Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

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Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

A Dissertation by

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Brandman University
Irvine, California
School of Education

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Education in Organizational Leadership

April 2015

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April 2015
Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

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This dissertation is dedicated to the men and women of the U.S. Armed Forces, both past and present. As a Chief Hospital Corpsman with 23 years in the U.S. Navy, I can personally speak to the sacrifices and commitments made to protect and serve our Nation. Specifically, I am grateful for the opportunity to provide a resource for our wounded warriors. I hope the results of this study increase awareness of the importance of quality health care and serve as an inspiration and encouragement for our wounded warriors as they recover and improve their lives.

I would like to thank God for granting me the strength and will to continue my educational goals. He has provided me the knowledge, wisdom, and understanding throughout this life’s journey.

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ABSTRACT

Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

by Webster F. Nicholson, Jr.

Serious health care issues were discovered first at Walter Reed Army Medical Center in 2007 and later at U.S. Department of Veteran Affairs health care organizations in 2014 (Brady, 2012; Cohen, Griffin, & Bronstein, 2014; Wright, 2013). The continued success of the Wounded Warrior Program requires a system that will constantly assess and analyze health care quality from the patient’s experience. From a systems perspective, health care quality encompasses six dimensions, and the study involved examining the dimension and four core concepts of patient-centered care (Institute of Medicine, 2001; Lees, 2011; Wexler, 2002; World Health Organization, 2006). A qualitative, phenomenological research method was selected for this study. Purposeful sampling was used to identify 10 marine veterans from the targeted population of wounded warriors previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment. The researcher as the instrument used an interview protocol with standardized, open-ended questions aligned with the research question. The findings of the study were reported according to the research question, and the following themes were identified: professional hospital staff, structured military culture, organized communication processes, shared decision making, and systematic teamwork.
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Chapter I: Introduction

Military service members volunteer to risk their lives for the United States every day. America’s Global War on Terrorism is defined by two conflicts. Operation Enduring Freedom is the war in Afghanistan, which began on October 7, 2001, and ended on December 28, 2014. Operation Iraqi Freedom is the war in Iraq, which began on March 20, 2003, and ended on December 18, 2011. Of the 2.5 million service members deployed to support the wars in Afghanistan and Iraq, more than 6,700 have been killed, and more than 51,700 have been wounded in action (Adams, 2013; DOD, 2013a). Many service members wounded in action would have died on the battlefield in past military conflicts, but advances in medical technology, protective uniform gear, and casualty evacuation protocols have saved the lives of more than 90% of the service members wounded, compared to 78% during World War II and 84% during the Vietnam War (Brady, 2012; Brown, 2008).

The U.S. Department of Defense (DOD) defines wounded warriors as the entire population of service members wounded, ill, or injured as a result of their participation in Operation Enduring Freedom and Operation Iraqi Freedom (DOD, 2009). Wounded warriors are sent to warrior transition units after sustaining injuries or contracting diseases. Each branch of the armed forces has its own warrior transition unit for meeting the needs of its wounded warriors: U.S. Army warrior transition battalions, U.S. Navy safe harbor units, U.S. Air Force patient squadrons, and U.S. Marine Corps wounded warrior detachments. Collectively, these warrior transition units provide leadership and housing, and facilitate appropriate health care, rehabilitation, and recovery for wounded warriors.
The mission of the U.S. Marine Corps Wounded Warrior Regiment is to provide and facilitate assistance to marines, sailors attached to or in direct support of marine units, and their families throughout the phases of recovery (U.S. Marine Corps Wounded Warrior Regiment, 2013). The regimental headquarters, located in Quantico, Virginia, commands the operation of Wounded Warrior Battalion East in Camp Lejeune, North Carolina, and Wounded Warrior Battalion West in Camp Pendleton, California. Each battalion has detachments at military medical treatment facilities and U.S. Department of Veteran Affairs (VA) centers at strategic locations throughout the United States. The detachments at medical treatment facilities foster the Marine Corps philosophy that “marines take care of marines” (U.S. Marine Corps Wounded Warrior Regiment, 2013, p. 1).

The lives of wounded warriors change forever after combat, and their ultimate goal is to achieve new normalcy. New normalcy is a state in which individuals adjust to a new way of living when returning to pre-event normal functions is not possible (Getha-Taylor, 2009; Griffin, 2012). The path to new normalcy is specific for each wounded warrior and may include physical rehabilitation, education, coaching, and counseling until a wounded warrior is able to return to active duty or separate from military service. Wounded warriors who served on active duty and have been separated from military service are known as veterans (U.S. Marine Corps Wounded Warrior Regiment, 2013). As of November 2014, there were over 29,000 marine veterans supported by the Wounded Warrior Regiment nationwide, and approximately 3,500 marine veterans previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment.
When the first group of wounded warriors returned home after combat in 2002, the military health care system collectively lacked the training, experience, and resources essential to meet their needs. Most doctors are accustomed to treating only a few ailments, but these service members displayed a combination of physical, mental, social, and emotional injuries and diseases. According to Berglass (2010), “America’s failure to prepare for and adequately address the impact of war upon service members and veterans is one of the most significant challenges of the post-September 11 era” (p. 1).

Since the Wounded Warrior Program’s inception, military leaders have been fired, government funding and regulation have increased, and design and implementation strategies have been refined. However, more information is needed to determine what opportunities may exist to improve health care quality for wounded warriors not only from a structural, bureaucratic perspective but also from the perception of program participants.

**Background**

A series of *Washington Post* articles published in 2007 revealed the serious health care issues and neglect scandal discovered at the Walter Reed Army Medical Center, once known as the Army’s top medical treatment facility (Brady, 2012; Wright, 2013). Wounded warriors were housed in Building 18, a former hotel that was rodent-infested, moldy, and uninhabitable. Here they waited, incurring delays for doctor appointments, for required signatures to authorize care, and for lost paperwork to be found (Hull & Priest, 2007b; J. Roberts, 2007). Frustrated with the lack of leadership and administrative oversight, soldiers and family members attempted to address their concerns at town hall
meetings and commander calls, but were ignored by leaders at many levels (Griffin, 2012).

President George W. Bush toured the Walter Reed Army Medical Center facilities and appointed a commission to investigate the concerns. The Army replaced leadership, and the DOD increased funding and training to improve the quality of the Wounded Warrior Program. In response to the failures of Walter Reed Army Medical Center and the need to develop a support structure and organization for wounded warriors, the first warrior transition units were established in April 2007 (Shaw, 2009; Tegler, 2013).

According to researchers at the Institute of Medicine (2013), “The DOD and VA health care systems have been struggling in certain health care areas to provide timely care to the over 2 million service members who have been deployed since 2001” (p. 413). Problems with the VA health care system were highlighted in May 2014 when Eric Shinseki, a prior U.S. Secretary of the VA, resigned due to the Inspector General’s report of 40 patients dying while being placed on a secret appointment waiting list, which raised questions regarding how many other veterans may have been forgotten or lost in the system (Cohen et al., 2014). Service members and their families share similar concerns about VA health care, such as the perception that programs and services are suboptimal, not uniform or available across different geographical locations, and not welcoming to certain minority groups (Institute of Medicine, 2013).

**Signature Injuries**

Signature injuries are polytraumatic, which indicates that a wounded warrior suffers from more than two severe injuries to the body or organ system; these injuries may include mental, psychological, or psychosocial impairment, along with physical
disability (Leskin, Lew, Queen, Reeves, & Bleiberg, 2007; Schmaltz, 2011). Wounded warriors with visible physical injuries of limb loss usually present some degree of invisible brain injuries. The complexity of these injuries often leads to secondary conditions such as depression, posttraumatic stress disorder (PTSD), traumatic brain injuries (TBIs), and cognitive issues that make reintegration into the military service and society difficult (Spelman, Hunt, Seal, & Burgo-Black, 2012; U.S. Department of the Army, 2012).

The secondary conditions of combat injuries affect the families of wounded warriors. Families cope with the absence and concern for safety of their service members while deployed, and many take on the burden of care when relatives return home injured. The lack of adequate health care and support for wounded warriors and their families leads to social and economic risks such as marital problems, financial decline, unemployment, domestic violence, abandonment, neglect, homelessness, and divorce (Berglass, 2010; Spelman et al., 2012; U.S. Department of the Army, 2012).

**Health Care Quality**

In the early 19th century, American medicine was disorganized, practitioners lacked adequate training, and the field was controlled by proprietors and nonprofit institutions. Leaders of the American Medical Association and American College of Surgeons established minimum standards for health care delivery within hospitals that focused on mandatory education, regulation, documentation, and appropriate infrastructure (Lombardozi, 2011; Luce, Bindman, & Lee, 1994). Over the past 200 years, ownership by proprietors and nonprofit institutions has been replaced by
corporations and health care systems, and financial rewards and market competition facilitate the business of increasing health care profit and productivity.

There is no specific, absolute definition of health care quality (Pennsylvania Health Care Quality Alliance, 2013; Wexler, 2002). From a systems perspective, health care quality is defined by six dimensions:

- **Effective**—Health care is delivered using evidence-based, proven results.
- **Efficient**—Health care is delivered in a manner that maximizes resources and reduces waste.
- **Accessible**—Health care is delivered in a timely manner, in an appropriate location.
- **Acceptable/patient centered**—Health care takes into account the preferences of the individual service user, customers, and culture.
- **Equitable**—Health care is delivered fairly and does not vary based on diversity or socioeconomic status.
- **Safe**—Health care is delivered in a manner that minimizes risk and harm (Institute of Medicine, 2001; Wexler, 2002; World Health Organization, 2006).

Donabedian (1966) developed a model to describe health care quality, which is the foundation still used in the 21st century. Describing health care quality requires an understanding of an organization’s structure, processes, and outcomes (Best & Neuhauser, 2004; Donabedian, 1966; Griffin, 2012). Specific provider, location, and medium of health care define structure. Processes examine the way health care is
delivered to, or on behalf of, the patient, while outcomes examine the result or cumulative impact of health care delivery (Cheek, 2010; Wexler, 2002).

**Patient-Centered Care**

The focus of this study was the dimension of patient-centered care. Several health care organizations function as a service industry, with patients being treated as customers. The Institute of Medicine (2001) defined patient-centered care as follows:

Health care that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care. (p. 7)

There are four core concepts of patient-centered care:

- **Dignity and respect**—Health care providers listen to and honor the patient’s and family’s perspectives and choices.
- **Information sharing**—Health care providers communicate and share complete and unbiased information with patients and families in an affirming and useful way.
- **Participation**—Patients and families are encouraged to participate in the decision making of their care.
- **Collaboration**—Health care providers, patients, and family members work as a team in the improvement and delivery of care (Abraham & Moretz, 2012; Institute of Medicine, 2001; Institute for Patient- and Family-Centered Care, 2014).
Patient-centered care is the cornerstone of health care quality that facilitates faster healing and recovery, increased productivity and staff morale, and fewer malpractice lawsuits (Institute of Medicine, 2001; Lees, 2011; Prakash, 2010). Patient-centered care is mutually beneficial for the customer and organization and has been successful in the military health care system.

**The Patient Perspective**

Measuring health care quality from the patient’s perspective most commonly involves using patient satisfaction surveys. Patient satisfaction “affects the timely, efficient, and patient-centered delivery of quality health care” (Prakash, 2010, p. 151). The Robert Wood Johnson Foundation defined patient satisfaction as “a measurement designed to obtain reports or ratings from patients about services received from an organization, hospital, physician or health care provider” (Leopold, 2012, p. 1). The quality of the patient satisfaction measure determines the quality of the results.

Researchers have demonstrated that bias may be introduced into patient satisfaction measures as a means to increase reported performance scores (Nix, 2013; Wong et al., 2013). Several health care organizations exclude specific data from reporting, such as patient complaints. The pressure to achieve high patient satisfaction scores increases performance but also increases the potential for unethical practices.

Griffin (2012) conducted patient satisfaction surveys to solicit participant feedback in determining the health care quality of the Wounded Warrior Program. According to the deputy public affairs officer for the Wounded Warrior Regiment, surveys are conducted to measure marines’ and family members’ satisfaction with the
various health care coordination components of the program (V. Long, personal communication, December 9, 2013).

When measuring health care quality from the patient’s perspective, allowing patients to share their story is a more accurate reflection of their reality within the health care organization. Lees (2011) noted, “There is limited evidence as to how useful patient surveys are for improving quality. . . . Methods that aid patient feedback need to provide more personal information and a richness of insight into the patients’ experience” (p. 26).

**Statement of the Research Problem**

The greatest by-product of war is the human casualty. Of the 2.5 million service members deployed to support the wars in Afghanistan and Iraq, more than 6,700 were killed, and more than 51,700 were wounded in action (Adams, 2013; DOD, 2013a). Due to the complexity of wounded warriors’ signature injuries, conditions, and diseases, the military health care system collectively lacked the training, experience, and resources essential to meet their needs.

In response to serious health care issues discovered at Walter Reed Army Medical Center, the Wounded Warrior Program was established in 2007 to provide structure, leadership, health care, and housing for wounded warriors. In 2014, poor quality of care and negative outcomes discovered at VA health care organizations raised questions on how many other veterans may have been forgotten or lost in the system (Cohen et al., 2014). According to Shaw (2009), “The continued success of any unit requires a constant assessment and analysis of effectiveness” (p. 3).

The problem is the need for more information to determine which opportunities may exist to improve health care quality for wounded warriors, not just from a structural,
bureaucratic perspective but also from the perception of program participants. Patient-centered care is the cornerstone of health care quality (Lees, 2011; Prakash, 2010). From the patient’s perspective, patient-centered care facilitates patient engagement and feedback, which leads to faster healing and recovery and lower health care costs (Institute of Medicine, 2001; Prakash, 2010). Not obtaining patients’ perspective on health care quality often leads to “mismatches between the perceptions of those who provide care and those who receive it” (Lees, 2011, p. 27). Specifically, more information was necessary to determine whether the Wounded Warrior Program’s health care demonstrates the four concepts of patient-centered care: dignity and respect, information sharing, participation, and collaboration.

**Purpose Statement**

The purpose of this phenomenological study was to explore the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

**Research Question**

The study addressed the following research question: What is the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration?

**Significance of the Problem**

There was a gap in knowledge between the quality of health care perceived by wounded warriors and actually delivered by the Wounded Warrior Program. Surveys
have been used to measure health care quality, but are biased, inadequate, and limited due to their structure (Lees, 2011; Marcinowicz, Chlabicz, & Grebowski, 2009). Direct feedback from patients provides accurate and personal information about their health care experience and allows them to tell their story. This topic is significant to the quality of life of and the cost of health care for wounded warriors.

**Improving the Lives of Wounded Warriors**

As wounded warriors strive to achieve new normalcy, the “federal one-size-fits-all programs” (Berglass, 2010, p. 4) do not apply equally to the unique circumstances facing these patients. According to the Institute of Medicine, as wounded warriors age, they may acquire life-long treatment for chronic conditions such as diabetes and heart disease (Spelman et al., 2012; Wilde, 2013). These potential chronic conditions combined with polytraumatic injuries sustained in combat have a major impact on the quality of life of wounded warriors and their families. An awareness of the core concepts of patient-centered care furthers the body of knowledge that could be used to enhance the health academic curricula, thereby improving the structure, processes, and outcomes of the health care delivery system. This topic may encourage wounded warriors to take an active, patient-centered approach in decision making regarding their health care treatment, recovery, and rehabilitation.

**Cost of Health Care for Wounded Warriors**

The Government Performance and Results Act of 1993 was established to improve federal program effectiveness and hold government-funded agencies accountable for performance results, service quality, and customer satisfaction (Griffin, 2012; Office of Management and Budget, 2013). Due to the 2013 federal government
shutdown, agencies are scrutinized to ensure fiscal responsibility. Each wounded warrior with polytraumatic injuries and conditions costs the VA an average of $136,000 per year; thus, the population of wounded warriors in 2012 cost the VA $2.8 billion of its $50.9 billion annual budget (Wilde, 2013). This topic may provide senior military leaders and legislators with additional knowledge of the health care challenges associated with wounded warriors, so they may lead initiatives to promote quality health care. A better understanding of the significance of quality health care would assist health care financial managers in allocating resources that directly meet the needs of wounded warriors.

**Definition of Terms**

**Theoretical Definitions**

*Culture.* Schein (1992) defined culture as follows:

A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 17)

*Maslow’s theory of motivation and hierarchy of needs.* Theory developed by Maslow (1954) based on his observation of human motivation. The five needs created range from basic human needs (safety, shelter, etc.) to self-actualization (reaching one’s full potential).

*Phenomenology.* A research design of qualitative methodology that explores a person’s perception, perspective, and understanding of the meaning of a particular phenomenon (Leedy & Ormrod, 2000).
Schein’s cultural model of organizations. Theory developed by Schein (1992) that examines organizational culture on three levels: artifacts, espoused beliefs and values, and basic underlying assumptions.

**Operational Definitions**

*Health care quality.* From a systems perspective, the six dimensions that define health care quality are effective, efficient, accessible, acceptable/patient-centered, equitable, and safe (Institute of Medicine, 2001; Wexler, 2002; World Health Organization, 2006).

*New normalcy.* A state where persons adjust to a new way of living when returning to pre-event normal functions is not possible (Getha-Taylor, 2009; Griffin, 2012).

*Operation Enduring Freedom.* Specific conflict of America’s Global War on Terrorism, the war in Afghanistan, which began on October 7, 2001 and ended on December 28, 2014.

*Operation Iraqi Freedom.* Specific conflict of America’s Global War on Terrorism, the war in Iraq, which began on March 20, 2003, and ended on December 18, 2011.

*Patient-centered care.* The Institute of Medicine (2001) defined patient-centered care as follows:

Health care that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care. (p. 7)
Patient satisfaction. The Robert Wood Johnson Foundation defined patient satisfaction as “a measurement designed to obtain reports or ratings from patients about services received from an organization, hospital, physician or health care provider” (Leopold, 2012, p. 1).

Polytraumatic. Having more than two severe injuries to the body or organ system; these injuries may include mental, psychological, or psychosocial impairment, along with physical disability (Leskin et al., 2007; Schmaltz, 2011).

Traditional disease-centered care. Health care based on the medical model developed during the early 19th century when health care was delivered based on scientific methods aimed to cure diseases (Stedman, 2012).

U.S. Marine Corps Wounded Warrior Regiment. Established in April 2007, its mission is to provide and facilitate assistance to marines, sailors attached to or in direct support of marine units, and their families throughout the phases of recovery (U.S. Marine Corps Wounded Warrior Regiment, 2013).

Veterans. Wounded warriors who served on active duty and have been separated from military service (U.S. Marine Corps Wounded Warrior Regiment, 2013).

Warrior transition units. Facilities that provide leadership and housing and facilitate the appropriate health care, rehabilitation, and recovery for wounded warriors; each branch of the armed forces has its own warrior transition unit for meeting the needs of its wounded warriors.

Wounded warriors. The entire population of service members wounded, ill, or injured as a result of participation in Operation Enduring Freedom and Operation Iraqi Freedom (DOD, 2009).
Theoretical Framework

The theoretical framework of the study was based on Schein’s cultural model of organizations and Maslow’s theory of motivation and hierarchy of needs. Both theories facilitate an understanding of the military health care environment and the lifestyle of wounded warriors as they strive to achieve new normalcy.

According to Schein (1992), organizational culture exists on three levels: artifacts, espoused beliefs and values, and basic underlying assumptions. The essence of organizational culture exists within the level of basic underlying assumptions (Schein, 1992). The environment of U.S. Marine wounded warriors is defined by the culture of the U.S. Marine Corps and the military health care system, and the basic underlying assumptions of the U.S. Marine Corps and military health care system vary based on perception and perspective.

Maslow (1954) developed the hierarchy of needs based on his observation of human motivation. The five needs created range from basic human needs (safety, shelter, etc.) to self-actualization (reaching one’s full potential). Wounded warriors have the opportunity to heal and achieve self-actualization when patient-centered care is successfully delivered in a health care setting (Gandolf, 2012; Pietra, 2013).

Delimitations

Delimitations are controlled by the researcher and indicate how the researcher narrows the scope of a study (C. M. Roberts, 2010). The location of the study was delimited to the Naval Medical Center San Diego, California.
Organization of the Study

The remainder of this study is organized into four chapters, a reference list, and appendices. Chapter II contains a review of literature to provide the background of the Wounded Warrior Program, concepts of health care quality, and significance of patient-centered care. Chapter III contains an explanation of the methodology, research design, population, sample, and data collection and analysis procedures selected for the study. Chapter IV will contain the findings of the study. Chapter V will contain the summary, conclusions, and recommendations for actions and future research. The study concludes with a reference list and appendices.
Chapter II: Review of the Literature

Introduction

Chapter II contains the historical and conceptual background on the main concepts presented in the study. The literature reviewed was drawn from articles, journals, dissertations, books, and websites related to the Wounded Warrior Program and health care quality. Using Chapman University’s Leatherby Library, public libraries, and military websites, the following key terms were searched: wounded warriors, Global War on Terrorism, Iraq War, Afghanistan War, Operation Iraqi Freedom, Operation Enduring Freedom, U.S. Department of Veteran Affairs, history of health care quality, measuring health care quality, traditional disease-centered care, patient-centered care, patient experience, patient satisfaction, health care culture, Schein’s cultural model of organizations, and Maslow’s theory of motivation and hierarchy of needs. Appendix A contains the synthesis matrix used to identify common themes across reference sources.

Specifically, Chapter II contains 10 sections with the American Psychological Association’s (2010) Level 1 heading. The first section defines wounded warriors and explores their journey from the battlefield of war, through Walter Reed Army Medical Center, to the establishment of the warrior transition units. The second section includes an explanation of the complexity of injuries and diseases sustained by wounded warriors and the impact these injuries and diseases have on the service members and their community. The third section includes an explanation of the health care services provided to wounded warriors and their families. The fourth section contains an introduction to the Recovering Warrior Task Force (RWTF), which was implemented to
evaluate the effectiveness of the Wounded Warrior Program and to make
recommendations for improvement.

The fifth section includes a brief history of the health care quality movement and of how medical organizations have evolved into professional regulated businesses. The sixth section defines health care quality from a systems perspective based on six dimensions. The seventh section defines traditional disease-centered care and explores its advantages and disadvantages. The eighth section outlines the four core concepts, advantages, and disadvantages of patient-centered care. The ninth section includes an explanation of the importance of the patient experience and satisfaction in measuring the quality of health care. The 10th section establishes the theoretical framework of the study using Schein’s cultural model of organizations and Maslow’s theory of motivation and hierarchy of needs. Chapter II concludes with the gap in the literature discovered and an explanation of the research problem and significance of the study.

Background of the Wounded Warrior Program

The Global War on Terrorism has been the longest sustained U. S. military conflict since the Vietnam War (Institute of Medicine, 2013). The greatest by-product of war is the human casualty. The mortality rate of casualties from Operation Iraq Freedom and Operation Enduring Freedom is less than 10% due to advances in medical technology, protective uniform gear, and casualty evacuation protocols, as compared to 22% during World War II and 16% during the Vietnam War (Brady, 2012; Brown, 2008). The DOD (2009) defined wounded warriors as the entire population of service members wounded, ill, or injured as a result of participating in Operation Enduring Freedom and Operation Iraqi Freedom.
Wounded warriors receive combat medical care on the battlefield at the time of injury and are stabilized at first aid stations or emergency medical facilities. Wounded warriors are then evacuated through Landstuhl Regional Medical Center in Germany to Walter Reed Army Medical Center, once known as the Army’s top medical treatment facility (Brady, 2012; Schmaltz, 2011).

**Walter Reed Army Medical Center**

The military health care system came under scrutiny after the serious health care issues and neglect scandal discovered at Walter Reed Army Medical Center (Brady, 2012; Wright, 2013). A series of *Washington Post* articles revealed the poor living conditions and health care experienced by wounded warriors. Hull and Priest (2007b) described Building 18, a former hotel used to house wounded warriors, as rodent-infested, moldy, and uninhabitable. Doctors’ appointments and medical evaluations were routinely cancelled and difficult to obtain, and wounded warriors wasted time waiting for health care as clerks and case managers often lost their paperwork (Hull & Priest, 2007b; J. Roberts, 2007). One wounded warrior injured in Afghanistan described the conditions at Walter Reed Army Medical Center as “dysfunctional” and noted that “the result is a massive stress and mental pain causing further harm” (Hull & Priest, 2007a, p. 2).

Many wounded warriors were frustrated with the bureaucracy, lack of leadership, and lack of administrative oversight provided by the military health care system. Sergeant Joe Baumann, a wounded warrior injured in Iraq in 2005, stated, “The system is not set up to be soldier-friendly at all. It’s designed to scare and belittle soldiers. It’s designed to be a fast and efficient process and get people out of the way” (Allday, 2007, p. 1). Several wounded warriors stated they would wake up early in the morning for
daily room inspections and were told not to speak to the media (Kennedy, 2007; McMichael, 2007). Soldiers and family members noted that their concerns were voiced at town hall meetings and commander calls, but were ignored by leaders at many levels (Griffin, 2012).

President George W. Bush toured the Walter Reed Army Medical Center facilities and appointed a commission to investigate the concerns. Results of the investigation revealed that Army leadership had been aware of the condition of the facilities since 2003, but took little or no action (Kennedy, 2007; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007; Winerip, 2007). The Army replaced leadership and the DOD increased funding and training to improve the quality of the Wounded Warrior Program. In response to the failures of Walter Reed Army Medical Center and the need to develop a support structure and organization for wounded warriors, an Army Medical Action Plan was developed, and the first warrior transition units were established in April 2007 (Shaw, 2009; Tegler, 2013).

**Warrior Transition Units**

Wounded warriors are sent to warrior transition units after sustaining injuries or contracting diseases. The mission of the warrior transition unit is to “provide command and control, primary care and case management for wounded warriors in transition to establish conditions for healing and promote timely return to the force or transition to civilian life” (Warrior Transition Unit Consolidated Guidance, 2009, p. 12). Each branch of the armed forces has its own specific warrior transition unit for meeting the needs of its wounded warriors: U.S. Army warrior transition battalions, U.S. Navy safe harbor units, U.S. Air Force patient squadrons, and U.S. Marine Corps wounded warrior
of health care and benefits by leveraging appropriate resources (Cheek, 2010; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007). The integrated health care management process begins with a screening by a multidisciplinary team of the following individuals:

- Specialty physicians and nurses.
- Allied health care professionals.
- Mental health care professionals.
- Rehabilitation and vocational rehabilitation specialists.
- Social workers.
- Chaplains and religious ministers (DOD, 2009; Warrior Transition Unit Consolidated Guidance, 2009).

It is critical that this screening is conducted early during a wounded warrior’s recovery process to address the ability to return to military duty or transition to civilian life (Cheek, 2010; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007).

Wounded warriors who are unlikely to return to military duty within a specific period of time are assessed by the multidisciplinary team using standardized tools and are
assigned to health care coordination categories. Table 1 illustrates the service member care coordination categories (DOD, 2009).

Table 1

*Service Member Care Coordination Categories*

<table>
<thead>
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<th>Category no.</th>
<th>Description</th>
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| Category 1   | Has a mild injury or illness  
Is expected to return to duty within a time specified by his or her military department  
Receives short-term inpatient medical treatment or outpatient medical treatment and/or rehabilitation |
| Category 2   | Has a serious injury or illness  
Is unlikely to return to duty within a time specified by his or her military department  
May be medically separated from the military |
| Category 3   | Has a severe or catastrophic injury or illness  
Is highly unlikely to return to duty  
Will most likely be medically separated from the military |

**U.S. Marine Corps Wounded Warrior Regiment**

Established in April 2007, the mission of the U.S. Marine Corps Wounded Warrior Regiment is to provide and facilitate assistance to marines, sailors attached to or in direct support of marine units, and their families throughout the phases of recovery (DOD, 2009; U.S. Marine Corps Wounded Warrior Regiment, 2013). The Wounded Warrior Regiment is an independent command serving a distinct population; the unity of
command and effort provides focused guidance, direction, and oversight. The Wounded Warrior Regiment is serviced by a medical cell, which is a team of health care experts of various disciplines that provides a liaison, subject matter expertise, and advocacy (U.S. Marine Corps Wounded Warrior Regiment, 2013).

A wounded warrior’s request for assignment to the Wounded Warrior Regiment is routed through the unit’s leadership and endorsed by the battalion commander. The following general conditions are considerations for acceptance to the Wounded Warrior Regiment:

- Injuries or disease requiring more than 90 days of health care treatment or rehabilitation.
- The parent command cannot support transportation requirements to the medical treatment facility.
- The marine cannot perform a job or serve a mission-related function in the parent command due to injuries or disease.
- The marine has three or more medical appointments per week (DOD, 2009; U.S. Marine Corps Wounded Warrior Regiment, 2013).

Each wounded warrior, with support from health care providers, family, and military leadership, creates a comprehensive recovery plan. The U.S. Marine Corps comprehensive recovery plan is structured and based on the wounded warrior’s concrete goals outlining specific action steps that will enable a new normalcy (Cheek, 2010; DOD, 2009; U.S. Marine Corps Wounded Warrior Regiment, 2013). The components of the recovery plan include the following:

- Identify and address immediate needs of the wounded warrior and family.
• Establish rehabilitation and quality of life goals, such as future education, training, and employment.
• Specify resources available to meet these goals.
• Establish milestones of recovery.
• Identify and network with the appropriate facilities and organizations.
• Evaluate the needs of family members and provide support (Warrior Transition Unit Consolidated Guidance, 2009).

A comprehensive recovery plan is created for individual wounded warriors and is not generalized, as the needs and circumstances of each patient vary.

**Challenge of Treating Signature Injuries**

The majority of combat-related injuries sustained by wounded warriors are classified as signature injuries. Signature injuries are polytraumatic, which indicates that the wounded warrior suffers from more than two severe injuries to the body or organ system; these injuries may include mental, psychological, or psychosocial impairment, along with physical disability (Leskin et al., 2007; Schmaltz, 2012).

The majority of these signature injuries are caused by improvised explosive devices (IEDs), which encompass a wide range of bombs, varying in size, composition, and complexity, used to target vehicles and individuals in suicide attacks and other terrorist activities (Brown, 2008; Schmaltz, 2012). In addition to the physical threat of IEDs, the unpredictability and presence of IEDs lead to stress and anxiety in service members.

There are also physical risks due to occupational exposure to a combat environment. The harsh climate temperatures of Iraq and Afghanistan, with daily
temperature extremes ranging from over 100 degrees Fahrenheit to subfreezing temperatures, combined with sandstorms and lack of adequate water, compromise daily hygiene (Spelman et al., 2012). Fungal and bacterial skin infections, hearing loss, dehydration, frostbite, and heat exhaustion are common conditions. Exposure to air pollutants often leads to long-term health problems.

**Invisible Brain Injuries and Mental Health Problems**

Wounded warriors who require medical and rehabilitative care for visible physical injuries of limb loss usually present some degree of invisible brain injuries. Posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) are the most common, serious, invisible brain injuries.

Posttraumatic stress disorder is an anxiety disorder that develops after direct, personal experience with, or witnessing, a terrifying event that involved physical harm or the perceived threat of physical harm (National Institute of Mental Health, 2014; Schmaltz, 2011). Symptoms of PTSD may include flashbacks, nightmares, irritability, and incontrollable thoughts about the event. Service members who experience combat exposure and are wounded appear to have a higher prevalence of PTSD (Institute of Medicine, 2013). According to Hoge et al. (2008), 31.8% of wounded warriors with a physical injuring also had PTSD.

Traumatic brain injury is caused by a blow or jolt to the head or a penetrating head injury that affects the normal function of the brain (Spelman et al., 2012; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007). Disruption of normal brain function as a result of TBI may include a loss of consciousness, loss of memory, confusion, and disorientation. The DOD and Veterans
Brain Injury Center estimate that TBI accounts for 22% all Operation Enduring Freedom and Operation Iraqi Freedom combat casualties, as compared to only 12% in Vietnam (Institute of Medicine, 2013; Summerall, 2012).

Studies have shown that wounded warriors may be diagnosed with both TBI and PTSD (Carlson et al., 2010; Hoge et al., 2008). Confusion between PTSD and TBI can occur because both may result from the same trauma and symptoms may overlap. The symptoms of PTSD and TBI may vary in severity and may occur immediately after the event and possibly reappear months or years later (National Institute of Mental Health, 2014; Schmaltz, 2011). Posttraumatic stress disorder and TBI may result in impaired cognitive abilities, judgment, motor skills, and reasoning (Schmaltz, 2011).

Of the 2.5 million service members deployed to support the wars in Afghanistan and Iraq, many have served multiple tours, and this reexposure to combat environments increases the risk of long-term mental health problems (Berglass, 2010; Spelman et al., 2012). Psychological stressors associated with combat deployment include the demands of job responsibility combined with separation from family and friends. As an avenue to cope with the physical and mental injuries, wounded warriors may resort to prescription drug and alcohol abuse. The number of service members under the age of 30 who commit suicide increased by 44% for males and 11% for females between 2009 and 2011 (Nicks, 2014). The complexity of these signature injuries often leads to other secondary conditions such as depression and cognitive issues that make reintegration into the military service and society difficult.

Wounded warriors often perceive seeking help for mental health problems as a sign of weakness (Berglass, 2010; Randall, 2012; Spelman et al., 2012). The military
culture teaches self-discipline, and values self-reliance and strength. According to Britt (2012) and Bush (2011), the military culture promotes a stigma associated with mental health problems, demonstrating the belief that seeking help is embarrassing, would affect a service member’s career, and may cause leaders and unit members to lose confidence.

Studies have been conducted with military units to examine the effects of stigma and culture. Gorman et al. (2011) reported that of 332 National Guard troops who met screening criteria for a mental health condition, 47% chose not to seek care because of concern about treatment influencing career advancement. From 48 focus group interviews across six military installations, Gibbs et al. (2011) and Kim et al. (2011) reported that service members in treatment for alcohol abuse or mental health conditions perceived a negative attitude from leaders and peers. Ironically, high alcohol use prior to treatment for alcohol abuse increased bonding with peers and was socially acceptable (Gibbs et al., 2011; Institute of Medicine, 2013). Beyond the stigma, barriers impeding appropriate care have also been related to available services and understanding of the combat environment by mental health providers (Ouimette et al., 2011; Randall, 2012).

**Effect of Signature Injuries on Family and Society**

Conditions and diseases of signature injuries affect the families of wounded warriors. Social and economic risks such as marital problems, financial decline, unemployment, and legal cases often result in domestic violence, abandonment, neglect, homelessness, and divorce (Spelman et al., 2012; U.S. Department of the Army, 2012). Families cope with the absence and concern for safety of their service members while deployed, and many take on the burden of care when relatives return home injured.
Resnik and Allen (2007) conducted a qualitative study to explore the challenges of wounded warriors and their families as they reintegrate into the community. The study used the World Health Organization’s International Classification of Functioning, Disability, and Health to code data and identify specific problems. Compared to service members not injured in combat, Resnik and Allen concluded that wounded warriors with polytraumatic injuries faced challenges of greater magnitude, specifically in the following domains: applying and learning knowledge, task completion, self-care, communication, and interpersonal relationships (Resnik & Allen, 2007; Schmaltz, 2011). The findings of the study highlighted the frustration and difficulty wounded warriors face as they seek new normalcy.

Wood (2011) explored the life of Jimmy Kinsey II, a marine wounded warrior injured in Iraq in April 2006 from an IED, and his wife, Karie, who became his primary caregiver. For 4 years after the injury occurred in Iraq, Jimmy was treated for an amputation (leg), TBI, PTSD, chronic pain, depression, and drug addiction (Wood, 2011). Karie explained the impact of Jimmy’s injuries and conditions:

We were fighting to get his life back, and fighting to make a marriage work through pill addiction, overdose, miscarriage, family feuds, infections, amputations, PTSD, and TBI. There were amazing times that made everything worth it, and there were times I truly felt like I was in hell. The thing that got me the most was the amount of time I told the military to please, please help me come up with a way to help him with his addiction and wean him off of the pills. I thought he needed inpatient drug addiction therapy. He needed help and I didn’t
feel like anyone would listen to me. I truly feel like I lost my husband to this war. (Wood, 2011, pp. 1-2).

Jimmy enrolled in a PTSD clinic call Project Victory in an attempt to seek help for a combination of his health care conditions but later died from an accidental overdose in April 2010 (Wood, 2011).

The health status of service members before serving in a combat environment is superior to that of the general population of the same sex and age (Spelman et al., 2012). The immediate health problems experienced by service members injured in a combat environment often increase the risk for chronic diseases, which contributes to a public health concern. Leskin et al. (2007) advocated a commitment to meeting the health care needs of wounded warriors across their lifespan:

Because of their chronic and evolving symptoms, deficits, and functional disabilities, patients with polytrauma who do not receive dynamic and coordinated health services are likely to have significantly reduced quality of life (QOL) and to overwhelmingly burden the health care system. (p. 24)

As a result of the Global War on Terrorism, meeting the consistent, comprehensive health care needs of the new generation of service members and their families continues to be a challenge for society and especially the health care system.

**Health Care Services Provided to Wounded Warriors and Families**

The health care services provided to wounded warriors and their families are coordinated through an array of DOD, VA, and civilian-sector organizations (Randall, 2012; Spelman et al., 2012; U.S. Marine Corps Wounded Warrior Regiment, 2013). These services primarily include rehabilitation and family support resources.
Rehabilitation Services

The goal of rehabilitation is “to achieve optimal physical, psychological, social, and vocational functioning” (U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007, p. 54). The vast majority of wounded warriors with major burns are treated at Brook Army Medical Center in San Antonio, Texas. Wounded warriors with traumatic amputations are treated at Walter Reed Army Medical Center, in Washington, DC, and Naval Medical Center, San Diego, California.

Polytrauma rehabilitation centers are located across the United States to meet the needs of wounded warriors not residing near a primary military treatment facility. The level and intensity of rehabilitation is based on the following factors: diagnosis, ability to recover, level of functioning prior to injury, support systems, and mental status (Brown, 2008; Schmaltz, 2011; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007). The focus of both military and civilian-sector rehabilitation services is on occupational, physical, and speech therapy and counseling.

Family Support Services

A vital aspect of the wounded warrior’s rehabilitation success is the integration of family into the planning and delivery of health care services. The following services are available to wounded warrior families through public and private organizational partnerships:

- Education about the injuries and diseases and their effects.
- Training and financial counseling for family members who will be personal caregivers.
• Counseling to deal with the emotional reactions and adjustments to new a way of life (DOD, 2009; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007).

**DOD and VA Health Care Challenges**

According to researchers at the Institute of Medicine (2013), “The DOD and VA health care systems have been struggling in certain health care areas to provide timely care to the over 2 million service members who have been deployed since 2001” (p. 413). Burnam et al. (2009) reported that the mental-health workforce of the DOD, VA, and civilian sector lacked the capacity and training to address the needs of wounded warriors and was using inadequate organizational resources to support quality improvement.

Service members and their families share similar concerns about VA health care, which include excessive wait times for appointments, the perception that programs and services are suboptimal, not uniform or available across different geographical locations, and not welcoming to certain minority groups (Institute of Medicine, 2013).

Problems with the VA health care system were highlighted in May 2014 when the U.S. Secretary of the VA, Eric Shinseki, resigned due to the poor quality of care and negative outcomes discovered at the Phoenix Virginia VA Medical Center. According to the inspector general’s report, 40 patients died while being placed on a secret waiting list from April 2013 to April 2014, raising question on how many other veterans may have been forgotten or lost in the system (Cohen et al., 2014). Kizer and Jha (2014) explained that the VA scandal was due to “an infocused performance-measurement program, increasingly centralized control of care delivery and associated increased bureaucracy, and increasing organizational insularity” (p. 1).
Sergeant Josh Renschler, U.S. Army (Retired), met with the House of Representatives Committee on Veteran Affairs on July 10, 2014, to discuss VA mental health care. Renschler, medically retired from the Army in 2008 after serving in Iraq, explained his case to the committee (U.S. House of Representatives, 2014):

Unfortunately, hospital leadership decided that well-staffed interdisciplinary care was too costly. Now veterans at the facility go through an impersonal intake/assessment process and then have to find their way to the different services scattered across the sprawling campus to get the care they need. For many warriors, just navigating around this complex facility is anxiety-provoking. . . . Veterans with mental health issues will seldom open up and discuss painful, private issues with a clinician they’ve never met. It takes time to build the trust to talk about deeper issues. . . . Working with a team increases the likelihood that someone will see things that others missed. The bottom line is that VA care must be veteran-centered! That has to mean recognizing each veteran’s unique situation and individual treatment preferences, and building flexible systems to meet the veteran’s needs and preferences, not the other way around. (p. 1)

Kizer and Jha (2014) suggested that the problems with the VA health care system can be addressed with strong leadership, greater reporting transparency, and collaboration with the private sector. Kizer and Jha proposed the following steps to restore trust in the VA health care system:

- Screen and triage all veterans on wait list as soon as possible.
- Align the performance management system with measures important to clinicians and patients.
• Improve patient access by using modern information systems and advanced communication technologies.

• Network and create partnerships with private-sector health care organizations to expand learning and service availability.

According to Sergeant Renschler, U.S. Army (Retired), wounded warriors “need a system that serves the veteran, not one that requires the veteran to accommodate the system” (U.S. House of Representatives, 2014, p. 3).

**Recovering Warrior Task Force**

Shaw (2009) noted, “The continued success of any unit requires a constant assessment and analysis of effectiveness” (p. 3). The Government Performance and Results Act of 1993 was established to improve federal program effectiveness and hold government-funded agencies accountable for performance results, service quality, and customer satisfaction (Griffin, 2012; Office of Management and Budget, 2013).

Congress directed the DOD to establish the Recovering Warrior Task Force (RWTF) to evaluate the effectiveness of the Wounded Warrior Program and make recommendations for improvement. The RWTF agenda for Fiscal Year 2013 included 14 visits to 21 DOD installations to conduct 30 focus groups, six business meetings, and over 120 briefings (DOD, 2013b). In the Fiscal Year 2013 annual report, the RWTF made 21 recommendations to the DOD and associated federal agencies. These recommendations include streamlining the continuity of health care; maintaining accurate and accessible information system resources; creating an alliance and relationship between federal, state, and local agencies; and training leadership and care providers.
During the warrior transition unit site visits, the RWTF conducted focus groups involving 263 participants from 36 locations (DOD, 2013b). The purpose of the focus groups was to determine the overall effectiveness of the Wounded Warrior Program from the perspective of the participants. Dialogue with wounded warriors during the focus groups consistently revealed the following concerns:

- Mental health services are not meeting needs.
- Information and support resources are not consistently communicated.
- Medical treatment and history are not consistently documented and transferable across health care service providers (DOD, 2013b).

Feedback provided to the RWTF revealed, “Service members continue to observe that the impression at the top does not always match the experiences and sentiments on the ground” (DOD, 2013b, p. 7). The infrastructure of the Wounded Warrior Program has improved since the failure of Walter Reed Army Medical Center, but many of the bureaucratic and administrative challenges still exist.

**History of Health Care Quality Movement**

The health care quality movement began due to public health concerns and the need to reduce the large number of deaths associated with the practice of medicine (Marjoua & Bozic, 2012). A discussion of the establishment of health care regulation and the introduction of quality improvement practices in the service industry follows.

**Health Care Quality Movement in the 19th and 20th Centuries**

The health care quality movement evolved to serve the public welfare and protect human welfare from the dangers of medicine. Florence Nightingale, a public health pioneer, identified the association between poor sanitation and the 60% fatality rate
among wounded soldiers during the Crimean War of 1854 (Chassin & Loeb, 2011; Marjoua & Bozic, 2012). While serving as a nurse, Nightingale developed sanitation practices such as bathing, cleaning surgical instruments, and changing bed linen that later became the standard used in hospitals. Ignaz Semmelweis, an obstetrician, introduced hand washing to health care (Lombardozzi, 2011). Ernest Codman, a surgeon, pioneered the creation of hospital standards and was the first American doctor to follow the progress of patients through recovery systematically (Chassin & Loeb, 2011). The current health care quality initiatives are based on a sequence of historical accumulative efforts.

In the early 19th century, American medicine was disorganized, practitioners, lacked adequate training, and proprietors and nonprofit institutions controlled the field. In 1847, the American Medical Association was formed to standardize the U.S. medical education system (Chassin & Loeb, 2011; Luce et al., 1994). Abraham Flexner published The Flexner Report in 1910 to document the poor conditions of the U.S. medical education system and hospitals (Lombardozzi, 2011). In 1917, leaders of the American Medical Association and the American College of Surgeons established the following five minimum standards for health care delivery within hospitals:

- Organize hospital medical staff.
- Mandate education and license for health care providers.
- Create rules and regulation for scope of practice.
- Retain medical records for patient history.
- Implement diagnostic and treatment facilities (Luce et al., 1994).
Establishment of Regulation and Accreditation Standards

Rigorous expectations set by federal and state governments led to health care regulation, professional licensure, and a focus on optimum performance measures. The Institute of Medicine published a report that cited many health services as inadequate and fixed national attention on the critical need for quality improvement in health care (Luce et al., 1994). The Joint Commission on Accreditation of Hospitals was founded in 1951 to ensure compliance with the five minimum standards for health care delivery within hospitals (Lombardozzi, 2011). The Joint Commission on Accreditation of Hospitals was renamed the Joint Commission on Accreditation of Healthcare Organizations in 1987 and simplified its name to The Joint Commission in 2007.

Leaders of the Joint Commission and the American College of Surgeons initially assessed doctor performance based on a peer review of medical records. The peer review of medical records became highly subjective and unstructured, which led to a hospital-wide quality assurance program. Practice guidelines developed by the consensus of professional societies using clinical investigations were adopted to help doctors manage patients (Luce et al., 1994; Marjoua & Bozic, 2012). A multidisciplinary approach of continuous quality improvement was implemented to enhance hospital performance.

The mission of the Joint Commission is “to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value” (The Joint Commission, 2014, p.1). Both military and civilian health care organizations are inspected and required to meet accreditation standards every
3 years. Accreditation standards and patient safety goals are updated annually, and this information is provided to the public to ensure transparency.

**Health Care Quality Movement in the 21st Century**

By the late 1980s, medical researchers were evaluating serious and consistent problems with medical errors and the misuse of health care resources, which prompted the health care community to adopt quality improvement methods used in the business industry (Chassin & Loeb, 2011; Khoury, 2012; Marjoua & Bozic, 2012). Quality improvement methods such as the automobile assembly line, total quality management (TQM), and Six Sigma have been very effective in hospital settings.

The automobile assembly line method of improving quality has been incorporated into health care procedures that required several specific steps (Hughes, 2008; Khoury, 2012). In the assembly line method, complex tasks are broken down into simple steps, and employees are trained to specialize in a small portion of the work, which increases productivity and reduces error. Each team member on the assembly line takes ownership in finding a defective part or safety problem before the end product is produced. This method has resulted in the establishment of surgical timeouts and checklists that have improved patient safety, efficiency, and teamwork in hospital settings (Hughes, 2008; Khoury, 2012).

The key principles of TQM, founded by W. Edwards Deming, were implemented in health care organizations to develop a shared responsibility of leadership, management, and customer loyalty. The TQM model fosters an organizational culture that promotes a health care environment of continuous improvement (Chassin & Loeb,
Using the TQM approach, hospitals established clinical practices and guidelines to measure the performance and methodology of patient care.

Six Sigma was introduced into the hospital setting to minimize waste, monitor resource allocation, and eliminate defects (Bandyopadhyay & Coppens, 2005; Schweikhart & Dembe, 2009). Six Sigma, developed by Bill Smith of Motorola in 1986, improves work-flow efficiency and product value by saving time. Using a statistical method approach, work is standardized and precise, and the analysis of defects is aligned to meet the customer’s expectations. Six Sigma has been very successful at improving patient satisfaction (Lazarus & Neely, 2003).

Leadership support and organizational commitment are critical at implementing health care quality improvement strategies (Cleary & O’Kane, 2014; Wexler, 2002; World Health Organization, 2006). Leaders must be visible change agents and ensure adequate financial resources, and the organization as a system must promote a culture of safety and quality improvement (Hughes, 2008).

The landscape and dynamics of American medicine has changed dramatically over the past 200 years. Ownership by proprietors and nonprofit institutions has been replaced by corporations and health care systems. Managed care organizations earn profits when their employees are able to treat patients under budget. Financial rewards and market competition facilitate health care productivity. The current trend is balancing this productivity while containing cost (Lombardozzi, 2011). The focus of health care has become business, not only treating patients.
Definition of Health Care Quality

There is no specific, absolute definition of health care quality (Pennsylvania Health Care Quality Alliance, 2013; Wexler, 2002). Health care quality can be viewed differently based on dimensions and perspectives. From a systems perspective, health care quality is defined by six dimensions:

- Effective—Health care is delivered using evidence-based, proven results.
- Efficient—Health care is delivered in a manner that maximizes resources and reduces waste.
- Accessible—Health care is delivered in a timely manner in an appropriate location.
- Acceptable/patient centered—Health care takes into account the preferences of the individual service user, customers, and culture.
- Equitable—Health care is delivered fairly and does not vary based on diversity or socioeconomic status.
- Safe—Health care is delivered in a manner that minimizes risk and harm (Institute of Medicine, 2001; Wexler, 2002; World Health Organization, 2006).

Health Care Quality: Structure, Processes and Outcomes

Donabedian (1966) developed a model to describe health care quality, which is the foundation still used in the 21st century. Donabedian explained that describing health care quality requires an understanding of an organization’s structure, processes, and outcomes. Specific providers, locations, and media of health care define structure. Processes examine the way health care is delivered to, or on behalf of, the patient, while
outcomes examine the result or cumulative impact of health care delivery (Chassin & Loeb, 2011; Cheek, 2010; Wexler, 2002).

The structural perspective of a health care organization must be specified when describing health care quality. Structure involves not only the tangible aspects of health care but also the policies and culture of the organization. An organization’s incentives and motivations that are structure-focused foster a system that promotes high-quality care. According to Cleary and O’Kane (2014), “One would expect care to be of higher quality when all staff are clear about their roles and responsibilities, when there are strategies for monitoring adherence to recommended procedures, and there are systematic approaches to continuously improving care quality” (p. 6).

The criteria for measuring processes are developed by identifying the health care condition of interest. Data are collected on this condition and the results are synthesized to create evidence-based guidelines. Even when data support the appropriateness and effectiveness of a process, there is often more than one way to treat a condition, and the appropriateness and effectiveness is then based on patient preference (Cleary & O’Kane, 2014; Pennsylvania Health Care Quality Alliance, 2013).

The criteria for measuring outcomes are developed by determining whether the observed results of health care are consistent with predictions validated by evidence-based guidelines (Hughes, 2008). Outcomes are not comprehensive measures of health care quality because demographics and the social environment also affect patient treatment.

Processes and outcomes complement each other in the health care system (Cleary & O’Kane, 2014; Donabedian, 1966). Collecting history of family illnesses or diseases
during a doctor’s visit is a process, because it involves certain steps. Tracking reasons for readmission to the hospital is an outcome. Processes are analyzed using logic that enables one to focus on the how of the step and creates accountability as health care is delivered. Outcomes are the synthesis of processes and enable individuals to focus on the what or conclusion of the total product.

Processes and outcomes of the Wounded Warrior Program are tracked and reported to military leadership (Cheek, 2010; Shaw, 2009). Processes include the wounded warrior’s length of stay, access to care, and medical evaluation board processing times; outcomes include readiness to return to duty, postdeployment social functioning, and patient satisfaction (Cheek, 2010; Shaw, 2009). Processes and outcomes complement each other in evaluating health care quality.

**Roles and Responsibilities in Health Care Quality Improvement**

There are three levels of responsibility when examining health care quality from a systems perspective (World Health Organization, 2006). At the national and regional level, decision makers develop strategies and approve policies that promote improved health care processes and outcomes. Health-service providers, the second level, are responsible for ensuring the delivery of the highest standard of quality health care to patients and their families. The third level consists of service users as coproducers of health. Service users have the critical role and responsibility of identifying and managing their own health needs with support from the other two levels (World Health Organization, 2006).
Health Care Quality and Traditional Disease-Centered Care

Traditional disease-centered care is based on the medical model, which was developed during the early 19th century when health care was delivered based on scientific methods aimed to cure diseases (Stedman, 2012). With the discovery of the germ theory by Louis Pasteur and Robert Koch, the treatment of diseases became the focus of medical education and training. According to Bowling and O’Hare (2012), the traditional disease-centered model targets treating the mechanisms that cause and the symptoms related to the specific diseases to achieve positive outcomes. In the traditional disease-centered model, the doctor assumes an authoritarian position and is seen as the expert in the delivery of health care.

Advantages of Traditional Disease-Centered Care

Traditional disease-centered care has the advantage of providing a systematic framework of treating simple diseases. It provides evidence-based management, outcome evaluation, and performance measurement for clearly defined disease processes and patient populations (Bowling & O’Hare, 2012). Because of its structured and consistent treatment plans, this approach can be readily adapted to newly established health care organizations.

Disadvantages of Traditional Disease-Centered Care

The primary disadvantage of traditional disease-centered care is that structured and consistent treatment plans are not aligned with the needs and expectations of the individual patients and have not been effective at sustaining high-quality health care (Peikes, Chen, Schore, & Brown, 2009; U.S. Department of Health and Human Services, 2010). This approach provides little guidance on managing conflicting treatment plans.
that occur in patients with multiple diseases, competing health priorities, and unique preferences and circumstances (Bowling & O’Hare, 2012). Traditional disease-centered care may lead to inappropriate treatment strategies that have the potential for more harm than benefit (DiGioia, Lorenz, Greenhouse, Bertoty, & Rocks, 2010).

**Health Care Quality and Patient-Centered Care**

Many health care organizations have begun to function as a service industry, with patients treated as customers. This type of health care is patient-centered care. The Institute of Medicine (2001) defined patient-centered care as

Health care that establishes a partnership among practitioners, patients, and their families to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care. (p. 7)

The concept of patient-centered care dates to the 1950s and the term was introduced by Enid Balint and colleagues in 1970 (Balik, Conway, Zipperer, & Watson, 2011). The value of patient-centered care evolved due to the presence of several social and economic forces:

- Aging of baby boomers and the associated rise in health care consumer expectations.
- Demand for patient rights and safety protocols.
- Demand for greater transparency of health care outcomes.
- Government incentives to report health care performance to the public.
- Increased access to health care information due to advances in technology.
- Health care reform and cost containment (Balik et al., 2011; Cliff, 2012).
According to the Institute for Health Improvement (2014), patient-centered care considers a patient’s culture, values, personal preferences, and lifestyle. A patient-centered health care system “may provide higher quality healthcare with greater efficiency while improving the patient experience” (Cliff, 2012, p. 86).

Four Core Concepts of Patient-Centered Care

The four core concepts of patient-centered care are as follows:

- **Dignity and respect**—Health care providers listen to and honor the patient’s and family’s perspectives and choices.

- **Information sharing**—Health care providers communicate and share complete and unbiased information with patients and families in an affirming and useful way.

- **Participation**—Patients and families are encouraged to participate in the decision making of their care.

- **Collaboration**—Health care providers, patients, and family members work as a team in the improvement and delivery of care (Abraham & Moretz, 2012; Institute of Medicine, 2001).

**Dignity and respect.** Immanuel Kant’s moral theory of the categorical imperative establishes a framework for understanding the significance of dignity and respect. Kant stated the formula of the end in itself as follows: “Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means but always at the same time as an end” (Ciulla, 2003, p. 95). To use someone as a means involves deception, coercion, or lack of principle consent. Treating persons with respect and dignity is “not a matter of acting on informed individual decisions, but rather
a matter of acting on principles that express the worth of humanity” (McClimans, Dunn, & Slowther, 2011, p. 915). According to Kant, people are respected simply because they are persons.

Respecting patients’ interests and autonomy is justifiable on moral grounds and aligned with the obligation of health care ethics (Dabney & Tzeng, 2013). The first principle of health care ethics is as follows: “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights” (American Medical Association, 2014, p. 1). Respect and dignity not only involves professional behavior but also facilitates the need for physicians and patients to challenge each other.

Chochinov (2013) noted, “Modern medicine has expanded its capacity to diagnose, treat, and even cure various ailments that afflict humankind, but all too often patients and families experience health care as impersonal, mechanical, and quickly discover that patienthood trumps personhood” (p. 757). Providing care to patients and caring correspond to each other with regard to dignity and respect. Tenor, or the tone of care, is an important indicator of whether a patient feels dignity is respected.

**Information sharing.** Information sharing, through communication, is the foundation of patient-centered care (Dabney & Tzeng, 2013; Institute of Medicine, 2001). Information sharing facilitates patient-centered care by developing healing relationships grounded in strong communication and trust (Epstein et al., 2010; Marcinowicz et al., 2009). The interaction between health care providers and the patient and their family is a two-way sharing of information in which the message and responsibilities of all parties involved are understood. Sharing information involves exploring the patients’ values and
preferences, fostering clinical decision making, and enabling patients to make the
behavioral changes needed to promote good health (Dabney & Tzeng, 2013; Epstein et
al., 2010). Health care providers must be transparent; frame the information based on the
patients’ literacy, experience, and expectations; and deliver feedback tailored to
individual need (Boykins, 2014; Levinson, Lesser, & Epstein, 2010).

Patient-centered information technology serves to reinforce and document
information sharing, but health care providers must be cognizant of patients’ access and
proficiency. Health information shared through the Internet, e-mail, telephone, and
means other than face-to-face visits have increased health care efficiency and access to
information (Boykins, 2014).

**Participation.** Epstein et al. (2010) noted, “Truly patient-centered care requires
knowing the patient as a person and engaging the patient as an active participant in his or
her own care” (p. 1490). Participation involves sharing information on available health
care treatments with patients and involving them in selecting appropriate options.
Studies have found that patients are demanding an active role in decision making, and
health care providers and staff respond to this demand by encouraging partnering
relationships (Guglielmi, 2014).

Participation includes allowing patients to direct the discussion during an office
visit while the provider listens, clarifies, and ask questions. The discussion includes a
dialogue of emotional and social issues as well as the chief complaint. A sustained
partnership is developed that promotes a provider–patient relationship oriented toward
patient empowerment, mutual decision making, and positive health care outcomes (Lein
& Wills, 2007).
**Collaboration.** Collaboration in patient-centered care requires a well-coordinated health care system and community of professionals and patients working together to promote a shared vision (Epstein et al., 2010; Senge, 2006). This shared vision may manifest as a consensus about treatment options when there are several choices. Health care experts share the advantages and disadvantages of each option and integrate multiple recommendations based on specific knowledge of the patient. The goal of collaboration is to achieve a sense of shared vision that is medically sound and aligns with a patient’s values (Balik et al., 2011; Epstein et al., 2010).

Collaboration includes the patient-centered care core concepts of dignity and respect, information sharing, and participation. Collaboration is a vital component of safe, high-quality, and accessible patient-centered care (Interprofessional Education Collaborative Expert Panel, 2011). It fosters open communication, demonstrates mutual respect, and engages decision making through participation (Boykins, 2014; Holmstrom & Roing, 2010). Collaboration creates a community of health care that results in patient-centered care as the norm, not the exception.

**Advantages of Patient-Centered Care**

The patient-centered model is a paradigm shift from the traditional disease-centered model. In the traditional disease-centered model, the doctor makes all health care treatment decisions based on experience and the results of clinical tests (Stanton, 2013). Due to advances in education and information technology, patients are more informed and aware of diseases and health care treatment options and have expectations of their care before they visit their doctor.
Patient-centered care is the cornerstone of health care quality (Lees, 2011). From the patient’s perspective, patient-centered care facilitates patient engagement and feedback, which leads to faster healing and recovery, lower health care costs, and better quality of life (Institute of Medicine, 2001; Institute for Patient- and Family-Centered Care, 2014; Prakash, 2010). From the health care organization’s perspective, patient-centered care results in increased productivity and staff morale and fewer malpractice lawsuits (Institute of Medicine, 2001; Institute for Patient- and Family-Centered Care, 2014; Prakash, 2010). Patient-centered care is mutually beneficial for the customer and organization.

The patient-centered care model has been effective in the military health care setting. Barido, Campbell-Gauthier, Mang-Lawson, Mangelsdorff, and Finstuen (2008) conducted a study of the military health system and indicated that patient-centered care improved patient satisfaction, access, and productivity. Health care provider and patient collaboration resulted in compliance with treatment plans by reducing high blood pressure and diabetes, which enhanced mission readiness for service members (Griffin, 2012; Robinson, Callister, Berry, & Dearing, 2008). Research conducted in a military substance abuse program using the patient-centered care model revealed that participants empowered to assist in decision making and daily operations remained committed to being drug free (Mitchell & Angelone, 2006).

**Disadvantages of Patient-Centered Care**

Despite the advantages of patient-centered care, there continues to be some resistance to implementation at the organizational level (Jayadevappa & Chhatre, 2011). Health care providers and staff members who oppose patient-centered care often cite
outdated policies and practices as justification for their resistance to change (Abraham & Moretz, 2012; Van Vianen, De Pater, Bechtoldt, & Evers, 2011). Health care providers, staff members, and patients accustomed to the traditional disease-centered model need training in patient-centered care, which requires time and may affect productivity and efficiency (Epstein & Street, 2011; Institute for Patient- and Family-Centered Care, 2014). Patients who are passive recipients of health care require training on their new roles, and health care providers and staff members require training in the implementation of new policies and practices (Holmstrom & Roing, 2010).

Health care providers must factor cultural competence into patient-centered care, given the cultural diversity and disparities in health care between race, ethnicity, and socioeconomic status (Jayadevappa & Chhatre, 2011). According to researchers at the Agency for Healthcare Research and Quality (2014), health care quality and access are suboptimal for ethnic minority and low-income patients. Language discordance is a serious challenge in the delivery of patient-centered care and lowers health literacy and patient satisfaction (Betancourt, Corbett, & Bondaryk, 2014; Jayadevappa & Chhatre, 2011). Health care providers and staff members must be aware of unconscious racial and ethnic biases and assumptions and build relationships of mutual trust with patients (Holmstrom & Roing, 2010).

**Health Care Quality and the Patient Perspective**

As heath care organizations continue to function as a service industry, the patient, as a customer, is seen as a buyer of health services. Prakash (2010) noted, “There is a need to recognize that every patient has certain rights, which puts a special emphasis on
to the delivery of quality health care” (p. 152). The success of health care organizations is measured by the quality of the patient experience (Balik et al., 2011).

Many health care professionals believe patients may be able to judge the service but not the technical entities of health care. When patients are viewed as customers, the service entity is the peripheral, interpersonal experience, and the technical entity is the direct intervention that treats injury and cures disease (Press, 2006). The manner in which health care is delivered defines the nature and effectiveness of care. Patients are not the technical experts of health care, but they do note the experience and compare each experience with previous encounters. Patients assume that doctors are competent and can be trusted. However, if patients feel that the doctor is not interested in meeting their needs or does not fully communicate treatment strategy, then the patients question competence and lose trust (Holmstrom & Roing, 2010; Press, 2006).

Health care does not guarantee a cure; however, the health care system can guarantee quality health care (Press, 2006). Health care, for some patients, yields a diagnosis and series of processes that minimize discomfort, even when there is no cure. Regardless of the subsequent health care outcome, if patients are not satisfied with the service experience, the overall quality of health care is affected.

**Measuring Health Care Quality**

Measuring health care quality from the patient’s perspective most commonly involves using patient satisfaction surveys. Patient satisfaction “affects the timely, efficient, and patient-centered delivery of quality health care” (Prakash, 2010, p. 151). Researchers at the Robert Wood Johnson Foundation defined patient satisfaction as “a measurement designed to obtain reports or ratings from patients about services received
from an organization, hospital, physician or health care provider” (Leopold, 2012, p. 1). As a measurement, the quality of the patient satisfaction measure determines the quality of the results.

Leaders at the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality developed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which provides a national, standardized, and publicly reported data collection instrument and methodology for measuring the patient’s perspective on health care quality (CMS, 2013; Leopold, 2012). The HCAHPS survey was developed to enhance health care quality by focusing on the following three goals:

- To provide objective, evidence-based data comparing health care organizations.
- To report survey results to the public as a means of creating incentives to improving health care quality.
- To increase the transparency of health care quality provided in return for public investment (Boykins, 2014; CMS, 2013).

The HCAHPS survey has 32 questions and 21 substantive items that encompass critical aspects of the health care experience. It includes the following composite, individual, and global topics:

- Nurse communication.
- Doctor communication.
- Responsiveness of hospital staff.
- Pain management.
• Communication about medicines.
• Discharge information.
• Cleanliness of hospital environment.
• Quietness of hospital environment.
• Overall rating of hospital.
• Willingness to recommend hospital (CMS, 2013).

Prior to the establishment of the HCAHPS survey, there was no standard instrument for collecting and reporting health care quality from the patient’s perspective, and the leaders of most health care organizations used only internal surveys reported to local leadership and management.

Limitations of Patient Satisfaction Surveys

Bias may be introduced into patient satisfaction surveys as a means to increase reported performance scores (Wong et al., 2013). Several health care organizations exclude specific data from reporting, such as patient complaints. Patients who do not respond to surveys can also shape results, and not all subgroups are represented (Leopold, 2012). Much of the patient satisfaction data are reported to the public, which allows patients to rate hospitals and health care providers. The pressure to achieve high patient satisfaction scores increases both performance and the potential for unethical practices.

Patient satisfaction surveys involve soliciting participant feedback to determine the health care quality of the Wounded Warrior Program (Griffin, 2012). A telephonic survey queries the wounded warrior on aspects of the program such as whether needs are being met, knowledge of the program services, and support provided. Surveys are also conducted at specific intervals to identify opportunities to improve the program. Results
of data collected from the Wounded Warrior Program are reported to headquarters for the associated branch of service. According to the deputy public affairs officer for the Wounded Warrior Regiment, surveys are conducted to measure marines’ and family members’ satisfaction with the various health care coordination components of the program (V. Long, personal communication, December 9, 2013).

When measuring health care quality from the patient’s perspective, allowing patients to share their story is a more accurate reflection of their reality within the health care organization. Lees (2011) noted, “There is limited evidence as to how useful patient surveys are for improving quality. Methods that aid patient feedback need to provide more personal information and a richness of insight into the patients’ experience” (p. 26). Due to the tradition of sharing information and knowledge through conversation, health care providers must also function as listeners while gaining a deeper understanding of the patient’s viewpoint.

**Theoretical Framework**

The theoretical framework of the study is based on Schein’s cultural model of organizations and Maslow’s theory of motivation and hierarchy of needs. According to C. M. Roberts (2010), “A theory is a discussion about related concepts, assumptions, and generalizations” (p. 130). The theories of Schein and Maslow facilitate an understanding of the military health care environment and lifestyle of wounded warriors.

**Schein’s Cultural Model of Organizations**

Schein’s cultural model of organizations is illustrated in Table 2. Schein (1992) formally defined culture as follows:
A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 17)

Table 2

*Schein’s Cultural Model of Organizations*

<table>
<thead>
<tr>
<th>Level of culture</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artifacts</td>
<td>Tangible, visible elements: logos, dress code, facilities</td>
</tr>
<tr>
<td>Espoused values</td>
<td>Stated values and rules of conduct: policies, strategies, standards</td>
</tr>
<tr>
<td>Assumption and beliefs</td>
<td>Unconscious thoughts, feelings, and behaviors: ultimate source of change</td>
</tr>
</tbody>
</table>

According to Schein (1992), organizational culture exists on three levels:

- **Artifacts**: Artifacts are tangible, identifiable elements of an organization that include dress codes, logos, equipment, and physical facilities.
- **Espoused beliefs and values**: Espoused beliefs and values are stated values and rules of conduct of an organization, such as policies, standards, and philosophies.
- **Basic underlying assumptions**: Basic underlying assumptions are deeply ingrained, unconscious behaviors often taken for granted due to routine and status quo.

Artifacts make up the surface level of Schein’s cultural model and include the visible products and behaviors of a group. According to Schein (1992), “The most important point to make about this level of culture is that it is both easy to observe and very difficult to decipher” (p. 26). The visibility and identification of artifacts often vary based on the observer.
Espoused beliefs and values comprise the conscious level and include individual and shared assumptions. Espoused beliefs and values become validated when they are confirmed by the experience of the group (Shafritz, Ott, & Jang, 2011). Beliefs and values become moral and ethical rules that guide the conduct of group members and teach new members how to behave.

The unconscious level of Schein’s cultural model is basic underlying assumptions, which are ingrained actions and behaviors reflecting the reality of group philosophy (Shafritz et al., 2011; Wright, 2013). Basic underlying assumptions are difficult to change, and group members often fear and challenge deviation from the norm. Change at this level requires structure and new learning to counteract the “psychological cognitive defense mechanisms that permit the group to continue to function” (Schein, 1992, p. 32).

Using a qualitative study, Shaller (2007) described the relationship of culture and patient-centered care in U.S. health care organizations. Interviews were conducted with leaders from the Medical College of Georgia Health System, Augustus, Georgia, and Bronson Methodist Hospital, Kalamazoo, Michigan. Shaller identified seven key factors that contribute to achieving patient-centered care:

- Leadership consistently committed, engaged, and focused on the mission.
- A strategic vision clearly and constantly communicated throughout the entire organization.
- Involvement of patients and families as full participants not only in health care but also in the success of the mission of the organization.
• Care for the health care staff and employees through a supportive work environment, demonstrating the same dignity and respect they are expected to show patients and families.

• Systematic measurement and feedback to monitor the effectiveness of change.

• Quality of the built environment that provides adequate and appropriate structure and support for patients, families, and employees.

• Supportive technology that facilitates information sharing and communication between health care staff, employees, patients, and families (Shaller, 2007, p. vi).

Schein (2004) explained that leadership is the most important factor in understanding the culture of an organization:

Our analysis of organizational culture makes it clear that leadership is intertwined with culture formation, evolution, transformation, and destruction. Culture is created in the first instance by the actions of leaders; culture also is embedded and strengthened by leaders. When culture becomes dysfunctional, leadership is needed to help the group unlearn some of its cultural assumptions and learn new assumptions. Such transformations sometimes require what amounts to conscious and deliberate destruction of cultural elements, which in turn requires the ability to surmount one’s own taken-for-granted assumptions, to see what is needed to ensure the health and survival of the group, and to make things happen that enable the group to evolve toward new cultural assumptions. Without leadership in this sense, groups would not be able to adapt to changing environmental conditions. (p. 414)
The environment of the U.S. Marine wounded warrior is defined by the culture of
the U.S. Marine Corps and the military health care system. According to Schein (1992),
artifacts and espoused beliefs and values are elements of the organization visible to its
members and visitors, and the basic underlying assumptions are usually unexplained and
invisible to members but discovered through external observation. Artifacts and
espoused beliefs and values of the U.S. Marine Corps and military health care system are
identified by uniforms, rank structure, military bearing, standard operating procedures,
and clinical guidelines. The basic underlying assumptions of the U.S. Marine Corps and
military health care system vary based on perception and perspective. The essence of
organizational culture exists within the third level of Schein’s cultural model: basic
underlying assumptions (Schein, 1992).

**Maslow’s Theory of Motivation and Hierarchy of Needs**

Maslow (1954) developed the hierarchy of needs based on his observation of
human motivation. The five needs range from basic human needs (safety, shelter, etc.) to
self-actualization (reaching one’s full potential). To traverse from a lower to a higher
need, all aspects of the lower need must be met, and people may move from one need to
another based on circumstances. Maslow’s hierarchy of needs is outlined in Table 3
(Maslow, 1954).

**Table 3**

<table>
<thead>
<tr>
<th>Need</th>
<th>Description</th>
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<tbody>
<tr>
<td>Self-actualization</td>
<td>Achievement and realization of one’s full potential and accomplishment of goals in life</td>
</tr>
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</table>
Esteem  Desire for status, self-worth, competence, or a higher position within a group

Love and belonging  Desire for social relationships, such as feeling wanted and having friendships and family support

Safety  Freedom from danger and the unexpected, such as physical security, economic security, insurance, and retirement plans

Physiological  Physical requirements to sustain human survival, such as food, clothes, shelter, and sleep

Gandolf (2012) and Pietra (2013) discussed the relationship of Maslow’s hierarchy of needs and patient-centered care. The basic and fundamental needs of patients are to be welcomed into a health care environment that is restful, clean, and safe. The ideal interaction between the patient and health care providers should facilitate dignity and respect. Participation and communication between the health care team and the patient’s family foster a sense of belonging. When patient-centered care is delivered in a health care setting, patients have the opportunity to heal and achieve self-actualization (Gandolf, 2012; Pietra, 2013).

Maslow’s hierarchy of needs provides the framework for wounded warriors to achieve new normalcy (Getha-Taylor, 2009; Griffin, 2012). Rehabilitation and recovery after sustaining signature injuries begin the process of meeting the physiological needs of wounded warriors. Wounded warriors who suffer from mental health problems such as PTSD and TBI need to feel safe and at ease. Support from military leaders, family, and friends provide a sense of belonging. According to Wright (2013), “Wounded warriors must continue to believe in themselves and surround themselves with people who not
only appreciate them, but treat them with dignity and respect” (p. 40). Positive health care treatment outcomes and success from the three lower needs will lead to increased self-esteem and self-actualization (Wright, 2013).

**Conclusion**

The review of literature involved exploring the history of the Wounded Warrior Program and the importance of providing quality health care to these service members. Serious health care issues and scandals were first discovered at Walter Reed Army Medical Center in 2007, and at VA health care organizations in 2014 (Brady, 2012; Cohen et al., 2014; Wright, 2013). The continued success of the Wounded Warrior Program requires a system that will constantly assess and analyze the effectiveness of health care from the patient’s experience.

Surveys have been used to measure health care quality, but are biased, inadequate, and limited due to their structure (Lees, 2011; Marcinowicz et al., 2009). When measuring health care quality from the patient’s perspective, allowing patients to share their story is a more accurate reflection of their reality within the health care organization. Lees (2011) noted, “There is limited evidence as to how useful patient surveys are for improving quality. Methods that aid patient feedback need to provide more personal information and a richness of insight into the patients’ experience” (p. 26). There is a gap in knowledge between the quality of health care perceived by wounded warriors and actually delivered by the Wounded Warrior Program.

The problem was the need for more information to determine which opportunities may exist to improve health care quality for wounded warriors not just from a structural, bureaucratic perspective but also from the perception of program participants. As
wounded warriors strive to achieve new normalcy, the “federal one-size-fits-all programs” (Berglass, 2010, p. 4) do not apply equally to the unique circumstances facing these patients.

This topic could benefit the military health care system and the quality of life of wounded warriors. Senior military leaders and legislators would have additional knowledge of the health care challenges associated with wounded warriors, so they may lead initiatives to promote health care quality. Health care financial managers would have a better understanding of the significance of quality health care and provide insight into resource allocation that directly meets the needs of wounded warriors. This topic furthers the body of knowledge that could be used in health education curricula, thereby improving the structure, processes, and outcomes of the health care delivery system. Wounded warriors may be encouraged to take an active, patient-centered approach in decision making regarding their health care treatment, recovery, and rehabilitation.

Summary

The Wounded Warrior Program evolved due to the failures of the Walter Reed Army Medical Center (Brady, 2012; Wright, 2013). Each branch of the armed forces has its own specific warrior transition unit, and the focus of this study was the U.S. Marine Corps Wounded Warrior Regiment. The complexity of injuries and diseases sustained by wounded warriors has a lasting impact on these service members and their community. Wounded warriors who require medical and rehabilitative care for visible physical injuries of limb loss usually present some degree of invisible brain injuries such as PTSD and TBI. The DOD and VA health care systems continue to struggle to provide appropriate and timely health care to wounded warriors (Institute of Medicine, 2013).
The health care quality movement began in the 19th century and evolved to serve the public welfare and protect human welfare from the dangers of medicine. Donabedian (1966) developed a model to describe health care quality based on structures, processes, and outcomes. From a systems perspective, health care quality is defined by six dimensions (Institute of Medicine, 2001; Wexler, 2002; World Health Organization, 2006). Patient-centered care is the cornerstone of health care quality and has the advantage over the traditional disease-centered model by resulting in positive outcomes for patients and increased productivity for health care organizations (Institute for Patient-and Family-Centered Care, 2014; Lees, 2011; Prakash, 2010). The four core concepts of patient-centered care are dignity and respect, information sharing, participation, and collaboration (Abraham & Moretz, 2012; Institute of Medicine, 2001). Health care organizations have been functioning as service industries, and patients are viewed as customers.

Schein’s cultural model of organizations and Maslow’s theory of motivation and hierarchy of needs served as the theoretical framework of the study. Both theories facilitate an understanding of the military health care environment and lifestyle of wounded warriors as they strive to achieve new normalcy.
Chapter III: Methodology

Introduction

Chapter III contains a description of the methodology used in the study and includes the following topics: purpose statement, research question, research design, population, sample, instrumentation, informed consent and confidentiality, validity and reliability, data collection, data analysis, limitations, and assumptions. The chapter ends with a summary.

Purpose Statement

The purpose of this phenomenological study was to explore the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

Research Question

The study addressed the following research question: What is the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration?

Research Design

The methodology was qualitative research, and the research design was phenomenology. A qualitative, phenomenological research method was selected for this study for two reasons. First, qualitative research methods such as interviews are designed to “help researchers understand people and what they say and do, as well as help researchers understand the social and cultural context within which people live” (Myers,
Qualitative research is used to understand a phenomenon as viewed from the perspective of research participants (Bloomberg & Volpe, 2008). Second, phenomenology involves exploring a person’s perception of the meaning of a particular phenomenon (Leedy & Ormrod, 2000; Wright, 2013). A researcher will “seek meaning from appearances and arrive at essences through intuition and reflection on conscious acts of experience, leading to ideas, concepts, judgments, and understandings. Phenomenology is committed to descriptions of experiences, not explanations or analysis” (Moustakas, 1994, p. 58).

**Quantitative Research Methods**

A quantitative research method was not appropriate for this study. Quantitative researchers “answer questions about relationships among measured variables with the purpose of explaining, predicting, and controlling phenomena” (Leedy & Ormrod, 2000, p. 101). Quantitative research methods focus on comparing numbers and not the perspectives of participants (Wright, 2013).

As a quantitative research method, patient satisfaction surveys are conducted to solicit participant feedback in determining the health care quality of the Wounded Warrior Program (Griffin, 2012). The exclusive use of surveys to obtain feedback on health care quality from the patient’s perspective is inadequate (Marcinowicz et al., 2009). Surveys often lead to a lack of adequate data due to a lower response rate than anticipated and reluctance of respondents to be honest and thorough (McMillan & Schumacher, 2010). An inability to clarify the meaning of survey questions often leads to confusion and inaccurate responses. Understanding a patient’s need using surveys is
challenging if the questions are developed from the health care organization’s point of view (Lees, 2011).

**Qualitative Research Methods**

Compared to quantitative surveys, interviews, which are a qualitative research method, are more flexible and appropriate when assessing the perception of a program from participants (Opdenakker, 2006). Interviews provide openness and detailed information not supported by surveys. Closed instruments such as surveys do not capture the feeling and experiences of participants, which are essential in completing a comprehensive assessment (Patton, 2002). Interviews are also ideal for subjects who are illiterate, speak a foreign language, or cannot write due to physical or mental disability. The combination of structured and unstructured questions during interviews provides depth and richness to a research study.

Research evidence indicates that interviews are ideal for exploring the perception of health care quality from the patient’s perspective. A study of 36 in-depth interviews of patients in different regions of Poland revealed that the processes of health care delivery were satisfactory or acceptable, but 40% of the sample were dissatisfied with the personal behavior and manner of doctors (Marcinowicz et al., 2009). Marcinowicz et al.’s (2009) study prompted Poland’s health care organizations to provide education and training on bedside manner and proper interactions with patients. Wong et al. (2013) conducted in-depth interviews of patients in Hong Kong hospitals to understand their perception of health care quality; findings of this study identified the need to improve patient privacy, customer service, and communication. Wright (2013) interviewed soldiers of the U.S. Army Warrior Transition unit to explore the patient experience and perception of the
quality of medical care and administrative services; findings identified opportunities to improve leadership training and reduce the institutionalized culture of the Army’s health care system. According to Lebrun-Harris et al. (2013), subjective feedback obtained from interviews often relates to objective measures of quality.

**Population**

A population is a large collection of individuals or objects that is the focus of interest in research (Patten, 2009). The population of this study consisted of 29,000 marine veterans supported by the Wounded Warrior Regiment nationwide. A target population is a collection of individuals or objects conforming to specific criteria and to which the research results can be generalized (McMillan & Schumacher, 2010). The study was generalized to the targeted population of approximately 3,500 marine veterans previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment of the U.S. Marine Corps Wounded Warrior Regiment.

**Sample**

A sample is a subset of the population (Patten, 2009). Purposeful sampling was used to select participants. In purposeful sampling, the researcher selects participants for a specific purpose, usually those who have experience with the central phenomenon or key concept explored (Leedy & Ormrod, 2000; Wright, 2013).

Patton (2002) noted,

There are no rules for sample size in qualitative inquiry. . . . 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 sample size. (pp. 244, 245)
Using purposeful sampling, 10 marine veterans were selected based on the following criteria:

1. Sustained polytraumatic injuries, conditions, or diseases after serving in combat during the Global War on Terrorism.
2. Assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, for at least 6 months.
4. Receiving health care treatment through services originally established by the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, at the time of the study.

**Instrumentation**

The researcher is the instrument in qualitative methodology (Creswell, 2009). This study included in-depth, semistructured interviews as the primary method of data collection. The researcher began with the same order of standardized, open-ended questions for each participant to provide consistency of data (Moustakas, 1994; Patton, 2002). Participants were allowed to provide additional information during the interview as they answered each question through probing. Patton (2002) noted, “Probes are used to deepen the response to a question, increase the richness and depth of responses, and give cues to the interviewee about the level of response that is desired” (p. 372). The
interviews were conducted face-to-face at the Naval Medical Center San Diego in a location convenient and comfortable for each participant.

Interviews allow researchers to explore phenomena that they cannot directly observe. Patton (2002) explained the purpose of qualitative interviewing:

The purpose of qualitative interviewing is to capture how those being interviewed view their world, to learn their terminology and judgments, and to capture the complexities of their individual perceptions and experiences. This openness distinguishes qualitative interviewing from the closed questionnaire or test used in quantitative studies. Such closed instruments force respondents to fit their knowledge, experiences, and feelings into the researcher’s categories. (p. 348)

The researcher as the instrument also requires reflexivity, an attitude of systematically addressing the context of knowledge construction, and being mindful of the effects of one’s own bias and perspective on the study (Creswell, 2009; Patton, 2002). Reflexivity was enhanced by recording researcher bias in a personal reflective journal and the dissertation. Reflexivity ensures the interview process is not distorted.

**Interview Protocol**

An interview protocol (see Appendix E) was developed using standardized, open-ended interview questions aligned with the research questions. The following questions were asked in sequence during the interview:

1. What events led to your assignment to the Naval Medical Center San Diego Wounded Warrior Detachment?
2. How would you define health care quality?
3. How would you describe the dignity and respect provided to you by the health care program at Naval Medical Center San Diego?

4. How would you describe the dignity and respect provided to other marine veterans by the health care program at Naval Medical Center San Diego?

5. How would you describe the information shared with you by the health care program at Naval Medical Center San Diego?

6. How would you describe the information shared with other marine veterans by the health care program at Naval Medical Center San Diego?

7. How was your participation in decision-making about your care facilitated by the health care program at Naval Medical Center San Diego?

8. How was the participation of other marine veterans in decision-making about their care facilitated by the health care program at Naval Medical Center San Diego?

9. How would you describe the collaboration demonstrated by you and the health care program at Naval Medical Center San Diego?

10. How would you describe the collaboration demonstrated by other marine veterans and the health care program at Naval Medical Center San Diego?

**Pilot Interview**

A pilot interview helped to verify the effectiveness of the interview process and questions and to identify research deficiencies. An informed marine veteran not selected as a participant from the purposeful sample was interviewed using the protocol developed. After the pilot interview, the researcher and pilot participant critiqued the
interview process and questions. There were no modifications to the interview process or research deficiencies warranted from the pilot interview.

**Informed Consent and Confidentiality**

Participants identified through purposeful sampling were thoroughly briefed on the purpose of the research study and interview process. Each participant received a research project information sheet (see Appendix B) that outlined the research study procedures, risks, benefits, and confidentiality. The researcher explained the informed consent form (see Appendix C) to each participant and obtained a signature. The informed consent form detailed the participants’ rights and confidentiality.

The identity of each participant was protected through pseudonyms. The researcher used a demographic data sheet (see Appendix D) to collect the following information: age, gender, rank at time of separation or retirement, race/ethnic background, time served in the U.S. Marine Corps, date assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, and date discharged from the Naval Medical Center San Diego Wounded Warrior Detachment. Each participant was identified during the study by a general title and chronological sequence number based on completion of each interview. For example, the first participant was identified as Marine 1, the second participant as Marine 2, and so forth. The researcher assured the participants that information provided during the interview would not be used against them and would add to the body of knowledge regarding improving health care quality for wounded warriors. Data collected during the research study will be stored in a locked file cabinet for security.
Prior to data collection, the research study was approved by the Institutional Review Board (IRB) for both Naval Medical Center San Diego and Brandman University. The purpose of an IRB is to ensure human subjects are not placed at risk of harm. The IRB approval letters from Naval Medical Center San Diego and Brandman University are illustrated as Appendix G and Appendix H, respectively.

**Validity and Reliability**

Validity and reliability are critical measures used in quantitative research, and trustworthiness is used in qualitative research. Trustworthiness consists of the following four components: credibility, dependability, transferability, and confirmability. For quantitative research, validity is the measure of accuracy of results, and reliability is the measure of consistency of results (Patten, 2009).

In qualitative research, validity is referred to as credibility and is based on whether the participant’s perception matches the researcher’s intent and portrayal of the study (Bloomberg & Volpe, 2008). Reliability is referred to as dependability, which determines whether the findings are consistent and dependable with data collected (Bloomberg & Volpe, 2008).

To ensure credibility, the researcher used a pilot interview and participant review (Creswell, 2009). The pilot interview allowed the researcher to identify questions and responses not aligned with the research questions. With permission of the participants through informed consent, interviews were recorded and transcribed. Participant review involved asking the participants to review the transcription to verify accuracy. Reflexivity was enhanced by recording researcher bias in a personal reflective journal and the dissertation.
To ensure dependability, the researcher used an interview protocol, documented participant observations in field notes, and obtained a third-party data analysis (McMillan & Schumacher, 2010). During the interview, the researcher began with the same order of standardized, open-ended questions for each participant to provide consistency of data (Moustakas, 1994; Patton, 2002). In addition to recording each interview, field notes were taken to document details of participant observation and facilitate replication of the study. The researcher employed a third party—two colleagues familiar with qualitative research methodology—to code statements from the interviews by themes and identify patterns and consistent themes.

Transferability is the ability of the research results to be generalized or the extent to which the results can apply to other settings or contexts (Patton, 2002). The researcher enhanced transferability by thoroughly explaining the research design, data collection, and data analysis. The researcher also provided a thick description of the research experience, which involved “documenting a broad range of experiences, and thereby providing an opportunity for the reader to enter into the study and better understand the reality of the research participants” (Bloomberg & Volpe, 2008, p. 111).

Confirmability is a measure of how well the data collected support the researcher’s findings (Bloomberg & Volpe, 2008). To ensure confirmability, a third party data audit—employing two colleagues familiar with qualitative research methodology—was conducted to examine the data collection and analysis procedures, which also limited the potential for bias or distortion.
Data Collection

The interviews were conducted face-to-face at the Naval Medical Center San Diego in a location convenient and comfortable for each participant. The interview process began by conducting a field observation to ensure the environment was safe, comfortable, and ready. The researcher introduced himself to establish rapport with each participant. Participants identified through purposeful sampling were thoroughly briefed on the purpose of the research study and interview process. A research project information sheet (see Appendix B) was provided to each participant that outlined the research study procedures, risks, benefits, and confidentiality.

The data collection process began after the researcher explained the importance of informed consent with each participant and obtained a signature on the informed consent form (see Appendix C). The researcher used a demographic data sheet (see Appendix D) to collect the following information: age, gender, rank at time of separation or retirement, race/ethnic background, time served in the U.S. Marine Corps, date assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, and date discharged from the Naval Medical Center San Diego Wounded Warrior Detachment.

The researcher began interviewing each participant using the interview protocol (see Appendix E) of standardized, open-ended questions aligned with the research questions. Each interview was audio recorded with permission from the participant to assist with data collection and analysis. Each participant was asked the same interview questions in the same order. The interviews were conducted until saturation was reached. Participants were debriefed after the interview, reassured of their privacy, and thanked for their time and participation.
In addition to the interview protocol, data were collected using a personal reflective journal and field notes. The reflective journal enhanced the reflexivity of research bias, and field notes documented the researcher’s observations of the participants during the interview. The interview protocol, personal reflective journal, and field notes collectively provided a thick description of the research experience.

**Data Analysis**

Data analysis began after all interviews were complete. Moustakas’s (1994) method of data analysis provided structure for the data analysis process:

1. Compile statements from participants verbatim and transcribe interview content.
2. Code statements by themes.
3. Identify patterns and consistent themes.
4. Decipher and examine the meaning of patterns and consistent themes.
5. Expose common patterns and groups.
6. Structure common patterns and groups into a comprehensive and cohesive configuration.
7. Synthesize the meaning and essence of configuration and report results.

The researcher used the qualitative research software NVivo 10 to organize the interview transcriptions and assist with the coding process. Two colleagues familiar with qualitative research methodology coded statements from the interviews by themes, identified patterns and consistent themes, and completed a data audit. According to Patton (2002), “Developing some manageable classification or coding scheme is the first step of analysis” (p. 463). NVivo 10 helped to organize and sort the codes into nodes that
represented the substantive significance of the findings. Substantive significance is a qualitative analysis tool that measures the consistency of the findings and the extent the findings increase and deepen understanding of the phenomenon (Patton, 2002).

**Limitations**

Limitations are areas of the study over which the researcher has no control and may negatively affect the results of the study (C. M. Roberts, 2010). Limitations also include weaknesses of the methodology (McMillan & Schumacher, 2010). Due to the background and personal nature of this study, it was important that the researcher identify and address limitations prior to data collection.

**Participant Apprehension**

Participants may be apprehensive in sharing personal experiences and choose to leave out or forget detailed information (Epstein et al., 2010; Marcinowicz et al., 2009). To address participant apprehension in sharing personal experiences during the study, the researcher explained to each participant that the study would be voluntary and his or her anonymity and confidentiality would be preserved. Participants could withdraw from the study at any time with no ramifications. Each participant received a research project information sheet (see Appendix B) and an informed consent form (see Appendix C) prior to conducting research.

**Difference in Perception**

The perception of patient-centered care is unique and different for each participant (Dabney & Tzeng, 2013; Institute for Patient- and Family-Centered Care, 2014). The variety of feedback provided from the interviews increased the body of
knowledge regarding the quality of health care demonstrated by the Wounded Warrior Program.

Assumptions

C. M. Roberts (2010) noted, “Assumptions are what you take for granted relative to your study” (p. 139). The researcher made four assumptions in this study:

1. Participants would understand the purpose of the study and be interested in sharing their perception of patient-centered care. To increase understanding and interest in the study, the researcher would explain to each participant that the study is voluntary, and anonymity and confidentiality would be preserved. Participants could withdraw from the study at any time with no ramifications.

2. Military leadership would provide adequate support to ensure completion of the study. To assist military leadership in providing adequate support to ensure completion of the study, the researcher obtained permission from supervisors and approval from the IRB from the Naval Medical Center San Diego and Brandman University.

3. The study would be generalized to the targeted population of approximately 3,500 marine veterans previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment of the U.S. Marine Corps Wounded Warrior Regiment. Generalization of findings to all wounded warriors of every military service was not feasible.

4. The sample size of 10 marine veterans would be adequate to represent the population and support the substantive significance of the findings.
Summary

The purpose of this study was to explore the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four concepts of patient-centered care. The research question aligned with the purpose statement. A qualitative, phenomenological research method was appropriate for this study (Leedy & Ormrod, 2000; Myers, 2009; Wright, 2013). Purposeful sampling was used to select 10 marine veterans from the targeted population of 3,500 wounded warriors previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment. The researcher as the instrument used an interview protocol with standardized, open-ended questions. A pilot interview, participant review, and third-party data audit ensured reliability and validity (Bloomberg & Volpe, 2008; Creswell, 2009). A systematic approach to data collection and analysis was developed to ensure accuracy of results. Limitations and assumptions were also identified and addressed.
Chapter IV: Research, Data Collection, Findings

The Wounded Warrior Program was established in 2007 in response to serious health care issues discovered at Walter Reed Army Medical Center. In 2014, poor quality of care and negative outcomes discovered at VA health care organizations raised questions regarding how many other veterans may have been forgotten or lost in the system (Cohen et al., 2014).

The problem is the need for more information to determine which opportunities may exist to improve health care quality for wounded warriors, not just from a structural, bureaucratic perspective but also from the perception of program participants. The focus of the study was patient-centered care, which is the cornerstone of health care quality (Lees, 2011; Prakash, 2010).

Chapter IV contains a description of the research, data collection, and findings of the study and includes the following sections: purpose statement, research question, methodology, population and sample, demographic data, presentation of the data, and summary.

Purpose Statement

The purpose of this phenomenological study was to explore the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

Research Question

The study addressed the following research question: What is the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior
Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration?

**Methodology**

A qualitative, phenomenological research method was selected for this study. The researcher as the instrument used in-depth, semistructured, face-to-face interviews as the primary method of data collection. An interview protocol (see Appendix E) was implemented using standardized, open-ended interview questions aligned with the research question. The researcher conducted a pilot interview with an informed marine veteran not selected as a research participant to verify the effectiveness of the interview process and to identify research deficiencies. There were no modifications to the interview process or research deficiencies warranted from the pilot interview.

**Interview Process**

The interviews were conducted from January 10, 2015, to January 30, 2015, at the Naval Medical Center San Diego. Participants were thoroughly briefed on the purpose of the research study and interview process using a research project information sheet (see Appendix B). The researcher explained the importance of informed consent with each participant and obtained a signature on the informed consent form (see Appendix C). The researcher began interviewing each participant using the interview protocol (see Appendix E) and each interview was audio recorded with permission from the participant. Each participant was asked the same interview questions in the same order. Immediately after the interview, participants were debriefed, reassured of their privacy, and thanked for their time and participation.
Reflective Journal and Field Notes

In addition to the interview protocol, data were collected using a personal reflective journal and field notes to provide a thick description of the research experience (Creswell, 2009; Patton, 2002). The personal reflective journal enhanced the reflexivity of research bias, and field notes documented participant observations during the interview. A summary of the journal entries and field notes appears in the Presentation of Data section of this chapter.

Population and Sample

The population of this study consisted of 29,000 marine veterans supported by the Wounded Warrior Regiment nationwide as of November 2014. The study was generalized to the targeted population of approximately 3,500 marine veterans previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment of the U.S. Marine Corps Wounded Warrior Regiment.

Purposeful sampling was used to select 10 marine veterans based on the following criteria:

1. Sustained polytraumatic injuries, conditions, or diseases after serving in combat during the Global War on Terrorism.

2. Assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, for at least 6 months.

4. Receiving health care treatment through services originally established by the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, at the time of the study.

**Demographic Data**

The researcher used a demographic data sheet (see Appendix D) to collect the following information: age, gender, rank at time of separation or retirement, race/ethnic background, time served in the U.S. Marine Corps, date assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, and date discharged from the Naval Medical Center San Diego Wounded Warrior Detachment. A summary of participant demographics is provided in Appendix F. The average age of the sample was 28. There were eight males and two females. All the participants were enlisted service members ranging from the ranks of E-3 to E-6.

Researchers at the Agency for Healthcare Research and Quality (2014) discovered that health care quality and access have historically been suboptimal for ethnic minority and low-income patients. Jayadevappa and Chhatre (2011) identified that cultural diversity and disparities in health care exist between race, ethnicity, and socioeconomic status. Table 4 includes a comparison of the race and ethnic background percentages for the U.S. Marine Corps active duty service members and the 10 marine veterans in the sample (DOD, 2014).

Table 4

*Race and Ethnic Background Comparison: U.S. Marine Corps Active Duty and Sample*

<table>
<thead>
<tr>
<th>Race/ethnic background</th>
<th>U.S. Marine Corps (%)</th>
<th>Sample (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>
Presentation of the Data

The structure of the data analysis process was based on Moustakas’s (1994) method. Each statement from the participants interviewed was transcribed and formatted into a Microsoft Word document. The researcher uploaded the Microsoft Word document into NVivo 10 to assist with the coding process. Two colleagues familiar with qualitative research methodology reviewed the transcriptions and sorted data into codes, which resulted in the discovery of themes used to support the findings of data analysis.

The findings of data analysis are reported according to the research question. Each of the four core concepts of patient-centered care is analyzed separately. Codes identified from each of the two colleagues are illustrated using tables and represented as Coder A and Coder B. Themes identified are discussed using narrative descriptions and direct quotes from participants.

Analysis of Research Question

The following sections include a summary of the data analysis for the four core concepts of patient centered care, as outlined in the research question: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

Dignity and respect. Table 5 illustrates the codes and participants’ frequency identified by Coder A from the transcriptions associated with the patient-centered care
core concept of dignity and respect. Table 6 illustrates the codes and participants’ frequency identified by Coder B from the transcriptions associated with the patient-centered care core concept of dignity and respect.

Table 5

*Codes for Dignity and Respect, Coder A*

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courteous hospital staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fair and equal treatment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strict military environment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
</tbody>
</table>

Table 6

*Codes for Dignity and Respect, Coder B*

<table>
<thead>
<tr>
<th>Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional hospital staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Effective military structure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

Several themes emerged from the results of Coders A and B for the patient-centered care core concept of dignity and respect.
**Theme 1: Professional hospital staff.** All 10 participants expressed the professionalism displayed by the hospital staff regarding dignity and respect. There was no perceived favoritism based on participant demographics.

Marines 1, 2, 5, and 9 explained how the staff were very courteous and treated each patient fairly and equally. Marine 1 stated,

> The staff were great. They treated you with a great level of respect not even so much because I was wounded, but just as people as they are; that’s how they work. I got a lot of respect from the staff. They give and they show respect for the injured. . . . My time here was pretty good. . . . It was all about the welfare of the injured at the time, and they showed that not only to marines, but every service branch that came through.

Marine 5 explained how his perception of providing dignity and respect was similar to a family relationship:

> From the minute I was wounded, to the minute I was seen at Naval Medical Center, it was, “Welcome aboard, shipmate.” You really felt as though we were a family. As much as they were doctors and officers in the military, they cared about you as if you were their own child sitting there on the stretcher suffering.

**Theme 2: Structured military culture.** Marines 2, 3, 4, 6, 7, 9, and 10 explained the impact of the military culture in regard to their perception of dignity and respect. These participants shared their experiences and their perspective of the advantages and disadvantages of the military structure in a health care environment.

Marines 3, 6, and 10 noted that the military environment of the U.S. Marine Corps is a distraction that impedes one’s focus on recovery and rehabilitation. Marine 3 stated,
The system kind of wants to make it seem like now . . . yeah, you’re recovering, but you still have to worry about checking in. You’re still in that battalion mentality. . . . I just feel like from the point of the Marine Corps and being stationed there, just let the guys be patients. You know what I mean? Let them recover and not focus too much on, “Oh, they got to wear green on green,” or “Oh, you are not wearing PT gear.” Also, you’re at PT exercising and you’re not wearing green on green, then you’re going to get in trouble, you know. It takes one to mess it up, you know. This guy’s wearing a shirt that has a middle finger and not in the proper uniform, and it’s just like, “Okay, now we’re going to go back to green on green because you want to wear that.” Just let the marines focus on recovery and less discipline.

Marine 6 described the challenges of being in a wheelchair and having to report for muster in the mornings:

Since I was on pain medication and in a wheelchair, my wife had to do everything for me, and we had a 1-year-old son, you know. They made me wake up early in the morning when I was on a lot of painkillers; I couldn’t drive, so my wife had to put me in the car with my wheelchair, and my 1-year-old son, take me over there, and take me out of the car, get the wheelchair ready, grab my son, and take me upstairs. We used the elevators of course, but just dealing with that was a pain in the ass and that sucked.

Marines 2, 4, 7, and 9 explained the military culture ensures that marines comply with health care treatment guidelines and facilitates marines’ dignity and respect as service members. Marine 7 stated,
We all had to wear our uniform. If marines couldn’t, or if they had a medical reason, they were expected to be in PT gear. There were no civilian clothes during normal working hours and they still upheld that uniform stuff and discipline. I think it helps coming from another marine... The staff are all military, but they get where each person is coming from. They have the military understanding. Whereas if it was a civilian that was in charge of that, I don’t think it would have gone smoothly, and there would have been that lack of respect, which would lead to marines missing appointments and not getting better right away.

**Information sharing.** Table 7 illustrates the codes and participants’ frequency identified by Coder A from the transcriptions associated with the patient-centered care core concept of information sharing. Table 8 illustrates the codes and participants’ frequency identified by Coder B, from the transcriptions associated with the patient-centered care core concept of information sharing.

Table 7

**Codes for Information Sharing, Coder A**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>communication</td>
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<tr>
<td>Delayed</td>
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</table>

85
Table 8

*Codes for Information Sharing, Coder B*

<table>
<thead>
<tr>
<th>Code</th>
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<th>Marine 2</th>
<th>Marine 3</th>
<th>Marine 4</th>
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<th>Marine 6</th>
<th>Marine 7</th>
<th>Marine 8</th>
<th>Marine 9</th>
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</thead>
<tbody>
<tr>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inconsistent information</td>
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</tbody>
</table>

The following theme was identified from the results of Coders A and B for the patient-centered care core concept of information sharing.

**Theme 3: Organized communication processes.** Participants described the information shared by the health care program as organized communication processes. Participants felt that they had access to health care information and the hospital staff were transparent in communication delivery. Communication was delivered through several forms, including word of mouth, electronically, social media, and paper.

Marines 1, 2, 3, 5, 6, 7, 9, and 10 all expressed that the information shared appeared to be organized and planned. Marine 1 stated,

As far as information being shared and communicated, it was good. It was pretty good. . . . They let me know what was going on, and most of the time, they would even schedule the appointment for me. They would just spread the paperwork out and all I had to do was really just show up.

Marine 2 stated,

Information sharing and communication has always been very, very good. If you have an appointment, there are reminder systems through the hospital, automated reminder systems, to help you remember the day before that you have an
appointment the next day at such-and-such a time. If you do miss an appointment, nine times out of ten, the actual clinic will call you, or the department will call you, and be like, “Hey, you had an appointment today, and you missed it. Can we reschedule?”

Marines 4 and 8 expressed that the information shared was organized, but with a slight delay on some key rehabilitation milestones. Marine 4 explained,

Communicating and sharing information worked out well. I felt like it could have been better, in terms of what I can and cannot order for my prosthetics. It’s a real gray area as far as that goes; they are not really clear with me on everything I can order. Some days . . . one time, I found out I actually can order different sockets, for example, and they weren’t clear with me when I could order them and I wasn’t able to order them when I needed them. I kind of had to hound them for a little bit about that, but communication got better.

**Participation.** Table 9 illustrates the codes and participants’ frequency identified by Coder A from the transcriptions associated with the patient-centered care core concept of participation. Table 10 illustrates the codes and participants’ frequency identified by Coder B from the transcriptions associated with the patient-centered care core concept of participation.
Table 9

*Codes for Participation, Coder A*

<table>
<thead>
<tr>
<th>Code</th>
<th>Marine 1</th>
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<th>Marine 3</th>
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<th>Marine 7</th>
<th>Marine 8</th>
<th>Marine 9</th>
<th>Marine 10</th>
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<tbody>
<tr>
<td>Available family support</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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<td></td>
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<td>X</td>
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<td>X</td>
<td>X</td>
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</table>

Table 10

*Codes for Participation, Coder B*

<table>
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<tr>
<th>Code</th>
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<th>Marine 2</th>
<th>Marine 3</th>
<th>Marine 4</th>
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<th>Marine 6</th>
<th>Marine 7</th>
<th>Marine 8</th>
<th>Marine 9</th>
<th>Marine 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good family support</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<td>X</td>
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<td>Accessible patient choices</td>
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<td>X</td>
<td>X</td>
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</table>

The following theme was identified from the results of Coders A and B for the patient-centered care core concept of participation.

**Theme 4: Shared decision making.** All 10 participants expressed that they and their family members were active participants in the decision making regarding their health care needs. Aligned with the patient-care core concept of information sharing, participants explained that they had the opportunity to make individual choices on rehabilitation and quality-of-life concerns.

Marine 1 explained the importance of providing feedback to hospital staff during the rehabilitation process:
If the things that they have, or the things that they try do, do not work for you, let them know so they can readjust and make things better for you. It’s pretty much a give and take. They give feedback and they may receive feedback so that way it’s not so much like this is what you got to do, this what is going to work this whatever you know, it’s back forth two-way role so it was pretty good like teamwork. It was really simple for me because I took the initiative to do what needed to be done, I reached out and to make it work for me.

Marine 2 explained the opportunity to make choices during the rehabilitation process:

I think that probably the best that I’ve seen is just with the treatment of my scars. I have a lot of skin grafts throughout my right arm and my right leg. They gave me the option, you can continue to get scar treatment or you can just leave it alone. We will see how well you heal; if you’re okay with it, you don’t have to continue to come back. Because scar treatment, it wasn’t the easiest thing to go through, and it’s definitely painful. It was kind of an option on me. Do I want to try and see if things are going to continue to get better, or am I happy with how things are now? They gave me the option.

Marine 4 explained the importance of family support in a wounded warrior’s recovery, stating, “My wife was with me. I think since she was with me every second of my recovery; she made me feel better even when dealing with the pain and stress.”

**Collaboration.** Table 11 illustrates the code and participants’ frequency identified by Coder A from the transcriptions associated with the patient-centered care core concept of collaboration. Table 12 illustrates the code and participants’ frequency identified by
Coder B from the transcriptions associated with the patient-centered care core concept of collaboration.

Table 11

*Codes for Collaboration, Coder A*

<table>
<thead>
<tr>
<th>Code</th>
<th>Marine 1</th>
<th>Marine 2</th>
<th>Marine 3</th>
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<th>Marine 8</th>
<th>Marine 9</th>
<th>Marine 10</th>
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<tbody>
<tr>
<td></td>
<td>X</td>
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<td>X</td>
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</table>

Table 12

*Codes for Collaboration, Coder B*

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<th>Code</th>
<th>Marine 1</th>
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</tbody>
</table>

The following theme was identified from the results of Coders A and B for the patient-centered care core concept of collaboration:

**Theme 5: Systematic teamwork.** All 10 participants were excited as they expressed the remarkable teamwork of the health care system. Several participants were grateful for specific individuals on the health care team committed to the Wounded Warrior Program who provided each marine with individualized support.

Marines 1, 4, 8, and 10 expressed that the teamwork demonstrated by the team of health care providers led to their successful recovery and rehabilitation. Marine 1 explained,

It was pretty much teamwork, what’s better not only for the patient but the organization as a whole. It was just teamwork all the way around. I don’t think
my rehab would have went as fast as it went if it wasn’t for the teamwork with everybody.

Marine 10 shared his experience through the health care system:

All the doctors and staff were synced to make sure that you’re on track. Yeah, it goes further than that. The orthopedic doctor communicated with the physical therapist, who then communicated with Prosthetics. The physical therapist sees how I run and walk, so she explains that to Prosthetics, so they would know exactly what they need to do, so that works out very well for everybody.

Marines 6, 7, and 9 attested to the importance of having a good case manager to help wounded warriors and their families navigate through the health care system and meet the daily quality of life needs. Marine 6 explained,

I had support from so many people. Well . . . my case manager, and my wife, they worked together a lot to get everything done. I mean, I had so much on my plate. I had so much on my plate that my wife and my case manager worked together to get us housing with a wheelchair ramp. My case manager also tracked all my appointments and medications. My case manager went above and beyond her normal job to make sure my family and I were taken care of.

**Analysis of Reflective Journal and Field Notes**

The researcher maintained a personal reflective journal to enhance the reflexivity of research bias. Prior to each interview, the researcher dressed in casual civilian clothing to establish a rapport with the participants and minimize the influence of the military uniform. The researcher made a conscientious effort to remain objective during the interviews by being mindful of body language, posture, and tone of voice.
The researcher used field notes to document participant observations during the interview. Each participant was comfortable and under no distress. The interviews were professional dialogues between the researcher and the participants. Participants were eager to explain their experiences and remembered exact dates, locations, and people.

**Summary**

A qualitative, phenomenological research method was selected for this study. The researcher used an interview protocol, a personal reflective journal, and field notes to collect data, and the findings of data analysis were reported according to the research question. Each of the four core concepts of patient-centered care were analyzed and the following themes were identified:

1. Dignity and respect: Professional hospital staff and structured military culture
2. Information sharing: Organized communication processes
3. Participation: Shared decision making
4. Collaboration: Systematic teamwork

A discussion of themes using narrative descriptions and direct quotes from participants enhanced the study’s substantive significance (Patton, 2002). Chapter V includes a detailed analysis of findings in relation to the review of literature. Chapter V also addresses the conclusions and recommendations for further research.
Chapter V: Findings, Conclusions, Recommendations

Overview

Chapter V contains a description of the findings, conclusions, and recommendations of the study and includes the following sections: purpose statement, research question, summary of methodology, population and sample, major findings, conclusions, implications for action, recommendations for further research, and concluding remarks and reflections.

Purpose Statement

The purpose of this phenomenological study was to explore the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

Research Question

The study addressed the following research question: What is the perception of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration?

Summary of Methodology

The researcher as the instrument selected a qualitative, phenomenological research method for this study. An interview protocol (see Appendix E), along with a personal reflective journal and field notes, were used to collect data. The interview questions aligned with the research question. Reflexivity of research bias was enhanced
with the personal reflective journal. Field notes documented participant observations during the interviews.

Moustakas’s (1994) method was used to analyze the data. Statements from each participant were transcribed and coded, and the findings were reported according to the research question. Themes were identified from the codes and participants’ frequency with regard to each of the four core concepts of patient-centered care: (a) dignity and respect, (b) information sharing, (c) participation, and (d) collaboration.

**Population and Sample**

The population consisted of 29,000 marine veterans supported by the Wounded Warrior Regiment nationwide, and the study was generalized to the targeted population of approximately 3,500 marine veterans previously assigned to the Naval Medical Center San Diego Wounded Warrior Detachment of the U.S. Marine Corps Wounded Warrior Regiment. Purposeful sampling was used to select 10 marine veterans based on the following criteria:

1. Sustained polytraumatic injuries, conditions, or diseases after serving in combat during the Global War on Terrorism.
2. Assigned to the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, for at least 6 months.
4. Receiving health care treatment through services originally established by the Naval Medical Center San Diego Wounded Warrior Detachment, U.S. Marine Corps Wounded Warrior Regiment, at the time of the study.

**Major Findings**

The findings of data analysis are reported according to the research question. The following themes were identified for each of the four core concepts of patient-centered care:

1. Dignity and respect: Professional hospital staff and structured military culture
2. Information sharing: Organized communication processes
3. Participation: Shared decision making
4. Collaboration: Systematic teamwork

**Theme 1: Professional Hospital Staff**

With regard to the patient-centered care core concept dignity and respect, participants described the professionalism of the Naval Medical Center San Diego’s staff and their commitment to caring for wounded warriors. Participants stated that health care was provided in a fair and equitable manner, and staff often made the patients feel like family.

Dignity and respect is justifiable on moral grounds and the principle of health care ethics. According to Kant’s moral theory of the categorical imperative, people should be respected based on the worth of humanity (Ciulla, 2003; McClimans et al., 2011). The principle of health care ethics charges Naval Medical Center San Diego’s staff with an obligation to provide care to wounded warriors with respect for human dignity and rights (American Medical Association, 2014). The professionalism and commitment to caring
demonstrated by the hospital staff aligned with the categorical imperative and principle of health care ethics.

**Theme 2: Structured Military Culture**

Participants described the effect of a structured military culture with regard to their perception of dignity and respect. The mission of the U.S. Marine Corps Wounded Warrior Regiment is to provide and facilitate assistance to marines and their families throughout the phases of recovery (DOD, 2009; U.S. Marine Corps Wounded Warrior Regiment, 2013). An integrated team approach that includes military leadership and health care staff enables wounded warriors to navigate the complex and cumbersome systems of health care and benefits by leveraging appropriate resources (Cheek, 2010; U.S. President’s Commission on Care for America’s Returning Wounded Warriors, 2007). Participants discussed the advantages and disadvantages of military leadership oversight within a health care environment. A few participants noted that leaders and the culture of the Wounded Warrior Regiment should allow marines to focus primarily on recovery and not military discipline. One participant cited the annoyance of having to wear the military uniform, while another explained the challenges of having to report for muster in a wheelchair. However, a few participants asserted that military discipline provides structure and facilitates the marine’s compliance with health care treatment guidelines.

Schein’s cultural model of organizations provides the theoretical framework for understanding the participant’s perception of dignity and respect. The third level of Schein’s model, basic underlying assumptions, reflects the reality of the group’s philosophy, despite the tangible artifacts, espoused beliefs, and values of the U.S. Marine
Corps (Schein, 1992; Shafritz et al., 2011). Even though marine veterans disagreed on the roles of military structure in a health care setting, all participants had been successful in their recovery and rehabilitation.

**Theme 3: Organized Communication Processes**

With regard to the patient-centered care core concept of information sharing, participants described the information shared by the health care program at Naval Medical Center San Diego as organized communication processes. Participants explained that health care information was accessible and the hospital staff were transparent in communication delivery. One participant discussed a communication delay regarding the process of ordering and receiving prosthetics, but stated that his needs were met after being more assertive in his request. Automated reminder systems and staff members preparing patient information in advance improved interactions between wounded warriors and hospital staff.

Information communicated as organized processes facilitates patient-centered care by developing healing relationships between hospital staff and patients (Epstein et al., 2010; Marcinowicz et al., 2009). The information shared by hospital staff must be framed based on the patients’ literacy, experience, and expectations (Boykins, 2014; Levinson et al., 2010). Participants expressed that the information shared regarding recovery and rehabilitation was customized to fit their individual needs, but also included standard processes to ensure the success of each wounded warrior.

**Theme 4: Shared Decision Making**

With regard to the patient-centered care core concept of participation, participants expressed a shared opportunity between wounded warriors, their family members, and
hospital staff in making decisions concerning their health care needs. Participants were grateful that they had the opportunity to make individual choices on rehabilitation and quality-of-life concerns. One participant shared his experience of choosing the desired time to receive treatment for scars and having to make a decision on health care treatment options. Other participants cited the importance of family support in making those challenging decisions.

Epstein et al. (2010) noted, “Truly patient-centered care requires knowing the patient as a person and engaging the patient as an active participant in his or her own care” (p. 1490). Shared decision making between wounded warriors, their family members, and the hospital staff creates a sustained partnership that promotes patient empowerment and positive health care outcomes (Guglielmi, 2014; Lein & Wills, 2007). Using the patient-centered care model, research conducted in a military substance abuse program revealed that participants empowered to assist in decision making remained committed to being drug free (Mitchell & Angelone, 2006).

**Theme 5: Systematic Teamwork**

Aligned with the patient-centered care core concept of collaboration, participants expressed the remarkable teamwork of the health care system. Specific persons such as specialized doctors and case managers on the health care team were committed to providing each marine with individualized support. The health care system as a whole ensured the successful recovery and rehabilitation of the wounded warriors and their family members.

Collaboration in patient-centered care requires a well-coordinated health care system and community of professionals and patients working together to promote a
shared vision (Epstein et al., 2010; Senge, 2006). Systematic teamwork of a health care system achieves a sense of shared vision that is medically sound and aligns with a patient’s values (Balik et al., 2011; Epstein et al., 2010).

**Conclusions**

The study involved exploring the perceptions of marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment regarding each of the four core concepts of patient-centered care. The following themes were identified:

1. Dignity and respect: Professional hospital staff and structured military culture
2. Information sharing: Organized communication processes
3. Participation: Shared decision making
4. Collaboration: Systematic teamwork

The sample of marine veterans provided positive feedback on the quality of health care delivered by the Naval Medical Center San Diego. Hospital staff treated the marine veterans in a professional manner, with dignity and respect. Information was shared and communicated as organized processes. Marine veterans and their families had the opportunity to make choices as active participants in decision making about health care treatment options. The health care organization as a system collaborated to ensure the success of each marine veteran’s individual needs.

Marine veterans disagreed on the role of military culture in a health care environment. A few participants suggested that the culture of the U.S. Marine Corps Wounded Warrior Regiment should focus not on military discipline but on the recovery of wounded warriors. Other participants believed that the military discipline provided structure that ensures compliance with health care treatment guidelines.
Communication barriers exist within military organizations. Service members are provided the same basic training curricula according to job description. However, personality and experience affect leadership effectiveness. The military’s chain of command is composed of several layers of leadership authority and responsibility. Disparities in personality and experience, combined with the structure of the military’s chain of command, may result in information being shared and interpreted in different ways. Based on the researcher’s military experience, information is often filtered or modified as it travels through the chain of command, losing its accuracy and consistency. It is important that leadership at each level of the chain of command connect and communicate with each other and wounded warriors.

Relationships must be established and maintained between military leadership and wounded warriors in order to facilitate patient-centered care. Maslow’s hierarchy of needs provides the framework for understanding the development of these relationships (Getha-Taylor, 2009; Griffin, 2012; Wright, 2013). The Wounded Warrior Program provides the physical environment to sustain human survival, such as food, clothes, and shelter. When wounded warriors perceive that they are being treated with dignity and respect, they begin to trust leadership, feel safe, and are more open to share information. This sharing of information leads to a sense of belonging, participation, and collaboration. The connection of Maslow’s hierarchy of needs with the four core concepts of patient-centered care fosters an opportunity for wounded warriors to achieve new normalcy and self-actualization.

Schein (2004) and Shaller (2007) described the relationships of leadership, culture, and patient-centered care. According to Schein, the actions of leadership create
organizational culture, and leadership helps groups unlearn destruction assumptions, promotes a positive climate, and ensures the health and survival of the group. Shaller noted that key factors contributing to achieving patient-centered care include leadership that is committed, engaged, and focused on the mission by communicating a strategic vision throughout the entire organization. The results of this study revealed an opportunity for leadership of the U.S. Marine Corps Wounded Warrior Regiment to address these cultural assumptions to ensure the sustained success of the Wounded Warrior Program.

To facilitate patient-centered care effectively, the four core concepts of dignity and respect, information sharing, participation, and collaboration must collectively align. Dignity and respect connects the patient with the health care organization, and often the first impression of staff is the last impression. Information sharing is facilitated by communication that is transparent, individualized, and appropriate and leads to healing relationships. Participation highlights the importance of partnership and trust in the health care organization. Collaboration promotes a community of quality of health care in which all participants respect and value the patient as the center of success. Although these four concepts of patient-centered care may be analyzed separately, they are all interrelated in the successful delivery of quality health care.

**Implications for Action**

Based on the findings and conclusions of this study, the researcher proposes tangible implications for action. In addition to patient satisfaction surveys, the commanding officers of Naval Medical Center San Diego and U.S. Marine Corps Wounded Warrior Regiment should implement a quarterly focus group to obtain
feedback from marines and their families on the quality of health care provided by the Wounded Warrior Program. An outreach program should be established connecting marine veterans who have transitioned from active duty and completed the recovery and rehabilitation process with recently injured wounded warriors. For active duty marines recently assigned to the Wounded Warrior Regiment, these marine veterans would be excellent mentors and provide real-world coping strategies.

**Recommendations for Further Research**

The study involved exploring the quality of health care provided to marine veterans previously assigned to the U.S. Marine Corps Wounded Warrior Regiment, focusing on the dimension of patient-centered care. The researcher proposes several recommendations for future research.

**Recommendation 1.** Researchers should explore the quality of health care perceived by active duty service members from each of the military services, focusing on the dimension of patient-centered care. These studies would involve comparing and contrasting the perception of health care quality across each of the military services.

**Recommendation 2.** Researchers could measure any of the other dimensions of health care quality: effective, efficient, accessible, equitable, and safe. These studies may provide comprehensive data that would improve health care delivery systems throughout the DOD, VA, and civilian health care organizations.

**Recommendation 3.** Most research studies on health care quality examine data involving the customers or recipients of health care. Researchers should explore the quality of health care perceived by the providers of health care: doctors, nurses, and staff.
These studies would involve comparing and contrasting the perception of health care quality delivered by health care providers and received by patients.

**Recommendation 4.** Researchers should explore the quality of health care perceived by the patients’ family members. Family members often have difficulty coping with patients’ conditions and diseases, and many take on the burden of care at home.

**Recommendation 5.** Similar to a military environment, the structure and culture of the criminal justice system may affect the quality of health care provided to individuals who are incarcerated. Researchers could measure the quality of health care provided in the prison system, especially regarding the concept of dignity and respect.

**Concluding Remarks and Reflections**

As a provider and patient of military health care for over 23 years, the researcher was inspired to conduct the study primarily to increase understanding and awareness of the importance of quality health care. As a provider of health care, the researcher reflects on working long hours with limited resources both at sea and on shore facilities, providing the best quality care for his patients. As a patient and recipient of health care, the researcher remembers health care encounters and hospital stays that were unsatisfactory based on his perceptions, and the researcher saw opportunities for improvement from both a clinical and a service perspective. Quality improvement is a dynamic cause that requires consistent and persistent passion, energy, and commitment from the entire health care system.

What do wounded warriors need the most? This question resonated with the researcher during lunch with a group of wounded warriors. Their ultimate goal is to achieve new normalcy, as discussed in the study, but they need the opportunity to move
on with their lives. Wounded warriors do not like the “dog and pony shows” perpetuated by politics and the media. For example, a group of wounded warriors described the experience of having to wake up at 5:00 a.m. on a Saturday morning because the San Diego Padres wanted to see wounded warriors. These wounded warriors stated they felt like animals on display in a zoo. Their injuries are a symbol of courage and sacrifice, and often a simple “Thank you for your service” is appropriate.

The researcher is grateful for the opportunity to connect specifically with the marine veteran wounded warriors. Throughout history, the U.S. Marine Corps has demonstrated an unparalleled sense of honor, pride, and courage. The price of freedom is never free, and marines are committed to making that payment. The researcher reflects on the excitement of listening to these wounded warriors share their story. Vivid accounts of their experiences and challenging journeys through the health care system inspired the researcher to make a conscious effort to seek resources to meet their needs. The researcher hopes that the findings of this study would be a catalyst for positive change in the military health care delivery system.
References


Griffin, J. (2012). *Qualitative evaluative study of the army’s warriors in transition program* (Doctoral dissertation). Available from ProQuest Dissertations and Theses Database. (UMI No. 3534628)


perceptions of quality in federally supported health centers. *Annals of Family Medicine, 11*, 508-516.


Appendices
### APPENDIX A

#### Synthesis Matrix

**Topic:** Qualitative Study of the U. S. Marine Corps Wounded Warrior Regiment

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Failure of Walter Reed Army Medical Center and need to establish Wounded Warrior Program</td>
<td>Building 18, a former hotel used to house wounded warriors, rodent-infested, moldy, and uninhabitable; poor health care administration</td>
<td>Doctors’ appointments and medical evaluations routinely cancelled and difficult to obtain</td>
<td>Army Medical Action Plan developed, and the first Warrior Transition Unit established in April 2007</td>
<td>Mission of the U. S. Marine Corps Wounded Warrior Regiment (WWR)</td>
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<tr>
<td>Definition and complexity of signature combat injuries</td>
<td>Signature injuries are defined as “polytraumatic,” which indicate that the wounded warrior suffers from more than two severe injuries to body or organ system.</td>
<td>The majority of these signature injuries are caused by Improvised Explosive Devices (IEDs).</td>
<td>Many wounded warriors have served multiple tours, and this re-exposure to combat environment increases risk of long-term mental health outcomes.</td>
<td>As an avenue to cope with the physical and mental injuries, wounded warriors may resort to prescription drug and alcohol abuse.</td>
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<td>Common Themes</td>
<td>Source #1 (Spelman et al., 2012; Dept of the Army, 2012)</td>
<td>Source #2 (Wood, 2011)</td>
<td>Source #3 (Institute of Medicine, 2013)</td>
<td>Source #4 (Leskin et al., 2007)</td>
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<tr>
<td>Effects of Signature Injuries on wounded warriors, family, community</td>
<td>Marital problems, economic problems, neglect, homelessness</td>
<td><em>Huffington Post</em> article on Jimmy Kinsey II and wife Karie, direct quote</td>
<td>Mental health problems such as PTSD and TBI, hard to treat, seen as sign of weakness</td>
<td>Advocated a commitment to meeting the health care needs of wounded warriors across their lifespan</td>
</tr>
<tr>
<td>Health Care Services provided to wounded warriors and families</td>
<td>Department of Defense, Department of Veteran Affairs (VA), and civilian-sector organizations</td>
<td>Rehabilitation and family support services</td>
<td>U. S. Secretary of the VA, Eric Shinseki, resigned due to the poor quality of care and negative outcomes</td>
<td>Sergeant Josh Renschler, U.S. Army (Retired), met with the House of Representatives Committee on Veteran Affairs on to discuss VA mental health care.</td>
</tr>
<tr>
<td>Common Themes</td>
<td>Source #1 (Luce et al., 1994)</td>
<td>Source #2 (The Joint Commission, 2014)</td>
<td>Source #3 (Saizberg, 2012)</td>
<td>Source #4 (Lombardozzi, 2011)</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>History of health care quality movement</td>
<td>American Medical Association and the American College of Surgeon’s established five minimum standards for health care delivery within hospitals.</td>
<td>Joint Commission on Accreditation of Hospitals was formed to ensure compliance with the five minimum standards.</td>
<td>Hospitals bill insurance companies for non-evidence-based, ineffective therapies that result in little or no success in recovery and rehabilitation.</td>
<td>Health care has become a business; current trend is balancing this productivity while containing cost.</td>
</tr>
<tr>
<td>Definition of health care quality</td>
<td>There is no specific, absolute definition of health care quality.</td>
<td>Health care quality viewed based on six (6) dimensions and perspectives, using systems perspective</td>
<td>Avedis Donabedian (1966) developed a model to describe health care quality, which is the foundation used today.</td>
<td>Three concepts of health care quality: structure, processes, and outcomes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Health care quality and patient-centered care</td>
<td>There are four core concepts of patient-centered care.</td>
<td>Patient-centered care is the cornerstone of health care quality; patient and organizational benefits</td>
<td>Paradigm shift from traditional disease-centered model to patient-centered model</td>
<td>Patient-centered care effective in the military health care setting</td>
</tr>
<tr>
<td>Health care quality and traditional disease-centered care</td>
<td>Advantages of traditional disease-centered care</td>
<td>Disadvantages of traditional disease-centered care</td>
<td>Origin based on the medical model</td>
<td>Not aligned with the needs and expectations of the individual patients, and have not been effective at sustaining high quality health care</td>
</tr>
<tr>
<td>Common Themes</td>
<td>Source #1 (Centers for Medicare &amp; Medicaid Services, 2013)</td>
<td>Source #2 (Griffin, 2012)</td>
<td>Source #3 (personal communication, December 9, 2013)</td>
<td>Source #4 (Department of Defense, 2013)</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Measuring Health Care Quality</td>
<td>HCAHPS survey provides a standardized data collection instrument and methodology for measuring the patient’s perspective on health care quality.</td>
<td>Patient satisfaction surveys are conducted to solicit feedback in determining health care quality of the Wounded Warrior Program.</td>
<td>Deputy Public Affairs Officer for the Wounded Warrior Regiment, Ms. Victoria Long state that surveys are conducted to measure the Marines’ satisfaction with health care.</td>
<td>Recovering Warrior Task Force (RWTF) conducts focus groups during site visits to Warrior Transition Units to get personal story and real feedback from wounded warriors.</td>
</tr>
<tr>
<td>Qualitative, Phenomenology Research Method appropriate for this study</td>
<td>Qualitative methods help researchers understand the social and cultural context within which people live.</td>
<td>Qualitative research is used to further understand a phenomenon as viewed from the perspective of research participants.</td>
<td>Phenomenology explores a person’s perception of the meaning of a particular phenomenon.</td>
<td>“Phenomenology is committed to descriptions of experiences, not explanations or analysis.”</td>
</tr>
<tr>
<td>Common Themes</td>
<td>Source #1 (Schein, 1992)</td>
<td>Source #2 (Maslow, 1954)</td>
<td>Source #3 (Shaller, 2007)</td>
<td>Source #4 (Gandolf, 2016; Pietra, 2013)</td>
</tr>
<tr>
<td>---------------</td>
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<td>---------------------------------------</td>
</tr>
<tr>
<td>Theoretical framework for the study: Schein’s Cultural Model of Organizations, Maslow’s Hierarchy of Needs</td>
<td>Organizational culture exists on three levels: artifacts, espoused beliefs and values, and basic underlying assumptions</td>
<td>Hierarchy of five needs based on observation of human motivation</td>
<td>Described the relationship of culture and patient-centered care in U.S. health care organizations</td>
<td>Wounded warriors have the opportunity to heal and achieve self-actualization when patient-centered care is successfully delivered in a health care setting.</td>
</tr>
</tbody>
</table>
Dear Subjects:

The Naval Medical Center San Diego is conducting a research project titled “Qualitative Study of the United States Marine Corps Wounded Warrior Regiment”.

Your cooperation is greatly appreciated.

Statement that this project is research:

Study Procedures – If you agree to participate, the following procedures will be performed:

The purpose of this study is to explore the perception of health care quality provided to marine veterans previously assigned to the United States Marine Corps Wounded Warrior Regiment. Specifically, the study will determine if the Wounded Warrior Program’s health care facilitates the four core concepts of patient-centered care—dignity and respect, information sharing, participation, and collaboration.

This study will involve one-on-one, face-to-face interviews as the primary method of data collection. You will be asked to answer questions pertaining to your perception of health care quality delivered while assigned to the Naval Medical Center San Diego Wounded Warrior Detachment. The researcher will begin with the same set of pre-formulated interview questions as to provide consistency of data. You will be allowed to provide additional information during the interview as you answer each question. With your permission, the interview will be audio recorded and transcribed. You will be given the opportunity to review the transcription for completeness and accuracy. No personal identifiers will be recorded to protect your privacy.

Risks – Every study that involves accessing or collection of patient information has an inherent risk of accidental disclosure of personal identifying information. Patient demographic information will be maintained by the Principal Investigator and kept in a locked file cabinet. Minimal risks or discomforts are anticipated related to participation in this study. This means that risks or discomforts, beyond those risks associated with any underlying medical condition which you might have or associated with standard health care which you might be receiving during the course of participation in this study, are felt to be no greater than the “normal” risks of day-to-day life.
Benefits – This study aims to explore the perception of health care quality of the Wounded Warrior Program. This study is significant because it furthers the body of knowledge that could be used in health education curriculums, thereby improving the structure, processes, and outcomes of the health care delivery system. This study is the most beneficial to wounded warriors. The results of this study may encourage wounded warriors to take an active, patient-centered approach in decision-making regarding their health care treatment, recovery, and rehabilitation.

Your participation in this study is entirely voluntary and the alternative, if you elect not to participate, there will be no penalty and you will receive standard of care medical treatment.

Confidentiality – Your name or personal identifiable information will not be used in the research study. In all publications and presentations resulting from this research study, information about you or your participation in this project will be kept in the strictest confidence and will not be released in any form identifiable to you personally.

PATIENT AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH (HIPAA)

(In Keeping with the Health Insurance Portability and Accountability Protection Act)

What is Confidentiality of records all about?

The Naval Medical Center San Diego makes every effort to maintain the confidentiality of protected health information we obtain about you. However, we cannot absolutely guarantee confidentiality because other people may need to see your information in the course of this research study. Most people and organizations will protect the privacy of your information, but may not be required to do so by the law. Also, if the results of this research study are presented at meetings or are published, your name will not be used.

What is HIPAA all about?

The Health Insurance Portability and Accountability Act (HIPAA) requires that we get your permission to use protected health information about you that is either created by or used in connection with this research study. This permission is called an Authorization. The information we use includes your entire research record and supporting information from your medical records, results of laboratory test, X-rays, MRIs, CT scans and observations made by a physician or nurse which are both clinical and research in nature.

What will we do with this information?

Your protected health information will be collected and used during the course of the research study, to monitor your health status, to measure the effects of drugs or devices or procedures, to determine research results, and to possibly develop new tests, procedures, and commercial products.
Your researcher will use this information to report the results of research to sponsors and federal agencies, like the Food and Drug Administration (FDA). The information may also be reviewed when the research study is audited for compliance. When the study is over, you have the right to see the information and copy it for your records.

Who will we share your information with?

Your information may be shared with any of the following:

- The sponsor of the study, or its agents, such as data repositories
- Other medical centers, institutions, or research investigators outside of the Naval Medical Center San Diego, participating in this research study
- State and Federal agencies which have authority over the research, the Naval Medical Center San Diego or patients. Good examples are: the Department of Health and Human Services (DHHS), the Food and Drug Administration (FDA), the National Institute of Health (NIH), the Office of Human Research Protections (OHRP), and the Department of Social Services (DSS) or other.
- This hospital or clinic.
- Accrediting agencies, such as JCAHO.
- A data safety monitoring board, if applicable
- Clinical staff who may not be involved directly in the research study, but who may become involved in your care, if it is possibly related to treatment

For this research study, the study investigator may share this authorization form and records which identify you to comply with regulatory requirements or for purposes related to this research to:

All documented Principal, Associate, and Sub-investigators, and the Medical Monitor (if one is assigned). In addition,

What if you want to revoke or cancel away your Authorization?

If you decide to participate in this research study, your Authorization for this study will not expire unless you revoke or cancel it in writing to the researcher. If you revoke your Authorization, you will also be removed from the study, but standard medical care and any other benefit to which you are entitled will not be affected in any way.

Revoking your Authorization only affects the use and disclosure (sharing) of information after your written request has been received. Federal law requires sending study information to the FDA for studies it regulates, like studies of drugs and devices. In a case like this, your information may need to be reported to them and cannot be removed from the research records once it is collected.
California Experimental Subject’s Bill of Rights

(a) Be informed of the nature and purpose of the experiment.

(b) Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

(c) Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

(d) Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

(e) Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

(f) Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

(g) Be given an opportunity to ask any questions concerning the experiment or the procedures involved.

(h) Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

(i) Be given a copy of the signed and dated written consent form as provided for by Section 24173 or 24178.

(j) Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject’s decision.

If you have any questions regarding this research study, you may contact HMC Webster Nicholson at (619) 822-3799. If you have any questions about your rights as an individual while participating in a research study at the Naval Medical Center, San Diego, you may contact CDR Dennis Spence, NC, USN, Chairman, Institutional Review Board at (619) 532-9927, or John D. Malone, M.D., Head, Clinical Investigation Department at (619) 532-6099. If you believe that you have been injured as a result of your participation in this research study, you may contact CDR Kevin Messer, JAGC, USN, Naval Medical Center, San Diego, Legal Department, at (619) 532-6475.

This form is yours to keep for your information. Thank you.
APPENDIX C

Informed Consent Form

NAVAL MEDICAL CENTER
SAN DIEGO, CALIFORNIA 92134-5000

CONSENT BY A SUBJECT FOR VOLUNTARY PARTICIPATION IN A CLINICAL INVESTIGATION (RESEARCH) STUDY

CIP#: NMCSD.2014.0090-EP6/7

1. You, _______________________________, have been asked to voluntarily participate in a research project entitled, "Qualitative Study of the United States Marine Corps Wounded Warrior Regiment" being conducted at the Naval Medical Center San Diego by a medical researcher.

2. WHY IS THE STUDY BEING DONE?

The purpose of this research project is to explore the perception of health care quality provided to marine veterans previously assigned to the United States Marine Corps Wounded Warrior Regiment. Specifically, the study will determine if the Wounded Warrior Program’s health care facilitates the four core concepts of patient-centered care—dignity and respect, information sharing, participation, and collaboration.

3. HOW LONG WILL YOU BE PARTICIPATING IN THE STUDY?

You will be participating in the study for one day, not to exceed 2 hours.

4. WHAT IS INVOLVED IN THE STUDY?

This study will involve one-on-one, face-to-face interviews as the primary method of data collection. You will be asked to answer questions pertaining to your perception health care quality delivered while assigned to the Wounded Warrior Detachment. The researcher will begin with the same set of pre-formulated interview questions as to provide consistency of data. You will be allowed to provide additional information during the interview as you answer each question. With your permission, the interview will be audio recorded and transcribed. You will be given the opportunity to review the transcription for completeness and accuracy.

5. WHAT IS THE EXPERIMENTAL PART OF THE STUDY?

There are no experimental parts of the study.
6. HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?

A total of 10 Marine Veteran Wounded Warriors will participate in this study.

7. WHAT ARE THE RISKS OF THE STUDY?

Every study that involves accessing or collection of patient information has an inherent risk of accidental disclosure of personal identifying information. Patient demographic information will be maintained by the researcher and kept in a locked file cabinet. When discussing stressful situations or frustrating times, there may be some stress, anxiety, or frustration during the interview. Minimal risks or discomforts are anticipated and related to participation in this study. This means that risks or discomforts, beyond those risks associated with any underlying medical condition which you might have or associated with standard health care which you might be receiving during the course of participation in this study, are felt to be no greater than the “normal” risks of day-to-day life.

7B. WHAT IF I AM OR BECOME PREGNANT?

This study will have no effect on a participant’s pregnancy.

8. ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

Your participation in this research project may not be of direct benefit to you personally. However, the results of this study may help the researcher gain important knowledge about the perception of health care quality of the Wounded Warrior Program. This study is significant because it furthers the body of knowledge that could be used in health education curriculums, thereby improving the structure, processes, and outcomes of the health care delivery system. This study is the most beneficial to wounded warriors. The results of this study may encourage wounded warriors to take an active, patient-centered approach in decision-making regarding their health care treatment, recovery, and rehabilitation.

9. WHAT OTHER OPTIONS ARE THERE?

This research study is not designed to treat any medical condition that you may have. Therefore, there are no alternative procedure(s) or course of treatment that would be advantageous to you.

10. WILL I BE PAID TO PARTICIPATE?

You will not be financially compensated for your participation in this study.

11. WHAT IF I AM INJURED AS A RESULT OF PARTICIPATION IN THIS STUDY?

If you suffer any injury directly related to your participation in this research study, immediate medical attention is available at the Naval Medical Center, San Diego, or at another closer medical treatment facility, if applicable. Any injury resulting from your participation in this study will be evaluated and treated in keeping with the benefits or
care to which you are entitled under applicable Navy, other Department of Defense, and other state or Federal regulations.

12. WHAT ABOUT CONFIDENTIALITY?

In all publications and presentations resulting from this research study, information about you or your participation in this project will be kept in the strictest confidence and will not be released in any form identifiable to you personally. However, authorized personnel from the Navy Medical Department and from the Food and Drug Administration (FDA), where applicable, may have access to your research file in order to verify that your rights have been adequately protected.

Per 21 CFR 50.25, a description of this study may be available on [http://www.ClinicalTrials.gov](http://www.ClinicalTrials.gov), as required by U.S. Law. This web site will not include information that can identify you. At most, the web site will include a summary of the results. You can search this Web site at any time.

**PATIENT AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH (HIPAA)**

(In Keeping with the Health Insurance Portability and Accountability Protection Act)

What is Confidentiality of records all about?

The Naval Medical Center San Diego makes every effort to maintain the confidentiality of protected health information we obtain about you. However, we cannot absolutely guarantee confidentiality because other people may need to see your information in the course of this research study. Most people and organizations will protect the privacy of your information, but may not be required to do so by the law. Also, if the results of this research study are presented at meetings or are published, your name will not be used.

What is HIPAA all about?

The Health Insurance Portability and Accountability Act (HIPAA) requires that we get your permission to use protected health information about you that is either created by or used in connection with this research study. This permission is called an Authorization. The information we use includes your entire research record and supporting information from your medical records, results of laboratory test, X-rays, MRIs, CT scans and observations made by a physician or nurse which are both clinical and research in nature.

What will we do with this information?

Your protected health information will be collected and used during the course of the research study, to monitor your health status, to measure the effects of drugs or devices or procedures, to determine research results, and to possibly develop new tests, procedures, and commercial products.
Your researcher will use this information to report the results of research to sponsors and federal agencies, like the Food and Drug Administration (FDA). The information may also be reviewed when the research study is audited for compliance. When the study is over, you have the right to see the information and copy it for your records.

Who will we share your information with?

Your information may be shared with any of the following:

- The sponsor of the study, or its agents, such as data repositories
- Other medical centers, institutions, or research investigators outside of the Naval Medical Center San Diego, participating in this research study
- State and Federal agencies which have authority over the research, the Naval Medical Center San Diego or patients. Good examples are: the Department of Health and Human Services (DHHS), the Food and Drug Administration (FDA), the National Institute of Health (NIH), the Office of Human Research Protections (OHRP), and the Department of Social Services (DSS) or other.
- This hospital or clinic.
- Accrediting agencies, such as JCAHO.
- A data safety monitoring board, if applicable
- Clinical staff who may not be involved directly in the research study, but who may become involved in your care, if it is possibly related to treatment

For this research study, the study investigator may share this authorization form and records which identify you to comply with regulatory requirements or for purposes related to this research to:

All documented Principal, Associate, and Sub-investigators, and the Medical Monitor (if one is assigned). In addition,

What if you want to revoke or cancel away your Authorization?

If you decide to participate in this research study, your Authorization for this study will not expire unless you revoke or cancel it in writing to the researcher. If you revoke your Authorization, you will also be removed from the study, but standard medical care and any other benefit to which you are entitled will not be affected in any way.

Revoking your Authorization only affects the use and disclosure (sharing) of information after your written request has been received. Federal law requires sending study information to the FDA for studies it regulates, like studies of drugs and devices. In a case like this, your information may need to be reported to them and cannot be removed from the research records once it is collected.

Do you have to sign this form?

You have the right to refuse to sign this Authorization form and not be a part of this study. You can also tell your researcher you want to withdraw from the study at any time without revoking the Authorization to use your health information. By signing this
research Authorization form, you authorize the use and/or disclosure of your protected health information described above.

This authorization expires 25 years from the date of signature.

13. WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

If you have any questions regarding this research study, you may contact HMC Webster Nicholson at (619) 822-3799.

If you have any questions about your rights as an individual while participating in a research study at the Naval Medical Center, San Diego, you may contact CDR Dennis Spence, NC, USN, Chairman, Institutional Review Board at (619)532-9927, or John D. Malone, M.D., Head, Clinical Investigation Department at (619) 532-6099. If you believe that you have been injured as a result of your participation in this research study, you may contact CDR Kevin Messer, JAGC, USN, Naval Medical Center, San Diego, Legal Department, at (619) 532-6475.

14. WHAT ARE MY RIGHTS AS A PARTICIPANT?

Your participation in this project is entirely voluntary and your decision not to participate will involve no penalty or loss of benefits to which you are entitled under applicable regulations. If you choose to participate, you are free to ask questions or to withdraw from the study at any time. If you should decide to withdraw from the research project, you will contact HMC Webster Nicholson at (619) 822-3799 to ensure your timely removal from the study. Your withdrawal will involve no prejudice to your future health care or any loss of rights or benefits to which you are otherwise entitled. Any new significant finding developed during the course of this study, which might affect your willingness to continue participation will be communicated to you.

California Experimental Subject’s Bill of Rights

(a) Be informed of the nature and purpose of the experiment.

(b) Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

(c) Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

(d) Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

(e) Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.
(f) Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

(g) Be given an opportunity to ask any questions concerning the experiment or the procedures involved.

(h) Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

(i) Be given a copy of the signed and dated written consent form as provided for by Section 24173 or 24178.

(j) Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject’s decision.

15. CAN I BE TERMINATED FROM THE STUDY?

The researcher may terminate your participation in this study for the following reasons: Participant’s failure to comply with study procedures.

16. SIGNATURE

You are making a decision whether or not to participate in the research project above. Your signature indicates that you have had this information presented to you, have had the opportunity to ask questions about the research and your participation, and agree to participate in the study.

SIGNATURES AND DATE SIGNED: PRINTED OR TYPED IDENTIFICATION:

<table>
<thead>
<tr>
<th>Patient / Subject</th>
<th>(Date)</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigator/Researcher</td>
<td>(Date)</td>
<td>Name / Grade or Rank</td>
</tr>
</tbody>
</table>

(Person obtaining consent)
APPENDIX D

Demographic Data Sheet

Naval Medical Center San Diego

Research Study

Title: Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

Date of Interview: _________

Time Started: ______

Time Finished: ______

Participant Number (Marine One, Two, etc.): __________

Age: ______

Gender: ______

Rank at time of separation or retirement: ______

American Indian or Alaska Native ______

Asian ______

Black/African American ______

Native Hawaiian or Other Pacific Islander ______

Hispanic or Latino ______

White ______

How long did you serve in the U.S. Marine Corps? ______

On what date were you assigned to the Naval Medical Center San Diego Wounded Warrior Detachment? ______

On what date were you discharged from the Naval Medical Center San Diego Wounded Warrior Detachment? ______
APPENDIX E

Interview Protocol

Title of Study: Qualitative Study of the United States Marine Corps Wounded Warrior Regiment

Principle Investigator: HMC Webster F. Nicholson

CIP#: NMCSD.2014.0090-EP6/7

Script for oral brief prior to participant interviews:

My name is HMC Webster Nicholson and I am the researcher responsible for the Wounded Warrior study.

Thank you for your interest in participating in this project. The purpose of this study is to explore the perception of health care quality provided to marine veterans previously assigned to the United States Marine Corps Wounded Warrior Regiment. Specifically, the study will determine if the Wounded Warrior Program’s health care facilitates the four core concepts of patient-centered care—dignity and respect, information sharing, participation, and collaboration.

Participation: This study will involve one-on-one, face-to-face interviews as the primary method of data collection. You will be asked to answer questions pertaining to your perception health care quality delivered while assigned to the Wounded Warrior Detachment. The researcher will begin with the same set of pre-formulated interview questions as to provide consistency of data. You will be allowed to provide additional information during the interview as you answer each question. With your permission, the interview will be audio recorded and transcribed. You will be given the opportunity to review the transcription for completeness and accuracy.

Risks: Every study that involves accessing or collection of patient information has an inherent risk of accidental disclosure of personal identifying information. Patient demographic information will be maintained by the researcher and kept in a locked file cabinet. When discussing stressful situations or frustrating times, there may be some stress, anxiety, or frustration during the interview. Minimal risks or discomforts are anticipated related to participation in this study. This means that risks or discomforts, beyond those risks associated with any underlying medical condition which you might have or associated with standard health care which you might be receiving during the course of participation in this study, are felt to be no greater than the “normal” risks of day-to-day life.

Benefits: Your participation in this research project may not be of direct benefit to you personally. However, the results of this study may help the researcher gain important knowledge about the perception of health care quality of the Wounded Warrior Program.
This study is significant because it furthers the body of knowledge that could be used in health education curriculums, thereby improving the structure, processes, and outcomes of the health care delivery system. This study is the most beneficial to wounded warriors. The results of this study may encourage wounded warriors to take an active, patient-centered approach in decision-making regarding their health care treatment, recovery, and rehabilitation.

Confidentiality: In all publications and presentations resulting from this research study, information about you or your participation in this project will be kept in the strictest confidence and will not be released in any form identifiable to you personally. Data obtained during the course of this study will be retained in compliance with federal regulations, Department of Defense research directives, and Department of the Navy Human Protection Program regulations.
Before we begin, do you have any questions?

The interviewee will be asked the following questions:

1. What events led to your assignment to the Naval Medical Center San Diego Wounded Warrior Detachment?
2. How would you define health care quality?
3. How would you describe the dignity and respect provided to you by the health care program at Naval Medical Center San Diego?
4. How would you describe the dignity and respect provided to other marine veterans by the health care program at Naval Medical Center San Diego?
5. How would you describe the information shared with you by the health care program at Naval Medical Center San Diego?
6. How would you describe the information shared with other marine veterans by the health care program at Naval Medical Center San Diego?
7. How was your participation in decision-making about your care facilitated by the health care program at Naval Medical Center San Diego?
8. How was the participation of other marine veterans in decision-making about their care facilitated by the health care program at Naval Medical Center San Diego?
9. How would you describe the collaboration demonstrated by you and the health care program at Naval Medical Center San Diego?
10. How would you describe the collaboration demonstrated by other marine veterans and the health care program at Naval Medical Center San Diego?
### APPENDIX F

Summary of Participant Demographics

Naval Medical Center San Diego Wounded Warrior Detachment

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Rank at Separation/Retirement</th>
<th>Race/Ethnic Background</th>
<th>Years of Service, U.S. Marine Corps</th>
<th>Date Assigned to Detachment</th>
<th>Date Discharged from Detachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marine 1</td>
<td>26</td>
<td>Male</td>
<td>E-5</td>
<td>Black</td>
<td>5</td>
<td>Mar 2011</td>
<td>Dec 2013</td>
</tr>
<tr>
<td>Marine 3</td>
<td>25</td>
<td>Male</td>
<td>E-4</td>
<td>Hispanic</td>
<td>5</td>
<td>Oct 2011</td>
<td>Nov 2013</td>
</tr>
<tr>
<td>Marine 4</td>
<td>24</td>
<td>Male</td>
<td>E-3</td>
<td>White</td>
<td>3</td>
<td>May 2013</td>
<td>Nov 2014</td>
</tr>
<tr>
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<td>Feb 2014</td>
</tr>
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</table>
APPENDIX G

Naval Medical Center San Diego IRB Approval Letter

Clinical Investigation Department
Naval Medical Center, San Diego
34800 Bob Wilson Drive, Suite 5
San Diego, CA 92134-1805
Tel. (619) 532-6125, FAX. 619-532-8137
Email: vanessa.tinney@med.navy.mil

August 6, 2014

From: Head, Clinical Investigation Department (CID)
To: Webster Nicholson, M.A
Sub: FINAL APPROVAL OF CLINICAL INVESTIGATION PROGRAM (CIP)
States Marine Corps Wounded Warrior Regiment"

Ref: (a) NAVMEDCEN SDIEGOINST 6500.9A

1. Two members of the Institutional Review Board (IRB) have reviewed and recommended approval of
your application and found that it meets the criteria specified in 63 CFR 60364-00367 category[a] [enter
category]. Based on the board members findings and recommendation, and his review, the IRB Chairman
concurred with the recommendation as specified and reported in the July 23, 2014 IRB meeting minutes.
The IRB members and Chairman reviewed all documents attached to the original submission. Naval
Medical Center San Diego holds Office of Human Research Protections Federal Wide Assurance number
FWA00002342 and DOD Navy Assurance number 40036.

2. IRB APPROVAL DATE: July 15, 2014
Type of Review: Expedited Review

This number is the clinical investigation program number and is required to be included with all
correspondence, consent forms, and research data files.

4. ADVERSE EVENT (AE) REPORTING: All problems that could possibly affect subject safety must be
reported to the IRB within five days; serious AEs must be reported within 24 hours. All deaths, whether or
not they are directly related to study procedures, must be reported.

5. AMENDMENTS: Prior IRB approval is required before implementing any changes to the protocol,
including investigator additions or deletions, edits to consent documents or any other modifications to the
documentation contained in the original submission package.

6. EXPIRATION DATE: Your protocol will expire on July 14, 2015. If the project is to continue, it must be
renewed prior to the expiration date.

7. COMMENT: The Research Administration Office will send you a Continuing Review Report
(CRF) approximately 60 days prior to the expiration of the study. The IRB wishes to remind you that,
according to the Department of Health and Human Services (DHHS) and NMCSD policy, the renewal of
exempt research projects is the investigator’s responsibility and a renewal application is required at
least annually for all projects involving human subjects.

8. ARTICLES/ABSTRACTS/POSTERS: If you wish to submit an item for publication or presentation, it
must be submitted to the CID Medical Editing staff. The Lead Editor, Ms. Elisea Avalos can be reached
at (619) 532-8134. She will assist in their preparation, will ensure proper acknowledgment of BUMED as sponsor, will obtain command approval and submit them to journals and publications.

9. QUESTIONS: Please contact the IRB Research Administration Division (RAD) if you have any questions:

Vanessa Finney at (619) 532-8125

J.D. Malone, MD
Head, Clinical Investigation Department
APPENDIX H

Brandman University IRB Approval Letter

BRANDMAN UNIVERSITY INSTITUTIONAL REVIEW BOARD
IRB Application Action – Approval

Date: 12/03/2014

Name of Investigator/Researcher: Webster F. Nicholson
Faculty or Student ID Number: B00066542

Title of Research Project: Qualitative Study of the U.S. Marine Corps Wounded Warrior Regiment

Project Type: ☑️ New ☐ Continuation ☐ Resubmission

Category that applies to your research:
☑️ Doctoral Dissertation EdD
☐ DNP Clinical Project
☐ Masters’ Thesis
☐ Course Project
☐ Faculty Professional/Academic Research
☐ Other: 

Funded: ☑️ No ☐ Yes

(Funding Agency; Type of Funding; Grant Number)

Project Duration (cannot exceed 1 year): December 2014 to March 2015

Principal Investigator’s Address: 799 Jet Place, Escondido, CA 92026

Email Address: nich3602@mail.brandman.edu Telephone Number: 619-822-3799

Faculty Advisor/Sponsor/Chair Name: Dr. Glenn Worthington

Email Address: gworthin@brandman.edu Telephone Number: 253-861-1024

Category of Review:
☑️ Exempt Review ☐ Expedited Review ☐ Standard Review

Brandman University IRB Rev, 3.20.14 Adopted November 2013
I have completed the NIH Certification and included a copy with this proposal

Signature of Principal Investigator: NICHOLSON, WEBSTER
FRANKLIN, 1110158234

Date: 12/03/2014

Signature of Faculty Advisor/ Glenn Worthington
Sponsor/Dissertation Chair: 

Date: 12/04/2014
BRANDMAN UNIVERSITY INSTITUTIONAL REVIEW BOARD
IRB APPLICATION ACTION – APPROVAL
COMPLETED BY BUIRB

IRB ACTION/APPROVAL

Name of Investigator/Researcher: Webster F. Nicholson

☐ Returned without review. Insufficient detail to adequately assess risks, protections and benefits.
☐ Approved/Certified as Exempt form IRB Review.
☒ Approved as submitted.
☐ Approved, contingent on minor revisions (see attached)
☐ Requires significant modifications of the protocol before approval. Research must resubmit with modifications (see attached)
☐ Researcher must contact IRB member and discuss revisions to research proposal and protocol.

Level of Risk: ☐ No Risk ☒ Minimal Risk ☐ More than Minimal Risk

IRB Comments:

IRB Contact

Name: Dr. Levy

Telephone: __________________________ Email: __________________________

IRB Certification Number: __________________________ Date: 12/5/15

Revised IRB Application ☐ Returned ☒ Approved

Name: Keith Larick

Telephone: __________________________ Email: larick@brandman.edu Date: 12/6/15

Brandman University IRB Rev, 3.20.14 Adopted November 2013