theory was a hypothesis of human motivation and the hierarchy of needs. Maslow developed a theory of motivations and hierarchical needs for humans from the physiological level to the self-actualization level to reach the full potential.

Descriptive phenomenology: A qualitative research design that explores the perception of a particular phenomenon descriptively (Giorgi, 2009).

Quality of life: A 2020 vision for health care quality of the U.S. population. They were considering an advanced quality of life. It captured a promise to a healthier United States (Acosta et al., 2020; Adams et al., 2020).

Health care quality: The health care system used perceptions of seven pillars. It includes efficacy, efficiency, optimality, acceptability, legitimacy, equity, and cost (Anhang Price et al., 2015; Hines et al., 2020; Llardo & Speciale, 2020; Marutha, 2020).

Patient-centered care: A key component from the National Academy of Sciences is ensuring all patients access the health care system with a chosen health care discussed between patients and physicians (Furin et al., 2020; Ito, 2020).

Person-centered care: An international health care perspective towards an individual received respect, rights to self-determine, and an understanding of health care choices (Zhao et al., 2016).

Patient satisfaction: A measurement designs obtained from patients in the VHA (Hines et al., 2020; Llardo & Speciale, 2020).

New normalcy: A person who tried to readjust from the military to civilian life but cannot live a safe life (Anhang Price et al., 2015; Marutha, 2020).

Department of Veterans Affairs: A federal agency developed for veterans' well-being (McCormick et al., 2019).

Veterans' Health Administration: A health care system designed by the VA (Carlozzi et al., 2020).

Polytraumatic Rehabilitation Center: An advanced medical field for wounded service members only from the combat zones (Armstrong et al., 2019).

The United States Armed Forces: Personnel of the U.S. military branches (Crawford, 2018).

Military Transition Programs: Each military branch for service members created programs about civilian life transitions (Forkin, 2015).

Global War on Terrorism: Launched as the war on terror. It was the war declared by the United States government after the terrorist attacks on September 11, 2001 (Clausen et al., 2020).

Operation Enduring Freedom: The war in Afghanistan started on October 7, 2001, and ended on December 28, 2014 (Clausen et al., 2020; Koebli et al., 2020; Ghai et al., 2020; Hamilton & Parko, 2020).

Operation Iraqi Freedom: The war in Iraq started on March 20, 2003, and ended on December 18, 2011 (Clausen et al., 2020; Koebli et al., 2020; Ghai et al., 2020; Hamilton & Parko, 2020).

War veterans: The U.S. military service members participated in OEF and OIF (Clausen et al., 2020; Koebli et al., 2020; Ghai et al., 2020; Hamilton & Parko, 2020).

Veterans of Foreign Wars: The U.S. war veterans' organization of service members fought in campaigns and expeditions on foreign land, waters, or airspace.

Assumption

Giorgi (2009) stated that a researcher must be guided by philosophical assumptions to the next step forward of a research study. For example, I made assumptions on the following: (a) The size of 10 OEF/OIF war vets was an adequate representation of the targeted population to find the significant results of a research study; (b) Qualitative research generalized a target population of approximately 3,500 OEF/OIF war vets previously assigned in the VHA; and (c) Military organizational leadership ensured the completion of the research study. The dissertation chair for this study assisted the research study, whereas Walden University's IRB approved. Finally, OEF/OIF war vets were participants in a research study interested in sharing their perception of patient-centered care in the VHA. The overriding piece of a research study was assumption. It directed argument and framed discussion to a new paradigm.

Scope and Delimitation

The scope of a research study explains the perceptions of OEF/OIF vets about patient-centered care in VHA. I focused on OEF/OIF vets in the VHA. The specific aspect of a research problem that I addressed in this study was the inadequacy of health care quality to war veterans. My focus of a chosen research was interviewing 10 OEF/OIF vets previously assigned in VHA of which representing a targeted population of approximately 3,500 war veterans in VHA. I have controlled delimitations to narrow the scope of a study about participants, site, and research design.

Limitation

Giorgi (2019) discussed limitations as features in a qualitative study that might negatively affect the results or ability to generalize the research study. I was fully aware of limitations in any areas without control or avoidance altogether. Giorgi (2009) helped me point out that qualitative research must address limitations without undermining its research values in the public eyes of readers and reviewers. The clarity of the potential problem would suggest ways the possibility of a researcher's unbiased data collection and results (Giorgi, 2009; Patton, 2015). The limitations of this qualitative study found on the following:

1. The sample size was a limitation of this study. Specifically, it focused on OEF/OIF veterans part of VFW. It could only represent issues on people adequately when attempted to hypothesize interpreted information in concerning on this veterans' population.

2. Researcher bias could be another possible limitation of this study due to my military background. Unintentionally, I could take qualitative research in the desired direction, influenced personal intentions, and lived experiences. On the other hand, it could succor me as a researcher to make the generalizations of the study into the next level because of a broad understanding of the veterans' population.
3. Relying on responses from the participants was another possible limitation of this study. During the interviews, I spoke with each participant with the hope that they answer questions honorably and honestly. It could present the implication of limitation with a level of the truthfulness of the interviewee's reasons that could not be a moral compass or dignified.
4. Participants had PTSD was a possible limitation of this study. The disorder could affect their interview responses that trigger their mental health issues with emotional and psychological intelligence.
5. Gender was also a limitation of this study. There were zero females participated in the qualitative research of the OEF/OIF veterans. This situation was the reason that this qualitative study could not focus on gender differentials. Gender differences could not note on empirical knowledge about gendered practices and norms.

I acquired safeguards of proper context to decrease possible outcomes affected by limitations of a qualitative study. I reduced any biases by having well-developed questions aligned with the qualitative research question. It guaranteed sufficiency towards participants' responses. The constraints on data analysis unveiled readers resolve about discoveries from a researcher. All participants are assured of confidentiality and able to withdraw at any time with this qualitative study. All these aforementioned incentives mentioned were essentials to safeguards a qualitative study.

Significance

A gap in literature exists in gaining knowledge between the quality of health care perceived by the OEF/OIF vets and delivered service by the VHA. The responses from interviews of the OEF/OIF vets provided accurate and personal information to voice their stories as post-service OEF/OIF vets in the VHA. It is a topic explores the gap between the quality of life and the cost of health care from OEF/OIF vets' unbinding services.

Improving the Lives of OEF/OIF Vets

The one-size-fits-all approach does not equally apply to the OEF/OIF vets. According to the National Academy of Science, as the OEF/OIF vets age, they may need more assistance for chronic conditions and lung disease (Linnerooth et al., 2017). The chronic conditions combined with polytraumatic injuries at OEF/OIF war zones sustain war veterans. It has muscular pain associated with combat-related polytrauma in high rates of blast injuries during the wars in Afghanistan and Iraq (Marutha, 2020). It upskills health professionals to deliver patient-centered care from the U.S. health care system. Both professionals from educational organizations and accreditation bodies must improve to provide a quality of health care to OEF/OIF vets to advance the development of core competencies (Wolf et al., 2019). Patient-centered care encourages OEF/OIF vets to learn more about enhancing comprehensive and coordinated care to improve patient experience and further improvement of health care quality.

Cost of Health Care for OEF/OIF Vets

There were many studies ahead of the screening, assessment, and conducting treatment for returning OEF/OIF veterans. The Government Performance and Results Act of 1993 authorized much learning for the OEF/OIF vets (Hankel, 2014). It was federally funded research in identifying several subjects for future research. It studied literature to shed light on the potential effectiveness of a variety of interventions. In 2013, the federal government experienced a shutdown. Lacking fiscal responsibility destroyed the trust of the VA (Bloche, 2016). The OEF/OIF per-veteran suffered from polytraumatic injuries with other conditions had cost the VHA an average of $20,903 for treating a mental health condition, $11,342 for PTSD, $14,202 for depression, and $12,600 for substance disorders (Marutha, 2020). The comorbidity is associated with worse health care outcomes, more complex clinical management, and increased health care costs. The Post-9/11 veterans in the Year 2012 cost the VHA approximately $2.8 billion of its annual $50.9 billion health budget (Marutha, 2020). This amount of numbers expected to increase by $510 million in upcoming years (Marutha, 2020). This subject matter provided knowledge to the U.S. Congress and military personnel with a high-ranking leadership position in the VHA. The subject matter was about improving the health care system of care delivery to OEF/OIF veterans. In today’s U.S. health care system, a better understanding of the linkage among health care financial managers would allocate resources in creative approaches to veterans. The health care costs are rising every year due to population growth and demographic shifts. It considered that the financial management needed to provide a high quality of cost data to veterans.

Summary

I organized this study in eleven sections for this chapter. In Chapter I, I pointed out the introduction, background, problem statement, the purpose of the study, research question, nature of the study, definitions, assumptions, delimitations, limitations, and significance. This chapter provided a synopsis of veterans' issues addressed in each section. It introduced key concepts, definitions, and previous articles. Chapter I showed the importance of conducting qualitative research on a problem statement and its purpose to understand war veterans in the VHA.

Chapter 2: Literature Review

Introduction

Chapter 2 is a literature search, and it encompassed a theoretical foundation in presenting qualitative research. The references were part of the literature review. Mostly, credential originated at Walden University Library and Google Scholar. I used the Ulrich Periodical Directory to determine whether the articles, books, dissertations, and websites are peer-reviewed. Key terms in researching documents for the capstone were *Afghanistan war*, *Iraq war, war symptoms*, *Operation Enduring Freedom*, *Operation Iraqi Freedom*, *OIF*, *OEF*, *United States Armed Forces*, *Veterans of Foreign Wars*, *Department of Veterans Affairs*, *Veterans Benefits Administration*, *Veterans Health Administration*, *advantages and disadvantages*, *transition assistance program*, *polytraumatic rehabilitation centers*, *mental health*, *invisible wounds*, *patient-centered care*, *health care quality*, and *Maslow's (1943) Theory of Human Motivation and Hierarchy of Needs*. The keywords were in Dissertation Prospectus Guide, online databases A-Z, Thoreau Multi-Database Search, Scholar Works, Articles, Journals, Dissertations & Thesis, Tests & Measures, and Statistics & Data. Appendix I shows the synthesis matrix that I used to pinpoint common themes across reference sources.

In Chapter 2, I present a literature review. I divided major sections into nine components using the American Psychological Association (2010) formatted with Level 1 heading. The nine prime components appear as follows:

1. The first component explored the establishment of the VA with elaboration on its advantages and disadvantages and Veterans Benefits Administration.

2. Second component explained the VHA's formation in helping war veterans accessed Polytraumatic Rehabilitation Center, Transition Assistance Program, and the Marine Corps Transition Program.
3. Third component described two conflict wars in OEF and OIF that caused war veterans to carry war symptoms, mental health, and war consequences.
4. Fourth component implemented an evaluation of the effectiveness of the VHA in improving health care coverage, vocational rehabilitation, and caregiver support.
5. Fifth component entailed the tipping point of global health care quality of which evolved from the 1850s to the 1950s, accreditation, and standardization, and the 21st century.
6. Sixth components defined health care quality with structures, processes, and outcomes. The roles, responsibilities, and improvements were significant aspects of health care quality.
7. Seventh component offered the notion of disadvantages and advantages for patient-centered care. It included the five-core concepts, quality, measures, and limitations of patient-centered care.
8. Eighth components highlighted a new definition of person-centered care.
9. Ninth components presented salient information on experience and satisfaction on the quality of life.

Problem Statement

Wars generate human casualties. A by-product of war was the loss of human life. In 2019, the U.S. Department of Defense (DOD) estimated that more than 7,000 deaths and more than 50,000 injuries of military personnel occurred from OIF and OEF (Viscusi, 2019). Many veterans who returned home from war were facing complexities of health care when seeking help at the VHA (Longman & Gordon, 2017). The VHA encountered health care issues from lacking focus, training, experience, and resources dealing with the needs of post service military veterans.

The VHA was one of the entities from the VA. In 2014, the U.S. Senate demanded that the VA to conduct its investigations of all VHA facilities to elaborate on what solution must be done for providers who delivered a low quality of care and negative consequences to post service U.S. veterans (Molina, 2018). According to McCormick et al. (2019), the health care system needs more development and must adopt continuous assessment and treatment will yield improvement and opportunities.

The problem is that more information is needed to uncover opportunities that exist to improve the VHA health care quality for the OEF/OIF veterans. This issue means that a researcher seeks more information to gain new knowledge in learning new opportunities that will improve a gap in health care quality for the VHA. This project studied the perceptions of actual patient-centered care participants. Patient-centered care is an essential element of health care quality that overhears the patient’s concerns (Anhang Price et al., 2015). The patient’s experience, engagement, and feedback are quality measurements of which facilitated efforts and improvements in the VHA. Patient-centered care inquiries about perceptions from medical providers and patients about obtaining health care quality (Anhang Price et al., 2015). It is necessary to seek more information that determines whether the VHA system of health care demonstrates the five concepts of patient-centered care: collaboration, respect and dignity, participation, information sharing, and decision making.

Purpose the Study

The purpose of this phenomenological study was to explore the perspectives of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision-making.

Background of the Department of Veterans Affairs

In mid-1930, the VA was established to help veterans in need (Kudler, 2019). An independent agency was under Executive Order 5398 of President Herbert Hoover (Kudler, 2019). In early 1988, President Ronald Reagan elevated the VA’s position to cabinet status (Kudler, 2019). On March 15, 1989, the Veterans Administration became the VA. All members of the U.S. Armed Forces sought help from the VA for the guidance of new normalcy.

The 2019 budget of the VA was currently $200 billion (Gaudet & Kligler, 2019). There were four agencies in the Department of Veterans Affairs as such the National Cemetery Administration, Veterans Benefits Administration, Veterans Day National Committee, and VHA. Each agency provided a specific purpose to a veteran’s problem. The National Cemetery Administration (NCA) maintained national cemeteries as sacred and memorialized to honor veterans (Longman & Gordon, 2017). The Veterans Benefits Administration (VBA) administered the VA for financial assistance for eligible veterans to receive support financially and with veterans’ dependents or survivors (Carlson et al., 2016). Veterans Day National Committee (VDNC) planned and coordinated observation of Veterans Day (Longman & Gordon, 2017). Last, the VHA integrated health care system (Gaudet & Kligler, 2019). The VA recorded 9 million veterans were being served each year in the VHA out of 19.5 million veterans in the United States of America (Gaudet & Kligler, 2019). The purpose of the VA is to help the community for veterans.

In late 1865, the VHAs mission statement reflected in the second inaugural address of late President Abraham Lincoln (Kudler, 2019). The VA used President Lincoln's words upon Congress to imparted the president's powerful quote to war veterans (Kudler, 2019). According to Kudler (2019), "To care for him who shall have borne the battle and for his widow, and his orphan" (p. 7). The quote was a phrase that came from the late Abraham Lincoln. The adaptation of these words became a motto of the VA (Kudler, 2019).

The VA found its core values. It confirmed support as a motivational motto in providing veterans with health care quality (Longman & Gordon, 2017). Core values included Integrity, Commitment, Advocacy, Respect, and Excellence. The acronym of these core values was ICARE (Longman & Gordon, 2017). ICARE is defined as the following: integrity provided to the highest professional standards, commitment to fulfill outstanding service to veterans and beneficiaries, advocacy served with truthfulness to appropriately protect all veterans, respect gave veterans with earned respect and dignity, and excellence strived the highest quality of standards in the leadership of the VA health care system (Longman & Gordon, 2017).

The VA is a community for veterans. Its role and responsibility ensure the best quality of service for veterans. It includes adherence to evidence-based medical practices, care coordination, patient safety, and patient satisfaction (Longman & Gordon, 2017). Wait times of appointments must be shorter for veterans to receive constructive treatment with the VA health care providers (Longman & Gordon, 2017). The VA provided an integrated treatment specifically to those veterans who are in urgent need (Longman & Gordon, 2017).

Advantages and Disadvantages

Many war veterans adhered to their support to the VA health care quality system of service (Anhang Price et al., 2014). Mostly war veterans would be able to distinguish what went well and did not do well while being participants at the VA. Veterans provided advantages and disadvantages at the VA (Carlson et al., 2016). Some of the edge at the VA for veterans listed the following: multiple services, unlimited facilities, hospital equipment, prescription coverage (Gaudet & Kligler, 2019).

Some of the disadvantages were the following: wait times, low in health care providers or practitioners, backlogs of veterans' appointments, ineffective treatments from war symptoms (Carlson et al., 2016). These were rudimentary information on why veterans disclose the VA. It was about the leadership was lacking resulted in inefficient service to veterans (Hankel, 2014). The VA was serving war veterans inadequately. It made health care services put veterans into a dangerous situation from depression and suicidal ademption of behaviors (Hankel, 2014).

Veterans' Benefits Administration

Veterans Benefits Administration provided financial assistance to the high demand for returning war veterans from foreign wars in Afghanistan and Iraq (Carlson et al., 2016). VBA must speed up the health care disability claims of OEF and OIF to have veterans received benefits of compensation, pension, education, employment, housing, life insurance, and much other funding for war veterans (Carlson et al., 2016). Diagnosed veterans with PTSD and Traumatic Brain Injury were a negative situation in transitioning to the civilian world (Carlson et al., 2016). The cost and benefits of war veterans depended on their military records, for instance, rank and deployment (Carlson et al., 2016). The exposure of combat zones was identically made war veterans eligible for benefits from VBA (Carlson et al., 2016).

Veterans' Health Administration

The VHA was currently the immense health care system in the United States (Gaudet & Kligler, 2019). VHA included 1,061 outpatient hospitals in more than 170 medical centers (Gaudet & Kligler, 2019). The direct deaths in paramount war zones in OEF and OIF ranged from 480,000 to 507,000 people (Crawford, 2018). More than 7,000 deaths among service members served the post-9/11 wars in Afghanistan and Iraq (Crawford, 2018). However, the tool deaths were not close to comparison during the Vietnam War era of which totaled a magnitude of 58,220 U.S. service members (Viscusi, 2019). Many service members of the U.S. Armed Forces paid the ultimate sacrifices.

The U.S. military service members who survived from war deployments had an opportunity to start a new life in a civilian world. There were constant injuries from the combat zones that resulted in more than 53,700 service members were wounded (Crawford, 2018). Over 300,000 war veterans have suffered Traumatic Brain Injuries (Crawford, 2018). Many war veterans were drastically found themselves in bad situations in transitioning from military to civilian life. It was because of their invisible wounds and limb amputations of injuries from the war. PTSD and Traumatic Brain Injury were among these invisible wounds that come from combat zones. It was unusual to find solutions in treatment to cure the mental health problems of veterans. Each year, the VHA noticed more than 6,000 veterans were committing suicides from post-9/11 wars (Crawford, 2018). Current OIF/OEF veterans were overwhelmingly feeling they were living a different lifestyle. The VHA was a public health hospital only for veterans.

Polytraumatic Rehabilitation Centers

Polytraumatic Rehabilitation Center provided intensive specialized care for wounded veterans. Injured war veterans admitted to the VHA's Polytrauma Rehabilitation Centers (Armstrong et al., 2019). At first, when service members wounded during the battlefield in combat zones, he or she would initially receive an advance medical treatment at the battlefield (Armstrong et al., 2019). After quick assistance and small treatment of pain, the wounded and injured service members evacuated straight t to the VA of Polytrauma Rehabilitation Center for further assistance of health care treatment (Armstrong et al., 2019). The role of the Polytrauma Rehabilitation Center is associated with the combat-related situation for service members in assistance to the road of recovery (Armstrong et al., 2019). Service members with severe combat-related injuries were in displacement to an increased amount of military fatalities (Armstrong et al., 2019). The Polytraumatic Rehabilitation Center has dedicated to serving war veterans in an integrated network with highly specialized VA providers.

Transition Assistance Program

The Veterans Benefits Administration (VBA) provided the Transition Assistance Program (TAP) to war veterans' status that it meant educational supports, dental hygiene benefits, financial planning, job counseling, job search, job placement, relocation assistance, and vocational training rehabilitations (Whitworth et al., 2020). This program was an outreach to men and women from foreign wars of Afghanistan and Iraq. Many war veterans were facing challenges and dilemmas in transitioning to civilian life. The importance of early access to give benefits would most likely help war veterans a better choice in living their lives positively (Whitworth et al., 2020). It would hinder war veterans from suicidal commitments in civilian-setting (Whitworth et al., 2020). However, TAP provided beneficial services and guidance to war veterans that the OEF/OIF veterans recognized for their unique challenges from their combative experiences (Whitworth et al., 2020). TAP provided VA benefits and services to specifically tailored war veterans on their capabilities to function well in U.S. society (Whitworth et al., 2020).

Veterans of Foreign Wars

The Veterans of Foreign Wars (VFW) are war veterans who fought in wars, campaigns, and expeditions on foreign land from air, land, and sea. The purpose of a nonprofit organization was to speed up the rehabilitation of veterans who need assistance in local communities. It meant to help war veterans’ needs at the VA as a third party. It served war veterans to their latter of nationwide programs services from governmental preferences. It included members of active with an honorably discharged citizen in the United States of Armed Forces.

Wars in Afghanistan and Iraq

Roughly, the 2.8 million U.S. war veterans served in OEF and OIF (Clausen et al., 2020). The United States government called these two conflict wars of operations the Global War on Terrorism (Clausen et al., 2020). On September 11, 2001, the United States of America was a country attacked. It specifically targeted the twin towers of New York City (Clausen et al., 2020). In response to the attack, former President George W. Bush announced airstrikes on the targeting population of Al Qaeda and the Taliban in the country of Afghanistan (Clausen et al., 2020). The war that happened in Afghanistan was OEF (Clausen et al., 2020). On May 1, 2011, the Navy Seals eventually killed Osama Bin Laden, who was the founder of the pro-Islamist Al-Qaeda organization and primary suspected of the attack happened in the United States (Clausen et al., 2020).

On March 20, 2003, former President George W. Bush declared war on Iraq (Clausen et al., 2020). The war in Iraq was named OIF (Clausen et al., 2020). The goal of OIF was to destroy the weapons of mass destruction. However, the war resulted in overthrowing the regime of Saddam Hussein (Clausen et al., 2020). In 2010, former President Barack H. Obama ended the combat operations in Iraq, and it changes the name of the war operation for one year into Operation New Dawn. On December 18, 2011, the combat troops in the United States withdrew from Iraq (Clausen et al., 2020). More than

2.8 million war veterans are exposed to combat trauma and at risk of combat-related disorders (Clausen et al., 2020).

War Symptoms

War veterans received illnesses from OEF and OIF. War symptoms are considered chronic disorders and polytraumatic injuries from war (Koebli et al., 2020). Current war veterans were most likely getting affected by these war symptoms (Koebli et al., 2020). War veterans indicated to suffer these war symptoms from Intermediate Explosive Device (IED), suicidal attacks, blasts buildings, vehicle explosions, and firefights (Melcer et al., 2020). It encompassed service members with severe body and organ injuries on psychological impairment and physical disability. Returning home veterans targeted symptoms in the United States (Hamilton & Parko, 2020). War veterans from foreign wars of Afghanistan and Iraq have experienced explosions result in Traumatic Brain Injury and PTSD (Hamilton & Parko, 2020). The symptom was signature injury (Hamilton & Parko, 2020). The term signature injury meant war veterans encountered conflict on the battlefield. It was combat-related injuries that shifted many veterans into depression and anxiety behaviors (Ghai et al., 2020). OEF/OIF veterans deployed to wars processed as a high-level of risk getting signature injuries.

The reality of traumatic injuries from combat deployments were severe injuries that cause long-term impairments and functional disabilities. Severe injuries were life-threatening that include physical, cognitive, psychological, psychological impairments, and functional disability. More than 2 million war veterans suffered from traumatic brain injury (TBI; Wolf et al., 2019). Severely wounded veterans were diagnosed with mental and physical injuries (Wolf et al., 2019). The patient-centered care of veterans prescribed medications for psychiatric and physical problems (Wolf et al., 2019). Many service members diagnosed with PTSD. They were in medical conditions of depressions, while service members with TBI were more likely to have problems of family relationships for their medical conditions (Wolf et al., 2019). It designed a careful assessment to develop care of these complicated conditions when war veterans were feeling upset, nightmares, emotional cut-off, and feeling numb. Critical issues of war veterans were the following: veterans are feeling upset when reminded of the experience of OEF or OIF, war veterans are experiencing flashbacks and nightmares, war veterans do not get along with family and friends, and war veterans have no interest in working on the things that they care about in life (Wolf et al., 2019). The physical and mental health were the impact of traumatic war experiences of OEF and OIF combat veterans.

Mental Health

The most common mental health issues among war veterans were invisible wounds that came from PTSD and TBI. PTSD was a symptom of war veterans encountered by a horrific event of service members. It trenched the body and mind that linked physically and emotionally from past war exposures gives diseases including irritability, lost interest, nightmares, numbness, sleeplessness, and constant guard (Wolf et al., 2019). Another combat-related injury was a TBI (Wolf et al., 2019). TBI was a symptom caused by explosions in the buildings or vehicles that knocked out a jolt of the head that would affect the plain sight of the brain functions (Wolf et al., 2019). TBI symptoms are related to PTSD with dizziness, fatigue, hypersensitivity, irritability, and restlessness (Wolf et al., 2019). Veterans' Health Administration recognized war veterans from OEF and OIF are diagnosed with both symptoms because of the traumatic events of experiences (Wolf et al., 2019).

Consequences

The consequences of war veterans living back at home in the United States were at risk of living a healthy lifestyle (Acosta et al., 2020). Many war veterans who suffered from mental health issues were usually getting a direct or indirect killing at war zones. These veterans had tendencies to have high-risk factors of suicidal ideation because of its experience from the war deployment of Afghanistan and Iraq (Acosta et al., 2020). Despite increasing access, the mental health care for veterans in VHA continued to provide adequate health care quality. War veterans still faced life challenges. War veterans were reluctant to seek mental health care due to the capacity of stigma and no trust in anybody in this world (Acosta et al., 2020). Thousands of these war veterans faced exposures during combat zones. They did not have adequate access to combat invisible wounds across the lifetime of war veterans in VHA (Acosta et al., 2020). Invisible wounds and mental health issues were among the increased risk factors of dying war veterans from cardiovascular diseases (Acosta et al., 2020). The health issues of war veterans remained unclear when VHA providers assessed the prevalence of wars in the OEF and OIF era (Acosta et al., 2020).

Health Care Coverage

Health care coverage found in the VA health care system. VHA was the colossal integrated health care system with more than 1,700 VA medical centers (Haibach et al., 2020). Veterans applied to take advantage of the entire network to receive high-quality health care. Comprehensive VA health care system provided medical benefits to veterans on the following: preventative care, prescriptions, medical prosthetics, mental health care, home health care, and geriatrics extended care (Haibach et al., 2020). Women veterans explored for more VA health care systems of services, such as primary care, breast cancer screenings, prenatal care, and gender-specific services (Haibach et al., 2020). Beyond other benefits, the VA health care system included: dental care, vision benefits, hearing benefits, drug treatment, alcohol treatment, mental health services, PTSD, assisted living, TBI rehabilitation, and caregiver program (Haibach et al., 2020). All service members who completed the full period of active duty can apply for the VA health care system of medical benefits.

Other war veterans had gotten health care coverage from a health care program. Beyond doubt, the families and beneficiaries were eligible for the scope of veterans on health care (Haibach et al., 2020). Over 20 million veterans and eligible family members received health care from three health care systems not-to-mention the DOD, VA, and Civilian contracted health care organizations (Haibach et al., 2020). War veterans and their beneficiaries were commonly using the health care system of navigation skills to learn what coping skills and strategies will support veterans (Haibach et al., 2020). The motives of these three health care systems were to make sure all veterans and their families receive health care that will improve their wellbeing (Haibach et al., 2020). War veterans received an enrollment program packet from the VA. There were many reasons to sign-up for health care coverage. Inclusively with low cost of health care, high risk of health changes, low coverage under the Affordable Care Act, keep Medicare health insurance, and extra options for wounded service members. Health care coverage was world-class health care at a little cost or no cost at all.

Vocational Rehabilitation Employment

The VA offered a Vocational and Rehabilitation Employment (VRE) program for current war veterans of OEF and OIF (Gundlapalli et al., 2020). VRE was an independent occupational functioning for war veterans (Gundlapalli et al., 2020). The participation of war veterans in the VRE would help them transition into the civilian world (Gundlapalli et al., 2020). VRE offered specialized knowledge and rehabilitation counseling for veterans for occupational options (Gundlapalli et al., 2020). The VA noted that it is up to the war veterans to use its services for employment purposes (Gundlapalli et al., 2020).

Caregiver Support

The VA of medical centers offered caregiver supports to war veterans. It was the program of comprehensive assistance that family caregivers take care of veterans would receive beneficial succor (Carlozzi et al., 2020). War veterans who had firm disabilities recognized in the VA (Carlozzi et al., 2020). Family caregivers enhanced the health and well-being of their war veterans for home care (Carlozzi et al., 2020). Veterans were eligible for caregiver supports on the following: earnest injury and in need of personal care services (Carlozzi et al., 2020). The momentous injury meant a veteran serves during post-9/11 that has TBI, PTSD, and mental health issues (Carlozzi et al., 2020). When a veteran needed personal care of services, it meant that a veteran could not perform one or more activities of daily living work. Supervision and protection were part of the healing of symptoms that had neurological damage (Carlozzi et al., 2020). Caregiver support was access to the VA health care system delivering health care quality to war veterans.

The demands of many families of war veterans made changes for caregiver support in the VHA (Carlozzi et al., 2020). The caregiver support services were often helping families of war veterans to understand mental health and invisible wound issues (Carlozzi et al., 2020). The current war veterans of OEF/OIF prioritized in the VHA for social support of mental health problems to support their families (Carlozzi et al., 2020). The hope to reintegrate war veterans in returning to their families must seek health care support initiatives to VHA (Carlozzi et al., 2020).

Tipping Point of Global Health Care Quality

The measurement of health care quality was a must to assess an accepted criterion of effectiveness on health care delivery as a whole on a global scale. Health care quality was a prioritized policy across the world that all people were receiving an appropriate health care delivery system (Sheingold & Hahn, 2014). Quality came before the world had recognized thousands of service members were facing deaths that could have been prevented (Sheingold & Hahn, 2014). The tipping points of health quality measurement developed in identifying global innovations in many countries found in Germany, England, and the United States of America (Sheingold & Hahn, 2014). The large gaps in providing adequate health care to people seen on structure and framework in the history of the health care delivery system. (Sheingold & Hahn, 2014). Paying attention was very important to learn in providing a quality of health care to workforce diversity.

From 1850s to 1950s

Health care quality evolved over the past decades. Providing health care quality meant improving the quality of patient care. The 19th and 20th centuries produced a different quality of innovation to serve an adequate health care delivery system of participating countries in Germany, England, and the United States of America (Sheingold & Hahn, 2014). Serious incentives built many hospitals to reduce inappropriate health care quality and health outcomes for many patients. There were popular events that conveyed critical inducement for the health care quality movement in reducing the inefficiency of health care outcomes of many patients.

During the Crimean War in late 1854, Florence Nightingale, an England nurse who has provided sanitary knowledge of which helped British troops at the Turkish territory hospital (Sheingold & Hahn, 2014). Florence Nightingale helped soldiers with Cholera and Diarrhea in dropping the mortality rate from 40 percent to 42 percent. Nightingale identified actions to hinder poor sanitation by making sure the beds of soldiers spaced three feet apart, turning on ventilation, removing horses away from hospital, flushing sewers, and disinfecting drains (Sheingold & Hahn, 2014). Provisions of Florence Nightingale saved many lives of soldiers that meticulously give health care quality of measurement and innovation.

During the U.S. Civil War in 1861, Clara Barton was an American public health pioneer. She launched the Sanitary Commissions influenced by Florence Nightingale (Sheingold & Hahn, 2014). The basics of sanitary establishment provided health care quality in promoting a clean environment to eat, sleep, and aid for a healthy living condition among the Union Army, in camps and hospitals (Sheingold & Hahn, 2014). Sanitary knowledge was the critical success of the Civil War.

In 1862, Dr. Rupert Blue was an American Surgeon General. He provided leadership in innovating the health care delivery system (Sheingold & Hahn, 2014). Dr. Blue influenced Louis Pasteur, a French Chemist who discovered microorganisms of pasteurization (Sheingold & Hahn, 2014). It utilized heat to destroyed germs on perishable food of which made food undamaged and eatable. In late 1860, it innovated extensive leadership for health care improvement in eradicating rats from bubonic plague from mosquito outbreak, quarantining tools to ships and people tested positive on a specific disease, and mandating medical exams on immigration requirements (Sheingold & Hahn, 2014).

In mid-1879, Dr. Charles Chamberland was a French physician. He invented a prototype of sterilization (Sheingold & Hahn, 2014). The design of Chamberland Autoclave was a heating solution to effectively destroy dangerous microorganisms (Sheingold & Hahn, 2014). In late-1881, health care quality advanced to many countries, France, Germany, Japan, the USA, and England. The discovery of vaccines, pharmaceuticals developed anthrax, diphtheria, tetanus, polio, and pertussis (Sheingold & Hahn, 2014). In 1895, Wilhelm Conrad Rontgen discovered X-rays (Sheingold & Hahn, 2014). The production of X-rays in Germany was a new health care technology. It revolutionized its ability to see skeletal disorders or injuries (Sheingold & Hahn, 2014).

In 1910, education, knowledge, and training experience implemented to provide proper health care to the community (Sheingold & Hahn, 2014). Health care education is improvised to improve services from the emergency simulation. It was vigorous to improve patients in utilizing an equipped ambulance transportation to go to the hospital (Sheingold & Hahn, 2014). The rapid increase of medical schools must show consistency in providing a quality of health care standards (Sheingold & Hahn, 2014). Dr. Abraham Flexner proposed a four-year medical school curriculum with two years of fundamental science education and two years of clinical training (Sheingold & Hahn, 2014). Dr. Flexner has followed by the Massachusetts General Hospital, and the American College of Surgeons established minimum standards new Hospital Standardization Program (Sheingold & Hahn, 2014). It included organizing hospital medical staff, limiting staff membership to well educated, framing rules, keeping medical records, and establishing treatment facilities. The health care reform provided medical schools with more health care training and education.

In early 1928, Sir Alexander Fleming discovered penicillin to fight for bacterial actions of the blood (Sheingold & Hahn, 2014). Fleming discovered anecdote to soldiers who were facing injuries from strep throat, syphilis, and gonorrhea (Sheingold & Hahn, 2014). Sincere stimulants of many hospitals were constructing to reduce inappropriate health care quality and health outcomes of many patients. The historical structure and framework of health care quality had found importance on events and people that made a difference to their communities.

Accreditation and Standardization

The American College of Surgeon formed the Joint Commission on accreditation of hospitals in providing health care quality (Hines et al., 2020). Health care quality evaluated for patients centered-care. The joint commission embraced the structure-process-outcome model in looking through measurement of quality by tracking medical records, managing patients from new methods of measurement, regulating license health care program, eliminating unnecessary hospital utilization, and validating peer review on health care organizations (Hines et al., 2020; Sheingold & Hahn, 2014). Effective communication between patients and providers were in the critical quality of health care from differences of language, culture, and health literacy.

In late 1951, the Joint Commission on Accreditation of Healthcare Organizations strived to enhance the quality of health care (Hines et al., 2014). In the 1970s, Dr. George Lundberg was a positive impact on laboratory values in the hospitals (Hines et al., 2020; Sheingold & Hahn, 2014). It was critical to value expeditious reports by calling respective patients and reading the caretaker’s duty (Sheingold & Hahn, 2014). The caregiver required to make a report on “So-called read-back” information in improving the safety of their patients (Sheingold & Hahn, 2014). In early 2008, the national patient safety goals assessed by the Joint Commission in learning the tipping points of current practices of reporting laboratory values, challenging critical measures, and treating patients must come from an accredited physician in the hospital (Sheingold & Hahn, 2014). The Joint Commission developed a health care delivery system that values reports from patients, inpatients, medical technologists, physicians, nurse practitioners, administrative clerks, and clinicians.

Twenty-first Century

A redesigned health care system offered quality health care to the workforce. It established the business industry in recognizing the expensiveness of financial payments on accounts to pay at many levels the values of providing high quality and performing the best health care delivery system (Hines et al., 2020). The cost of health care levels to its quality dominated health care issues in United States medicine (Hines et al., 2020). A vital recognition of the health care system delivered an efficient and high quality of care to the patients.

The quality of improvement looked at the safety of patients in hospitals. In 2009, the American Academy of Pediatrics agreed with the World Health Organization and the United Nations Children's Fund in providing ten steps to breastfeeding children successfully (Sheingold & Hahn, 2014). One of the ten steps in making the hospital as baby-friendly health care system was to train all health care staff in skills necessary to implement this policy (Sheingold & Hahn, 2014). The hospital breastfeeding policy was designed for mothers and newborn babies to develop safe and healthy beginnings toolkit.

There are five aspects of the health care system that improved in the 21st century. The inclusive part gave the renewal focus of a promotional program. It meant making a Baby-Friendly Hospital Initiative, educating the family-centered needs of mothers, infants, and families, standardizing smoking programs, screening management to detect depression, and assisting PTSD during postpartum (Sheingold & Hahn, 2014). The approach made hospitals family-centered maternity care in prioritizing the wellness of childbirth, mother, and family (Hines et al., 2020). The complexity of improvement opportunities centered on health care for a family (Hines et al., 2020). In 1970, the National Academy of Sciences used to be known as the Institute of Medicine. It reported many questions to the health system that could have been preventable errors in hospitals, especially in the perinatal community. Improvement strategies were among useful tools to prevent mistakes in pregnancy (Sheingold & Hahn, 2014). The entirety of the U.S. health care system failed to provide consistency to provide high-quality medical care to all people.

Health Care Quality

In 1919, Dr. Avedis Donabedian researched health care quality (Sheingold & Hahn, 2014). He performed medical research that led to an outcome of creating the original health care quality concept called the Donabedian Model of health care (Sheingold & Hahn, 2014). Donabedian's seven pillars were efficacy, efficiency, optimality, acceptability, legitimacy, equity, and cost (Hines et al., 2020). VHA congregated the seven components defined by the Donabedian Model of health care quality that included safety, effectiveness, patient-centered care, timely manner, efficiency, and equity (Sheingold & Hahn, 2014). The National Academy of Sciences landmark wanted to improve the health care system by looking into the description of health care quality (Sheingold & Hahn, 2014). Recently, the health care reform law was passed (Sheingold & Hahn, 2014). It offered opportunities for disease prevention programs and health care promotion (Sheingold & Hahn, 2014). Either individual or family preferences, the cost, and quality of health care were beyond the extent that assured people would receive plans that attempt to achieve health care competency

(Sheingold & Hahn, 2014). Health care quality is derived from structures and programs to improve the process of health care delivery systems.

Structures, Processes and Outcomes

Avedis Donabedian and the National Academy of Sciences worked diligently to build structures, processes, and outcomes of health care quality (Hines et al., 2020). The whole motifs were to improve the quality and delivery of the health care system (Hines et al., 2020). Structures meant credentialing providers, facilitating adequacy, and delivering care to the health care system (Hines et al., 2020). Processes observed health care delivery of appropriateness and competencies. These were the outcomes involved in evaluating recovery, restoring function, and survival (Hines et al., 2020). The three types of metrics were part of definitions on looking through the quality of health care.

Roles, Responsibilities and Improvement

The roles and responsibilities of patients and families provided perinatal care. *Patient-and family-centered care* was defined by focusing on women's experience of care (Sheingold & Hahn, 2014). The essential components of patient-and family-centered care included respect, collaboration, information sharing, diversity, support, empowerment, active participation, and individualization. In perinatal care, the woman patient and family became the same progress (Sheingold & Hahn, 2014). A woman defined her family as a husband, partner, mother, doula, and others (Sheingold & Hahn, 2014). With the aspect of who wished to be involved with the infant's care (Hines et al., 2020; Sheingold & Hahn, 2014). The concepts of a woman and family are informed together as supportive participants and decision-makers.

Other health care quality of improvement approached educational initiatives. It included decision-making at the hospitals, finding accredited organizations, and public reporting of breastfeeding quality (Hines et al., 2020; Sheingold & Hahn, 2014). The spur of improvement met specific standards in collaborating to work together to implement improvement goals in the hospital (Sheingold & Hahn, 2014). It was overriding to initiate health professional organizations to integrate best practices in clinical supports.

Patient-Centered Care

Patient-centered care was an indispensable component of the health care system by ensuring all patients accessed their chosen care (Brown et al., 2015). In early 1998, the Salzburg group from Austria suggested computer-based guidance and communication systems build relationships among clinicians and patients in the health care system (Brown et al., 2015). Community leaders played significant roles in integrating community resources and representing health care in financing processes at the legislative level (Brown et al., 2015). The vision of patient-centered care in 2020 included automatic payments and affordable health insurance to all people (Brown et al., 2015). Patient-centered care is defined as health care quality by patients and physicians together in desiring good health outcomes (Brown et al., 2015). It was a considerable attribute of the primary care health care system defined by patient-centered care (Brown et al., 2015). It included superb access to care, patient engagement in care, clinical care information systems that support high-quality care, care coordination in comprehensive information across the virtual team of providers with feedback from patients, and publicly available direction on practices (Brown et al., 2015). Patient-centered care has recommended health care quality concepts to many health care professionals and organizations for more than 25 years (Brown et al., 2015).

Five Core Concepts

Patient-centered care was patient and family engagement care. Patient-centered care defined a patient and family engagement care as working together with the health care system to deliver safety, delivery, and health care quality (Brown et al., 2015). Patient-centered care provided five schemas of patient-family engagement care plus collaboration, respect and dignity, participation, information sharing, and decision-making (Brown et al., 2015). The definition of each schema included the following: (1) Collaboration outlined a genuine partnership between providers, patients, and families that would deliver direct care to design successfully, (2) Respect and dignity expressed patients and families are valued and treated very well with compassion in the hospitals, (3) Participation stated patients and families supported to every level of health care, (4) Information and sharing explained patients and families receive information and decide on status and condition, and (5) Decision-making marked patients and families who participated in care must decide on the quality of health care (Brown et al., 2015).

These five schemas facilitated to break of barriers of health organizations to improve the experience of patients in delivering quality health care (Brown et al., 2015). Patient-centered care provided a conceptual basis in proposing new ways to research about allowing a quality of health care. **Collaboration** in patient-centered care meant everyone is working together to accomplish the quality of care transitions patients, families, health providers, and institutions (Hines et al., 2020). The essentials of collaboration in the World Health Organization delivered the highest quality of care for the patients, families, and communities (Hines et al., 2020). Patient-centered care believed in working collaboratively to meet the needs of patients (Hines et al., 2020). It was a team-based practice in the health care system to promote coordination on supporting patients and health care providers to a shared goal across achievable settings (Hines et al., 2020). Collaboration between health care professionals and patients functioned effectively in health care institutions.

Respect and Dignity. Patient-centered care believed in giving patients respect and dignity. Health care professionals and institutions valued patients in treating all people concerning the patients' needs (McCormick et al., 2019). The health care providers ensured each patient has treated with health guidance from clinical values (McCormick et al., 2019). Patient-centered care confirmed positive results when treating patients with respect and dignity to improved health care outcomes and greater satisfaction as inpatients in the hospitals (McCormick et al., 2019). Recognizing respect and dignity meant each individual received a high quality of patient-centered care.

Participation. Medical providers believed in participation in providing adequate health care quality. Activation empowered patients in patient-centered care (Sheingold & Hahn, 2014). Participation sustained health care quality because patient-centered care required the involvement of the physicians and patients together for a common goal (Sheingold & Hahn, 2014). Each patient equated with participation as more likely would understand his or her role in the health care system (Sheingold & Hahn, 2014). Participation was the compliance of many patients to follow the advice of medical providers (Sheingold & Hahn, 2014). With participation, many patients understood the knowledge, skills, and confidence to manage health care quality.

Information Sharing. Patient-centered care supported the information-sharing approach. Patient-centered care believed in information sharing to patients and family members that will fully be informed promptly about decisions (McCormick et al., 2019). Information sharing was highly encouraged and facilitated throughout all organizational health care systems (McCormick et al., 2019). Patient-centered care supported information sharing from taking the optimal decision of evidence-based information to patient-centered care outcomes of accountability (McCormick et al., 2019). Information sharing tailored to the needs of the patient to achieve a meaningful deliberation and shared mind. Frequently, information sharing among patients and family members evolved into high-quality information.

Decision-making. Decision-making transpired when a health care provider and patient were working together to make an appropriate health care decision. Patient-centered care empowered patients, caregivers, and health care professionals in decision-making (Hines et al., 2020). Decision-making conveyed current evidence-based practice, values, desires, and preferences (Hines et al., 2020). The reason decision-making was a key component of patient-centered care because it was a process between health care providers and patients altogether (Hines et al., 2020). Decision-making informed consent to the patient in responding to the health care quality of patient-centered care.

Advantages and Disadvantages

The advantages and disadvantages of patient-centered care promoted patients' responsibilities. The advantaged health care system were improvements to understand disease and treatment (Llardo & Speciale, 2020). Providers did not treat patients to healing but preventing diseases spread across the country. Providers were supposed to cure patients rather than caring for patients. These were advantageous effects on patients from a health care system (Llardo & Speciale, 2020). The cost was also part of the advantages of patient-centered care because it provided better financial payments (Llardo & Speciale, 2020). Health care quality of patient-centered care fostered positive outcomes from diseases and symptoms using the approach of patient-centered care (Llardo & Speciale, 2020). The digital communication of the health care system made it easier for the patients access to patient-centered care (Llardo & Speciale, 2020). Planning was one of the many cases of health care management programs offered advantaged care for patients in proper health care delivery (Llardo & Speciale, 2020). Positive outcomes happened when utilizing a patient-centered care approach between patients and physicians that show close relationships (Llardo & Speciale, 2020). The advantages of patient-centered care sought cornerstone of concerns for health care quality.

The disadvantages of patient-centered care remained far beyond approach implementations. Patient-centered care became disadvantageous when providers were not incorporating cultural competence in not seeking an equitable and high quality of health care (Llardo & Speciale, 2020). Physicians and nurses must use their knowledge and skills in identifying antecedents, mediators, and triggers of the symptoms or diseases

(Llardo & Speciale, 2020). Collaboration showed a significant advantage of patient-centered care of which involved communication and collaboration between patients and physicians (Llardo & Speciale, 2020). The disadvantages of patient-centered care were the ineffectiveness between patients physicians were not engaging in racial groups in health care quality (Llardo & Speciale, 2020).

Quality

Quality of patient-centered care defined preferences, needs, and values that ensure clinical decision. The cardinal aspect of patient-centered care emphasized the health care quality of a patient perspective on health situations (Llardo & Speciale, 2020). Quality of patient-centered care has meaning to understand the culture, knowledge of culture, appreciation of culture, and awareness of health disparities (Llardo & Speciale, 2020). Patient-centered care reduced tensions on ethnicity and socioeconomic status. Patient-centered care approached prime to health care improvement outcomes (Llardo & Speciale, 2020).

Measures

Patient-centered care was a component of the health care system by ensuring all patients accessed their chosen care (Brown et al., 2015). In late 1998, the Salzburg group from Austria suggested computer-based guidance and communication systems build relationships among clinicians and patients in the health care system (Brown et al., 2015). Community leaders played significant roles in integrating community resources and representing health care in financing processes at the legislative level (Brown et al., 2015). The vision of patient-centered care in 2020 included automatic payments and affordable health insurance to all people (Brown et al., 2015). Patient-centered care is defined as health care quality by patients and physicians together in desiring good health outcomes (Brown et al., 2015). It was a considerable attribute of the primary care health care system defined by patient-centered care (Brown et al., 2015). It included superb access to care, patient engagement in care, clinical care information systems that support high-quality care, care coordination in comprehensive information across the virtual team of providers with feedback from patients, and publicly available counsel on practices (Brown et al., 2015). Patient-centered care has recommended health care quality concepts to many health care professionals and organizations for more than 25 years (Brown et al., 2015).

Limitations

Patient-centered care played vital responsibilities in integrating patient and physician perspectives. Some patient-centered care articles, journals, and books had limited information about health care policy, allocation of resources, and efficiency of delivering health care quality (Llardo & Speciale, 2020). Some patient-centered care concepts created biases to develop strategies (Llardo & Speciale, 2020). There were profound implications of planning, delivering, and evaluating health care quality from patient-centered care (Llardo & Speciale, 2020). Facts of strong evidence were also exclusive for the potential nuance of health care quality (Llardo & Speciale, 2020). Community engagement challenged professional monopoly and authority about health care policy to be explicitly no limitations and prohibitions (Llardo & Speciale, 2020).

Person-Centered Care

Person-centered care was an approach to deliver respectful care toward a patient (Zhao et al., 2016). It allowed the negotiation of health care and offered a choice in therapeutic relationships (Zhao et al., 2016). Person-centered care empowered a person to make their own decision for interventions and treatments (Zhao et al., 2016). The values of person-centered care enabled a person to receive respect, right to self-determination, and understanding (Zhao et al., 2016). Patient-centered care was a relationship structured between health care providers and a patient to reach a simple set of health goals.

Quality of Life

The vision of many Americans in the year 2020 was to eliminate health disparities and increase the quality of life. The quality of life meant identifying public health priorities in helping each other by promoting health advancement. The fourth generation of people planned healthy lifestyles that healthy development and behaviors across life stages would create a social and physical health environment. The American people prompted to consider the quality of life in living at healthy places away from diseases. The focused-on health care quality has proven as health measures to a healthy population (Koh et al., 2010).

Theoretical Foundation

The theoretical framework of this study was on the theory of Maslow (1943) described human motivation and the hierarchy of needs. According to Maslow (1943), “furthermore any classification of motivations must deal with the problem of levels of specify or generalization the motives to be classified” (p. 55). Maslow’s (1943) Theory facilitated an understanding of the military health care environment and lifestyle of wounded service members. “A person who is lacking food, safety, love, and esteem would most probably hunger for food more strongly than for anything else” (Maslow, 1943, p. 58). This quote argued that the theory of motivation and hierarchy of needs could be relevant to the OEF/OIF vets. The theoretical framework was a foremost understanding for a qualitative study.

Theory of Human Motivation and Hierarchy of Needs

The development of Maslow’s (1943) theory explained human motivation and the hierarchy of needs. Maslow’s (1943) “If all needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background” (Maslow, 1943, p. 59). This quote showed his theory depicted hierarchical levels of the pyramid as it staged into a model of five motivational needs from physiological, safety, love, esteem, and self-actualization. Human motivation has fulfilled from a lower to higher demand, and all lower requirements had met, and people move from one to another based on circumstances. Maslow’s (1943) Theory has outlined human motivation with the hierarchy of needs below in Table 1.

Table 1

Maslow’s Hierarchy of Needs

The need	Definition
Self-actualization	An achievement was of one’s full potential in accomplishing the goals in life. Realization of personal potential, self-fulfillment, sought personal growth, and at the peak of the experience.

Esteem	It was a soaring desire for status, the worthiness of self, and competence. Higher position within a group includes achievement, mastery, independence, stature, dominance, prestige, self-respect, and respect from others.
Love and belonging	It was a desire for social relationships as well as love and affection. Affection could be coming from workgroup, belongingness, family, friends, and community.
Safety	Freedom was from danger and expectation. It includes protection from elements, security, order, law, limits, stability, and freedom from fear.
Physiological	A physical requirement sustains human survival air, food, drink, shelter, warmth, sex, and sleep.

Costi et al. (2020) discussed the relationship between Maslow's (1943) theory of human motivation with the hierarchy of needs and patient-centered care. By the basic needs of patient-centered care was to be able to welcome patients in the current health care environment situation as safeties, cleanliness, and restfulness. Health care providers worked with patients generalized to have a good interaction with each other. "Another peculiar characteristic of the human organism when it is dominated by a certain need is that the whole philosophy of the future tends also to change" (Maslow, 1943, p. 76). This quote assigned patient-centered care veterans were ideally able to make participation and communication as possible for a sense of belonging with your providing health care team. Achievable self-actualization was the situation of health care quality being delivered successfully to patient-centered care (Maslow, 1943). Maslow's (1943) theory showed a hierarchy of needs supreme ladder of human needs for self-actualization. Self-actualization was very difficult to ignore because it offered intuitive focal exigency addressed. The patient-centered care approach is rooted in human motivation and the hierarchy of needs for health care practices from the well-being of patients.

Maslow’s (1943) theory uttered human motivation with the hierarchy of needs applied a framework to understand how motivating factors relate to war veterans (Costi et al., 2020). Health rehabilitation and assistance to the road of recovery were basic physiological needs of wounded service members after being sustained with signature injuries from combat zones. “The tendency to have some religion or world-philosophy that organizes the universe and the men in it into some sort of satisfactorily coherent, meaningful whole is also in part motivated by safety-seeking” (Maslow, 1943, p. 146). This quote showed wounded service members from wars of OEF and OIF suffered severe mental health issues from PTSD and TBI must now need feeling safety and belongingness. Support of love once could make current war veterans provide veterans a sense of belonging to family and community. According to Haibach et al. (2020), “It is also crucial to ensure respect and dignity for servicemembers and veterans, as well as consider potential negative consequences of findings for other stakeholder groups and health care organizations throughout the study and dissemination process in balancing transparency, confidentiality, and organizational missions” (p. 15). Satisfaction of the self-esteem need leads to feelings of self-confidence, worth, strength, capability and adequacy of being useful and necessary in the world” (Maslow, 1943, p. 191). This quote showed adequate health care treatment with positive outcomes provided a successful interpretation of Maslow’s (1943) Theory showed on three lower needs that interpreted in increasing self-esteem and self-actualization (Costi et al., 2020).

Conclusion

The literature review explored the background of the VA. The principal mission was to provide war veterans a health care quality. The VHA needed to make social change in realizing the deaths of war veterans in VHA facilities. It became unforgettable scandals that occurred in 2014. It was vital to provide health care quality to many war veterans. Maintaining health care systems that satisfy the needs of war veterans would give reasons that the VA was proactively committed to making a difference. Veterans' Health Administration was improving every year to become the backbone of war veterans.

The observation of focus groups and interviews found measurements of health care systems. The voice of many war veterans could make a social change to veterans in the community. The VA must stay committed to the health care quality approach to work on the most pressing challenges. Mental health services were cardinal on health care systems. It was unlimited in transferable skills of war veterans from military to civilian life. There were significant causes of veterans knowing the war symptoms. The health care system must deliver appropriate health care quality. The health care system found the significance of researching war veterans. It was essential to hear their stories and know their perspective about the health care system for proper delivery. It was an immense gap in knowledge between the quality of health care perceived by war veterans and delivered by the VHA.

The problem was to find more information to determine opportunities of which may exist to improve health care quality for war veterans. The study was a whole intuition in improving war veteran’s access to the VA health care system. It was vigorous that the VA health care system provides the highest quality of care. This qualitative study could benefit many military veterans and live a quality of life. Past and present military leaders and legislators might have additional knowledge about the health care challenges that war veterans were going through in terms of health care quality. Health care financial supervisors must have the potentials to teach health care quality and allocation of resources just for war veterans in need. The study could provide better knowledge or perhaps educational information to many war veterans for their stakeholders. War veterans were encouraged to receive health care treatment to help them get a better life to live.

Summary

War veterans sought improvement in the VA on the health care system in delivering health care quality (Haibach et al., 2020). The VA found their program for veterans were transitioning to civilian life. The focus of this research study was to understand the war veterans in shifting to a transition program and working together with VHA from the VA. When service members came home from serving the OEF and OIF, they were carrying the unrecognized war symptoms. Many war veterans were still in need to get help from mental health and invisible wound problems (Hamilton & Parko, 2020). Now, VHA was struggling to provide adequate health care quality to war veterans.

Health care quality evolved in the 18th century. It was a predominant aspect of the health care system to serve the welfare of war veterans. In 1966, health care quality was from Donabedian. It provided implementation to improve structures, processes, and outcomes of patient-centered care. Patient-centered care showed dominant roles and responsibilities to their patients in providing adequate health care quality. The five core concepts of patient-centered care displayed a principal yearning for war veterans embrace collaboration, respect and dignity, participation, information sharing, and decision-making.

The descriptive phenomenological research design needed a theoretical framework of Maslow's (1943) theory of human motivation and the hierarchy of needs. This theory was relevant to this qualitative research methodology because it provided new knowledge of health care quality to OEF/OIF vets in transitioning to civilian life. Health care quality was far beyond without limitations to help the United States veterans.

Chapter 3: Research Method

Introduction

In Chapter 3, I address the research method that I used in this study. The purpose of this research study was to better understand the OEF/OIF veterans. The perceptions of OEF/OIF vets has rendered their abilities to successfully transition from active duty to civilian life through rehabilitations with regard to the health care quality of the VHA. A better understanding of OEF/OIF vets will help to the gap of health care quality from the delivery system of VHA. The research method that I used contains a statement of purpose, research question, research design, role of a researcher, participant logic, population, sampling strategy, criterion selection based, instrumentation, interview protocol, pilot interview, data collection, data analysis, credibility, validity, ethical procedures, and summary.

Purpose

The purpose of this phenomenological study was to explore the perspectives of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

Research Design and Rationale

The methodology that I used in this study was qualitative research, and the research design was descriptive phenomenology. Descriptive phenomenology allows researchers to explore the perceptions of OEF/OIF vets with a particular phenomenon (Giorgi, 2009). This research design sought the meaning of OEF/OIF vets' intuition and reflection on conscious experience and understanding (Giorgi, 2009). A qualitative is a method for interviews that helps researchers to understand the lives of OEF/OIF vets socially and culturally (Patton, 2015). Qualitative research allows researchers to explore the phenomenon in understanding the perceptions of OEF/OIF vets (Patton, 2015). I used snowball sampling to identify 10 OEF/OIF vets from the targeted population of war veterans to the VHA (Cosco et al., 2015). A data collection must clarify in understanding the interview protocol of the VHA that provides a quality of care (Cosco et al., 2015). In this phenomenological study, I assessed the implementation of organizational programs with provisions in the behavioral management of care contracts (Giorgi, 2009). I used a qualitative research method with descriptive phenomenology to appropriately analyze OEF/OIF vets who received patient-centered care who were not experiencing a quality of care in the VHA. I also used a qualitative research method used the design of a phenomenological study to describe and translate the experiences of OEF/OIF vets in the VHA (Patton, 2015). Conducting qualitative research for this study allowed significant information in providing a quality of care for vets from OIF or OEF.

Research Question

RQ1–Qualitative: What were the perceptions of current OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making?

Role of the Researcher

My role as the researcher required me to inquire about intensive experiences among the participants. Rudestam and Newton (2014) stated, “the character of the researcher is to clarify the relationship between a particular proposition and the broader context of theory and previous research" (p. 6). This quote affirmed that my role involved experience in the field and must know beforehand the conceptualization of recent topics. Creswell (2014) noted, "With these concerns in mind inquirers has explicitly identified reflexively their biases, values, and personal backgrounds such as gender, history, culture, and socioeconomic status that shape their interpretations formed during a study" (p. 237). This quote indicated that my role introduced the personal relevance of experiences into a quality of research process.

Research bias occurred when a researcher would influence the results of their work. As the research process formed the biased role of a researcher; the tolerance of conducting a qualitative study is inherited when I am involved in a potential bias situation of a specific program during data collection and analysis. I maintained cognizance of the significant guidelines to eliminate bias in a research study. Gender-biased words and gender-neutral words have been designated to promote equality (Rudestam & Newton, 2014). Guidelines expelled any certain assumptions of the gender-related profession and avoided gender-biased pronouns (Rudestam & Newton, 2014). Significant guidelines disregarded the process of identifying people by race or ethnic group and whether the information was irrelevant and avoided the language that reinforces stereotypes. This instruction eliminated all unsupported assumptions on age or group of people (Rudestam & Newton, 2014). I revealed the influential critical components on potential biases and assumptions of this study.

Previously, I stated my military background and worked in the U.S. Marine Corps. I am an Iraqi war veteran and served during OIF, 2003-2007. The Medical Center in the Department of Veterans Affairs assisted me with my health care. I believe strongly in the VA. The VA provides adequate health care quality due to the analyst's positive experience in attaining health care quality in the VHA delivery system. I am fully aware of health care delivery to one's own experiences, wounded service needs, and satisfaction levels in the VHA.

I have maintained the objectivity of the study. To put aside any values or biases of manners that might affect the interpretation of a research study is called *impartiality* (Creswell, 2014). I identified phenomenological scientific reduction and the concept of epoké that refers to a precise understanding of human experiences for an usual group of people (Giorgi, 2009). Giorgi (2009) has defined *epoké* as a way to put aside any biases in textural data that dominates the Western cultural views of research designs to create meaning of objectivity, consciousness, and rhythm of the relationship between researcher and participants. Creswell (2014) contributed to the *epoké* term as sequential and concurrent designs. The role of a researcher is never to use a prejudged mental state and preconceived ideas that disqualify commitment to a research study on new knowledge and experience. I employed techniques of bracketing during the interviews. Bracketing interview was a cognitive process to put one's own beliefs and judgments off the pence from received from one's own experiences (Giorgi, 2009). I made sure that I do not have any preconceived feelings that would influence biased manners. I trusted in my ability to conduct a research study on U.S. war veterans.

Methodology

The methodology that I used presents qualitative research from a descriptive phenomenological study. Further, the qualitative research method that I used appropriates research to lived experiences of individuals (Patton, 2015). Descriptive phenomenology helped me to explore the perceptions of 10 OEF/OIF vets of a particular phenomenon (Giorgi, 2009). Descriptive phenomenology sought the meaning of OEF/OIF vets' intuitions and reflections on conscious experiences and understanding (Giorgi, 2009). Qualitative research methods for interviews help researchers understand the lives of OEF/OIF vets socially and culturally (Patton, 2015). Qualitative research allowed me to explore the phenomenon in understanding the perceptions of 10 OEF/OIF vets in the VHA (Patton, 2015). Researchers must understand data collection on interview protocol from the VHA in providing a quality of care (Waters, 2015). Research design presents the following: population, sampling strategy, instrumentation, data collection, researcher-developed instruments, procedures for pilot studies, recruitment of participants, data analysis, ethical procedures, and summary.

Population

The population was a sizeable collection of individuals to focus on a research study (Patton, 2015). The populace of this qualitative research estimated that more than 30,000 U.S. Armed Forces veterans nationwide are supported by the VHA. Approximately, the percentage of OEF/OIF veterans was 10% in the VHA population (Viscusi, 2019). The identified target population comes from observation and interviews of present findings for generalization (Waters, 2015). In this qualitative study, I generalized the targeted occupants with an estimation of approximately 3,500 OEF/OIF war veterans previously assigned to the VHA.

Sample

A sample was a subset of the population developed the sampling strategy (Patton, 2015). I was using a descriptive phenomenology and adopted a snowball sampling technique. The participants contacted and selected through personal contacts and social networking to identify and explore the OEF/OIF vets' perceptions of health care quality in the VHA. Snowball sampling in this study selected participants that possibly reach the target population (Patton, 2015). Snowball sampling was a useful technique because it has many veterans who have a sensitivity to information (Patton, 2015). Palinkas et al. (2015) noted that I selected participants for a specific purpose of the study. It was the participants who were experiencing a phenomenon that will explore the research. "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than with a sample size" (Patton, 2015, p. 10). This quote was affirmed by Patton (2015) in stating that there are no rules for sample size in qualitative inquiry. Snowball sampling identified the inclusion criteria of 10 OEF/OIF war vets from the targeted population on the following criteria: 1. Veterans sustained polytraumatic injuries, war symptoms of conditions, or traumatic diseases after serving in combat zones during OEF and OIF, 2. Veterans assigned to the VHA for at least one month, 3. Veterans discharged from the VHA between October 2004 and October 2020, and 4. Veterans received health care treatment through services established by the VHA at the time of the research study (Palinkas et al., 2015).

The idea in using qualitative research methodology was to select participants of the proposed phenomenological study (Creswell, 2014). I understood the problem and the research question (Creswell, 204). Notice that this snowball sampling strategy was not suggesting to randomly conduct sampling or select a large number of participants at sites (Creswell, 2014). The aspects of identifying cites and participants included setting, actors, interviews, and process. A phenomenological study typically ranged from 3 to 10 participants (Creswell, 2014). There was no specific answer to the question of how many sites and participants should be conducted (Creswell, 2014). But the sample size depended on the qualitative design used in the study (Creswell, 2014). It impacted war veterans on patient-centered care for the quality of health care delivery outcomes (Creswell, 2014). The approach tended the ways veterans are encountering adversity in the VHA (Creswell, 2014). The study examined institutional structured and programmatic efforts to help OEF/OIF veterans engage new ideas (Creswell, 2014). It selected individuals to explore the results in more depth qualitative research of methodology (Creswell, 2014). In the data collection, the snowball sampling approach and the forms of data collected in virtual interviews (Creswell, 2014). Qualitative research design helped the snowball sampling strategy identifies the site and individuals (Creswell, 2014). Creswell (2014) emphasized that the sample of 10 participants can represent a reasonable size because a qualitative study is about quality and not quantity. The motives of the snowball sampling selected sites and participants. The qualitative researcher was selecting individuals who will ask if they were meeting the inclusion criteria, interested in taking part in the study and going to help stakeholders to understand the research problem and research questions.

Instrumentation

All data was collected by the researcher. According to Creswell (2014), the researcher was a pitched instrument in the research study. I collected data by examining documents and interviewing participants (Creswell, 2014). I used demographic data to accurately describe each participant incorporate age, branch of service, current rank, deployment information, ethnic background, gender, marital status, race background, and time of service. I ensured the confidentiality of each participant. The virtual phone interviews took place in the VFW. The duration of interviews lasted approximately 30 to 60 minutes were depending on the response from each participant, especially if they need to take more time. I gathered data collection by exercising protocol guidance (Creswell, 2014). I was organizing to review data collection and finding the results to themes from a developed interview protocol (Creswell, 2014).

All research uses data collection. I utilized the in-depth and semi-structured type of interviews. It was the reason to focus on the issues to get the participants to talk about their perceptions about health care quality (Patton, 2014). The standardized order of questions was consistent for the reliability of the interview process across data collection (Patton, 2014). I made sure to ask open-ended questions to get the responses of participants in their own opinion on matters (Patton, 2014). It allowed participants to provide detailed information through follow-up probing questions (Patton, 2014). I maintained unbiased with credible instrumentation in reporting data collection.

Interview protocol guided participants to fill in the gap of a phenomenon. Jamshed (2014) stated, "an in-depth and extensive understanding of the issues using their textual interpretation and the most common types are interviewing and observation" (p. 4). This quote acknowledged the importance of qualitative interviewing captures the openness of knowledge, experiences, and feelings to the research study. The reflective journal of data collection process addressed my own biases to its context of knowledge. Researchers reflexed systemic attitudes towards instruments that address its content or context of knowledge to hindrance biases of the research (Patton, 2014). I have ascertained prominent issues of extensive understanding.

Interview Protocol

Interview protocol (see Appendix A) developed standardized, open-ended interview questions that aligned with the qualitative research question (Jamshed, 2014). The interview protocol cultivated research questions asked in the following sequence: (1) What events led to your assignment to the VA? (2) How would you define health care quality? (3) How would you describe the collaboration demonstrated by you and the VHA at VA? (4) How would you describe the partnership exhibited by other war veterans and the VHA at VA? (5) How would you narrate the respect and dignity provided to you by the VHA at VA? (6) How would you describe the respect and dignity provided to other war veterans by the VHA at VA? (7) How was your participation in decision-making about your care facilitated by the VHA at VA? (8) How was the participation of other war veterans in decision-making about their care assisted by the VHA at VA? (9) How would you describe the information sharing with you by the VHA at VA? (10) How would you describe the information sharing with other war veterans by the VHA at VA?

Pilot Interview

I piloted interviews to add reliability and validity to a research study. A pilot interview has helped authenticate the efficiency of the interview process in a research study (Patton, 2014). I applied experience from the investigator techniques (Jamshed, 2014). The OEF/OIF veterans interviewed with protocol procedures in the study. The interview conducted a virtual interview in the VFW facility in the state of Washington. I proceeded on the following, to ask permission if it is possible to record interviewing, review data with participants to transcribe coding and determine if some questions are puzzling (Patton, 2014). Designing this pilot interview allowed the necessary modifications to a major study (Jamshed, 2014).

Data Analysis

Data analysis began after completing all interviews. Giorgi (2009) provided a method of structure process for data analysis. Giorgi appended verbatim transcriptions in writing the exact words from participants. It unified statements to create codes from the phenomenological study. The findings formed patterns of material that had common themes. It uncovered the meaning of a phenomenon through the identification of essential motifs. It exposed perceived figures from experiences in a group. It informed comprehensive ornamentation that describes the recurrent structure and outlining criteria that synthesize the overall quality of the analysis. The software NVivo 12 was utilizing in qualitative data analysis. I operated the software of NVivo 12 to organize interviewing transcriptions and manage coding procedures efficiently (Giorgi, 2009). Qualitative software became a popular tool to use for data inquiry, in particular, importing, coding, and organizing transcripts (Giorgi, 2009). Qualitative researchers needed to choose what fits in a qualitative research study through questioning and analyzing data procedures (Giorgi, 2009). The qualitative researcher knew creativity is principal. And, open-mindedness made the research study jubilation. It created the human mind and attitude by not limiting data to only one consideration of real acts in data analysis (Giorgi, 2009).

Issues of Trustworthiness

The descriptive phenomenology ensured the trustworthiness of results from a research study (Giorgi, 2009). Trustworthiness was an urgent indicator of the authenticity of a research study (Creswell, 2014). Qualitative research made validity and reliability. Validity and reliability are concerned in a research study about training interviewers and transcribing sources. It recognized that the accurateness of data collection would convince audiences about critical investigations (Rudestam & Newton, 2014). I have modified the coding scheme after analyzing data collection (Rudestam & Newton, 2014). I inquired about the validity and reliability or trustworthiness of a qualitative research study. The usage of its standards was to judge and rigors to research methodologically with factful evidence. Trustworthiness accounted for academic research. Trustworthiness delimitation the structures of qualitative research (Patton, 2014). Rudestam and Newton

(2014) described the issues of authenticity. Qualitative research evaluated on criteria of credibility, transferability, dependability, confirmability, and ethical procedures.

Credibility

Credibility was the internal validity of a research study (Rudestam & Newton, 2014). It meant that the value of the findings included spending sufficient time with participants, checking distortions, exploring experience from participants, clarifying tentative results with participants, revising sources of data, and checking on other investigator's records of field notes (Rudestam & Newton, 2014). I understood that a supported study obtains adequate findings that allow greater credibility to member checking, peer-reviewing, prolonged contacting, reflexibility, saturation, and triangulation. Member checks presented a written narrative and interpreted information in confirming credibility (Rudestam & Newton, 2014). Peer review played the role of the devil's advocate by questioning data collection, analysis, and interpretation (Rudestam & Newton, 2014). Prolonged contact realized a new version of reality in recognizing community and representing people adequately (O'Sullivan et al., 2016). Reflexibility enhanced the strength of critical journal reflection by recording researcher biases and acknowledged a research study (O'Sullivan et a., 2016). Saturation attained widespread acceptance in qualitative research (O'Sullivan et al., 2016). Triangulation solicited data from multiple sources by corroborating evidence and illuminating themes (Rudestam & Newton, 2014). Independent review confirmed extensive support for attaining credibility (O'Sullivan et al., 2016). In qualitative research, the methodology section must describe research design, sample, population, and measure of the study in letting audiences know that they can decide if findings are credible or not credible (O'Sullivan et al., 2016). I developed a well-designed strategy with sufficient input of time to produce credibility.

Transferability

Transferability was an external validity (Rudestam & Newton, 2014). The research study conveyed generalization from the findings (Rudestam & Newton, 2014). In a qualitative research study, external validity emphasized thick description in varying participant selections (Rudestam & Newton, 2014). Thick elucidation described behavior and context of which gave meaning in a research study (Rudestam & Newton, 2014). The computer-based qualitative data analyzed the program and organized data (Rudestam & Newton, 2014). Transferability saved time in coding, sourcing, storing, and manipulating textual data (Rudestam & Newton, 2014). A detailed set of research study allowed sufficient transferability in looking at descriptions of participants (Rudestam & Newton, 2014). Even if a sample is a research design change, I generalized it in a modest mindful way. I made sure it represented the context of participants' lives (Rudestam & Newton, 2014). Transferability interfered with the database that emphasizes context and generalized sample of the population. Transferability indicated external validity.

Dependability

Dependability was a qualitative counterpart to reliability. It meant that the findings of a research study were dependable. The dependability established strategies of audit trails and triangulation (Patton, 2014). The triangulation of data analysis continued discussion to dependability (Patton, 2014). Dependability was a design from a dependable system. It implied audit trails and reliability in the operation of a health care system (Patton, 2014). The dependability of audit trails gave me a recording process on data collection. It interpreted accurateness on data collection. A qualitative research study needed reliability.

Confirmability

The confirmability sought validity confirmation on the findings of qualitative research (Patton, 2014). The confirmability has established data collection from saturating sample of a population (Patton, 2014). Many researchers evaluated experiences as it confirmed the life-changing transition in becoming a professional scholar (Patton, 2014). The concept of confirmability through reflexivity. It kept a self-reflective journal as a tool to assist me become aware of subjectivity (Patton, 2014). Confirmability evolved me from overlapping waves of data collection. It reflected on confirmation from the results of a research study (Creswell, 2014).

Ethical Procedure

Ethical procedures described agreements about gaining access between participants and data. The research ethics of the review process complied with an application of Institutional Review Board (IRB) that includes: (Step one) I completed Form C and D to enable IRB approval that will provide tailored guidance. (Step two) I finalized the documents requested from IRB from Step one was working on ethical issues before the proposal of approval. And (Step three) the IRB and I was closing the loop after proposal approval at Walden University. The treatment of human participants complied with the IRB application:

- The institutional permission was part of the requirement. The research proposal and dissertation submission needed to obtain IRB approvals in the research process (Rudestam & Newton, 2014).
- The ethical concerns must have informed consent to research. The IRB standards required a purpose statement, time duration, and procedures. It has the right to decline or withdraw from participation, foreseeable factors of risk, discomfort on adverse effects, incentive from participation, contact information for the participants in case questions might have to ask about research and rights for a research study. Informed consent provided opportunities for prospective participants (Rudestam & Newton, 2014).
- The ethical concerns were relevant to data collection and intervention activity. I conducted a research study to protect prospective participants. Participants were adverse on consequences from declining. I honored participation in the course of the requirement. Prospective participants had the opportunity for extra credit as the equitable or alternative intervention of activity (Rudestam & Newton, 2014).

Informed consent of data lists on the following:

- In dispensing the informed consent, the research study included not to be reasonably assumed in creating distress or harm. Never placed participants to become at-risk of criminal charges or civil liability under any circumstances. It was not ideal to risk participants from employability and confidentiality that otherwise permitted by law or federal or institutional regulations (Rudestam & Newton, 2014).

- In offering inducements, the research participants included efforts that avoid inappropriate offering of financial to participants. I clarified the risk, obligation, and limitation to avoid the professional services of an inducement (Rudestam & Newton, 2014).
- In recaptioning research study included my role as the researcher. I conducted a research study that never involved pain or severe emotional distress to all participants (Rudestam & Newton, 2014).
- Participants of debriefing included obtaining appropriate information. Participants were aware and able to correct guidance from the results or conclusions of the research study (Rudestam & Newton, 2014).
- In sharing research data included protection for confidential data. Data destroyed after published research in the next five years. I did not withhold data to make conclusions on professional competency to any substantive claims of all participants (Rudestam & Newton, 2014).

This researcher took responsibility to credit the people who performed a tremendous job to get this research study finally unfold (Rudestam & Newton, 2014). The publication was accurately crediting relative scientific and professional contributions that involve in this study (Rudestam & Newton, 2014). I mentioned the impact of the doctoral dissertation from the guidance and helped of many faculty advisors to make this a feasible study (Rudestam & Newton, 2014). I presented its dissertation, publication, grants funding, and proposal concerning confidentiality and rights of information before submission.

Summary

The perception was valuable to a research study. It understood human behavior in perceiving the world and approaching the research differently. The research study explored the perception of OEF/OIF war vets assigned to the VHA regarding the five core concepts of patient-centered care. The research study made alignment on research questions with the statement of purpose that utilizes qualitative research into a descriptive phenomenological study (Giorgi, 2009). Snowball sampling proceeded with the 10 OEF/OIF war vets to a targeted population of approximately 3,500 war veterans assigned to the VHA. It noted that I was an instrument of a research study with a guiding interview protocol of open-ended and standardized questions. Chapter 4 provided the results of the research study. The research study achieved findings from perceived experiences of the OEF/OIF war vets in the VHA about health care quality. The purpose of Chapter 4 summarized the collected data and descriptive analysis. The research study answered the research questions and interpreted the results of qualitative research. Chapter 4 reminded the audience of the research questions and findings of information in qualitative research.

Chapter 4: Results

Introduction

In mid-2014, the VHA recognized the negative impact of post-9/11 veterans in receiving inadequate health care quality. The problem was the need for more information in meeting our current military veterans' needs. The main focus of the qualitative study explored patient-centered care that determines if it was an epicenter of dealing with the health care quality of the VHA (Anhang Price et al., 2015). The qualitative study existed because numerous questions send to the VA health care system concerning an enormous number of veterans who have been gone in the system (Koebli et al., 2020; Kudler, 2019). Chapter IV covered the descriptions of the research findings of this qualitative research. The preview of this chapter’s organization included an introduction, word frequency criteria, purpose of the study, research question, setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary.

Figure 1

Word Frequency Criteria Inspired by the Perceptions of the Participants

Purpose of the Study

The purpose of this phenomenological study was to explore the perspectives of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

Research Question

RQ1–Qualitative: What were the perceptions of current OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making?

Setting

The descriptive phenomenological study explored on the lived experiences of combat veterans on the five core concepts of patient-centered care. Giorgi (2009) noted that I observed the participants as they describe their lived experience in their own words. Descriptive phenomenological psychological method was specific to human consciousness in studying human behavior. The qualitative research question guided the perceptions of current combat veterans regarding the five concepts of collaboration, respect and dignity, participation, information-sharing, and decision-making. The qualitative study connected with descriptive phenomenology as a research design for this project. I employed in-depth, semi-structured, and virtual interviews as the primary method of data collection. It followed with an interview protocol (see Appendix A) of which implemented standardized, open-ended interviews in making sure that aligned with a qualitative research question. I used a pilot interview that informed a selection of a participant and none participants in verifying the interview process that identified research requirements. The interview process was significant in a qualitative study because there was no room for modifications.

The interviews were conducted from August 18, 2020, to October 18, 2020, at the Old Guard Post of VFW in the State of Washington. Briefed participants were on the purpose statement of this qualitative study. I explained the importance of conducting this study using a pilot interview with an informed consent form is obtained (see Appendix B). I followed the interview protocol (see Appendix A) procedure to asked participants the same order of questions. The virtual interviews were being audio recorded of which permitted by participants. Directly right after interviewing the participants, I debriefed assured confidentiality and thanked participants for participating in this qualitative study.

Demographics

The population of this qualitative study comprised of 30,000 OEF/OIF veterans supported by the VHA nationwide as of the year 2018 (Rudestam and Newton, 2014; Viscusi, 2019). I generalized the study to its targeted population of approximately 3,500 OEF/OIF veterans previously assigned to the VHA at the VA (Cosco et al., 2015; Patton, 2015). Snowball sampling was a nonprobability sampling technique used to select 10 OEF/OIF veterans' population-based for analysis to meet a criterion of holding the requirements including (Cosco et al., 2015): (1) Discharged from the VHA during OEF/OIF era; (2) Assigned to the VHA for at least one to seven months; (3) Received health care treatment through services was established by the VHA at the time of the study; (4) Sustained polytraumatic injuries, conditions, or diseases after serving in combat during the Global War on Terrorism.

I shaped its demographic population data sheet (see Appendix G). It collected the following military information included date of interview, time started, time finished, participant number, age, gender, rank at time of separation or retirement, deployment service, race/ethnicity, the date assigned, and disenrolled to the VHA (Creswell, 2014; Patton, 2015; Rudestam and Newton, 2014). A summary of the demographics provided in Appendix H. The average age of the sample was 39. There were 10 males were participating in this research. Five participants served in the OEF and OIF altogether. The nine participants had enlisted in the United States Marine Corps. There was only one officer participant commissioned in the military with a paygrade of O-5 and ranked as Lieutenant Colonel in the United States Army.

Researchers at the Journal of Medical Internet Research discovered that racial and ethnic minority groups faced the worst patient experiences about health care quality and access (Hswen et al., 2020). Hswen et al. (2020) evaluated the patient experience among racial and ethnic minority groups lacked in the representation of adequate health care quality. Sheinghold and Hahn (2014) identified socio-cultural barriers that would improve health care quality in achieving equity. It existed the role of cultural competence to help reduce racial and ethnic disparities in health care quality (Sheinghold & Hahn, 2014). Table 2 included differences of comparison group on race and ethnic background percentages for the OEF/OIF veterans and 10 OEF/OIF veterans in the sample (Carlson et al., 2016).

Table 2

Race and Ethnic Background Comparison: OEF/OIF Veterans and Sample

Race/ethnic background	OEF/OIF (%)	Sample (%)
American Indian/Alaska Native	6	0
Asian	2	20
Black/African American	15	0
Hispanic/Latino	10	20
Native Hawaiian/Pacific Islander	2	0
White	65	60
Other	0	0

Data Collection

I reviewed the data collection. Descriptive phenomenological psychological method, which in turn draws upon Husserl's development of phenomenology, involved a five stages process. These stages were: (1) collection of verbal data, (2) a thorough reading of each interview transcript, (3) breaking data into parts by demarcating meaning units, (4) organizing data by translating meaning units into units of psychological experience through coding, and (5) arriving at a summary of the data which involved organizing and reviewing units of psychological experience. This process of reflection led to the formulation of an essential psychological structure of the lived experience of the natural world (Giorgi, 2009). This phrase indicated initial step was to meet with the VFW. The research study confirmed by VFW that it was acceptable to conduct a research study to their organization in collecting official data. The privacy and confidentiality of war veterans with PTSD are regarded highly at VFW. It included the statement on VFW while promoting a qualitative study of 10 OEF/OIF veterans (see Appendix C). The email announcement to the veteran's organization clarified the purpose of qualitative research and contact information in participating in this research (see Appendix D). It noted that the qualitative study was voluntary, all names remained private, and there were no consequences if participants did not want to proceed.

VFW was a nonprofit organization that helped veterans in supporting health care quality issues transitioning from military to civilian lives. The VFW did not have access to personal records of medical descriptions to the VHA. I found advocates not needed for this study because VFW did not have direct access to medical records in the history of war veterans' health care issues. Above all, qualitative research relied upon an honor system, word of war veterans from the OEF and OIF transitioned through the VHA. Additionally, I contacted the VA's Institutional Review Board about conducting qualitative research outside the VHA. The VA's IRB noted that the VA and VHA had nothing to do with an outside study conducted. The VA's IRB told me that the VA and VHA had their principal investigators. With this in mind, I only recognized to follow all rules and procedures from Walden University's IRB protocol to conduct this research project effectively.

Before conducting qualitative research in collecting data, the qualitative study received approval from Walden's IRB. After approval, I conducted the process of data collection. (See Appendix B) Informed consent was given to me from the approval IRB at Walden University. The informed consent explained to all interviewees the importance of privacy and confidentiality of a qualitative study. The qualitative research would not be able to make data collection if there was no approval from Walden University's IRB.

VFW promoted flyer announcements. Many participants responded to the flyers about conducting interviews. Such news from email or social media had the same information compared to the flyer posted around VFW. Also, finishing the interview process, participants were able to contact me via phone text messages about virtual interviews, times, and dates upon their availabilities.

I began interviewing participants for a qualitative study. I have utilized a developed interview protocol during interviews. The interviews consisted of not restricted questions associated with specific ten research questions. All participants were audio-recorded with permission to participants to transcribed their words into Microsoft Word. Each participant asked the same interview questions. Interviews were concluded and received from the responses of all participants. In the closing interviews, all participants were thanked and given full assurance for their confidentiality and summaries of recorded interviews.

Data Analysis

Data analysis began after completing all interviews. Giorgi (2009) stated that data analysis must have an overall process and conceptualized in a qualitative study. It coded the broader categories or themes and displayed comparisons that explain phenomena from observation (Creswell, 2014; Giorgi, 2009; Patton, 2015). In a qualitative study, the most pertinent part of data analysis was the management that researcher organized data collection to its consistency of coding.

Using the process involved with inductive data analysis as a direction presented by Giorgi (2009), I used a general inductive approach for less complication in using qualitative data analysis. It did not leave any data collection behind for the data analysis process. I examined the data after completing the transcription process. It sorted into the appropriate categories (Giorgi, 2009). Giorgi addressed qualitative studies that allowed researchers to understand more about life experiences and perspectives of people.

A common form of a qualitative study is an inductive approach (Giorgi, 2009). This interpreted the attributes of qualitative research was using the inductive style from interview questions and observation (Creswell, 2014; Giorgi, 2009; Patton, 2015).

Inductive was a probing method devoted to participant observation that benefited semi-structured data collections and focused attention (Giorgi, 2009).

I used NVivo 12 software. It was a qualitative data analysis type of software that assisted me in the coding process and transcriptions of interviews. I used qualitative data analysis in discovering themes, classifying repetitions, and concluding a statistical assessment. According to Giorgi (2009), qualitative data derived from concepts, subjects, or interpretations made from data collection. The inductive analysis was the development of categories in making sense of the data (Creswell, 2014; Giorgi, 2009; Patton, 2015). Helping in the data analysis process, NVivo 12 was undertaking a vital part of sorting codes into nodes and substantiating clear discoveries. I followed the steps in the qualitative analysis illustrated by Giorgi (2009), which pointed out the modification in satisfying scientific criteria to its relation to obtaining data. Giorgi helped me with the data analysis process resulted in the quality and effectiveness of a study.

Evidence of Trustworthiness

Giorgi (2019) discussed limitations as features in a qualitative study that might negatively affect the results or ability to generalize. I was fully aware of limitations in any areas without control or avoidance altogether. Giorgi also pointed out that qualitative study must address limitations without undermining its research values in the public eyes of readers and reviewers. The clarity of the potential problem would suggest ways the possibility of a researcher's unbiased data collection and results (Giorgi, 2009; Patton, 2015). The limitations of this qualitative study found on the following: (1) Participants had PTSD was also a possible limitation for confirmability of this study. The disorder could affect their interview responses that trigger their mental health issues embrace emotional and psychological intelligence; (2) Researcher bias could be another possible limitation for the transferability of this study due to my background. Unintentionally, I could take qualitative research in the desired direction, influenced personal and lived experiences. On the other hand, it could succor to generalize to the next level because of an understanding of the veterans' population; (3) The sample size was a limitation to produce credibility. Specifically, it focused on OEF/OIF veterans part of VFW. It could only represent issues on people adequately when attempted to hypothesize interpreted information in concerning on this veterans' population; (4) Relying on responses from the participants was another possible limitation for the dependability of this study. During the interviews, I spoke with each participant with the hope that they answer questions honorably and honestly. It presented the implication of limitation with a level of the truthfulness of the interviewee's reasons that could not view with a moral compass or dignified; (5) Gender was also a limitation of this study. There were zero females participated in the qualitative research of the OEF/OIF veterans. This situation was the reason that this qualitative study could not focus on gender differentials. Gender differences could not note on empirical knowledge about gendered practices and norms.

I acquired safeguards of proper context to decrease possible outcomes impacted by limitations of a qualitative study. Giorgi (2009) stated that the descriptive phenomenology focuses on the whole person, participants' descriptions, raw data analyzed by a researcher, which preventing potential biases. I reduced any biases by having well-developed questions aligned with the qualitative research question. It guaranteed sufficiency towards participants' responses. The constraints on data analysis unveiled readers resolve about discoveries from a researcher. I assured all participants of confidentiality and could withdraw at any time with this qualitative study. All these incentives mentioned above were essentials to safeguards a qualitative study.

Results

Giorgi (2009) based his data analysis process that relies on methods and techniques. "The results reflect a careful description of precisely the features of the experienced phenomenon as they present themselves to the consciousness of the researcher" (Giorgi, 2009, p. 130). This quote explained the importance of transcriptions that each statement was transcribed and formatted into a Microsoft Word document from participants. The word document was uploaded into NVivo 12 software that assisted the coding process. "The researchers get a sense of the ways that the experiences given by the participants were lived, which is in turn described. During this process, however, theoretical or speculative interpretation should be avoided to flesh out the full lived meaning inherent to the descriptions themselves" (Giorgi, 2009, p. 127). This quote convinced me to conduct a qualitative study with the familiarity of descriptive phenomenological research design. I made sure to review transcriptions and categorized data into codes that the coding resulted in discoveries of themes for the utmost findings of the data analysis process.

While I was beginning to combine and formulate new codes, several similar themes have emerged in the coding process. Table 3 illustrated the final codebook with the preliminary coding framework, categories, emerging codes, keys, coding themes, and deducing the coding plan from Maslow's (1943) theory concerning the research question. The themes that emerged from the participant perceptions on the final codebook would be discussed later in this chapter to provide an overall view of the final themes.

Table 3

Final Codebook of Participant Perceptions

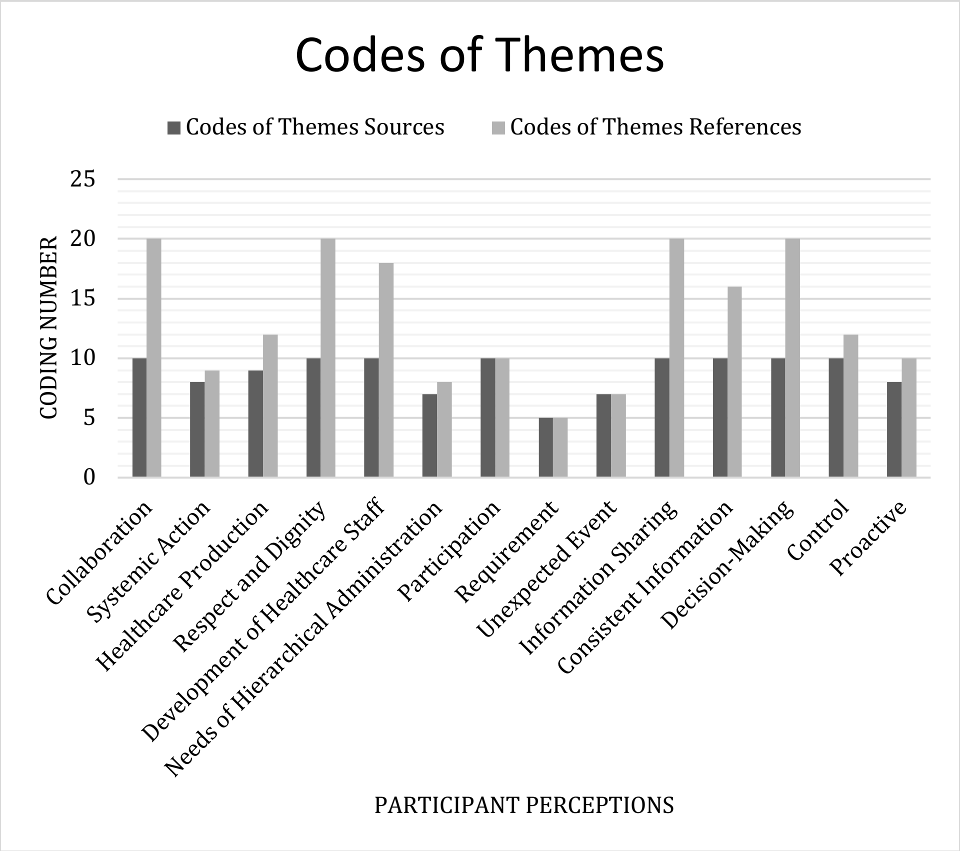
Theory	Preliminary Codes	Categories	Emerging Themes
Maslow (1943) Theory developed the hierarchy of needs based on human motivation	Veterans' Organizations Veterans' Health Administration Incentives Patient-Centered Care Perceptions Veterans of the Operation Iraqi Freedom Veterans of the Operation Enduring Freedom	Collaboration Respect and Dignity Participation Information-Sharing Decision-Making	Systemic Action Healthcare Production Development of Healthcare Staff Needs of Hierarchical Administration Requirement Unexpected Event Consistent Information Proactive Control

The main research question reported the findings of data analysis. There were five core concepts of patient-centered care analyzed separately. It identified codes from each learning and illustrated finding into categories of tables and representations of codes (See Figure 2). Figure 2 showed It executed the identification of themes from narrative descriptions and direct quotes of particular participants. There was a summary of data analysis for the five core concepts of patient-centered care outlined from a qualitative research question in the following sections. The research question included exploration of (a) collaboration, (b) dignity and respect, (c) participation, (d) information sharing, and

(d) decision-making. The complete table of themes indicated every code which was mentioned by participants from the final coding. Nine of these themes represented 10 participants. It showed the broad summary that participants were thinking in terms of patient-centered care core concepts.

Figure 2

Codes of Themes Inspired by the Perceptions of Each Participant



Collaboration. Figure 3 presented an illustration of frequency from each participant's perceptions that I identified from coding transcriptions associated with the patient-centered care core concept. The coding identified from the following results on collaboration for the patient-centered care core concept. Coding analyzed each participant on perceptions about the VA health care system provided the five core concepts of patient-centered care to provide adequate health care quality. Figure 3 refined the themes of collaboration in the patient-centered care core concept.

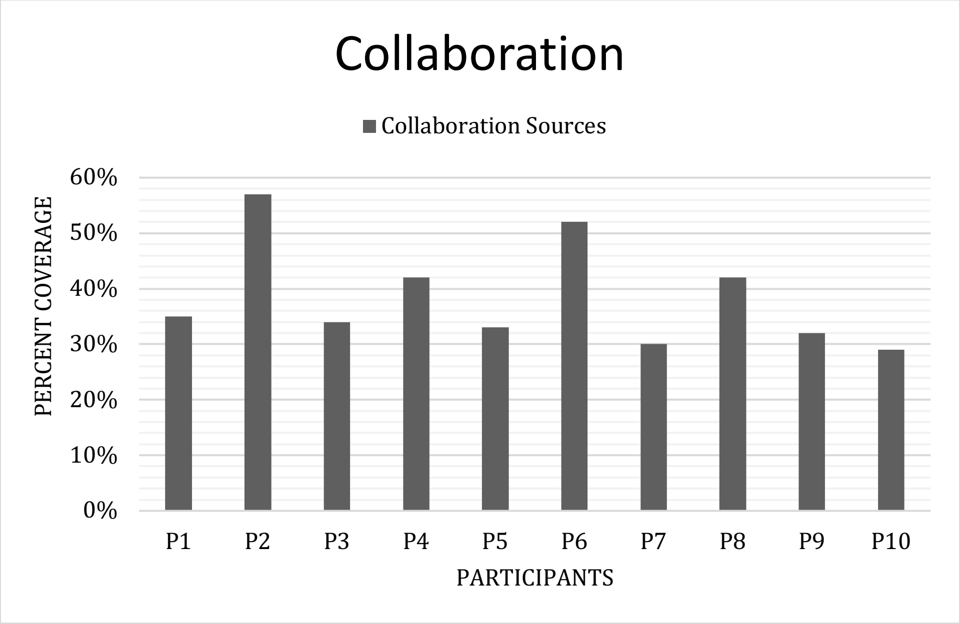
Theme 1: Systemic Action.

The study participants responded to the research question about collaboration regarding one of the core concepts of patient-centered care. It was about collaboration experience at the VHA, and the following themes were “Systemic action” and “Healthcare production” appeared. Participant 2 has 57%, while participant 6 has 52%; these participants believed that the VA health care system provided health care actions of collaboration by going through their health care appointments and without any hesitations to help patients need. Both participants 4 and 8 had 42% believed collaboration through a third-party was notable in utilizing one of the veteran organizations that would most likely get health care resources at the VHA. Other six participants 1, 3, 5, 7, 9, and 10 were ranging from 29% to 35% thought of their situations at the VHA providers, doctors, nurses, and other practitioners that collaboration existed appropriately as best they could do for the betterment of patients.

The remaining six participants mentioned their perceptions of collaboration that the VHA must maintain its systemic action to help improve patients with their systemic issues of health care quality. It relayed participants 1, 3, 5, 7, 9, and 10 thought that the VHA would reach out too many patients if hardship from collaboration happened through actions via sending emails, letters, phone calls, and updates at the VHA website in reminding patients about their health care situations. If a patient and family members had a hard time collaborating with the VA health care system, a third-party veteran organization would act as a representative to understand fully in collaborating about what other individual health care quality needed for a patient. The VHA was ready whenever a patient would like to collaborate with their specific health care providers about their health care needs. The VA health care system was resolutely improving the VHA with the hope of getting all military patients to get accessibility as fast as possible to the nearest health care facilities. Patients had a yearly check-up at the VA health care system. Systemic action was a word triangulated that summed up each perception of the participants. It was systemic actions because it emerged to appropriately collaborate to their patients that there was no way out at the hospital without collaboration in finding the best way to deal with war veterans as patients healing their war symptoms.

Figure 3

Codes for Collaboration



Participant 1 explained,

> The Department of Veterans’ Affairs does make good collaboration from advising and spreading the words out. It becomes a systemic action because I have a specific VA facility for my own health care. Veterans have choices to go to of what VA health care that they preferred. This becomes adequate health care quality to me.

Participant 2 shared his knowledge through the VHA.

> The VA will continue in making positive collaboration with you to spread systemic action on a positive impact of your health care quality. It is up to you to keep going through your health care appointments, and if you are not going to your health care appointments then the VA will not force you.

Theme 2: Health Care Production.

Health care production was another coding theme that emerged in the collaboration concept of patient-centered care. It emerged from descriptions that the VA health care system provided to their medical institution of productions for the patients. The VHA understood their patients in need that accommodated all of the help needed incorporating medicines, prescriptions, employment, personal counselors, psychiatrist, and many other incentives. All participants believed that the VA health care system provided appropriate collaboration towards them as patients at the VHA. However, eight of these participants also heard others of the OEF/OIF patients that they did not receive adequate health care quality. Nevertheless, accessible health care production has contributed potentials of impacting war veterans of health care quality. Participant 3 yielded his experience through the VHA about health care production.

> Ever since I came to the VHA at the VA health care system, it has been very smooth, and I did not have any issues about my health care quality.

Participants 1, 3, 5, 7, 8, 9, and 10 accorded the quality of continuing their communication to the VHA would make explicit health care productivity. Participant 7 explained,

> I think that there is much collaboration what the VA healthcare has done to veterans. The OIF veterans of whom I have spoken more with have different kinds of care they need. The health care is being based on what is availability of their local VHA facilities. Many veterans are living farther away from the VA facilities and it is one of the reasons that they are not receiving care. It becomes disadvantages to veterans living far away to the VA facilities. However, the VHA program has Veterans' Care Act of which helps many war veterans to go to the closest hospitals whenever they cannot make it to their VA appointments. Health production is very important to maintain. Collaboration is the key. Now, we have the VHA program utilizes private practices approved by the government to take care on war veterans.

Respect and Dignity. Figure 4 illuminated each participant of their frequency that I identified from the codes transcriptions associated with the patient-centered care core concept of respect and dignity. The coding identified from the following results on respect and dignity for the patient-centered care core concept. Coding examined perceptions of each participant who participated in the VA healthcare system provided patient-centered care in providing adequate health care quality and utilizing the VHA. Figure 4 refined the themes in respect and dignity concept of patient-centered care.

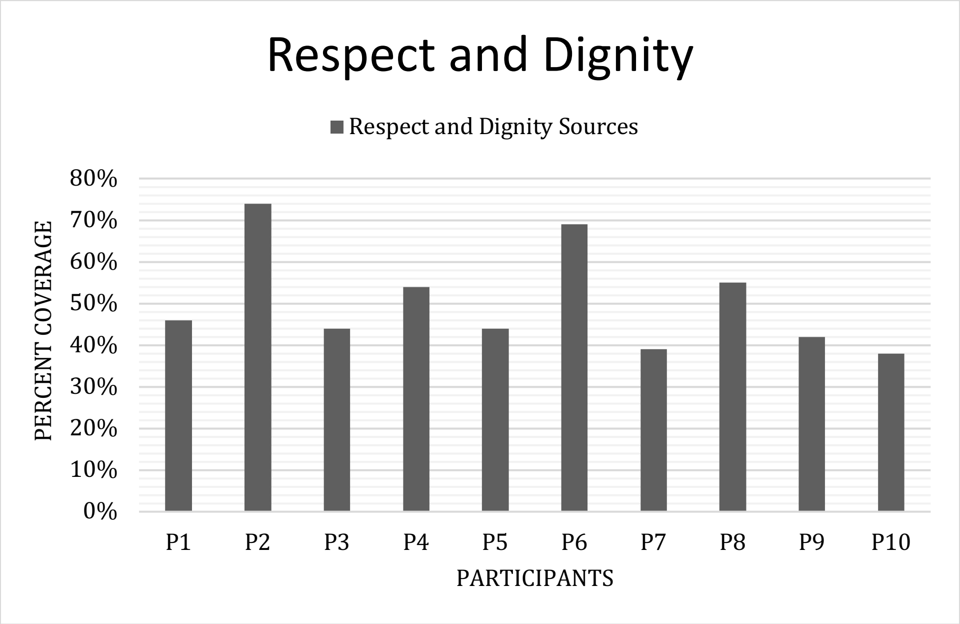
Theme 3: Development of Health Care Staff.

Another theme identified was the development of health care staff. All participants identified their appreciation to the VHA staff regarding respect and dignity. Participant 2 received 74%, while 69% was accumulated by participant 6. Participants 2 and 6 had the highest closest gap that believed in VHA staff were highly respectful. They acknowledged patients from valuable services for the country. Participants suggested that patients must need to keep up with their health care providers. Participant 4 has 54%; he guessed patients were not receiving respect and dignity from improper or poor care treatment. And these other patients who received respect and dignity from VHA practitioners would most likely do not make any complaints. Participant 8 has 55%. Participant 8 felt that the VHA had disrespectful health care providers during the beginning of health care and determined to find another VHA health care provider that helped him with his war symptoms profoundly. Participants 1, 3, 5, and 9 ranged from 42% to 46% on respect and dignity concept thought of VHA can be improved furtherly in making this conversation more about the development of health care staff.

Participants 1, 3, 5, and 9 suggested to patients must know that there were other VHA facilities to choose from locally if the current hospital did not provide them respect and dignity. Patients were concerned about health care staff not having the interest of communicating, examining, improving health care quality, and filling up the gap of their war symptoms. Respect and dignity were meant to many patients as life encouragement to achieve goals of new normalcy. War veterans who were patients knew that the VHA in this era was consistent with improvement every year. The most common experience was that they received help at the VHA, where they found respectful manners of conduct, clinical values, and the principle of human dignity. Figure 4 showed the respect and dignity of the VA health care system towards the participants in this study.

Figure 4

Codes for Respect and Dignity



The participants appreciated the VHA more compared to civilian hospitals. Participants valued respect with the VHA staff. All participants stated that VHA staff were getting better in providing health care quality to war veterans. All participants weighed in on respect and dignity at the VHA. Participant 3 mentioned his perception of respect and dignity was very different in comparing from other civilian hospital.

> For me, it is better than other civilian hospitals. I notice this experience when I went to the VHA. In comparison with my wife being pregnant right now. We have been going to local hospital. My wife and I did not experience proper treatment and hospital staff did not treat my wife well at local hospital. In comparison to my experience at the VHA, the quality of health care with respect and dignity was very different . The VHA is much better than other hospitals.

Participant 5 stated his experience with respect and dignity at the VHA.

> The VHA staff are leaders who provide respect and encouragement to all veterans. I see that positive happening for the most part of my health care perception. In the hierarchical administration like the military is not the worst component of the VA. Learning from the hierarchical responsibilities, all veterans are generally receiving respect and dignity pretty good. In general, the VHA highly values all veterans' welfare as service members of the United States of America.

Theme 4: Needs of Hierarchical Administration.

The participants stated their knowledge about the hierarchical cultures in regards to their perception of respect and dignity. Participants distributed their experiences and perspectives on the advantages and disadvantages of military structures on health care quality. Participants 3 and 5 noted military cultures impede their focus on recovery and rehabilitation. Participant 3 said,

> You know, as veterans, we always like to complain in many things. I think of the military culture carries out to our civilian lives. And, we all complain to the VA because we feel like the hierarchy would be able to find a way to fix it. Like I said for me, yeah, I have no issue about my health care quality at VHA. I'd been having a good experience. I have been going a lot now because you know I have so many injuries. I have to go for my PTSD. For the last ten years, I have no complain about the VA.

All participants stated the hierarchical culture ensures veterans comply with health care treatment guidelines. It promoted veterans with respect and dignity to service members. Participant 4 stated,

> Veterans who complains about not receiving health care quality are usually the veterans received poor care. The idea perceives as disrespect. Without that military hierarchical type of administration of checking in daily on veterans about how they are doing on their health care disability's statuses, which are needed into the civilian world. Therefore, having military environmental presence of ideals will get a veteran straighten out.

Participant 9 added,

> For the most part, it is fine. Recently, there are times of altercations because we were running some issues out to some of my doctors and VHA hospital staff. I think about this in having hierarchical responsibilities would straighten out the VHA staff. I have back and forth with negative and positive results. Some people get treated great and others get treated poorly. You know, a lot of guys got through the VA that really need help would never ask for help. Once military personnel would ask for help like the Marines, it means that there is nothing left in inside them beside suicidal behavior or harming oneself. Like in the military

> culture, once we seek help, it must be attended or else we get discourage on life because we ask the question of when we ask for help and does not attended then that it discourages us is it ever going to get done.

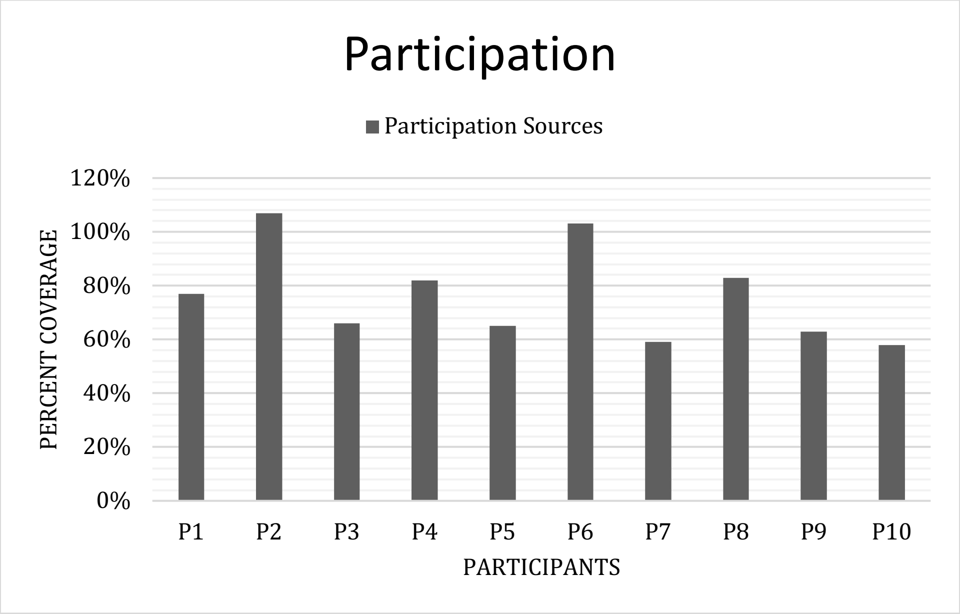
Participation. Figure 5 illustrated each participant on a frequency that I identified from the coding transcriptions associated with the patient-centered care core concept of participation. It identified from the following results of coding about participation concept of the patient-centered care. The coding has examined each participant their perceptions in the VHA in providing adequate health care quality to the U.S. veterans of patients. Figure 5 elaborated the themes in the participation concept of patient-centered care.

Theme 5: Requirement.

The fifth themes identified regarding the participation of patient-centered care were a requirement and an unexpected event. Each participant discussed their perceptions of patient-centered care. The results were either requirement, not expected event, or both in participating in the VHA. Participants 2 and 6 had more than 100% participation in the VHA specifically as part of requirements before being discharged honorably in the military service. Participant 1 has 77% while participant 10 has 58% of participation at the VHA; both participants strived in the VHA program because the unexpected event from full service and medical retirements happened; it discontinued their military services. Participants 3, 4, 5, 7, 8, and 9 ranged similarly close together from 59% to 83% participation asserted that because of what happened in their cooperation in the military, they were both part of requirements and unexpected events of their military career. The participants and their family members were active participants of the VHA for their health care needs. Upon aligning to the patient-centered care core concept of participation, participants utilized their opportunities in participating in the quality of health care and life concerns.

Figure 5

Codes for Participation



Participants 2, 3, 4, 5, 7, 8, and 9 jointed their requirements in the VHA for health care needs. Participants segmented the importance of going to the VHA during the treatment process. Participant 8 explained his situation prior to honorably discharged in the military.

> It is part of the requirement to attend the United States Marine Corps Transitional Program from the military. It is basically giving those people getting out the military to enroll in VHA program as part of health care quality.

Theme 6: Unexpected Event.

The participants articulated their experiences in participating at the VHA for their health care needs. Each participant has family members that were quite a shock in becoming active in participation in receiving health care quality. Participation aligned with the patient-centered care core concept. Participants 1, 3, 4, 5, 7, 9, and 10 articulated their opportunities in participating through VHA without knowing an event would happen to end their military careers.

Participant 1 articulated his none expectancy of participation to VHA during the rehabilitation process:

> I never knew that I will retire sooner than I expected. I just realized it was time to move on to a civilian life.

Participant 9 articulated the opportunity without any choices. It was a must be done during the rehabilitation process:

> I was medically retired through the DOD from a suicide vehicle with Intermediate Explosive Device (IED) on 2007. It has caused me injuries. It caused me with disability and hinder me to do my job. I have to be medically retired from the United States Marine Corps.

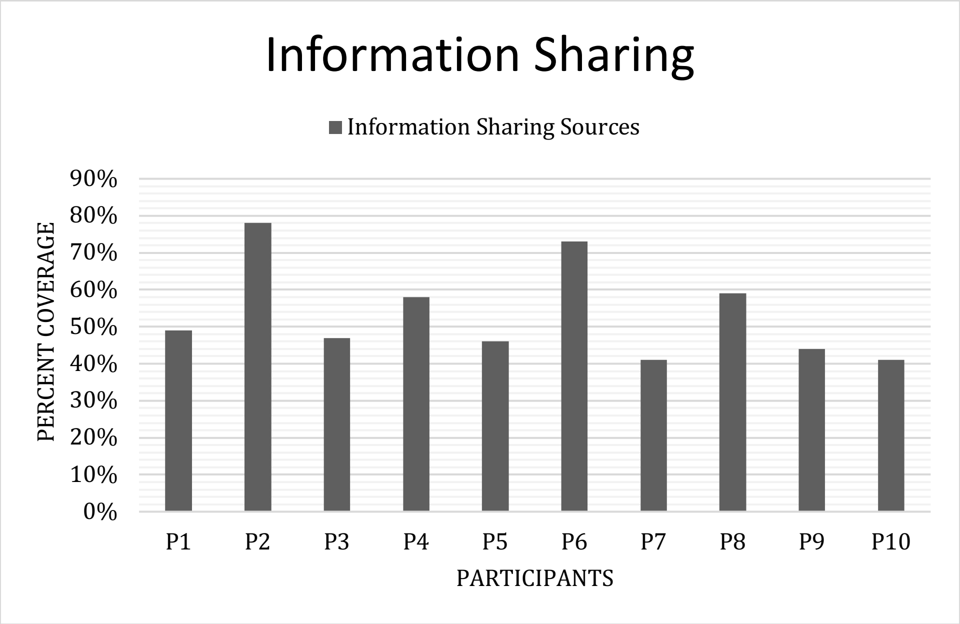
Information sharing. Figure 6 depicted each participant on a frequency that I identified from the coding transcriptions connected with the patient-centered care core concept of information sharing. The coding identified the following theme from results on information sharing for the patient-centered care core concept. Coding examined each participant about health care perceptions in the VHA provided patient-centered care. Figure 6 developed the theme of “consistent information” of information sharing in terms of patient-centered care.

Theme 7: Consistent Information.

Participants discussed the consistency of information sharing of the VHA in the VA health care system. Participants 1, 3, 5, 7, 9, and 10 ranged from 41% to 49% of information sharing; these participants received notices on phone calls, text messages, emails, letters, and updates online in answering their questions that informed them beforehand about health care information of their health care providers. The participants suggested that being patients could be very overwhelming in terms of information shared that the VHA provided to the patients on health care needs. Making appointments to speak with specific health care providers ensured receiving adequate health care information. Participant 2 has 78%, while participant 6 has 73%; both participants had the highest percentages of information sharing. Participants 2 and 6 considered the VHA health care provider had health care plans shared relevant information. Also, it made certain information was maintained with confidentiality. The participants accessed health care from information sharing of the VHA health care communication of delivery. Communications are delivered through several forms, including word of mouth, electronically, social media, and paper. While participants 4 and 8 had 58%, both agreed on the VHA about health care communication delivery were not lacking in the concept of information sharing. Many participants sounded their opinions on the concept of information sharing that resembled in VHA. Participants made statements on consistency in spreading the word of mouth out. It was in the constant communication process in reaching out to veterans to receive adequate health care quality.

Figure 6

Code for Information Sharing



All participants voiced the information sharing appeared to be efficient and well-organized to connect with war veterans. Participant 10 voiced,

> I feel that information sharing has been good. I would not say that communication is perfectly amazing, but I say the VHA have been on top of information sharing really well. I get emails, letters, text messages of updates, reminders of appointments, and upcoming health care. I have primary care reaches up to me with ideas for my treatment. I feel that it is very good. Not greatly amazing, but I feel some work can get done as well. Right now, it is not bad.
>
> In addition, I have a conversation with other couple OIF vets. They did not have any complaints about information sharing. Their perception on health care quality about information sharing were greatly amazing. It is good and it works at the VHA.

Decision making. Figure 7 represented each participant on the frequency that I identified from the coding transcriptions associated with the patient-centered care core concept of decision-making. The coding distinguished from the following results on decision-making for the patient-centered care core concept. Coding examined each participant of their perceptions of the VHA of the VA health care system. Figure 7 embellished the themes of being “Proactive” and have “Control” in the decision-making concept of patient-centered care.

Theme 8: Proactive.

In this theme, the participants focused on being “Proactive” in terms of decision-making of patient-centered care on health care quality. Each participant explained decision making about their situation of health care quality. Each participant thought supervisions supervised by their advisers from their VHA health care providers and professionals. Each participant was fully aware of their health care professionals that they made sure to fully grasp what better medical treatment options would benefit and could risk their health care quality before decision-making. Participants 1, 3, 5, 7, 9, and 10 had the same opinions as they ranged from 34% to 41% of decision-making. Participants 1, 3, 5, 7, 9, and 10 assumed there were shortages of workers in the VHA facilities, and these VHA professionals were overworked. The participants suggested that patients must know to be proactive about their issues if something new comes up. The VHA professionals were more likely to respect the decision-making of patients in providing them with health care. Other remaining participants 2, 4, 6, and 8 ranged from 48% to 65% on decision-making concepts; they believed that the VHA gave them support with the help of their family members and third-party veteran organization. It motivated participants to become proactive regarding decision making for their health care needs. Decision-making aligned with the patient-centered care core concept that explains their opportunities to decide on better choices for their health care quality and concerns.

Figure 7

Codes for Decision Making

Participant 1 declared the importance of being proactive with any issues that may come up about the rehabilitation process:

> I have to say in decision-making is good. It could always get better. Veterans must have unique understanding to VHA workers. I feel that many of VHA workers are overworked. Shortages of stuff may happen sometimes. Veterans must push through and be proactive of their health issues to their VHA doctors. Veterans must ask questions and let the VHA doctors know if any issues came up.

Participant 8 announced the opportunity to communicate his opinion about decision making on the rehabilitation process:

> It is pretty good. I am very proactive about my health care quality. I have voiced all of my concerns about my health. The VHA providers have asked me what I

> thought I needed. Through my experiences, it reflects on my health care quality, which I have been doing good every day.

Theme 9: Control.

Participants spoke in receiving support from their family members with the third-party veteran organization was vital for veterans to exercise their freedom in decision-making about their health care quality. Participants were able to control the situation with the VHA doctors and practitioners. Decision making aligned with patient-centered care core uttered their opportunities in making individual choices on rehabilitation and quality of life concerns at the VHA. Participants 3 talked to share decision making to the VHA about appropriate health care quality must be used:

> I have a freedom to make decision of my health care quality. The VHA provider respect my decision because I remember whenever I was not satisfied with the VHA provider in handling my PTSD symptom. I directly reported and shared this situation to the VHA providers, and they changed my VHA provider as soon as possible. It respected my decision making together with the VHA providers. I think all veterans have freedom make decision on their health care quality.

Participant 5 indicated the opportunity to make choices on many options for his rehabilitation process.

> There are lists of options in decision-making together with my VHA providers. I understand that sometimes I only have one option. Always stay on the positive side of getting things done. Many veterans did not take to account when they show up there in the VHA. It is depending on the approach you want to go for your health care quality. Generally, the VHA is there to help. It is very overwhelming, but the VHA is there to help war veterans.

Participant 10 inferred opportunity to control a situation of being a privilege or had the best of luck in decision making throughout his rehabilitation process:

> I feel that I have good amount of control in decision-making. Most of the time, in case by case of the most part of time whenever I add something to bring it up to

> my VHA doctor. I am a patient. I am doing my best way to articulate my health care quality. I have to understand and define what exactly I have been through. I have tried to be emotionally intelligent with the situation and not allow myself to be floored out. I sometimes felt that I do not understand what the VHA providers are saying. Although, they are trying to work with me. Just because I am not getting what I wanted immediately. It does not mean that I will give up. I just need to be emotionally intelligent. I must be very strong for that regards of my health care quality.

Summary

This chapter presented the process used to obtain the findings from this qualitative study using a descriptive phenomenological research design of current ten veterans on their perceptions of patient-centered care core concepts. The interview protocol was part of data analysis reported following a qualitative research question. It analyzed the five idea concepts of patient-centered care in the following identifications: (1) Collaboration: Systemic action and health care production; (2) Respect and dignity: Development of health care staff and needs of hierarchical administration; (3) Participation: Requirement and unexpected event, (4) Information sharing: Consistent information, and (5) Decision-making: Proactive and control. The findings of this qualitative research study supported the perceived impacts of public policies and social services. The perceptions of the VHA were unanimously optimistic towards the future of current war veterans. A discussion of thematic analysis illustrated to clear narrative descriptions and direct quotes from participants enhanced a qualitative study's substantive significance (Creswell, 2014; Giorgi, 2009; Patton, 2015). Chapter V detailed data analysis about its findings relevant to the literature review. Chapter V addressed discussions, conclusions, and recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This qualitative study used a descriptive phenomenological research approach in exploring the lived experiences of war veterans in transitioning from military to civilian life. The participants provided valuable feedback on their experiences about inadequate health care quality at the VHA could be improved. Chapter V interpreted the findings using the themes presented in Chapter 4. It contained a description of the discussion, conclusions, and recommendations of a qualitative study and includes the following sections: purpose statement, a summary of the research methodology, and condensation of tonality findings. It conveyed an introduction, interpretation of the uncovering, limitations of the study, recommendations, implications, and conclusion. The key findings included theme one: systemic action, theme two: development of health care staff, theme three: hierarchical administration, themes four: requirement, theme five: unexpected event, theme six: consistent information, seven: proactive, and theme eight: control.

Purpose of the Study

The purpose of this phenomenological study was to explore the perspectives of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

Research Question

RQ1–Qualitative: What were the perceptions of current OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making?

Summary of Methodology

I selected a qualitative study with a descriptive phenomenological research design for this study. I developed an interview protocol (see Appendix A) to utilized while interviewing participants using digital audio recording equipment to make transcriptions from responses of participants for data collection. The interview questions aligned with a qualitative research question. Giorgi's (2009) method analyzed the data collection in transcribing statements and coding to themes from each participant. It reported results by the alignment of a research question. The research identified themes from codes and participants' frequency about each of the five core concepts of patient-centered care: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

Population and Sample

The population consisted of 30,000 OEF/OIF veterans supported by the VHA (Giorgi, 2009). The study generalized targeted inhabitants of approximately 3,500 OEF/OIF veterans previously assigned to the VHA of the VFW (Creswell, 2014; Palinkas et al., 2015; Patton, 2015). Waters (2015) emitted snowball sampling to use in selecting 10 OEF/OIF veterans based on the following criteria: (1) Sustained polytraumatic injuries, war symptoms of conditions, or traumatic diseases after serving in combat zones during OEF and OIF, (2) Assigned to the VHA for at least one month, (3) Discharged from the VHA between October 2004 and October 2020, and (4) Receiving health care treatment through services established by the VHA at the time of the research study (Palinkas et al., 2015).

Interpretation of the Findings

Health care was amid significant life changes, with substantial emphasis on priorities. “Patient-centered care has become central to the core goals of better health, better quality, and lower costs while highlighting the necessity of incorporating patients’ efforts, needs, and perspectives into health care at all levels” (Brown et al., 2015, p.2). This quote stated formed strategies to war veterans’ health care quality in utilizing the patient-centered care concept. Based on my qualitative study, current war veterans had experienced many personal and social challenges in the life of new normalcy living back at home in the United States of America. According to Acosta et al. (2020), “When service members return from conflicts abroad, some bring with them depression, PTSD, substance use disorders, and other mental health issues that can affect their quality of life, their ability to function at home and on the job, and their relationships with family and friends” (p. 5). The quote comprehended to gain knowledge about the stigmatized population that required principal investigations of their lived experiences. This qualitative study could be the first study to analyze the lived experiences of current war veterans transitioned from the military to civilian life contributed effects a better conclusion of the adequate health care quality of experiences. I have proposed a qualitative research question that served as a lens to emerging themes. I interpreted reports that showed signs for possibilities of new public policies and social services to the VHA and on the lived experiences of current war veterans in utilizing the core concepts of patient-centered care. These were reported findings under a qualitative research question, the perceptions of OEF/OIF vets regarding the five core concepts of patient-centered care in the VHA: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making.

From descriptions of the ten war veterans provided new understandings about lived experiences before they become less hope and their experiences with the VA. There were differences in their experiences and backgrounds. The nine themes surfaced that consisted of the base of the live experience for these participants. The following themes were identifiable from each of the five core concepts of patient-centered care:1. Collaboration: Systemic action and health care production, 2. Respect and dignity: Development of health care staff and needs of hierarchical administration, 3. Participation: Requirement and unexpected event, 4. Information sharing: Consistent information, and 5. Decision making: Proactive and control. The themes connected with my qualitative research question and embellished other policy implementations of sustainable social service in the public policy and administration disciplines. And, it influenced the VHA access to the lived experiences of current war veterans in American society today.

Theme 1: Systemic Action

Regarding the patient-centered care core concept of collaboration, participants talked about the systemic action of the VA health care system. *War veterans* defined collaboration from their experience at many facilities of the VHA. It addressed the commitment of VHA's primary providers, doctors, nurses, and other practitioners at the VA health care system. It provided each OEF/OIF with individual support. The VA health care system ensured successful recovery and rehabilitation to war veterans and their family members altogether.

The *collaboration* defined the VHA in the patient-centered care concept. It was a well-coordinated VA health care system with professionals that patients thought of communities are working together that promoted a shared vision (Hines et al., 2020). Systemic action at the VA health care system achieved a sense of shared vision aligned with the patient's values (Hines et al., 2020).

Theme 2: Health Care Production

Regarding the patient-centered care core concept of collaboration, participants talked about the health care production at the VHA. War veterans defined collaboration of the VHA were outstanding communications that ensured them to receive health care quality. From their experience at many facilities of the VHA, the primary providers, doctors, nurses, and other practitioners at the VA health care system had been valuable on their behalf as the OEF/OIF veterans. The VA health care system was committed to maintain health care productivity.

Theme 3: Development of Health Care Staff

Concerning the patient-centered care core concept of respect and dignity, participants described the VA health care's institution and professionalism committed to treating OEF/OIF veterans with respectful manners on the patients' needs (McCormick et al., 2019). Participants described the VA health care system provided fair and equitable respect and dignity from the VHA's staff that often-ensured patients with clinical values (McCormick et al., 2019).

Respect and dignity are justifiable on ethical principles. According to McCormick et al. (2019), the value of caring toward persons brought the principle of respect for human dignity. The principles of the VA health care system of ethics charges VHA's staff with vital obligations to fulfill the OEF/OIF veterans with respect for human dignity and rights of health care ethics (McCormick et al., 2019; Sheingold & Hahn, 2014). The professionalism and commitment from the VA health care system demonstrated by the VHA's staff aligned with respect and dignity as basic ethical principles.

Theme 4: Needs of Hierarchical Administration

Regarding the patient-centered care core concept of respect and dignity, participants described the effect of military structured hierarchical administration into the civilian setting. The VA health care system provided and facilitated assistance to OEF/OIF veterans and their families throughout the phases of recovery (McCormick et al., 2019). Participants conferred on the advantages and disadvantages of military leadership within the VA health care system. A couple of the participants noted that military veterans had no room for complaints because VHA's leaders were doing their best to fulfill the rational nature of respecting patients' dignities. These two participants noted that the VA health care system made sure that war veterans were treated with respect and dignity to receive adequate health care quality. However, there were eight participants noted that all war veterans would have received respect and dignity if the military hierarchy type of administration was pre-owned. It would have straightened out the VHA's staff for their hierarchical responsibilities in providing respect and dignity for war veterans in receiving adequate health care quality.

Maslow's theory of hierarchical needs in the VA health care system provided the theoretical framework for understanding the OEF/OIF veterans' perception of respect and dignity. The fourth level of Maslow's theory was the hierarchy of needs on the esteem with basic underlying assumptions, reflects an excessive desire for status, worthiness of self and competence, and higher position within a group including achievement, mastery, independence, stature, dominance, prestige, self-respect, and respect from others for war veterans (Maslow, 1945). Mostly OEF/OIF veterans agreed on the roles of military structure in the VA health care system's setting for their successful recovery and rehabilitation.

Theme 5: Requirement

The participation core concept concerning the patient-centered care; participants expressed their requirements. In learning about veterans' health care issues in the civilian world setting to learn about other veterans' organizations, deal with family, and local VHA hospitals in participation for their health care needs. Participation was the veterans' opportunities to getting ready to transition from active duty to civilian life. Almost all of the participants had the opportunity and were grateful that they had to make individual choices on rehabilitation and quality of life concerns. One participant expressed his experience of choosing the desired time to receive treatment from his invisible wound symptoms received serving in combat zones and having to participate in the health care treatments. Other participants expressed the importance of family support in participating in the VA health care system.

Sheingold and Hahn (2014) observed that patient-centered care-acquired patients to engage with the VA health care system. Participation required veterans with their family members, VHA hospital staff, and a third-party veteran's organization to sustain partnership in promoting patient empowerment and positive health care outcomes (Sheingold and Hahn, 2014). The patient-centered care model revealed OEF/OIF veterans empowered in participation in the VHA.

Theme 6: Unexpected Event

Concerning the patient-centered care core concept of participation, participants expressed an unexpected event that happened in their lives from serving in war zones. The unforeseen circumstance leads their family members in shock to happen to veterans of OEF/OIF. The post-9/11 veterans with their family members and hospital practitioners were in the participation process for health care quality. Many of the participants were thankful for the VA health care system in helping them to have opportunities in the rehabilitation process and quality of life concerns. Two participants expressed their experiences of participating in the VA health care treatment options. The participants also expressed their gratitude for the importance of family support in participation in the VHA.

The patient-centered care addressed the patient as a person and engaged in their medical needs. Participation required uncommonly in the unexpected events of war veterans. The support of their family members, VHA hospital staff, and third-party organization were vital for participation in the patient-centered care concept (Sheingold and Hahn, 2014). The model of patient-centered care revealed empowerment to participants from assistance on partaking the VHA.

Theme 7: Consistent Information

Regarding the patient-centered care core concept of information sharing, participants described information shared by the VHA at the VA as consistent information. Participants outlined the VA health care system on shared information context that OEF/OIF veterans had accessibility and transparency of hospital staff in delivering adequate health care quality. One participant disagreed with the VHA program's health care communication delivery that it was lack of collaboration. The rest of the nine participants agreed to the VA health care system that it shared automated reminders. The VHA staff prepared their patient information to improved their interactions between war veterans and VHA staff.

Information sharing held a critical role in patient-centered care. It must be organized processes that war veterans as patients, family members, and VHA staff would be fully informed on time (McCormick et al., 2019). The information shared by VHA hospital staff must bring the encouragement of which facilitates patients' accountability on literacy and expectations (McCormick et al., 2019). Participants expressed information sharing among their family members with their VHA staff helped them from recovery and rehabilitation processes.

Theme 8: Proactive

Concerning the patient-centered care core concept of decision-making, participants transpired their opportunities to appropriately make health care decisions with their family members and VHA hospital practitioners for adequate health care quality. Participants were grateful for the fact they felt valued by caregivers and VA health care system professionals in deciding on rehabilitation processes. All participants uttered the significance of their experiences in being proactive in decision-making for their care needs.

Patient-centered care described decision-making through patients, family members, and health care professionals as empowerment for adequate health care quality (Hines et al., 2020). Participants noted their experience that war veterans must be proactive in understanding their health care needs at the VA health care system. War veterans must always remind themselves that VHA staff overworked at the VA. With this situation, a veteran must persistently voice their health care concerns and never give up in pushing through their health care issues towards the VA health care system. Decision-making was critical to the VHA's patient-centered care concept because it gave literacy on evidence-based practice, values, desires, and preferences (Hines et al., 2020).

Theme 9: Control

Regarding the patient-centered care core concept of decision-making, participants termed the importance of control in deciding their health care needs (Hines et al., 2020). Participants mentioned their appreciation to the VHA of the VA in exercising their freedom in decision-making to receive adequate health care quality (Hines et al., 2020).

Decision-making was the satisfaction of many participants in having opportunities to make individual choices on rehabilitation and quality of life concerns (Hines et al., 2020). Eight participants shared their experiences in deciding on health care treatment options. The participants have voiced their health care needs on the importance of the decision for appropriate health care quality. It included veterans who had individual choices (1) in changing their team on health care providers, (2) in finding better options what approach they wanted for their health care quality, and (3) in articulating the health care system on emotional intelligence to better their understanding of health care needs. The VHA followed the decision-making on the patient-centered care concept (Hines et al., 2020).

Limitations of the Study

Giorgi (2019) discussed limitations as features in a qualitative study that might negatively affect the results or ability to generalize the research study. I was fully aware of limitations in any areas without control or avoidance altogether. Giorgi helped me to point out that qualitative research must address limitations without undermining its research values in the public eyes of readers and reviewers. The clarity of the potential problem would suggest ways the possibility of a researcher's unbiased data collection and results (Giorgi, 2009; Patton, 2015).

The limitations of this qualitative study found on the following: (1) Relying on responses from the participants was another possible limitation of this study. During the interviews, I spoke with each participant with the hope that they answer questions honorably and honestly. It could present the implication of limitation with a level of the truthfulness of the interviewee's reasons that could not view with a moral compass or dignified; (2) Participants who had PTSD were also a possible limitation of this study. The disorder could affect their interview responses that trigger their mental health issues emotionally and psychologically intelligence; (3) Researcher bias could be another possible limitation of this study due to my background. Unintentionally, I could take qualitative research in the desired direction, influenced personal and lived experiences. On the other hand, it could assist to generalize the study to the next level because of an understanding of the veterans' population; (4) The sample size was a limitation of this study. Specifically, it focused on OEF/OIF veterans part of VFW. It could only represent issues on people adequately when attempted to hypothesize interpreted information in concerning on this veterans' population; (5) Gender was also a limitation of this study. There were zero females participated in the qualitative research of the OEF/OIF veterans. This situation was the reason that this qualitative study could not focus on gender differentials. Gender differences could not note on empirical knowledge about gendered practices and norms.

Finally, I acquired safeguards of proper context to decrease possible outcomes impacted by the limitations of a qualitative study. I reduced any biases by having well-developed questions aligned with the qualitative research question. It guaranteed sufficiency towards participants' responses. The constraints on data analysis unveiled readers resolve about discoveries from a researcher. I assured all participants of confidentiality and could withdraw at any time with this qualitative study. All these incentives mentioned above were essentials to safeguards a qualitative study.

Recommendations

A qualitative study comprised explorations on health care quality afforded to the OEF/OIF veterans while being assigned to the VHA in focusing on patient-centered care dimensions. My study's findings supported the patient-centered care concept that public policies and social services were vital resources to help current war veterans. The identification of recommendations is considered an integral part of the future research endeavor. Given the limitations of this study, I proposed recommendations for future research.

Recommendation 1. Researchers should replicate this qualitative study in applying 2025 OEF/OIF veterans transitioning from military active duty to civilian life setting with invisible wounds living all over in the United States. This idea would broaden the descriptive phenomenological research on patient-centered care of five core dimension, rather than staying focused on a specific organization.

Recommendation 2. Researchers should explore health care quality perceived by active duty from each service in the U.S. Armed Forces, focusing on the patient-centered care concepts. The studies would involve comparing and contrasting the perceptions of each representative of military branches.

Recommendation 3. Researchers should explore the perceptions of OEF/OIF female veterans concerning the five core concepts of patient-centered care on five core concepts in the VHA. Descriptive phenomenological research would reveal the differences between female OEF/OIF veterans in reporting their invisible wounds.

Recommendation 4. Researchers should explore the health care quality of the perceptions of patient-centered care on five core concepts by the VHA hospital staff. This study would bring the importance of perceptions on the VA health care system of medical providers to OEF/OIF veterans. Researchers could measure the quality of health care being provided to war veterans from the VA health care system by focusing on medical providers, doctors, nurses, and other practitioners' viewpoints.

Recommendation 5. Researchers should explore the health care quality perceived by the patients of veterans' family members. PTSD, TBI, and invisible wounds were challenging diseases for many family members of their war veterans trying hard to cope with the symptoms from combat zones to home.

Recommendation 6. Researchers should explore the health care quality perceived by military veterans without any disabilities at home. Observing these war veterans would allow probing diverse study about another efficient way in the transition from military to civilian life. This type of research would reveal how veterans' treatment from military to civilian life in living with health care quality.

Recommendation 7. Researchers should explore other hierarchical structures of the police department on health care quality perceived by war veterans incarcerated in the patient-centered care concept. Researchers could measure health care quality provided in the criminal justice system. This study could also help other war veterans impede in going to prison from their invisible wound symptoms.

Recommendation 8. Researchers should explore in a specific one military branch on health care quality perceived by war veterans in the OEF and OIF together of patient-centered core dimensions. Using a qualitative study in looking through the VHA, it would focus directly on actual perceptions of the targeted population from a sample size. It would help to compare and contrast the health care quality issues on veterans in the United States to those current war veterans who recently came home within two years. The study could help many audiences have a better understanding of the stages of transitioning from military to civilian life.

Implications for Social Change

During the transition period from military to civilian life, combat veterans expressed their patient-centered care experiences through in-depth interviews with the hope to voice their perceptions about a meaningful life in creating a social change in the veterans' community. Stakeholders had never forgotten that more than 7,000 deaths and 50,000 injuries resulted from the OEF and OIF wars (Viscusi, 2019). Combat veterans who survived from war battled back at home in the United States of America to live a healthy lifestyle. From then, there were countless deaths of veterans escalated from the VA facilities. Although numerous organizations were assisting veterans, qualitative studies lacked research (McCormick et al., 2019). Because of the horrific events that happened to our American veterans, I have carefully disseminated in attaining qualitative research with fellow scholars, non-profit sectors, advocate groups, community organizations, and leaders hoping for a brighter future for the OEF/OIF veterans. I was hoping that all people interested in health care quality would have a chance to read about war veterans, military members' families, friends, hospital providers, military veterans' communities, diversities, political leaders, and many other stakeholders (Bloche, 2016).

The essentials of perceptions among actual patient-centered care participants on health care quality overheard its concern (Anhang Price et al., 2015).

I proposed tangible implications for positive social change that should involve assigning combat veterans with the five core concepts of patient-centered care in increasing public knowledge. Based on the findings and conclusions of this study, there were no simple solutions have been found. It showed out the importance of vital communications among veterans' to the VA. Numerous veterans were becoming hopeful about their health care quality. The United States of Armed Forces should utilize its commanding officers to implement a quarterly focus group. It would capture feedback from OEF, and OIF veterans were outstanding subsidies. The situation obtained family members aware that their veterans would receive appropriate health care quality provided by the VHA. It must establish military veterans outreach in connecting OEF/OIF veterans to a complete recovery and rehabilitation process about transitioning from military to civilian life. The opportunities to work together with other vets assigned in the VHA must be accessible to war veterans to make an impact in mentoring fellow veterans and providing strategic skills to cope with war symptoms. In this qualitative study, it emerged that the VHA of the VA health care system delivered healthcare quality to the OEF/OIF veterans of this current year 2020 positively. The VA utilized patient-centered care to utter health care to combat veterans appropriately. These were the findings and results of my dissertation project that I would like to share with audiences as takeaways from this reading.

Conclusion

The signature injuries and other invisible wounds from OEF and OIF veterans established the patient-centered care study. The VA provided a VHA to their polytraumatic injuries and comprehensive rehabilitation utilizing the patient-centered care concepts that would establish a vast array of resources for a broader VA health care system (Armstrong et al., 2019). Cognitive difficulties or impairments might have been an early step in the development of dementia (Adams et al., 2020). Examining data was the key outcome in finding new knowledge from the respondents with their symptom conditions, disability, quality of life, and composite measures. (Adams et al., 2020). The VA health care system was viewed as a leader in medical advances in the past when it comes to releasing performance data. In early 2013, the VA health care system had a high satisfaction survey by VA found 93 percent of patients aid they had a good experience in receiving care (Hankel, 2014). However, "The VA's inspector general found that out of about 800,000 records stalled in the agency's system for managing health care enrollment, there were more than 307,000 records that belonged to veterans who had died months or years in the past" (Devine, 2015, p. 4). The quote noted the VA's inspector general report found 307, 000 vets died before applications processed from the VHA facilities. The occurring PTSD and TBI of service member populations shown in both civilian and military populations. My study existed to make general guidelines that could be useful when treating the war veterans population. The study outlined current knowledge of war veterans about their interactions of patient-centered care concepts as a diagnostic criterion at the VHA facilities.

More than 200,000 U.S. military members left their military careers each year (Whitworth et al., 2020). “While many separating military members successfully adapt to civilian life, 40 percent to 75 percent describe some difficulties managing this major adjustment” (Whitworth et al., 2015, p. 7). This quote informed audiences that war veterans had difficulties adjusting educational careers, work settings, substance abuse, homelessness, financial mismanagement issues, confrontations with the criminal justice system, family problems, and military related war symptoms. War veterans probed their dilemmas in dealing with their health care system. It was a systemic issue that required a new wholistic view and multiple policy players to make a social change. My qualitative study focused on exploring the perceptions of OEF/OIF veterans previously assigned to the VHA regarding each of the five core concepts of patient-centered care. The identified themes of Collaboration: Systemic action and healthcare production; Respect and dignity: Development of health care staff and hierarchical administration; Participation: Requirement and unexpected event; Information sharing: Consistent information; and Decision making: Proactive and control.

The sample of OEF/OIF veterans stored positive feedback on health care quality delivered by the VHA. The VA health care system made unequivocal collaboration to ensure the success of each veteran's healthcare needs. VHA hospital staff treated OEF/OIF veterans in the professionalism of hospital staff with dignity and respect. The participations of the OEF/OIF veterans were an unexpected event but gave them the opportunity on receiving health care quality at the VHA on patient-centered care concepts. Information was shared and communicated consistently. The OEF/OIF veterans and their family members had opportunities to make appropriate choices with the help of VHA health care providers in decision-making for their health care treatment on the rehabilitation process. The OEF/OIF veterans had agreed upon the role of military culture in the VHA environment. A couple of participants suggested that the military culture was not necessary for the rehabilitation process or recovery. Almost all participants gathered that cultural discipline provided decent services as the structure complied with health care treatment and summons. Collaboration barriers existed within military institutions. It provided active duty service members with full training by their job descriptions. However, personality and experience were efficient in leadership effectiveness. The chain of command in the military principled with specific responsibilities on leadership authority. The inconsistencies of confronting and temperament with the structure of a military chain of command would combine with information sharing but interpreted information with the completeness of different ways. In my experience in the United States Marine Corps, the information sharing was filtered or modified in communications throughout the chain of command and losing its consistency. The key to communication was for the chain and the collaboration of the OEF/OIF veterans.

Establishing the importance of relationships would help OEF/OIF veterans to receive health care on patient-centered care concepts. Maslow’s theory of the hierarchy of needs provided the framework in developing relationships between patients, family members, hospital staff, and third-party veteran organizations (Maslow, 1945). The VHA on the hierarchy of needs on the physiological level provided a physical requirement that sustains human survival part of air, food, drink, shelter, warmth, sex, and sleep. The

OEF/OIF veterans were perceiving with respect and dignity. War veterans began to trust leadership, felt protected, had no fear, and more often shared information. In this situation, it was a sense of the social relationship of information sharing to their friends, family, and community leading to participation and collaboration, which was the third level of the hierarchy of needs on love and belongingness. “The need for self-actualization. Even if all these needs are satisfied, we may still often (if not always) expect that a new discontent and restlessness will soon develop unless the individual is doing what is fitted for” (Maslow, 1943, p. 192). Furthermore, “the clear emergence of these needs rests upon prior satisfaction of the physiological, safety, love and esteem needs. It is from these that we may expect the fullest (and healthiest) creativeness” (Maslow, 1943, p. 200). The quote fortified Maslow’s hierarchy of wants connected to the five core concepts of patient-centered care reflected learning opportunities for OEF/OIF veterans in achieving new normalcy and hierarchical needs of self-actualization.

In streaming the patient-centered care efficiently, the five core concepts of collaboration, respect and dignity, participation, information sharing, and decision-making must cooperatively align. Promoting health care quality between doctors and centering the patients were signs of collaboration in working together for a better cause. I found the bonds as part of respect and dignity when all participants bonded together with patients. Participation highlighted the significance of partnership in the VA health care system. Information sharing facilitated by different ways of communication with transparency to heal relationships of war veterans. Decision-making brought the importance of valuing decisions as a team altogether. All concepts were relevant to each other in delivering health care quality from the five core concepts of patient-centered care. I hope that the information provided by my qualitative research study could be useful as guide to policymakers and service providers to develop an in-depth understanding of war veterans from their perceptions of patient-centered care concepts.

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Appendix A: Interview Protocol

Title of Study: Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans in the Veterans Health Administration (VHA)

Principal Investigator: Exekiel Aranez

Script for an oral brief before participant interviews: My name is Exekiel Aranez. I am responsible for the research study. Thank you for your interest in participating in this interview. The goal of the overall project is to explore the perception of health care quality provided to war vets previously assigned to VHA. I am conducting this research study to determine if the VHA had health care facilitates the five core concepts of patient-centered care inclusive of collaboration, respect and dignity, participation, information sharing, and decision making.

Participation:

This interview is voluntary. This study involves face-to-face interviews as the primary method of data collection. The interview questions that I will be asking you pertains to your perception of health care quality delivered while being assigned in the VHA. I will audio-record and transcribe your responses to interview questions. Only me as the researcher and my Walden supervisors are allowed access to the participant identities and data. The researcher will also review the transcription for accurate interpretation.

Risks and Benefits:

This interview will not pose any risk or harm to participants beyond those experienced in daily life. The benefits of this project are to help other veterans to transition effectively for health care treatment, recovery, and rehabilitation n living a healthy lifestyle.

Privacy:

The interviewee's identity will be kept confidential in this research study and all resulting reporting. The data collection complies with federal rules and regulations. Let us start by asking you a question of do you have any questions for me before we proceed?

These are the questions that will ask the interviewee on the following:

1. What events led to your assignment to the VA?
2. How would you define health care quality?
3. How would you describe the collaboration demonstrated by you and the VHA at VA?
4. How would you describe the collaboration demonstrated by other war veterans and the VHA at VA?
5. How would you describe the respect and dignity provided to you by the VHA at VA?

6. How would you describe the respect and dignity provided to other war veterans by the VHA at VA?
7. How was your participation in decision-making about your care facilitated by the VHA at VA?
8. How was the participation of other war veterans in decision making about their care facilitated by the VHA at VA?
9. How would you describe the information sharing with you by the VHA at VA?
10. How would you describe the information sharing with other war veterans by the VHA at VA?

Concluding statement:

Thank you for participating in this research project. Do you have any questions for me or concerns at this time? Please, feel free to contact me if you have any questions. I appreciate your time for this project. Thanks again!

Appendix B: Consent Form

Consent Form

#08-17-20-0758938

I am inviting you to take part in a research study about the Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) experience with the Veterans Health Administration (VHA). The researcher is enticing OEF/OIF vets to be in the study. This form is part of a process called Informed Consent. It allows you to understand this study before deciding whether to take part. This study is being conducted by a researcher named Exekiel Aranez, who is a Ph.D. student at Walden University.

Background Information:

The purpose of this study is to explore the perceptions of health care quality provided to OEF/OIF vets in one particular VHA location. The research documents the VHA if it did or did not facilitate the five core concepts of patient-centered care inclusive of respect and dignity, collaboration, participation, information-sharing, and decision-making.

Procedures:

- The study involves interviews as the primary method of data collection.
- You will be asked to answer questions about your perception of health care quality experienced in VHA.
- With your permission, the interview will be audio-recorded and transcribed.
- You will be allowed to review the transcription for completeness and accuracy.
- The discussion will be approximately 30 minutes to 60 minutes.
- The procedures include remote/virtual methods to comply with the COVID-19 restrictions.

These are the questions:

1. What events led to your assignment to the VA?
2. How would you define health care quality?
3. How would you describe the collaboration demonstrated by you and the VHA at VA?
4. How would you describe the collaboration demonstrated by other war veterans and the VHA at VA?
5. How would you describe the respect and dignity provided to you by the VHA at VA?
6. How would you describe the respect and dignity provided to other war veterans by the VHA at VA?

7. How was your participation in decision-making about your care facilitated by the VHA at VA?
8. How was the participation of other war veterans in decision-making about their care facilitated by the VHA at VA?
9. How would you describe the information sharing with you by the VHA at VA?
10. How would you describe the information sharing with other war veterans by the VHA at VA?

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at the VHA will treat you differently if you decide not to be in the study. In this research, you can still change your mind later. You may stop at any time. If the researcher is recruiting in a manner that might not make use of all volunteers. Please note that the researcher will follow up with all volunteers to let them know whether or not selected for the study.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts in daily life, such as when discussing stressful situations or frustrating items, there may be some stress, anxiety, or frustration during the interview. Being in this study would not pose a risk to your safety or wellbeing. Veterans can contact the VA Health Care System hotline for support as needed.

Your participation in this research project may not be of direct benefit to you personally. However, the study indicated benefits to many veterans in obtaining knowledge about the perception of the health care quality of the VHA. The results of this study could help improve the health care delivery system.

Payment:

You will not be receiving any payment, thank you gifts, or reimbursements.

Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the research, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by the researcher and VHA. The counsel of the participants fed by the Principal Investigator and kept in a locked file cabinet. Data will be subsidized for at least five years, as required by Walden University.

Contacts and Questions:

You may ask any questions you have now. Or you have catechized, you may contact the researcher via phone number and email address. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at

Walden University. Walden University's approval for this study is IRB. It expires on IRB will undertake the expiration date. The researcher will give you a copy of this form to keep.

Obtaining Your Consent:

If you wish to consent via email, please reply, I Consent.

Appendix C: Social Media Flyer

Interview study seeks Operation Enduring Freedom (OEF)/ Operation Iraqi Freedom (OIF) veterans' perceptions of health care quality in the Veterans Health Administration (VHA).

There is a new study called *"OEF and OIF vets in the VHA"* that could help improve the health care delivery system. I am inviting you to describe your experience of health care quality provided to OEF/OIF vets previously assigned to VHA.

This interview is part of the doctoral study for Exekiel Aranez, a Ph.D. student at Walden University. Interviews will take place during July 2020.

About the study:

- One 30-60-minute phone interview that will be audio-recorded.
- You will not be receiving any payment or thank you gifts.
- Your name will not remain private, known only to the interviewer.

Screening questions for volunteer requirements:

- Have you separated from the U.S. military branch?
- Have you gone through the VHA?
- Were you discharged from Patient-Centered Care?
- If the answer to each of these questions is yes, sharing your experiences can help provide quality to veterans.

To confidentially volunteer, contact the researcher.

Appendix D: Research Invitation

Confirmation Request

#08-17-20-0758938

September 1, 2020

Dear Post Quartermaster of Veterans of Foreign Wars (VFW),

I am a VFW member and current doctoral candidate at Walden University. I am conducting a study on the experiences and perceptions of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans with Post-traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), or Invisible Wounds who are transitioning from active duty to civilian life, regarding their participation in the Veterans Health Administration (VHA).

I am asking you for your assistance by permitting me to recruit veterans within your organization to participate in this study. A drafted email to recruit veterans with invisible wounds who served in the OEF/OIF war zones transitioning out through VHA at the Department of Veterans Affairs (VA). My recruiting method consists of sending the drafted email through your organization as correspondence with your approval.

If you agree to afford me this opportunity, then please email me. Formal consent to conduct the research in the VFW on the organization's letterhead or through email that covers VFW information would be appreciated.

Please note that all data collected will be completely confidential. There are no names will be attached to any notes or records from the interview. All information will remain in the locked files accessible only to the researcher. No one will have access to the interview information other than the participants.

I am available at phone or by email. I am here to answer any questions you may have because your contribution to this study is valued.

Sincerely,

Exekiel Aranez

Appendix E: Email Invitation

Participants Email Invitation

Requestor: Exekiel Aranez, a doctoral candidate at Walden University

Population: Operation Enduring Freedom (OEF)/ Operation Iraqi Freedom (OIF) veterans of patient-centered care veterans who went through the Veterans Health Administration (VHA) and part of the Department of Veterans Affairs (VA) Medical Center Health Care System.

Purpose: To identify research participants for the study

Sender: exekiel.aranez@waldenu.edu

Message:

Greetings members, I am Exekiel Aranez. I am currently a doctoral candidate in the Public Policy and Administration at Walden University. As an OIF PTSD Marine veteran expert, I am seeking to further my knowledge to have a better understanding of the experiences and perceptions of veterans from the OEF and OIF veterans. It is about Patient-Centered Care, who are transitioning from active duty to civilian life, regarding their participation in the VHA. Due to the profusion amount of this population, I decided to funnel in on the VA Health Care System veterans, as it would be most appropriate. Besides, I hope that the results from this study will help reveal what these veterans go through while transitioning out of the military using the VA's VHA, identifying the following: What are the perceptions of current OEF/OIF vets in the VHA regarding each of the five core concepts of patient-centered care: (a) collaboration, (b) respect and dignity, (c) participation, (d) information sharing, and (e) decision making?

I am inviting you to contribute to this study by participating in an individual virtual interview that will last between 30-60 minutes. If you agree to participate in an interview, it is assured confidentiality. There are no names will be attached to any notes or records from the interviews. All information will remain in locked files accessible only to the researchers. All information will remain in locked files reachable only to the researchers. No staff leaders or members of the VHA and VFW will have access to the interview information. You will be free to stop the interview and withdraw from the study at any time. You are encouraged to ask any questions, at any time, that will help you better understand the research.

To participate in this study, you must meet all the following conditions:

1. OEF/OIF veterans.
2. Diagnosed with invisible wounds in Patient-centered care.
3. Discharged from the U.S. Armed Forces (separation, retirement, or medical).

4. Went through the VHA while transitioning into civilian life.

Please, contact me for further questions and concerns in participating in this study. Do not hesitate to contact me via email or by phone. You may communicate or write the Research Participant Advocate, Walden University.

Thank you so much for your time and your consideration.

Respectfully,

Exekiel Aranez

Appendix F: CITI Certificate

CITI PROGRAM

Completion Date 02-May-2020
Expiration Date N/A
Record ID 36498291

This is to certify that:

Exekiel Aranez

Has completed the following CITI Program course:

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Student's (Curriculum Group)
Doctoral Student Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?web9fc07e-251c-414e-a771-6cff9fc70ea7-36498291

Appendix G: Demographic Data

Washington Veterans of Foreign Wars (VFW) Research Study

Title: *Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) in the Veterans Health Administration (VHA)*

Date of Interview:
Time Started:
Time Finished:

Participant Number (Participant One, Two, etc.):
Age:
Gender:
Ethnicity:
  American Indian or Alaska Native:
  Asian:
  Black/African American:
  Native Hawaiian or Pacific Islander:
  Hispanic or Latino:
  White:

Rank at time of Separation or Retirement:
War Deployment of Service:
Branch of Service:
How long did you serve in the U.S. Armed Forces?
What date were you assigned to the VHA?
What date were you disenrolled from the VHA?

Appendix H: Summary of Participant Demographics

Veterans of Foreign Wars (VFW)

Participant	Age	Gender	Rank/ Grade	Race/Ethnic Background	Years' Service	Branch Service	Date enrolled
Participant 1	59	Male	O-5	White	28	U.S.A.	2010
Participant 2	36	Male	E-4	Hispanic	4	U.S.M.C.	2016
Participant 3	40	Male	E-4	Asian	4	U.S.M.C.	2007
Participant 4	38	Male	E-4	White	4	U.S.M.C.	2017
Participant 5	36	Male	E-5	White	8	U.S.M.C.	2008
Participant 6	36	Male	E-4	White	4	U.S.M.C.	2007
Participant 7	37	Male	E-4	White	4	U.S.M.C.	2006
Participant 8	35	Male	E-4	Asian	8	U.S.M.C.	2014
Participant 9	37	Male	E-5	Hispanic	4	U.S.M.C.	2007
Participant 10	36	Male	E-6	White	8	U.S.M.C.	2011

Appendix I: Synthesis Matrix

Common Themes	**Source #1 (Carlozzi et al., 2020)**	**Source #2 (Koebli et al., 2020)**	**Source #3 (Wolf et al., 2019)**	**Source #4 (Koven, 2017)**
Failure of Veterans Health Administration (VHA) at the Department of Veterans Affairs (VA)	VHA lacked sufficient training in evidence-based practices	The VHA with collective medical services delivered an inadequate health care system for more than 2 million veterans who returned home to a great extent from first war disposition did not receive a quality of health care	Many war veterans returned home but stigmatized because of their mental health illnesses of military trauma in combat deployment	Rigorous research was essential in addressing the challenges that the U.S. war veterans are facing today. It was our task to find a long-term solution
Common Themes	**Source #1 (Carlson et al., 2016)**	**Source #2 (Hicks, 2014)**	**Source #3 (Devine, 2015)**	**Source #4 (Hankel, 2014)**
Exploring health issues of war veterans for their well-being, family members, and community	Closing the gap in health care quality among war veterans was the goal of health care organizations. Several programs were created and designed for implementation,	The Inspector-General affirmed that the VA was inadequate in providing appropriate health care quality to U.S. veterans	The investigation identified resulting health care issues together with fraud hotline office for complaints, unrevealed reports of patient experiences, and lack of access to patient care	The VHA facilities provided long wait times, ignored severe infectious diseases, showed signs of potential neglection, and unreported dissatisfactions of many veterans

	dissemination, and prevention that would justly deliver health care quality			
Common Themes	**Source #1 (Bloche, 2016)**	**Source #2 (Devi, 2014)**	**Source #3 (Robeznieks, 2015)**	**Source #4 (Wolf et al., 2019)**
Services for the combat veterans' need	The 44th U.S. President Barack H. Obama vowed to address VHA scandals about providing inappropriate health care quality to the U.S. war veterans	The United States Congress approved new funding of $16 billion for the VA health care systems. The amount of financial support via funding divided into three parts is counting $10 billion in emergency spending to pay for private doctors and health care professionals, $5 billion in hiring medical staff, and $1.3 billion in opening 27 new VA clinics across the country. In response to better its leadership of	VHA developed mental health care practices and health care transitions for many returning war veterans	The reality of traumatic injuries from combat deployments was causing veterans with severe injuries that take long-term impairments and functional disabilities

		an organizational structure and fundamental management. The VA support increased that veterans would transition back to civilian life successfully		
Common Themes	**Source #1 (Viscusi 2019)**	**Source #2 (Molina, 2018)**	**Source #3 (McCormick et al., 2019)**	**Source #4 (Anhang Price et al., 2015)**
Effects of war symptoms to combat veterans, family members, and society	the Department of Defense (DOD) estimated more than 7,000 deaths and more than 50,000 injuries of military personnel from the Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)	the U.S. Senate demanded VA conduct its investigations of all VHA facilities to elaborate on what solution must be done for providers delivered a low quality of care and negative consequences to post-service U.S. veterans	the health care system needed more development and must adopt continuous assessment and treatment that will yield improvement and opportunities	The problem was more information to uncover opportunities that exist to improve the VHA health care quality for the OEF/OIF veterans. It meant that a researcher seeks more information to gain new knowledge in learning new opportunities that will improve a gap in health care quality for the VHA.
Common Themes	**Source #1 (Sheingold & Hahn,**	**Source #2 (Hines et al., 2020)**	**Source #3 (Brown et al, 2015)**	**Source #4 (Carlozzi et al., 2020)**

	2014)			
Health Care's History	Dr. Avedis Donabedian advanced a study of health care quality	VHA congregated the *seven components* that were defined by the Donabedian Model of health care quality that includes safety, effectiveness, patient-centered care, timely manner, efficiency, and equity	the Salzburg group from Austria suggested computer-based guidance and communication systems build relationships among clinicians and patients in the health care system	The demands of many families of war veterans made changes for caregiver support in the VHA
Common Themes	**Source #1 (Haibach et al., 2020)**	**Source #2 (Gundlapalli et al., 2020)**	**Source #3 (Llardo & Speciale, 2020)**	**Source #4 (McCormick et al., 2019)**
Quality of Health Care	Comprehensive VA health care system provided medical benefits to veterans on the following: preventative care, prescriptions, medical prosthetics, mental health care, home health care, and geriatrics extended	VRE offered specialized knowledge and rehabilitation counseling for veterans for occupational options	). Quality of patient-centered care has meaning to understand the culture, knowledge of culture, appreciation of culture, and awareness of health disparities	Health care professionals and institutions valued patients in treating all people concerning the patients' needs

	care			
Common Themes	**Source #1 (Brown et al., 2015)**	**Source #2 (Hines, 2015)**	**Source #3 (Anhang Price et al., 2015)**	**Source #4 (Llardo & Speciale, 2020)**
The five core concepts of patient-centered care for the quality of health care	Patient-centered care was a precondition component of the health care system by ensuring all patients accessed their chosen care	*Patient-centered care* defined a patient and family engagement care as working together with the health care system to deliver safety, delivery, and health care quality. Patient-centered care provided five schemas of patient-family engagement care in conjunction with the collaboration, respect and dignity, participation, information sharing, and decision-making	It was necessary to seek more information that determines whether the VHA system of health care demonstrated the five concepts of patient-centered care: collaboration, respect and dignity, participation, information sharing, and decision making.	Patient-centered care played vital responsibilities in integrating patient and physician perspectives. Some patient-centered care articles, journals, and books had limited information about health care policy, allocation of resources, and efficiency of delivering health care quality
Common Themes	**Source #1 (Zhao et al., 2016)**	**Source #2 (Llardo & Speciale, 2020)**	**Source #3 (Koh et al., 2010)**	**Source #4 (Brown et al., 2015)**
Quality of Health care of traditional	Person-centered care	*Quality of patient-centered care*	The focused-on health care quality has	Patient-centered care has

centered care and measures	empowered a person to make their own decision for interventions and treatments	defined preferences, needs, and values that ensure clinical decision. The cardinal aspect of patient-centered care emphasized the health care quality of a patient perspective on health situations	proven as health measures to a healthy population	recommended health care quality concepts to many health care professionals and organizations for more than 25 years
Common Themes	**Source #1 (Giorgi, 2009)**	**Source #2 (Patton, 2015)**	**Source #3 (Cosco et al., 2015)**	**Source #4 (Creswell, 2014)**
The qualitative research study, Descriptive Phenomenology Research Design appropriate for this study	Descriptive phenomenology explored the perceptions of OEF/OIF vets with a particular phenomenon. It sought the meaning of OEF/OIF vets' intuition and reflection on conscious experience and understanding	Qualitative research methods for interviews helped understand the lives of OEF/OIF vets socially and culturally. Qualitative research explored phenomena in understanding the perceptions of OEF/OIF vets	Data collection must be concise in understanding the interview protocol of the VHA provides a quality of care	with these concerns in mind inquirers has explicitly identified reflexively their biases, values, and personal backgrounds such as gender, history, culture, and socioeconomic status that shape their interpretations formed during a study
Common Themes	**Source #1 (Maslow, 1943)**	**Source #2 (Maslow, 1943)**	**Source #3 (Maslow, 1943)**	**Source #4 (Maslow, 1943)**

A theoretical framework for the qualitative study, Maslow’s Hierarchical of Needs	Physiological: A physical requirement sustains human survival air, food, drink, shelter, warmth, sex, and sleep	Safety: Freedom was from danger and expectation. It includes protection from elements, security, order, law, limits, stability, and freedom from fear	Love and belonging: It was a desire for social relationships as well as love and affection. Affection could be coming from workgroup, belongingness, family, friends, and community	Esteem: It was a soaring desire for status, the worthiness of self, and competence. Higher position within a group includes achievement, mastery, independence, stature, dominance, prestige, self-respect, and respect from others

Appendix J: Journal Notes

The following journals are two examples of notes that this researcher took after reflecting on two different days of interviews with participants:

Today, I had a great time interviewing my participant. The interview went very well. So far, in conducting data collection, I thought far many military veterans would participate in this qualitative study to help all fellow veterans cope with their traumatic symptoms from the wars of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). I had great confidence in conducting interviews. I think it was because of my experience in conducting qualitative research in my other graduate school. I had good practice in handling data collection that brought my confidence to this research project. I made sure of alignment to my research question. I noticed my situation that several participants responded to the specific question asked to my participants. As a researcher, I must be fully aware if participants were responding to questions or responding with irrelevance to my research questions. I had thoroughly kept in mind the researcher role in this project. The participants could have great stories to share. But, I must make sure the response adds relevance in answering my research project. It must respond to the questions that were asked by the principal investigator. The average time of discussions was usually taking 15 to 45 minutes after the audio recording ended. I have interviewed military veterans, and I recognized their unique stories in the United States of Armed Forces. It directly reminded me why this project happened for a research study. The interview questions aligned with my research question. It was surprising to learn how mostly military veterans have been very optimistic in their health at the Veterans Health

Administration (VHA). Their stories were great reminders of the military experiences that I experience in the United States Marine Corps. I saw how my life changes from the military to an educational career compared to other military veterans that participated in this qualitative study. As a researcher, I learned new knowledge of public policy and administration that would make a social change to the life of many military veterans in the United States. One of the participants told me that the VHA of the Department of Veterans Affairs (VA) provided positive systemic actions towards the priceless impact of health care quality to many military veterans. This researcher managed as an investigator of this capstone project with objectivity in making no assumptions to interviewees. I generally had no sides to take on. I had nothing against the VA as well. Frequently veterans were siding with the health care system. I will be taking my time to analyze significant aspects, content, and context to capture the participants' perceptions of health care quality. This qualitative study must be in-depth and provide value to the veterans' community. I anticipate the next time of interview for my third day of conducting virtual interviews. (Aranez, 2020, Thursday, September 24th, unpublished raw data from personal journal).

I had a great afternoon interviewing my only participant to interview today. More interviews to come means the more common responses that I have seen. I saw common themes regarding the five core concepts of patient-centered care includes collaboration, respect and dignity, participation, information-sharing, and decision-making. Thus far, I saw so much correlation from the information given to me that I would start coding and analyzing each transcription for the data collection. Hence, I still have three more interviews to go for this capstone project. I am tired but motivated simultaneously by learning new perceptions about my qualitative study of the topic. I had been very fortunate to conduct this research study to make a difference in the veterans' community. I am inspired and look forward to the results of my coding and analyzing this data collection. (Aranez, 2020, Wednesday, September 30th, unpublished raw data from personal journal).

Appendix K: Codebook

Complete Query Codes Table

Code names	Number of times that the word occurred of which being referenced by the participants	Number of characters in the word that participants mentioned the theme at least once
Veterans	44	9
Care	40	4
Making	31	6
Respect	29	7
Information	28	11
Decision	27	8
Get	26	3
Know	24	4
Collaboration	23	13
Health	23	6
Sharing	22	7
Dignity	21	7
Good	20	4
Like	20	4
Help	17	4
Need	17	4
Department	13	10
Lot	13	3
Providers	13	9
VHA	13	3
Going	12	5
Think	12	5
Time	12	4
Affairs	11	7

Ask	11	3
Led	11	3
Marines	11	7
Military	11	8
Assignment	10	10
Quality	10	7
Trying	10	6
Appointments	9	12
Disabled	9	8
Experience	9	10
Got	9	3
Issues	9	6
Mean	9	4
Just	8	4
People	8	6
Systemic	8	8
Take	8	4
Better	7	6
Medically	7	9
Never	7	5
Pretty	7	6
Different	6	9
Doctors	6	7
Facility	6	8
Guys	6	4
Hospitals	6	9
Party	6	5
Positive	6	8
See	6	3
Sometimes	6	9

Thing	6	5
Third	6	5
Attended	5	8
Many	5	4
Must	5	4
Now	5	3
Organizations	5	13
Part	5	4
Program	5	7
Receiving	5	9
Retired	5	7
Talk	5	4
Understand	5	10
War	5	3
Work	5	4
2007	4	4
Bad	4	3
Caused	4	6
Complain	4	8
Corps	4	5
Discourage	4	10
Done	4	4
Feel	4	4
Group	4	5
Injuries	4	8
Life	4	4
Much	4	4
One	4	3
Question	4	8
Reach	4	5

Really	4	6
Service	4	7
Situation	4	9
Stuff	4	5
Suicidal	4	8
Treated	4	7
Want	4	4
Way	4	3
Years	4	5
Altercations	3	12
Back	3	4
Civilian	3	8
Connect	3	7
Depending	3	9
Else	3	4
Emotionally	3	11

The complete query codes table indicated every code that was mentioned at least once by participants from the initial round of coding. The five core concepts conveyed the nine themes mentioned by participants.