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Exploring Management Practices of the Health Care System for Contractors

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2018

Abstract

Exploring Management Practices of the Health Care System for Contractors

by

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MA, Webster University, 2002

BS, Saint Leo University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Researchers have found that military members serving in war experienced changes in physical and mental health. Military members' healthcare is managed by the Department of Defense. The problem was that management practices of the system for providing long-term healthcare for employees of a contracting company working in foreign combat zones is either minimal or nonexistent. The purpose of this case study was to explore ways that contractor managers and government managers can work together to provide healthcare for those contract employees who will be deployed with the U.S. military. The primary research question was to determine what managers of contractors could do to improve the management practices to support their personnel who will serve in hostile environments. To analyze data, content analysis was used. Two theories were used in the conceptual framework for this case study, Bandura's self-efficacy theory and Kolb's experiential learning theory. Ten American contractor managers and 10 government managers were interviewed regarding the information they provided to their contract employees. One major finding identified was that contractor managers and government managers had little understanding about the disparity of information, services, and assistance available to contractors before participating in this study. Additional findings were that all managers understood they play a key role in the modification, development, and mitigation of any healthcare management systems for contractors in the future. Regarding social change, the contractor managers and government managers can use the findings to improve how the U.S. government and contractor management teams provide short term as well as long-term healthcare management system for future contractor personnel who serve in combat zones thus benefiting both contractors and their families.

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Chapter 1: Introduction to the Study

Contractor personnel are individuals deployed with the U.S. military and include American employees and managers working directly within the combat zone. While they may not actively engage the enemy as part of their mission, contractor personnel work in the same hostile environment as their military counterparts. Although weapons are not distributed to most contractors, they are exposed to gunfire, improvised explosions, serious injury, kidnappings, and deaths. The U.S. government has programs in place to assist noncombatant military members during and after deployment; however, the contractor is not authorized to use these programs. The objective was to analyze how contracting company managers could improve the future system provided to contractors in receiving short-term and long-term healthcare that may be needed because of injuries received during their employment in a combat zone. This chapter includes the background of the study, the problem and purpose statements, the research questions and other related sections.

Background of the Study

Contractors have a long history of working with the U.S. military, dating back to the American Revolutionary War. However, it was not until the Vietnam War that the United States experienced the greatest use of contractors, leading to the coining of the term *war by contract* expressed by Francioni and Ronzitti (2011). Francioni and Ronzitti stated that during the Vietnam War the number of noncombatant military members to contractors, at its highest, was 8:1. Although this ratio of contractors seems dispiriting,

currently, contractors comprise more than 50% of personnel in areas like Afghanistan, and that percentage is currently rising due to the exodus of noncombatant military personnel.

In 2010, the Government Accountability Office (2012) stated there were roughly 100,000 contractors in Iraq. This number included approximately 25,000 Americans, 20,000 local nationals (LNs), and more than 50,000 third-country nationals (TCNs). Based on information provided by the U.S. Government Accountability Office (2012), the exact number of casualties, deaths, or injuries within this group is not known. The Government Accountability Office did not start keeping even minimal records until after 2003. Mooney, Knox, and Schacht (2015) found that an estimated 750 American contractors have been killed or injured during the war on terror. The Congressional Research Service (CRS; 2010) found that "The United States military casualty statistics for Operation New Dawn (OND), Operation Iraqi Freedom(OIF), and Operation Enduring Freedom(OEF) far exceed those of contractors; however, that does not speak to diminish their sacrifice or their commitment" (p. 1). The U.S. Department of Defense (DoD) increasingly relies on contractors to support operations in Iraq and Afghanistan. Figure 1 shows some of the major services provided by contractors.

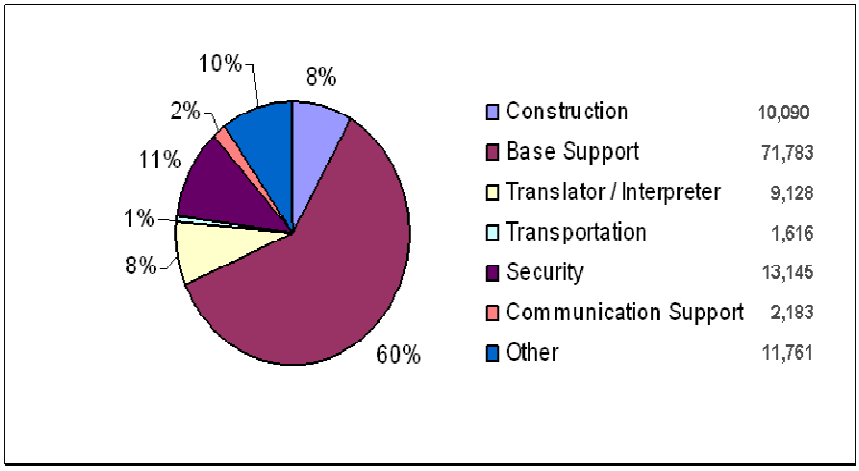

Figure 1. Breakdown by job performed by contractors in area of responsibility. *Note.* From *Iraq and Afghanistan: DOD, State, and USAID Face Continued Challenges in Tracking Contracts, Assistance Instruments, and Associated Personnel,* by Government Accountability Office, 2010b, Washington, DC: Author. Reprinted with permission.

Civilian workers who suffered injuries while supporting the U.S. war effort in Iraq and Afghanistan may come home to find it difficult to receive basic medical care, artificial limbs, psychological counseling, and other services. Francioni and Ronzitti (2011) found that unlike noncombatant military members and their families, contractors are not offered the services, support, and resources they may need following their deployment. There appears to be no universal healthcare assistance for contractors who return from war, and none for their families. Their research was important because many contractors are deployed to fill vacancies left by noncombatant military members. I defined noncombatant military members in Iraq or Afghanistan as military members performing personnel, truck drivers, computer operators, and administrative jobs roles. The Department of Labor (2013) suggested that the exact number of civilian contractors killed, injured, or hurt is not known; however, an estimated 7,000 civilian contractors

have been killed, wounded or, injured in the U.S. Central Command Area of Responsibility (USCENTCOM) Area of Operation (AOR) since early 2000. The DoL is the government agency in charge of collecting information about contractors.

Most of the doctrine for war-related assistance is focused on the military member and not the contractor. Rothbart, Korostelina, and Cherkaoui (2012) indicated that civilians working in a war zone are civilians at war. This new kind of war penetrates all fronts. Asymmetrical warfare battles are fought with uniformed soldiers fighting alongside civilians; this modeling expands the battlefield by removing any clear frontline in battle. Given the proximity of civilian contractors to hostile activity, they are just as likely to develop some form of physical or mental injury and are entitled to medical and mental assistance when needed.

Contractors working overseas in contingency operations and combat zones augment the noncombatant military members in certain career fields, such as logistics, motor movements, and customer-service-related services (Rothbart et al., 2012). Tirman (2011) explained that governments have always relied heavily on private initiative and enterprise to assist in filling those gaps during times of war. Before the Vietnam War officially started, contract companies, like Air America, performed support functions as well as aided small U.S. Military factions in training Vietnamese troops. In addition to aiding the U.S. Military, the Air America planes were also used to fly in economic assistance for French troops and peacekeepers in Indochina (Leeker, 2013). Most of these

contractors, working for Air America, came from the Special Operations and Central Intelligence Agency (CIA) communities.

During the twentieth and twenty-first centuries, there were four wars in which contractors were used, especially during the Vietnam War. During this time, technology and combat equipment became more advanced. During the Vietnam War, U.S. involvement at its peak included deployments of 500,000 contracted personnel. As the typical combat soldier had little or no specialized training on the equipment used, contractors were brought in to maintain the equipment for companies such as AT&T, General Electric, and Piper. During the current wars in Iraq and Afghanistan, contractors comprised more than 50% of the personnel on the ground (DoL, 2013). Kinsey and Patterson (2012) noted that contractors, in addition to having a 1 to 1 ratio with noncombatant military members, they maintained almost 30% of the weapons systems for the U.S. Military. With the present tempo of the U.S. military is deployed, contracting could have future growth potential. There is a continuing need for contractors as long as the U.S. government has military working abroad.

Federal law requires employers to provide temporary deployment medical insurance for workers in a war zone. In 1941, the United States developed the Defense Base Act (DBA) to care for civilian casualties of war. Dunigan, Farmer, Burns, Hawks, and Setodji (2013) found that the DBA mandates that all contractors working overseas under a U.S. government contract have access to workers' compensation insurance while deployed overseas and working on a contract. Tirman (2011) found that during the

twenty-first century more than 6 million civilians died because of wars, this number includes civilians killed because of collateral damage as well as those hired to directly support a combat mission. This is far more than the number of military causalities. This insurance is paid by American taxpayers, and built into contract costs and overseen by the U.S. Department of Labor. Francioni and Ronzitti (2011) explained that the DoL had over 700 claims were filed by American contractors, and over the next 5 years, the number of filings was well over 1,500. This number, although large, underrepresents the systemic number of American contractors who need or require information because they did not file a claim, seek medical assistance, or know how to do it. This number is based on the number of claims filed by relatives and does not represent all contractor fatalities. Francioni and Ronzitti explained that despite the availability of insurance, the issue of disability claims for contractors remains a subject of controversy. The system works because the insurance is mandatory for all government contractors, while they are deployed. Francioni and Ronzitti indicated that employers usually fulfill their responsibilities by buying DBA insurance for employees, however, once the contractors leave the combat zone and redeploy this insurance is no longer provided. If the contractor needs healthcare for injuries sustained in the war zone or dies, then a claim can be made even if the injury did not occur in the performance of duties. Benefits can include disability compensation, medical treatment, vocational rehabilitation, and death benefits. Table 1 shows the categories of personnel in the USCENTCOM AOR.

Table 1

Department of Defense 2009 Total Contract Personnel by Area of Responsibility

	Total contractors	U.S. citizens	Third country nationals	Local/host country nationals
Iraq only	119,706	31,541	56,125	32,040
Afghanistan only	73,968	10,036	11,806	51,126
Other USCENTCOM locations	50,061	9,381	35,053	5,627
USCENTCOM AOR Total Number	243,735	50,958	102,984	89,793

Note. From *Congressional Research Services, Department of Defense Contractors in Afghanistan and Iraq: Background and Analysis*, by M. Schwartz, 2011, p. 409. Reprinted with permission.

Combat is probably the most intense stressor known to human beings. Stress disorders have been a significant health feature of major wars (Seahorn & Seahorn, 2016). The most common stress disorder of returning noncombatant military members has been labeled as post traumatic stress disorder (PTSD), which is defined as a mental health disorder in which the nervous system and brain functions are altered to an extent that the person has painful memories, nightmares, and feeling *on guard*, avoids certain situations, and has physical difficulties, depression, and emotional numbing. Seahorn and Seahorn (2016) explained that stress disorders develop when the participant is exposed to events beyond those that are normally expected. This explanation can be developed by all noncombatant military members and contractors on the battlefield because both are thrust

into chaos while deployed to Iraq or Afghanistan and both are in noncombat roles while deployed. Rothbart et al. (2012) explained the principle of proportionality, stating that life and death decisions often rest on the nebulous issue of interpreting military advantage and the expected harm to civilians.

Although many contractors work alongside their noncombatant military counterparts, they are not eligible for treatment by the Veterans Administration (VA) or other military healthcare systems. Rothbart et al. (2012) found that symptoms are similar to those of the noncombatant military members; however, treatment and access to treatment is not. Contractors are as likely to seek assistance for healthcare related issues and need to have access to treatment and information if needed (Rothbart et al., 2012). Contractor company managers may not require routine screening for their employees, and many serious conditions are undiagnosed because of the limited number of professionals in the private sector trained to deal with combat stress disorder (Rothbart et al., 2012). Little research has been conducted about healthcare in a combat zone and contractors who have worked for the U.S. military. Study of the long-term healthcare needs of these civilians is needed.

Problem Statement

The treatment for noncombatant military members returning from war is a historical problem as militaries throughout the world have been dealing with this issue for hundreds of years. However, for contractors, there is no formal system in place for assistance when they return from combat zones. During this study, the information

government managers gave to noncombatant military members was compared to information managers made available to contractors pertaining to treatment for short-term and long-term healthcare, if needed. Specifically, 10 contractor company managers and 10 government managers who deployed contractors to Iraq or Afghanistan for a minimum of 365 days were asked for company documentation provided to contractors employed overseas in a combat zone. Additionally, information from interview questions were used to determine the extent of the information that was provided to contractors. In summary, the general problem that guided this study was the system for providing long-term healthcare for American contractors who are serving in a foreign combat zone is either minimal or nonexistence. The specific problem was that contractors leave the combat zone and may not have access to healthcare for treatment for conditions acquired while deployed with the U.S. military in a combat zone.

Purpose of the Study

The purpose of this qualitative case study was to explore ways that contractor company managers and government managers can improve management practices to provide a system for long-term healthcare for contractor personnel in the future. The objective was to analyze how contractor company managers could improve the system provided to contractors in receiving short-term and long-term healthcare. A case study approach was used to better understand the inequalities in current practices of the DoD and private contracting companies. Research used in this qualitative case study was conducted by gathering documentation and asking structured interview questions of

participants. There was no special coding scale used for this qualitative case study. The objective of qualitative case study research is to dig deep by looking for explanations to gain an understanding of the phenomenon through multiple data sources, using a method called triangulation. Babbie (2013) found that case study findings are strengthened by the convergence of information from a variety of sources and providing multiple measures of the same phenomenon. I attempted to gather the information by exploring multiple avenues to bring awareness of the issues facing contractors with the hope that contract company management will work with the DoD managers to provide more healthcare and assistance to their contractor employees in the future.

Research Questions

The general research question that guided this study was:

> How can contractor managers and government managers provide their future contractors with long term healthcare after deployment to a foreign combat zone?

The specific research questions that guided this study was:

> RQ1. How can the information that contractor managers and government managers provide be improved to ensure that contractors understand their options for healthcare after leaving the company?
>
> RQ2: What are the barriers that contractor managers and government managers may face in trying to provide for long-term healthcare for their contractors after they leave their companies?

RQ3.What are possible solutions that contractor managers can incorporate to ensure that healthcare can be made available to contractors after leaving their companies?

Conceptual Framework

Self-Efficacy

I used Bandura's self-efficacy theory and Kolb's experiential learning theory to formulate the conceptual framework for this study. Bandura (1977) introduced self-efficacy as a key component in social cognitive theory, contemplating that human motivation is based on outcome expectations. Bandura (1997) sought to measure it using a *task-specific scale*; predicting it would play a bigger role because the type of outcomes people anticipate, depending largely on their judgment of how well they will be able to perform in each situation. Bandura defined self-efficacy as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave (Bandura, 1997). The focus of this study was social equality relating to the difference in how contractor management teams provided healthcare to their employees compared to military managers managing healthcare to noncombatant military members. Contractors, even under good circumstances, share many experiences with soldiers. Most contractors in Iraq and Afghanistan live and work in conditions not markedly different from those of noncombatant military members.

After returning, noncombatant military members have multiple outlets, if needed, for addressing healthcare-related issues, such as rehabilitation for physical handicaps, counseling primarily at a VA or military hospital, and wounded warrior programs. Contractors have no such systems in place and are not authorized to use any of the facilities or services provided to the military member. Perhaps using Bandura's self-efficacy theory will help the contractor managers in identifying the key points of research and assist future employees in receiving short-term and long-term healthcare, if needed. The interview questions mentioned earlier in the chapter identified above ask very specific questions aiming to gauge whether contractors receive pertinent information from their managers, and if not, whether they know where to get it.

Self-efficacy describes a broad and stable sense of personal competence to deal effectively with the outcome expectancy in a variety of stressful situations. Bandura (1997) wrote there are four major sources of self-efficacy, outcome expectancy, that influence personal competence. The first source for influencing personal competence can be enhanced through personal accomplishment. Bandura (1997) defined self-efficacy as past successes or failures. These experiences form expectations that are generalized to other situation that may be similar or substantially different from the original experience. For example, failure is the leading factor of reduced efficacy expectations. In addition, strong efficacy expectations are established through the repeated success of a behavior. Bandura (1997) explained that a person could increase personal mastery for a behavior through participant modeling, performance exposure, self-instructed performance, and

performance desensitization, the process through which aversive behavior is paired with a pleasant or relaxing experience.

The second source of self-efficacy is through vicarious experience. In 1997, Bandura's study of self-efficacy indicated that vicarious experience is enhanced through live modeling or symbolic modeling. Vicarious experience may be particularly effective in raising self-efficacy in situations where the individual has no prior experience on which to base judgments of capability. For example, students observing a model successfully perform in a threatening situation are more likely to develop an expectation that they can acquire the same skill. The learners can imitate their skills or copy the strategies that they are using.

The third source of self-efficacy is known as a symbolic experience through verbal persuasion by others. Bandura (1997) defined this as a person's belief that they can successfully accomplish a task or behavior using suggestion, exhortation, or self-instruction. Verbal persuasion is often used to influence perceived capabilities, especially in the context of rehabilitation. For example, people who are internally oriented believe persuasive information may have the greatest impact on their action, which can produce the required effects of an outcome. However, Bandura, verbal persuasion is not grounded in personal experience, it is a weaker inducer of efficacy and may be extinguished by histories of past failures.

The fourth source of self-efficacy is known as emotional arousal. Bandura (1997) explained that this occurs when a person experiences stress in a threatening situation and

feels incapable of mastering or developing a coping mechanism. For example, millions of people are afraid of going to the dentist and associate it with intense pain and stress. In this case, emotional arousal affects self-efficacy, and self-efficacy affects decisions people make. Bandura also stated that emotional state improves, that is, emotional arousal or stress has reduced, a change in self-efficacy can be expected. Emotional arousal can be mitigated with repeated symbolic exposure that allows people to practice dealing with stress, relaxation techniques, and symbolic desensitization. By using Bandura's self-efficacy model, perhaps managers of contracting companies can test how companies can provide healthcare to an employee who might need assistance or knows someone who needs assistance with healthcare related issues.

Experiential Learning Theory

Kolb's experiential learning theory (ELT), first introduced in 1971, is a holistic theory that defines learning as the major process of human adaptation involving the whole person (Kolb, 2014). ELT is applicable not only in the formal education classroom but also in all areas of life. Kolb (2014) indicated that it is not surprising to see that experiential learning theory research is highly interdisciplinary, addressing learning and educational issues in many fields. The ELT has been used in management to describe the management process as a process of learning by managers, teams and organizations for problem solving and decision making, entrepreneurial opportunity seeking and strategy formulation. By applying this theory to contractor company managers, perhaps a better healthcare system to support future contractors returning who may need assistance with

healthcare related issues can be designed. Although learning from experience is recognized as important for the development of managers, Kolb indicated that work experience is a primary source of manager development. Since the war started over 10 years ago, there seems to be some disparity between the systems that managers for noncombatant military members have in place compared to the systems that contractor company managers have in place for contractors working for them in a combat zone. ELT is an adult learning theory that highlights the critical role experience plays in learning and changing. ELT has been identified as one of the most influential and pervasive models in managing learning today (Kolb, 2014). Kolb has proposed a four stage model, which consist of the following four states of experiential learning: concrete experience, reflective observation, abstract conceptualization, and active experimentation.

Concrete experience is the first stage and begins by doing something in which the individual, team or organization are assigned a task. The key to this learning stage is active involvement. The second stage in the model is reflective observation which means to take time out from doing and stepping back from the task and reviewing what has been done and experienced. At this stage, questions are asked and communication channels are opened to members of the team. The third stage is abstract conceptualization which is the process of making sense of what has happened and involves interpreting the events and understanding the relationship between them. This is the stage where learning makes comparisons between what they have done, reflect upon and what they already know.

The fourth and final stage is active experimentation, at this stage learners consider how they are going to put into practice what they have learned. Planning enables taking a new understanding and translates it into predictions as to what will happen next or what actions should be taken to refine or revise the way a task is to be handled (Kolb, 2014).

Kolb explained that different people naturally prefer a certain single learning style. Various factors influence a person's preferred style. Kolb (2014) explained that the propensity to reconcile and successfully integrate the four different learning styles improves as people mature through their development states. Perhaps using this theory is very beneficial because as the U.S. is decreasing the number of troops and increasing the number of contractors, managers of those contractors will need to develop a new methodology in dealing with physical and mental health issue as they appear.

Nature of the Study

This case study was qualitative in nature. Yin (2014) defined qualitative research as a form of systematic empirical inquiry into meaning. A case study design was used to compare the deployment documents and information given to noncombatant military members to the information given to contractors by their contractor company managers. This qualitative case study involved 10 contractor company managers, 10 government managers, and their experiences with disseminating information to contractors providing healthcare related issues.

There are many advantages to using a qualitative methodology approach for this study. Case studies can be flexible; researchers can select a topic and decide the

boundaries of the topic, depending on the extent of their research topic (Babbie, 2013). This topic fits well in that category; also, this type of study on this topic has not been conducted previously, which means it could be used as an independent study by some or as an element in a large-scale research design in the future (Yin, 2014). Although the nature of case study research can be a mix of qualitative or quantitative methods, a qualitative methodology best fits these criteria. This study was conducted to understand the social effect of getting insufficient assistance for civilian veterans; and the case study does not meet the statistical significance inherent with quantitative studies due largely to a larger randomly selected group (Johnson & Christensen, 2012), which makes the qualitative research methodology the better choice.

The rationale for this choice of research methodology is due in part to irregularity between the information provided to contractors from their contractor company managers compared to what noncombatant military members receive; the commonality is that both served in a combat zone. However, after returning from war, contractors usually leave the company that deployed them overseas. Subsequently losing contact with their management team, this leads to having limited or no access to healthcare. The viewpoint of the researcher in a dynamic situation is to address social and personal issues with the most common research objective being to explore the breadth and depth of the phenomena (Lichtman, 2012). During this case study, an attempt was made to address these irregularities.

Definition of Terms

AT&T: AT&T is a global networking leader, focused on delivering IP-based solution to enterprise and government customers (AT&T, 2013). This definition is relevant to my study because I am showing how the government relies on companies like these and the contractors that work for this company.

Central Intelligence Agency (CIA): An independent U.S. government agency responsible for coordinating the nation's intelligence activities and correlating evaluating and disseminating intelligence affecting national security (CIA, 2007).

Combat-operational stress reaction (COSR): The adverse reaction personnel may experience when exposed to combat or combat-like situations (U.S. Department of Veterans Affairs, 2014).

Congressional Research Services (CRS): The public policy research arm of the U.S. Congress (CRS, 2011, p. 1).

Department of Defense (DoD): The federal department responsible for safeguarding national security of the United States since 1947 (U.S. Department of Veterans Affairs, 2014).

Government Accountability Office (GAO): The U.S. Government Accountability Office (GAO) is an independent, nonpartisan agency that works for Congress (GAO, 2012a, p. 1).

Human resources (HR): The function in an organization that focuses on recruitment, management, and the direction of the people in the organization (Quran, 2012).

Local nationals (LN): A term used to define nonmigrating workers and referring to individuals who are working or applying for work in their native country (GAO, 2012, p. 12).

National Institute of Mental Health (NIMH): The largest scientific organization in the world dedicated to research focused on the understanding, treatment, and prevention of mental disorders through research (NIMH, 2013).

Operation Enduring Freedom (*OEF)*: Refers to the current war in Afghanistan (U.S. Department of Veterans Affairs, 2014).

Operation Iraqi Freedom (*OIF):* Refers to the current war in Iraq (U.S. Department of Veterans Affairs, 2014).

Post traumatic stress disorder (PTSD): A common stress disorder. The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association APA, 2000) specified that it develops after exposure to terrifying events or ordeals in which physical harm occurred or was threatened.

Synchronized predeployment and operational tracker (SPOT). A system set up by the Department of Defense to track contractors in Iraq and Afghanistan (Schwartz & Swain, 2011).

Third country national (TCN): A term often used in the context of migration, referring to individuals who are in transit or applying for visas in countries that are not their countries of origin (GAO, 2012, p. 13).

Veterans Health Administration: A branch of the U.S. federal government that deals with separated military members, also known as the Department of Veterans Affairs (Rothbart et al., 2012).

Veterans Administration (VA): A branch of the U.S. federal government that deals with separated military members from all branches (Rothbart et al., 2012).

Assumptions, Limitations, Scope, and Delimitations

Assumptions

I assumed that contractors who currently serve and will serve in Iraq or Afghanistan would desire information and direction on where to get information or help with healthcare related issues if needed. I assumed that the participants responded honestly to interview questions. To ensure contractor company managers would give honest answers, anonymity was provided by me to hide their names, address, and any identifying information from the public. Further, I assumed that documentation requested from contractor companies and the DoD was readily available or accessible.

Limitations

As with any research, there were limitations to this study. First, getting contractor company managers to speak to me, as some could have been reluctant to divulge information that might be harmful or cause discredit to their organization. Second, it may be difficult to get individuals to communicate and not be biased about the companies they work for while deploying contractors to Iraq or Afghanistan. Some may have felt ousted and had disdain for the organization, seeing the organization as the enemy. Another

limitation mentioned was the deployment manuals or documentation having access to this information may take some time and or the information may be misplaced. However, a significant limitation that would have affected the research was the lack of research available on contractors in war.

To offset the limitations, I did not rely solely on HR deployment manuals but also used responses to interview questions from contractor company managers and government managers. Byrman (2012) wrote that using multiple methods for collection of data in research makes studies "more complete and informative" (p. 8). The interview questions used were open-ended structured for a qualitative research study. Bryman indicated that the aim of these types of questions is for all interviewees to be given the same context of questions. The primary strengths of structured interviews are that the researcher has control over the topics and the format of the interview.

Scope

I contacted enough contractor managers and government managers so that at least 10 from each sector would agree to participate. These managers must have deployed contractors to Iraq or Afghanistan for a minimum of 365 days. Once approved, the participants were contacted using the World Wide Web and sent an e-mail asking to speak to them, explaining the type of research being conducted, and the reason why. After the participants agreed to speak with me, I then asked the contractor managers for a copy of the deployment documentation they gave to contractors before they deployed them to Iraq or Afghanistan. The second source of deployment documents on

noncombatant military members was from different sources ranging from DoD supported organizations, such as chaplain services, wounded-warriors program, or deployment facilities located on DoD installations. In addition to, deployment documentation, I also conducted interviews with the 10 contractor managers and 10 government managers using semistructured interview questions. The additional step gives the research redundancy and validate information provided by the deployment documentation.

Delimitations

Delimitations are boundaries that researchers set for the study (Denzin & Lincoln, 2012). The scope of my study was limited to participants, both men and women, both, contractor managers and government managers, who deployed to Iraq or Afghanistan for a minimum of 365 days. Though the contractors companies and government agencies have managers who have deployed to Iraq or Afghanistan, I limited the interviews to managers who met the criteria of being deployed for 365 days. The prerequisites of this study excluded contractors managers who did not deploy contractors to Iraq or Afghanistan for 365 days and government managers who did not have oversite of contractors deployment to Iraq or Afghanistan for 365 days.

Significance of the Study

Significance to Theory

A theory is a set of interrelated concepts, definitions, and propositions that explains or predicts events or situations by specifying relations among variables. Past studies conducted on military members and healthcare related issues have led to

numerous studies and treatments. Studies on the lasting effects of war on contractors and the issue they could face with healthcare related issues have been anecdotal at best. Combat exposure in Iraq and Afghanistan is associated with increased risk of developing a stress disorders issues and elevated use healthcare services during the postdeployment period. Theories provide complex and comprehensive conceptual understanding into situations of this nature that cannot be pinned down: how societies work, how organizations operate, why people act a certain way (Lichtman, 2012). Current conflicts around the globe have noncombatant military members and contractors working side by side. Contractor company managers may need to get treatment for their contractors, who may need treatment, have limited documentation regarding their health conditions, and they may lack the ability to get adequate treatment for war related injuries. By using theories, researchers can use different *lenses* through which to look at complicated problems and social issues, focusing their attention on different aspects of the data and providing a framework within which to conduct their analysis. Good theory based research is immediate, insightful, and applicable in practice.

Significance to Practice

This study could offer researchers with increased opportunities to review the system in place or create a system for contractors similar to that given to noncombatant military members. It is important to note that much of the literature available only study the effects of war on military members. It is also important to note that the average deployment to Iraq and Afghanistan is 12 months for both noncombatant military

members and contractors. However, noncombatant military members are given extensive coping training, spiritual guidance, and combat training ranging from weeks to months before being deployed; the contractor is not afforded the same training or the same timeline. Further research into the effects of war on noncombatants, in this case, contractors, is necessary to understand the entirety of healthcare needs, stress disorders, and war-related issues. A better understanding of what contractors need after returning is necessary to facilitate procedural change to create or improve a system for them.

Significance to Social Change

This study could contribute to the literary body of knowledge because no such system for contractors is currently available. Contractors returning home from war are not authorized to receive assistance from the federal government, which is the branches of the government that deal with returning military members; they are directed to the civilian sectors for treatment. This study could launch additional research on this topic. Examining this issue now may be more important than in recent history; research fueled by the study could help promote the development of documentation, treatment facilities and possibly new processes and management practices in support of contractors returning from combat zones.

Summary

The Vietnam War and the psychological and emotional effects it had on soldiers who returned was instrumental in bringing awareness of the diagnosis of war related healthcare (Department of Veterans affairs 2011). War-related healthcare has been

mainly focused on U.S. soldiers. Cozza, Goldenberg, and Ursano (2014) found that civilians in a combat zone also experience traumatization. An immense amount of information has been published about healthcare related stress disorders; however, very little has been published about the effects of healthcare related stress disorders and the effect that war has on contractors participating in a war zone like Iraq or Afghanistan and the treatment available to them. Rothbart et al. (2012) indicated that personal risks and fear for one's safety and that of a friend keep individuals in a survivor mode. War-related stress is a result of being in a violence situation and witnessing death both become a source of traumatic stress for those trying to survive war (Rothbart et al., 2012). Noncombatant contractors and noncombatant military members can experience this stress, not just noncombatant military members. Rothbart et al. found that in war, everyone experiences traumatization, including civilians. There has been a lack of research into healthcare, war related stress, treatment, and documentation of these problems for contractors. Francioni and Ronzitti (2011) indicated that this activity highlights the need for a more effective healthcare system, better training for professionals who treat healthcare related issues and more accessible for people who may require healthcare related counseling. Because the current U.S. Military is quite active and capabilities limited, the need for contractors will continue.

Chapter 2 is a review of the literature related to the history of healthcare related issues, how they affect noncombatant military members, and the difference in treatment made available by contractor company managers and government managers to

contractors compared to that of noncombatant military members. Chapter 3 is an explanation of the methodology used to gather original data.

Chapter 2: Literature Review

This chapter includes the two theoretical frameworks and establishes a clear understanding of healthcare related issues and attempt to explain how war related issues related to contractor company managers and the system for assistance for the contractors working for them in combat zones. This literature review provided a broad and deeper understanding of the current process that noncombatant military members experience in getting healthcare assistance if needed, and it showed the inequalities in the system available to contractors. This chapter included a brief history of healthcare needs for stress disorders, as well as how this illness relates to civilian contractors. In this chapter, a critical review of relevant literature about the treatment made available by contractor company managers and government managers to contractors compared to what is provided to noncombatant military members was presented. Rothbart et al. (2012) stated that studies regarding war related stress experienced by civilian contractors are infrequent and should be at the forefront of the U.S. government agenda. The infrequency of healthcare related issues studies is due to the unexpected exposure many believe that contractors experience in contrast to what noncombatant military members experience.

Search Strategy

I gathered data using EBSCO*host* databases, PsycINFO, and PsycARTICLES, from the Walden University Library. A variety of key phrases related to the topic, including *war*, *history of war*, *Vietnam War*, and *contractors in war*, were used to search these databases, using peer-reviewed articles in consistent parameters. Additional

resources included web searches using Google scholar, Google book, text reviews, and access to the Hillsborough County Library. Additionally, books on the history of PTSD, the current *war in Iraq and Afghanistan*, and its relationship to PTSD were used.

Conceptual Framework

Self-Efficacy

The conceptual framework that supports this qualitative study draws on two different theories, self-efficacy and experiential learning theory (ELT). There is a growing body of evidence that human accomplishments and positive well-being require an optimistic sense of efficacy. Bandura (1977) introduced self-efficacy, theorizing that self-efficacy was a component in social-cognitive theory that influences expected outcomes of behavior, also known as outcome expectation. Outcome expectation is defined as a person's estimate that a given behavior will lead to certain outcomes. Self-efficacy theory states that outcome expectancies are clearly distinguished from self-efficacy because self-efficacy is one's perceived ability to do a behavior; whereas outcome expectancies are judgments about the likelihood of outcome that flow from behavior Bandura (1997). Self-beliefs of efficacy plays a major role in the self-regulation of one's motivations. Human motivation is cognitively generated; people motivate themselves and guide their actions anticipatorily by the exercise of forethought. Bandura hypothesized that motivation was affected by self-efficacy and outcome expectations, and suggested that self-efficacy would play a larger role because the types of outcomes people anticipate depend largely on their judgments of how well they will be able to

perform in given situations. Self-efficacy theory fundamental influences outcome expectancies, but not the other way around.

During the last 2 decades, self-efficacy has been tested in a wide variety of disciplines and setting. Broad application of self-efficacy makes it quite useful across various domains of behavior, becoming a popular choice in contemporary motivation research (Sensing, 2011). Self-efficacy has also been used in educational research dealing with academic motivation and self-regulation (Sensing, 2011). In education, Sensing explained that self-efficacy focused on three areas:

1. Linking college majors and career choice.
2. The belief that teachers' instructional practices are linked to various student outcomes.
3. Students' self-efficacy beliefs are correlated with other motivation constructs in addition to academic performance and achievements.

Self-efficacy beliefs have also been used to identify clinical problems such as phobias; depression; assertiveness; and stress in a variety of contexts. Sensing (2011) stated that individuals possess a self-system that enables them to exercise a measure of control over their thoughts, feelings, motivations, and actions. This self-system provides reference mechanisms and a set of subfunctions for perceiving, regulating, and evaluating behavior.

Self-efficacy, as it relates to this qualitative study, is more about the physiological states of the person. The person who is suffering from a traumatic event can develop

symptoms such as, anxiety, stress, arousal, and fatigue. A traumatic event is not an isolated transient event; for example, a potential loss of life or physical injuries present pervasive and prolonged stressors and can lead to physical and mental health issues. Self-efficacy plays a key role in stress reactions and quality of coping in threatening situations Bandura (1997). The psychosocial fallout that military members experience after war has been the subject of special attention through the years because of the prevalence and enduring seriousness of war and the emotional and physical damage that can occur. However, little or no research has been done for the noncombatant contractors. Seahorn and Seahorn (2016) stated that the ravages of war take a toll on civilian populations, as well as on the combatants. Contractors have limited information from documentation and no structured system in place for assistance. Currently, the system in place for contractors is controlled by the U.S. Department of Labor. The information is clouded by bureaucratic red tape and is not standardization. It requires a resilient sense of efficacy to face such daunting problems and endure such hardships. Perhaps using this study could spark conversation between contract companies and the U.S. Military to create a system for future contractors returning from war that would emulate the systems available to military members.

Experiential Learning Theory

Experiential learning theory emphasizes how managers learn from experience. Nam, Cho, and Lee (2014) noted that the experiential learning theory is used to determine a process for creating knowledge. Developed by Kolb in 1971, much of the experiential

learning theory is concerned with the learner's internal cognitive processes. Kolb stated that learning involves the acquisition of abstract concepts that can be applied flexibly in a range of situations. In addition, experiential learning is a cycle of learning that starts with learners being involved in the experience. Several researchers have called experiential learning the *heart of higher ambitions* because this is where individuals learn from their experience. The experiential learning theory is a process where the individuals take the information and process the information to use it (Nam, Cho, & Lee, 2014). In applying this theory to cross-cultural training programs, managers may acquire knowledge and competency to deal with cross-cultural teams, which could be needed to develop a system for managing contractors returning from combat zones with issues and require assistance, if needed.

Research on experiential learning in management has highlighted ELT to describe the management process as a process of learning by managers, teams, and organizations for problem solving and decision making, entrepreneurial opportunity seeking and strategy formulation. It also has had a major influence on the design and conduct of educational programs in management training and development and formal management education. ELT integrates the work of the foundational experiential learning scholars around six propositions, which they all share:

1. Learning is best conceived as a process, not in terms of outcomes. To improve learning in higher education, the primary focus should be on engaging students in

a process that best enhances their learning, a process that includes feedback on the effectiveness of their learning efforts.

2. All learning is relearning. Learning is best facilitated by a process that draws out the students' beliefs and ideas about a topic so that they can be examined, tested and integrated with new, more refined ideas.
3. Learning requires the resolution of conflicts between dialectically opposed modes of adaptation to the world. Conflict, differences, and disagreement are what drive the learning process. In the process of learning one is called upon to move back and forth between opposing modes of reflection and action and feeling and thinking.
4. Learning is a holistic process of adaptation. It is not just the result of cognition but involves the integrated functioning of the total person. Thinking, feeling, perceiving and behaving. It encompasses other specialized models of adaptation from the scientific method to problems solving, decision making and creativity.
5. Learning results from synergetic transaction between the person and the environment. Stable and enduring patterns of human learning arise from consistent patterns of transaction between the individual and his or her environment. The way we process the possibilities of each new experience determines the range of choices and decisions we see. The choices and decisions we make to some extent determine the events we live through, and these events

influence our future choices. Thus, people create themselves through the choice of actual occasions they live through.

6. Learning is the process of creating knowledge. ELT proposes a constructivist theory of learning whereby social knowledge is created and recreated in the personal knowledge of the learning. This stands in contrast to the transmission model on which much current education practice is based where preexisting fixed ideas are transmitted to the learner. During experiential learning, one tries out strategies and procedures of an action theory, gets results and feedback, and then organizes present information and experiences into an action theory (Kolb 2014).

Experiential learning theory as it relates to this study is more about the state of the management team and training they receive. This theory can provide information on how cross cultural training programs can be applied to improve the effectiveness in managing cross cultural team or the creation of new methods of dealing with contractors and getting assistance for physical or mental health if needed.

Literature Review

History of Stress Disorder

Three thousand years ago, an Egyptian combat veteran, *Hori,* wrote about the feelings that soldiers experienced before going into battle. Seahorn and Seahorn (2016) explained that the emotions those men felt during that epic time are no different than what combat veterans feel today. The history of ancient battles in Egypt, Greece, and Rome provided not only accounts of victories but also accounts of those who broke away

from the fighting. These fighters were thought to be cowards, but may have had physical and mental health related issues. National Institute of Mental Health (NIMH) (2013) explained just as suicide, PTSD, and other healthcare related issues are noted in ancient sources, other symptoms of physical and mental health issues may be similarly detected.

The Swiss military was the first to identify the symptoms of what is now known as PTSD. The Swiss military originally label this reaction *nostalgia*, named so because of symptoms, including melancholy, incessant thinking of home, disturbed sleep, and fever. Different militaries called it different names: the Germans called it *heimweh* (homesickness), the French called it *maladie du pays* (illness of the country), and the Spanish named the illness *estar roto* (to be broken). French surgeons during this time described the disorder as having three different stages: heightened excitement, a period of fever, and frustration (Shay, 2010). During the war between Russia and Japan in the early 1900s, the Russian military identified war because of stress and deemed what is now called PTSD a legitimate medical condition (Seahorn & Seahorn, 2016). PTSD is the dominant term used to describe this medical condition today.

During the U.S. Civil War, in which more than 450,000 Americans lost their lives, PTSD was termed cardiac neurosis, nervous heart, and neurocirculatory asthenia, and eventually, soldiers' irritable heart. Doctors noticed soldiers exhibiting symptoms of shortness of breath with a dull aching chest pain and dizzy spells, combined with nausea and diarrhea. During World War I (1914–1918), the term *shell shock* emerged; soldiers showed increased dizziness and deafness because of the introduction of larger cannons on

the battlefield. During this war, many who did not fight were labeled malingerers. Later, the U.S. Military realized these soldiers were incapable of movement, paralyzed by panic and an overwhelming sense of fear because of intense fighting. Most diagnoses of shell shock were recanted by military doctors, stating that those soldiers were not in range of large canons or exploding artillery. These soldiers were consequently diagnosed with war neurosis (Seahorn & Seahorn, 2016). Today names like neurosis and combat stress have been replaced with PTSD by the United States of American and most western countries.

Seahorn and Seahorn (2016) stated during World War II, more soldiers were discharged for *battle fatigue* than during the Civil War and WWI combined. Seahorn and Seahorn (2016) indicated that this term was later referred to as a *traumatic neurosis*. Seahorn and Seahorn (2016) wrote that battle fatigue was the successor to shellshock, and was caused by four combined elements: sudden exposure, cumulative exposure, physical stressors, and home-front issues. The symptoms and diagnoses were nearly identical to those found in soldiers in the Civil War and WWI. Individuals experienced depression, memory loss, and poor motivation.

During the Vietnam War, these symptoms received significant public attention and were diagnosed as post-vietnam syndrome because of the delayed symptoms former soldiers exhibited, which ranged from depression to anger. Vietnam veterans who suffered from this disorder pushed the military medical community and the VA to recognize post-Vietnam syndrome as a legitimate disorder. In 1987, the American Psychiatric Association (APA) officially recognized PTSD as an illness, which led to the

development of several effective treatments for this unique stress disorder (Rothbart, Korostelina, & Cherkaoui, 2012). The treatments for PTSD developed over the last 30 years are still widely used today.

Stress Disorder Today

Stress disorder is defined as an emotional illness that develops when a person is exposed to a highly dangerous, terrifying, and possibly life-threatening event. These events range from military actions to terrorist incidents, serious accidents, or violent personal assaults (Rothbart, Korostelina, & Cherkaoui, 2012). Physical and mental health related issues can become chronic which could if left untreated become persist for a lifetime, with the onset of symptoms delayed for months and sometimes years. Certain forms of mental health such as PTSD continues to be classified as a stress disorder. Stress disorder has only been diagnosed from a Western perspective, with little to no data from non-Western societies and cultures, with no data about contractors. The official diagnoses for mental health related stress disorders only come if a person has been exposed to a traumatic event.

Although PTSD has been the term for military members dating back to our first wars, it was not made officially a title until the late 1980s. *PTSD* did not appear as an official label until 1987 in the (DSM III) *Diagnostic and Statistical Manual of Mental Disorders* published by the (American Psychiatric Association, 2000). This information was updated in the *DSM-IV-TR* (APA, 2000) with the addition of more stressors, including a history of exposure, duration of symptoms, and functioning. This broadened

the definition but more updated criteria indicating that a person with persistent symptoms could be at risk for developing stress disorders. Figure 2 shows the criteria for PTSD.

DSM-IV Criteria for Post-Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) The person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

(2) Recurrent distressing dreams of the event.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated).

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) Inability to recall an important aspect of the trauma

(4) Markedly diminished interest or participation in significant activities

(5) Feeling of detachment or estrangement from others

(6) Restricted range of affect (e.g., unable to have loving feelings)

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Figure 2. Diagnostic and statistical manual of mental disorders criteria for post-traumatic stress disorder. Note. From Diagnostic and statistical manual of mental disorders (4th ed., Text rev.), by American Psychiatric Association, 2000. Washington, DC, Author. Reprinted with permission.

In addition, family members if burdened with the graphic effects of what their loved ones went through might be at risk for certain forms of stress disorders, commonly referred to as PTSD. The DSM-IV (American Psychiatric Association, 2000) also stated that if people learn that a family member or close friend has been injured or seriously hurt, they too might be at risk from stress disorders from a condition called secondary-stress syndrome. During more recent combat actions, OIF and OEF only 10% of returning veterans were diagnosed with having a mental health related stress disorders. Shiner (2011) stated that of the 10%, less than half of returning military members even sought assistance. Seahorn and Seahorn (2016) stated that prolong exposure to combat stress has produced high rates of veterans with mental health related stress disorder and other psychiatric disorders. Seahorn and Seahorn (2016) also found that from 2003 to 2008, 600,000 U.S. noncombatant military members returned from deployment to Iraq or Afghanistan. Based on the population at risk, if 15% of returning U.S. noncombatant military members will require healthcare services, Seahorn and Seahorn indicated that, in addition to an, estimated over 50,000 noncombatant military members requiring healthcare treatment. These factors are based on several criteria such as existing health issues, the location of the conflict, the politics surrounding the conflict, and the type and tenacity faced.

Combat-Operational Stress Reaction (COSR)

Since the start of these wars, the military has changed or adopted a new term in place of PTSD, combat-operational stress reaction (COSR). This term has sparked debate

from all branches of the military. The DoD initially called COSR combat-stress reaction, but other branches wanted the name changed mainly because service members could also experience stress during peacetime (e.g., during humanitarian assistance such as hurricane Katrina and the September 11, 2001, attack on the World Trade Center). The Department of the Army, DOA (2009) explained that combat and operational stress reaction is defined as" the adverse reactions personnel may experience when exposed to combat or combat-like situations" (p. 1). Historically, COSR has had a high rate of casualties in all wars over the past 100 years (DOA, 2009). The levels of intensity in which those conflicts were fought were essentially identical; however, the lethality of the modern conflicts is potentially greater and the way the conflicts are waged is more asymmetrical. Combat and operational stress was a reality of all military missions DOA (2009). Combat stressors are not limited to a singular incident, which has the potential to significantly affect the military members experiencing them; and they can range from multiple sources. Listed below are some examples of combat stressors and operational stressors.

Combat stressors:

1. Personal injury
2. Killing of combatants
3. Witnessing the death of an individual
4. Death of another unit member
5. Injury resulting in the loss of a limb

Operational stressors:

1. Prolonged exposure to extreme geographical environments such as desert heat or arctic cold.
2. Reduced quality of life and communication resources over an extended period of time.
3. Prolonged separation from significant support systems such as family separation.
4. Exposure to significant injuries over multiple missions such as witnessing the death of several military members over the course of a yearly rotation. (DOA, 2009)

Current research shows noncombatant military members continue to struggle with negative physical or mental health issues long after redeployment. Noncombatant military members surveyed in Iraq indicated that those who experienced a threat were most likely to screen positive for needing some form of healthcare, including stress disorders (DOA, 2009). Combat and operational stress reaction and stress disorders share common symptoms; however, COSR is recognizable immediately or shortly after exposure to traumatic events and captures any recognizable reaction resulting from exposure to that event or series of events DOA (2009). COSR has four general characteristics:

1. Emotional—hopelessness that will lead the service member to develop feelings of fear

2. Behavioral—acting on impulse with little to no care
3. Physical—nausea and vomiting, which in some cases leads to insomnia
4. Cognitive—difficulty concentrating and having nightmarish visions. (U.S. Army Public Health Command, 2013)

Posttraumatic stress disorder differs from COSR because of its specific chronological requirements and symptom markers that must be met to diagnose. Operational stress describes a range of possible outcomes along the continuum of stress reactions, which may be experienced weeks or even years after combat and operational stress exposure (DOA, 2009). Posttraumatic stress disorder is only diagnosable by a trained and credentialed healthcare provider.

Prevalence of Stress Disorder

Stress disorders can manifest after a person survives a traumatic event or a incident in which they believe themselves to be in significant danger. Many who survive car accidents, sexual assault, and the Holocaust reported having recurring nightmares or feelings about their stressful events. NIMH (2013) explained that a stress disorder has substantial social, human, and economic effects. These health disorders account for almost half the disability cases in the United States alone. The NIMH (2013) estimated that nearly 25 million adult Americans (roughly 13%) suffer from stress disorder, 10% exhibit depression disorder, and 1% show signs of or have been diagnosed with other mental health issues, schizophrenia, and bipolar disorder. Gender and social status also affect mental health. NIMH (2013) indicated that women are more likely to experience

stress and depression than men. Individuals diagnosed with a mental illness are likely to be single, divorced, work in low-income jobs, or be jobless. The NIMH (2013) statistics on the prevalence of stress disorder for the populace follows:

1. Seventy percent of Americas have experienced a traumatic event at least one in their life with 20% of those developing stress disorder.
2. Five percent of that populace develop and live with stress disorder.
3. One in 13 or 8% of Americans will develop a stress disorder.
4. Less than 20% men and more than 10% of women have had three traumatic events in their lifetime.

The mean for all types of traumatic experiences estimated for lifetime prevalence of stress disorder was 7.8% (see Table 2).

Table 2
Rates of Post-Traumatic Stress Disorder in the General Population: National Comorbidity Study

	Males	Females
One lifetime incident	60.7%	51.2%
Four or more incidents	10.0%	6.0%
Lifetime rates of PTSD	7.8%	7.8%

Note. From *Home,* National Institute of Mental Health, 2009, Bethesda, MD: Author. Reprinted with permission.

The NIMH has information relating to multiple causes for developing a stress disorder or any related stress disorder. The NIMH (2009) stated that the demographics for those at risk range from survivors of rape or school violence to survivors of unexpected events in daily life, such as terrorist acts or those diagnosed with a life-threatening illness.

Stress disorder has no boundaries and can affect anyone including noncombatant military members, spouses of noncombatant military members, and contractors. Those who develop stress disorder can have limited symptoms and can be treated and resolved by the individual themselves; others, NIMH (2013) indicated will need and should seek professional assistance. The Department of Veterans Affairs (2014) explained that coping means accepting the effect of trauma and acting to change. Coping comes in the form of positive and negative. Positive coping mechanisms are: learning about trauma, talking to others for support, talking to your doctor, and distracting yourself with positive activities. Negative coping methods are: substance abuse, avoiding others, staying always on guard, and anger. The definition of stress disorder was not well known until after the Vietnam War and especially the National Vietnam Veterans Readjustment Study (*NVVRS)* (Seahorn & Seahorn, 2016). Defining healthcare needs for many types of disorders was a major win. NIMH (2013) explained that the key to beating the illness will be identifying early, then treatments, and eventually living a productive life.

Diagnosis of Stress Disorder

Stress Related Disorders have had multiple mislabeling, mistreatments, and a lot of misunderstanding about them. Stress disorders, such as PTSD was first codified in *DSM-III* as a formal diagnosis to identify individuals who had experienced extreme stressors *especially in combat* and were more than transiently (e.g., at least 1 month) troubled by stress associated with those stressor exposures (NIMH, 2009). The effects of psychological trauma, a precursor to stress disorders have been noted throughout history

and intermittently have been a focus for mental health professional (Seahorn & Seahorn, 2016). Stress disorders in the same context have been the focal point in many discussions about trauma and have had substantial utility and heuristic value as the central construct in the field of traumatic stress. Tsuang, Mauricio, and Jones (2011) explained:

> Most of the conversation deals with the nature of trauma and the unique effects; extensive revision of the diagnostic criteria; poorly defined and overlapping symptom criteria; high rates of comorbidity and concerns regarding differential diagnosis; lack of an objective, definitive tests or biological marker; overreliance on retrospective self-report; and concerns about response bias, especially the potential for symptom exaggeration or malingering. (p. 24)

Stress related disorders are complex, often chronic and debilitating mental disorder that develops in response to catastrophic life events such as combat. Maestas et al., (2011) stated the core stress related disorders syndrome involves 17 symptoms in three symptom clusters: re-experiencing the trauma (Criterion A), avoidance (Criterion B), numbing (Criterion C), and hyperarousal (Criterion D). Duration of at least one month (Criterion E); and clinically significant distress or impairment in social or occupational functioning (Criterion F) were added to the definition. Stress disorders are multifaceted disorders that manifest in cognitive, affective, behavioral, and physiological response channels. Seahorn and Seahorn (2016) explained that in the most severe form, of stress disorder can disrupt virtually every aspect of normal functioning and presents multiple targets for assessment and intervention.

Establishing a diagnosis involves adherence to *DSM-IV-TR* (America Psychiatric Association, 2000) guidelines and diagnoses. The current *DSM-IV-TR* (APA, 2000) has limitations in its approach mechanisms, such as categorical versus dimensional classifications, and limitations of the mental health disorders criteria specifically. Although these shortcomings are valid, (Seahorn & Seahorn, 2016) wrote that the current classification represents the current official conceptualization of mental health disorders and should be followed closely to maintain a consistent operational definition of the constructs throughout the field of traumatic stress. There are ample resources available to assess mental health issues. U.S. Department of Veterans Affairs (2012) explained that during the last 20 years, we have started to use standardized measurement; this was lacking before in most published studies and certainly absent in many clinical settings. Standardized measurements are now strongly recommended for clinical work. This practice has been welcomed because of the advances in the measurement of trauma and stress disorders and existing measures have been extensively validated and improved (Seahorn & Seahorn, 2016). One of the more prominent measurements used for assessing mental health is the training given to clinical staff to incorporate evidence-based measures into routine assessments and treatment activities.

The National Vietnam Veterans Readjustment Study

Most of the studies related to mental health were based on Vietnam-era veterans who fought in the Vietnam War between 1964 and 1975. In the early 1980s, Seahorn and Seahorn (2016) indicated that Congress was mandated to investigate mental health

disorders and other postwar psychological problems occurring with Vietnam veterans. The purpose of the study was to assess the commonality of mental health disorders in returning Vietnam veterans. The assessment of mental health was conducted using a multitier-methodology approach, self-report, and clinical interviews, to study representative national samples of Vietnam veterans and their peers.

The results of the study showed a shocking recurrence of Vietnam-theater veterans suffering from a variety of psychological problems and experiencing a wide range of life-adjustment problems at work, socially, and in marital problems. The NVVRS reported 30.9% of all men who served in that conflict developed a mental health disorder, even though only about 15% had been assigned to combat units (NIMH, 2009). The finding in the NVVRS also found that, in addition to the 30.9% with a mental health disorder, another 22.5% developed a partial mental health disorder. The NVVRS calculated that 53.4% of all male Vietnam veterans had developed either a full or a partial mental health, which means that of the 500,000 men who served, more than 250,000 may have developed a mental health disorder (Kulka et al., 1990a).

NVVRS data revealed that higher levels of war-zone exposure tended to contribute to more depression, stress, and emotional symptoms. Shay (2010) explained that:

> The Vietnam War was especially traumatogenic because: (a) the war was unpopular, (b) leadership was poorly trained, (c) distinguishing between friend or

foe was difficult in a guerrilla war without clear boundaries, (d) the military objectives were unclear, (e) atrocities were common, and (f) America lost.

Shay (2010) explained that several researchers have reanalyzed the data from the NVVRS which identified further prewar and war-zone stressor risk factors, as well as postwar resilience and recovery factors. This research has led to other surveys and studies like the National Comorbidity Survey (NCS).

National Comorbidity Survey

A person diagnosed with stress disorder may also be diagnosed with alcoholism, which is a mental illness this is known as comorbidity. Comorbidity is defined by Tsuang, Mauricio, and Jones (2011) as "having two or more diseases (conditions) existing in the same individual simultaneously" (p. 221). NIMH (2009) explained that many people addicted to drugs are also diagnosed with other disorders and these disorders could also be caused by shared risk factors such as overlapping genetic vulnerabilities, overlapping environmental triggers, and involvement of similar brain regions. First introduced by Feinstein (1970), comorbidity has drawn more attention because of the introduction of explicit descriptive, operational criteria for specific mental disorders and associated shifts of paradigms in psychopathological research. An ongoing controversy exists about which disorder to treat first if a person is diagnosed with both trauma and addiction (NIMH, 2013). Tsuang et al. (2011) wrote the NCS (1990) conducted a survey in the early 1990s, showing that "over 60% of men and less than that of women suffered from some type of exposure to a traumatic event in their life time"

(p. 223). During this study, several prevalent factors contributing to an event of stress were sexual assault *mostly reported by women*, combat exposure, natural disaster, and a life-threatening event. In addition, one can be at risk if someone they know is injured or fatally injured. In the proposed study, information for future treatment, ease of obtaining that information, and the involvement of the contracting companies and government agencies in providing this information for future combat-exposed contractors is the focal point used, and the population is 10 contractor company managers and 10 government managers, who deployed contractors to in Iraq or Afghanistan.

Combat-Related Stress Disorder

Further investigation into mental health disorders for WWII and Korean War veterans continued into the late 1950s. Shay (2010) reported a 10% prevalence of traumatic war neurosis in a series of 200 veterans studied. They noted that many had not sought treatment half a decade after the war ended. Shay (2010) explained that many from the Korean and Vietnam Wars did not seek assistance, partly due to cultural definitions of manhood and bravery, systemic issues with the availability of care, and because little or no information was given or known. Today more Korean and Vietnam veterans are being diagnosed and treated due largely to a better understanding of stress disorders.

Vietnam-era stress disorder was defined as a social problem that affected many military members. Seahorn and Seahorn (2016) explained that most of the thinking about the American veteran has been shaped by the image of the troubled and scorned Vietnam

veteran that has emerged over the past 30 years in the United States. The medical community, during this time, regarded Vietnam veterans as suffering lingering mental problems centering on what currently is called PTSD. Some reasons Vietnam veterans differed from veterans of past wars follow:

1. It involved guerrilla warfare, which meant it was difficult to distinguish the enemy from innocent civilians.
2. It lasted more than 10 years.
3. Soldiers had a short tour, which affected unit cohesion.
4. It involved a high number of drafted soldiers, many of whom protested against the war.

Of Vietnam veterans, approximately 11,000 women served, they too witnessed gruesome and upsetting scenes when they tended the wounds of soldiers returning from the front lines. Shay (2010) suggested that the women in Vietnam had it worst because they were never treated as returning warriors, but were simply forgotten. Today's female military combat veterans are receiving treated equal to their male counterparts.

During the Reagan administration, the notion of wartime stress disorders came into existence as an officially recognized psychiatric syndrome, Post-Vietnam Syndrome, became stress disorders. Studies into stress disorders varied in their approaches:

- Biological structural changes into the nervous system
- Cognitive or information processes
- Behaviorist conditioned responses

- Psychoanalytic internal conflict between oneself and society
- Developmental interaction war stress and early adult development

The U.S. Department of Veterans Affairs (2012) indicated that different approaches require different treatments for mental health issues. For combat-related mental health disorder, two treatments were developed:

1. *Cognitive processing therapy* helps one figure out what they are experiencing and tries to help them deal with those experiences. It has four main parts:
    - Learning about one's mental health symptoms—by educating the individual about the treatment, giving them a way to commit to the process.
    - Becoming aware of thoughts and feeling—helping the individual focus on the thoughts they are experiencing.
    - Learning skills—after informing and educating the individual, the treatment makes them more aware of their thoughts.
    - Understanding changes in beliefs—this final stage brings individuals closer to the experience and helps them find a balance between stress and trust issues.
2. *Prolonged exposure* works mainly with individuals who try to avoid their illness and or symptoms. It also has four functional areas for treatment:
    - Education—this key process helps the individual understand the goal of treatment and gives insight to the next step in treatment.

- Breathing—focusing on relaxing techniques, this skill can assist when an individual becomes overly anxious or afraid.
- Real-world practice—gives the individual, in a controlled environment an experience similar to the one they have been avoiding.
- Talking through the trauma—gives the person a way to talk through the trauma, thereby offering some control over the issue, which could lead to recovery.

Although considered effective if the disorder is caught early, the effectiveness of the treatment diminishes if a significant amount of time passes between when the trauma occurred and when counseling starts. Seahorn and Seahorn (2016) explained that people believe war-related stress disorder is a disease appearing out of the blue during the past 40 years. However, history tells us that mental health disorders have occurred in every war.

In the past 3 decades, more research on mental health disorders has emerged. This research not only focused on mental health during war but also studied military members before and after service. Seahorn and Seahorn (2016) explained that many investigations attempted to determine the etiology of the syndrome by asking veterans about their premilitary home life and adjustments, as well as their experiences in combat. More recently, Seahorn and Seahorn explained more military members have been hospitalized for mental health disorders than for battle wounds or other injuries. Prolonged exposure to combat is the root cause of the issue for military members, due largely to multiple

deployments to Afghanistan and Iraq. In addition, the types of dangers military members face add to the numbers of those who could develop mental health disorders. Seahorn and Seahorn explained that the issue ranges from low-intensity combat peacekeeping missions to high-intensity events during times when bullets are flying and explosions are going off all around the individual. In addition to traditional threats, current noncombatant military members, like Vietnam noncombatant military members, deal with terrorist activities as well as guerilla warfare tactics, such as car bombings, remotely detonated explosives, and mortar attacks, in contrast to walking through the jungle.

Clinical assessments must not assume that the experiences of all in a war zone are identical. Seahorn and Seahorn (2016) wrote that exposure to military conflict can be of a variety of types and intensities, and can affect those in the combat zone military members and civilians differently. The destructive nature of war creates an atmosphere of chaos, and everyone must face the terror of unexpected injury, loss, and death (Francioni & Ronzitti, 2011). Dunigan, Farmer, Burns, Hawks, and Setodji (2013) explained that today people are much more willing to assign stress disorders diagnosis to military members than to civilian contractors during war. That was the case until September 11, 2001, when firefighters and police officers were killed along with civilians in New York City; their experiences were quite different from those of military members. Despite those differences, the assignment of the stress disorders diagnosis was given to them. The U.S. Department of Veterans Affairs (2012) explained that recent studies of Operation Iraq Freedom and Operation Enduring Freedom veterans suggest most military members are

returning with symptoms of stress disorders. This diagnosis provided a tenuous link between civilians, first responders, and military members for the assessment and criteria for having a mental health disorder. The stress disorders classification is assigned to those in combat and noncombat situations.

Noncombat-Related Stress Disorder

When many hear the term battle fatigue, stress, and stress disorders, they immediately get a sense of combat, military, and war. In contrast, stress disorders are not just related to war and many private citizens can develop them. Silvers, McAllister, and Yudofsky (2011) wrote that cited stress disorders in the general civilian population occur from a variety of mechanisms. These commonly include falls, motor vehicle collisions, assaults, and sports-related accidents. Occasionally, civilians are exposed to rape, natural disaster, terrorist attack, and even living through a fire. Today, civilians experience stress disorders or noncombat-related terrorism just like their military counterparts. Morris (2015) explained that civilians are targeted as much as military members. For example, on September 11, 2001, more than 2,600 civilians died; the Bali bombings of October 2002 killed 200, and in Madrid in 2004, 190 civilians were killed. These acts were intentionally directed at the civilian population. The connection between terrorist attacks on civilians and armed conflict involving soldiers is complex. Morris (2015) wrote that terrorism can occur in the context of an ongoing protracted conflict, such as in the Israeli–Palestinian conflict. It can lead to military intervention and war, as in the U.S. ousting of the Taliban regime in Afghanistan. A terrorist attack can occur as a reaction to

an intervention, such as in the Madrid bombings. Addressing any type of health disorder in the population is different from that of armed soldiers because these acts of terrorism are usually one sided and the victims, being noncombatants, cannot surrender, save their lives, or defend themselves. Contractors also tend to exhibit the same kinds of behaviors in the face of adversity that are demonstrated by noncombatant military members (Morris, 2015). These civilians are susceptible to stress disorders like other civilians. Civilians working with the U.S. Military in the current war zone in Iraq and Afghanistan are susceptible.

Contractors in Combat

In the Iraq and Afghanistan conflicts, the U.S. military relied on civilian workers than ever before, from guard duty to cooking meals, cleaning latrines, and delivering fuel. Francioni and Ronzitti (2011) explained that the ration of noncombatant military members to contractors in Iraq and Afghanistan is almost equal in number and living conditions. Francioni and Ronzitti (2011) determined that in many ways, the life of a contractor in a combat zone parallels very closely to that of military members. In the current era of modern warfare, military members and contractors alike are sustaining new and complex patterns of injuries (Silvers et al., 2011). Military members, after returning from war are given healthcare, if needed, from multiple sources such as the Warrior Transition Command. The U.S. Military Warrior Transition Command is a major subordinate command under the U.S. Army Medical Command. Its mission is to develop, coordinate, and integrate the military's Warrior Care and Transition Program for

wounded, ill, and injured military members. If military members enter the Warrior Transition Command and the local U.S. Army medical command decide they will leave the military, and then the task of caring for them falls to the VA. As stated earlier, there are no such systems in place for contractors returning from Afghanistan or Iraq. Francioni and Ronzitti (2011) explained:

> Recent U.S. Military audits reveal the inadequacies of response by the DoD to psychological harm suffered by contractors in Iraq or Afghanistan and tell us that these findings are not being well documented. Furthermore, PTSD can manifest in these contractors, just as it can in the military member, returning from the war zones. (p. 285)

With multiple contracting companies using different systems, software, and processes, there is no central database to track these contractors. Francioni and Ronzitti (2011) explained that despite the availability of insurance, the issue of disability claims, death claims, and healthcare for contractors remains a subject of controversy. Since 2010, as stated by the CRS (2011), over an 18-month time frame, almost 1000 claims by American contractors for war-related compensation were filed, with insurance companies unfairly denying medical treatment and disability payments for the claims filed. These claims made by these contractors are allowed under the Defense Base Act, a WWII-era law that requires all companies employing contractors overseas to carry workman's compensation insurance of this nature. The Defense Base Act is financed by taxpayers and was rarely used until the wars in Iraq and Afghanistan. Several analysts have

questioned the reliability of DoDs contractor claims from the DoL, along with information from the insurance companies.

To better assist in tracking contractors and contractor data on injuries, movements from base to base, and deaths, the DoD implemented a database tracking and monitoring system Synchronized predeployment and operational tracker, SPOT (CRS, 2011). These systems seemed to help contractors while they were in the theater; however, these systems remain an inadequate source of this critical information because once contractors leave the war zone, their information is deleted and the DoL has no access to the SPOT report and no way to check the data on it. As stated earlier, the job of collecting statistics on contractors falls to the U.S. DoL Division of Longshore and Harbor worker's compensation. The DoL only tracks contractor injuries and deaths based on insurance claims submitted under the Defense Base Act. The DoL (2013) wrote that the issues that remain are that there is no mechanism to accurately track claims; postemployment claims are difficult to investigate because the employee has left the company; initial medical reports often lack proper diagnoses because contracts are not authorized for medical care in the theater, unless it is for loss of limb, life, or eyesight.

The exact number of contractors diagnosed with stress disorders or having a mental health issue is not known. However, according to DoL statistics, since 2010 over 1200 American contractors have been injured or killed in Afghanistan or Iraq. In contrast, Carafano (2008) wrote:

> Contractors have received military distinction. Andrew Bendy, an employee of Aegis, received the Commander's Award for Civilian Service. According to news coverage of the award ceremony, if he had been in uniform, Bendy would have received a medal for bravery. During an honest-to-God, extended mortar barrage, Bendy continually exposed himself, leaping across rooftops to maintain Army communications lines. (p. 103)

There have been many stories of bravery from both contractors and military members; however, Kinsey and Patterson (2012) explained, there has been no definitive study on military members and contractors about heroics or other acts of valor. The psychological and physical health of contractors has long been a festering, half hidden issue. The fact that contractors serving alongside military members can suffer from many of the same physical or mental ailments should not come as a surprise. There is a significant unmet need for healthcare, which Kinsey and Patterson (2012) explained that fewer than 30% may have probable mental health or physical issues and over 30 percent with probable depression but they are not allowed to use services like the Veterans Administration or military facilities when they return from war zones. When military members complain about lapses in their healthcare, top military healthcare managers demand improvements. Many contractor company managers provide predeployment psychological screening but provide few resources when their workers return from the war zone and go off the payroll.

Management Practices

There is no one size fits all solution to managing someone with healthcare needs when they return from a war zone, so the key is to remain flexible. Bevan and Kipka (2012) explained that more information you have, the more you can do to help. Accommodating an employee with their individual healthcare needs can be complex and is unique for everyone. What may be helpful for one individual may not be helpful for the next. First, it is important for the employer to be educated on identifying healthcare related symptoms. Bevan and Kipka (2012) explained that knowledge can lead to understanding reactions, which may seem out of the ordinary. It can also provide a framework for adapting the work environment to suit the needs of the individual with mental or physical issues. Organizations perform better when their staff is healthy, motivated and focused. Smart employers support employees who are experiencing mental health problems to cope and recover. Bevan and Kipka (2012) wrote that the support employees receive from employers is key in determining how well and how quickly they are able to get back to peak performance. Birasnav (2014) explained that there are universal principles designed to support a diverse range of people across a range of workplaces.

1. How to create a culture that supports staff to be open about their mental health.
2. How to have a conversation with someone about their mental health.
3. How to support someone experiencing a mental health problem.
4. How to manage an employee's time off sick and their return to work.

Too often employees are scared to tell their manager about their healthcare needs and so problems can spiral. Birasnav (2014) stated that organizations need to send a clear signal to staff that their healthcare needs matters and being open about it will lead to support, not discrimination. Working in a war zone is one of the most stressful situations a person can experience; people do not feel able to ask for help when they are struggling. This silence feeds misunderstanding and prejudice, which can make it harder for people to be open. Therefore, it is vital that managers routinely ask staff how they are doing and discuss their healthcare needs. Contractor managers should try not to make assumptions about employees' healthcare needs, Birasnav (2014) provided clues to an employee having issues:

- Changes in behavior or mood or how they interact with coworkers
- Changes in their work output, motivation levels, and focus
- Struggling to make decision, get organized and find solution to problems
- Appearing tired, anxious or withdrawn and losing interest in activities and tasks they previously enjoyed
- Changes in eating habits, appetite and increased smoking and drinking

Once employers are aware of healthcare related issues their employees are having they should continue to give employees work that is challenging and engaging but at the same time, it is important to be there to offer support. Bevan and Kipka (2012) explained that the only way to get the balance right is to maintain regular communication, keep asking employees what works for them, and tweaking the level of support and involvement in

response. Contractor company managers should also train staff in issues relating to stress disorders so employees who have difficulties do not experience prejudice or discrimination and are appreciated for the contribution they make in the workplace. In some case, an independent support worker may also help support staff.

Review of Research Method

For this study, I used a qualitative case-study methods approach, especially cluster sampling. Babbie (2013) stated that cluster sampling is the process of sampling complete groups or units. For example, if a researcher wanted to sample a small town and the unit of inquiry *the unit from which data will be gathered* would be the individual household. The general guideline for cluster sampling is to maximize the number of clusters selected while decreasing the number of elements in each cluster (Babbie, 2013). Cluster sampling is frequently employed when the researcher is unable to compile a comprehensive list of all the elements in the population of interest.

For this study, cluster sampling was the appropriate model to use. With cluster sampling, Lohr (2010) explained, "you do not need a complete population list, just a list of clusters and then a list of elements for the selected cluster" (p. 168). The research population for this study was government managers and contractor company managers who deployed contractors to Iraq and Afghanistan for 365 days and their documentation, if available. The lists of elements used were interview questions inquiring how contractor company managers feel about information provided to contractors, and whether there was enough information about healthcare treatment during and after deployment to Iraq or

Afghanistan. This interview questions were cross-checked with the information given to military members and correlated. Cluster sampling was used for this qualitative case study and is highly effective when used correctly.

Cluster sampling has multiple advantages and disadvantages. The disadvantages of using cluster sampling are listed below:

1. Samples can be biased: if the population chosen as a cluster sample has a biased opinion, then the entire population is inferred to have the same opinion.
2. Sampling errors: other probabilistic methods give fewer errors than cluster sampling.

The advantages of using cluster sampling are listed below:

1. Feasibility: because the groups associated with cluster sampling are so large, deploying any other sampling technique would be very difficult.
2. Economy: traveling and time are limited when using cluster sampling.
3. Reduced variability: estimates by any other method of probabilistic sampling reduce variability in results. (Babbie, 2013)

Using cluster sampling, one must ensure that the elements and population contained in the cluster are heterogeneous; when this is the case, the cluster sampling is as precise as any other sample method. If the heterogeneity of the cluster is less than that of the population, then the estimates will be less precise (Babbie, 2013). For this study, a cluster of American contractors' company managers and government managers was used.

These contractors' managers, to qualify, must have deployed contractors with the U.S. military overseas in a hostile area and deployed for 365 days. Babbie (2013) rated cluster sampling high when the clusters have similar characteristics. This cluster was large enough to ensure 20 participants were selected.

Gap in Literature

There seems to be a disparity between the management of healthcare available to noncombatant military members compared to what contractor company managers make available to contractors. Kinsey and Patterson (2012) indicated that thousands of contractors who worked in Iraq or Afghanistan are returning home with the same kinds of combat-related healthcare problems that afflict noncombatant military members. Many contractors did not seek treatment because they feared embarrassment and being perceived as weak, a sentiment shared by noncombatant military members. Kinsey and Patterson (2012) wrote that contractors reported that cost was a consideration, and over 20% of U.S. contractors said when they leave Iraq and Afghanistan they have limited or no health insurance after leaving the contract company that employed them while overseas in a combat zone. Because of issues like these perhaps more research must be done on this population to fully understand how contractors are affected. In addition to, contractor company managers increasing access to healthcare resources, and a decreased stigma by educating its employees and staff about healthcare needs for the contractor and deployment to Iraq and Afghanistan.

Summary

In this research, I wanted to explore to what extent the contractor company managers and government managers for contractors deploying to Afghanistan or Iraq gave them adequate information for healthcare related issues, if needed, compared to that given to noncombatant military members. Compared with the general population, personnel in wartime situations are at increased risk for a range of physical health issues and stress disorders (Department of Veterans Affairs, (2013). For this study, I did not focus on past contractor's experience because that would make the focus of this study on public policy. Although current contractors are mentioned in this study the focus of this study was on the future contractors. Currently, I could find no research that was focused on contractors in Iraq and Afghanistan, especially issues with contractors and healthcare. Multiple studies have been conducted on military members in war, querying their access to healthcare. The need for a unified healthcare system for contractors is apparent. Consequently, I looked to bridge the informational gap for this research by exploring ways to make treatment more available for future contractors who may be deployed with the U.S. military in combat zones. Contractor company managers and government managers will have the opportunity to suggest or implement postdeployment programs that will better assist employees for the challenges and stressors they may encounter after returning from deployment to an austere environment.

Chapter 3: Research Method

The purpose of this qualitative case study was to explore ways that contractor company managers and government managers can improve management practices to provide long term healthcare for future contractor's personnel. This chapter includes a detailed explanation of the methods used to conduct this qualitative case study. Topics include the research design, participants and how they were recruited, a description of the measures used, the procedures, data analysis, and ethical consideration for protecting the participants. The details provided in this chapter should allow the study to be replicated by others in the future.

Research Design and Rationale

For this qualitative case study, many research methodologies were considered. I considered conducting a mixed methods study, which Yin (2014) defined as a research design or methodology for collecting, analyzing, and mixing both quantitative and qualitative data in a single study or series of studies to better understand the research problems. This methodology was found unfeasible for this type of study. Yin indicated that these types of studies were expensive and time consuming, researchers have to learn multiple methods and be able to know how to mix each method effectively, and researcher has to know how to interpret conflicting results. In addition to the mixed methods research methodology, I also considered a quantitative study, which is defined as, a social or human inquiry based on testing a theory composed of variables, measured with numbers, and analyzed with statistical procedures, to determine whether the theory

holds true (Babbie, 2013). The design of this research is to identify inequalities between information available to contractors and that for military members for mental health support. A qualitative research approach with a pragmatic design model was used for this study. To emphasize this point, Yin (2014) stated "you would use the case study method because you deliberately wanted to cover contextual conditions believing that they might be highly pertinent to your phenomenon of study" (p. 13). Qualitative research is defined as a holistic approach that involves discovery. A quantitative study would not yield the type of information desired from this study. Yin (2014) indicated that qualitative research builds premises on inductive rather than deductive reasoning. I am not trying to diagnose whether a person has a mental health issue. I am trying to understand whether the contractor can access healthcare, information on healthcare, or assistance like the noncombatant military member.

I also considered other research designs for the current study. This study uses a qualitative design as proposed by Yin (2014) who first defined the prominent methods for conducting qualitative research as narrative, grounded theory, ethnography, case study, and phenomenology. The qualitative data was acquired from individual interviews, data collection, and material comparisons. Each qualitative method was considered for this study.

Narrative

Narrative research involves one or more individuals who through interviews acquire data. This information is compiled in a chronological sequence thereby creating

the individual's story (Yin, 2014). This story can be presented as a biography, autobiography, a lift or oral history (Yin, 2014). Yin (2014) also noted that researchers using the narrative method will most likely have to restructure the information provided to make sense, a process called restoring. Because the research required gathering information from larger sample size and not just one or two individuals, I chose not to use the narrative method; the small number of participants for a narrative research design would limit the researchers' ability to compare data from each participant.

Grounded Theory

Grounded theory requires the researcher to develop theories about a phenomenon of interest that is grounded in systematically gathered and analyzed data. This data is then used to generate categories that define the processes experienced by participants in the study (Yin, 2014). This data Denzin and Lincoln (2012) indicated aids the researcher in designing a theory or expand on a current theory, regarding the phenomenon. This study excluded the grounded theory methodology because this research methodology does not need to draw from lived experiences and beliefs to conduct this qualitative case study. The extent of the detail necessary for this study would not be possible using the grounded theory methodology.

Ethnography

In ethnographic research, study data are acquired through observation of the participants within their own cultural group (Yin, 2014). If researchers use ethnographic methods, they are required to spend time with the participants to gather data from

observation of behaviors shared within the group. Because this study incorporates participant data, case study, and data analysis, this study excludes ethnography as the best research design for this study.

Phenomenology

Each facet of the individual experience regarding the phenomenon is seen exactly as the individual perceives them to exist. Yin (2014) explained that, when the research uses phenomenology the researcher will ascribe meaning to the individual description of the phenomenon in question. Studies that use a phenomenology design strive to identify repetitive themes from the data collected from which the essence statement regarding the phenomenon is written. Babbie (2013) indicated that the processes for determining the overall essence statement in phenomenology can be acquired through a heuristic approach or through a transcendental phenomenological approach. Because this qualitative case study does not require any problem solving or experimentation, phenomenology was excluded as the best research design.

Case Study

Case study was the choice for the design of this study. In case studies, the researcher composes the data collected from one or more individuals within a small group (Yin, 2014). Yin (2014) indicated that the process of using a bound system in case studies is ideal for this study due largely to the structure of the research question and interview questions, which required that the group have experienced the phenomenon individually, but the results of the data analysis are explored for the group. Babbie (2013)

further emphasized that the real business of case study research is to understand the case or cases themselves through an interpretation of the data. Case study research is suitable for answering questions that start with how, who, and why.

Role of the Researcher

First, the researcher must adopt the stance suggested by the characteristics of the naturalist paradigm. Second, the researcher must develop the level of skill appropriate for a human instrument, or the vehicle through which data will be collected and interpreted. Finally, the researcher must prepare a research design that uses accepted strategies for naturalistic inquiry. Babbie (2013) maintained that a researcher must do the following before conducting a qualitative study. For this study, interview questions and analysis of documents were used as the method of data collection. Morris (2015) instructed that conversation is the common technique people use to communicate.

The documentation came from information given to military members during and after deployment. The documentation gave detailed information into healthcare outreach give to military members. Documentation for contractors was drawn from information given to them by the contract company and government managers' team that deployed them to Iraq or Afghanistan. Interview questions were also used to gather information. The use of documentation was vital for the case-study approach to be used in this study. Documentation did enhance the information from the interview questions and solidify the data. Morris (2015) explained that documentation is a crucial element to ensure that quality of the data gathered. From the point of view of research, it is not a coincidence

that scientific publications increasingly require that the data relevant to any work be available through archival documentation.

Methodology

A case study research design is used for this study. Using a case study methodology, the researcher needs to compare the information available to noncombatant military members and the contractors who work alongside them in a war zone. NIMH (2009) explained that scholars indicated there is a higher prevalence of mental health issues among individuals who were intentionally traumatized from war-related events, compared to individuals who were exposed to unintentional traumatic experiences, such as hurricanes or floods. In a combat situation, no distinctions can be made between contractors or noncombatant military members. However, there may be dissimilarity between the amount of information and access to healthcare available to them during and after they return from Iraq or Afghanistan.

Participant Selection Logic

The population for this study was 20 Americans, 10 contractors' company managers and 10 government managers who sent workers to Iraq or Afghanistan. Dunigan et al. (2013) wrote: "contractors working in conflict environments are a diverse group, with individuals working as independent agents on contracts sponsored by a variety of government and nongovernmental entities and for an unknown number of contracting firms" (p. 3). A total sample of 10 American contractor managers and 10 government managers, who deployed contractors to Iraq or Afghanistan, were

interviewed. To collect data for the study, managers were asked predetermined questions during an interview. The interview questions were derived from the research questions. Because I am employed within the DoD and have access to contractors' managers and government managers, I could recruit them from the surrounding military community or any place where a mass of people congregates outside the base and, through email. Dunigan et al. (2013) noted there is no reasonable sampling frame for the entire population of contractors if one wanted to extend the analysis beyond contractors employed by a single company. The criterion for being chosen was that the managers must have deployed contractors to Iraq or Afghanistan for a total of at least 365 days, which is the identical amount of time most noncombatant military members deploy. Participants were asked to describe their most recent contractor deployment experience using interview questions modified from the research questions. After conducting the pilot study, the interview questions could have been tweaked. This would only have been done if I found the interview question lack depth or breadth needed to narrow contractor's managers and government managers who fit the research criteria reflecting on contractor experiences more authentically omitting, for instance, questions about taking part in invasions or assaults on entrenched positions, because contractors are not supposed to engage in offensive combat. Some contractor company managers deployed contractors as employees of the DoD, State Department, Red Cross, or other government agency. Perhaps 20 participants or until data saturation occurs, was enough managers and yielded enough data to attain the needed outcome because, qualitative studies generally

use a small number of participants, but sample size is still important (Babbie, 2013). A general rule that guides sample size was saturation of data or redundancy of data. Babbie (2013) explained that instead of using random sampling as is the goal in quantitative research, qualitative research employs purposive or theoretical sampling, meaning the researcher intentionally selects participants who can contribute an in depth, information rich understanding of the phenomenon under investigation. This study compared the differences between two groups which cluster sampling methodology is well suited for.

The current issue is: Does the management team provide the contractor with adequate access to healthcare as the noncombatant military member? Do they know where to get help? Were they ever informed about where to get help, if needed? The purposes of the questions were to qualitatively explore what is not known about this issue. The data were examined and compared with information available to noncombatant military members. The cluster-sampling approach was used; clustering uses groups of elements instead of individuals from a sample of the population. (Babbie, 2013) explained that sometimes it is not possible to randomly select from the entire population, an alternative is to use clusters to save time and expense, and for convenience. Because of the huge number of contractor company managers and government managers who have deployed contractors to Iraq and Afghanistan, this sampling method was the best.

Analysis and interpretation of the data could result in a deeper understanding of the issue. The goal of this study was to establish a baseline that hopefully begin a dialogue on the issue for future contractors. Babbie (2013) maintained that a qualitative

methodology helps establish a point of reference wherein a detailed understanding of a central issue establishes a guide for further study.

Instrumentation

The purpose of this qualitative case study was to explore ways that contractor company managers and government managers can work together to provide healthcare for those contract employees who are and will be deployed with the U.S. government. Interview questions were used to obtain information from the managers. Before selecting the managers for this study, I assessed if the managers had any bias toward contractors or government by seeking *attitudinal measures* (Yin, 2014). Participants were asked to describe their current contractor deployment experience and how they manage the contractors' healthcare related issues while they are deployed and after they return.

The interview questions were open-ended questions. Babbie (2013) indicated this is done to allow the participants to create options for responding; voice their experiences and perspectives. Participants are always asked identical questions, but the questions are worded such that responses are open-ended Babbie (2013). Open-ended questions allow all participants to contribute much more detail information than closed-ended questions. Also, open-ended questions allow the researcher to ask probing questions as a means of follow-up. Yin (2014) explained that the only weaknesses with open-ended interviewing is with coding the data. As open-ended interviews allow participants to fully express their responses, it can be quite difficult for researchers to extract similar themes or codes from the interview transcripts as they would with closed-ended responses, making open-ended

questions more cumbersome. However, Babbie (2013) indicated this reduces researcher biases within the study, particularly when the interviewing process involves many participants. Additional data was collected from the Department of Defense and Veterans Administration. This information was available on public websites and faith and non-restricted location on military installations.

Pilot Study

I conducted a pilot study before collecting any data for the case study. Morris (2015) stated that using a pilot study is recommended when conducting a qualitative case study. Four participants' two contractor company managers and two government managers were asked to participate in the pilot study. Interviews were then conducted with the participants separately starting with the initial interview question that I developed from the research question. After the interview, pilot participants were asked whether any question during the interview was unclear and if they have any questions pertaining to the study. The participants understood the questions and the instructions thus no further explanation was needed.

Procedure for Recruitment

Once approval was given from Walden University Institutional Review Board, I started recruiting participants. Participants were recruited using a recruitment strategy, which is defined as a project-specific plan for identifying and enrolling people to participate in a research study (Morris, 2015). The plan should specify criteria for screening potential participants, the number of people to be recruited, the location, and

the approach to be used (Morris, 2015). This qualitative case study involved a minimum of 20 participants unless data saturation occurs, and to be selected, these participants must have been contractor managers and government managers who deployed along with noncombatant military members to a combat zone. Further, the participants came from the local community recruited from current managers local to my area. To further screen candidates six questions were asked with yes and no response options. Questions for the participants are:

1. Did you deploy contractors to Iraq or Afghanistan for 365 days or more?
2. Did they live next to or near noncombatant military members?
3. Did their base camp come under hostile incoming fire from small arms, artillery, rockets, mortars, or bombs?
4. Did the contractors get information on military procedures and management best practices on what actions to take while under attack, meaning did you educate them on assuming a defensive posture?
5. Were your contractors in a vehicle that was under fire?
6. Did they witness someone being seriously wounded or killed?

These questions were only used to determine if the candidate meets the criteria to be accepted in the case study.

Once participants were contacted, a consent form was provided to participants along with an explanation about the process and the participants' role in conducting this study. I also explained what I would do with the information receive from the

participants, how it would be used and my intended outcome. I also stressed to the participants that their involvement is voluntary and that they were not obligated to speak with me and can disengage at any time. Morris (2015) indicated that in developing recruitment guidelines, it is important to take special care to avoid saying anything that could be interpreted as coercive. The voluntary nature of participation in research studies should always be emphasized. Therefore, all participants were asked if they understand and be given multiple opportunities to leave during the interview.

Data Collection

Data were collected using multiple techniques such as *interview questions* and analyzing documents and materials. The documents for contractors were drawn from documentation provided to contractors from the contractors' managers and government managers during deployment, and after deployment. The documents for noncombatant military members came from unrestricted sources throughout the DoD (e.g., faith services), deployment center (located on military compounds), Wounded Warrior Centers, and Veteran Administration. The interview guide was used to conduct and control the interview questions and the same guide was used in each interview. This ensured the focus of the semistructured interview and coverage of the same content for each participant. In using semistructured open-ended-response interviews, each participant sees or hears the same set of questions. The interviews were documented using predetermined interview questions to capture the true and exact communication of

the participant. Bryman (2012) indicated that individual interviews can be conducted in several ways:

1. One-to-one format: one interviewer meets with one participant; questions are asked, the answers recorded.
2. Face-to-face or by telephone.

Morris (2015) explained the four advantages of using the individual interview are:

1. Almost always produces a better response rate.
2. The sample of persons actually participating in the study tends to represent a large percentage.
3. Personal contact in the interview helps encourage or put more pressure on a person to respond fully.
4. Better at revealing information that is complex and/or emotionally laden.

Open-ended questions are interactive and allow the participants to express their meaning completely. When direct or closed questions are used, Morris (2015) instructed that the interviewer asks the same questions and participants are asked to choose answers from among the same set of alternatives. Questions for the interview were derived from the research questions. In this study, the sample population was interviewed regarding information they disseminated to contractors they deployed to Iraq or Afghanistan. This information was triangulated with deployment manuals given to the contractors by their contractor managers and government manager teams. To further improve the accuracy of

this qualitative research study member checking was used Morris (2015) explained that member checking is the period of data collection when feedback is obtained from the participants about the accuracy of the data they have given. Data was collected from interview questions and documented materials such as, HR manuals and benefits packages, given by the contractor company managers and government managers to the contractor that deployed them to Iraq or Afghanistan. This information was compared to information given to noncombatant military members during and after deployment. The interview questions given to the participants and content analysis was the elements in the study. In inquiring about the contractor deployment healthcare needs, the interview lists the following general and specific research questions and the following interview questions were derived from them:

The general research question that guided this study was:

How can contractor managers and government managers provide their future contractors with long term healthcare after deployment to a foreign combat zone?

The specific research questions that guided this study was:

RQ1. How can the information that contractor managers and government managers provide be improved to ensure that contractors understand their options for healthcare after leaving the company?

RQ2: What are the barriers that contractor managers and government managers may face in trying to provide for long-term healthcare for their contractors after they leave their companies?

RQ3.What are possible solutions that contractor managers and government managers can incorporate to ensure that healthcare can be made available to contractors after leaving their companies?

The information provided to noncombatant service members, in relation to the qualitative case study, was collected from the local healthcare facilities: the unit (working group); and chaplain (spiritual counselor). These interview questions are intended to give insight into the inequalities between the information given to noncombatant military members and the contractors serving beside them.

The data collection took place as soon as Institutional Review Board approval was granted. Ten government managers and 10 contractor company managers who deployed contractors to Iraq or Afghanistan were interviewed and their documentation was collected. Information collected and analyzed was the materials available to the contractors for their deployment, as well as information given to the noncombatant military members for deployment. For reasons of confidentiality, participants were presented with consent forms and asked to provide signatures. For those that were interviewed by telephone, they were sent the same consent forms but could give consent through e-mail, with a follow-up form mailed through the U.S. Postal Service. Interviews

were conducted in my office, participant's office, or by telephone. Each interview lasted approximately 25 minutes and I conducted the interviews.

Data Analysis

Content analysis was the preferred method for analyzing the data. Leedy and Ormrod (2012) defined content analysis as a detailed and systematic examination of the contents of a body of materials for identifying patterns, themes, or biases. This process involves developing a plan for organizing the data for analysis, reviewing data from various viewpoints, and attaining an in-depth understanding and interpretation of the data (Morris, 2015). The purpose of this data analysis was to compare the information and identify any irregularities between information given to noncombatant military members and contractors. No special coding software was used for this study. Coding the data was a very important stage in qualitative data analysis processing. Coding involves subdividing the data into categories adding tags or labels for allocating identified themes (Morris, 2015). To develop categories and themes of the data collected from the interview questions, content analysis was the preferred coding system used.

1. What are some of the pitfalls your organization has with managing long term healthcare for contractors who have deployed to a foreign combat zone? (RQ1)
2. How does your organization feel about the future management of healthcare for contractors who will return from a foreign combat zone? (RQ1)
3. What information does your organization provide to contractors after they return from a combat zone? (RQ1)

4. How can the information your organization provides be improved in the future? (RQ2)
5. How does your organization manage the healthcare issues for contractors after they leave your organization? (RQ2)
6. What are some of the difficulties your organization finds with managing healthcare for contractors in the future? (RQ2)
7. What solution can your organization propose to further manage the healthcare for contractors when they leave your organization now? (RQ3)
8. What solution does your organization have in place now to ensure healthcare is provided to contractors in the future after they leave your organization? (RQ3)
9. What process can your organization put in place to manage healthcare for future contractors who may need healthcare services in the near future? (RQ3)

The interview questions above were coded using content analysis to identify themes and patterns. By conducting a line-by-line coding which Babbie (2013) indicated in a good starting point to identify phenomena and produce a list of themes of importance to the interviewer. Also, labels were given to almost every line in the interview transcript to capture the information from the interview. Codes were assigned to participants' words and statements to develop concepts. Babbie (2013) stated that the detailed and meticulous process of line by line coding helps to open the text and interpret the transcript and helps test the researcher's assumptions. A response of 1 indicated (yes) and a response of 0 indicated (no). Items were dichotomized so that responses indicating (yes) were assigned

a score of 1 and the rest received a score of 0. For the data analysis, the information was compared the information from the interview questions and the data given to noncombatant military members. Using triangulation, I searched for patterns in the interview questions and the documentation. For information that matched, a numbered was assigned to the line, highlighted in yellow. For all information that did not match, the letter X was used to mark that line.

Trustworthiness

Credibility

The data was checked for consistent patterns of theme development to ensure validity and authenticity. Babbie (2013) stated that a good strategy to use to check the accuracy of the finding is to adequately perform a detailed check. This can be conducted during the data-collection and interview processes. If done correctly, Yanow and Schwartz-Shea (2015) indicated that it will increase the credible internal validity of a qualitative study. Also, to assure dependability, member checking was used. During the interview, I restated the information and then restated the questions to the participant to determine accuracy and used only the summaries that the participants agree to reflect their views, feelings, and experiences. This enhanced the credibility and trustworthiness of the data.

Transferability

Transferability is the potential for the reader to consider the data in a study to be applicable to other contexts or situation. Babbie (2013) wrote that transferability in

qualitative research is accomplished with thick description, which in qualitative research is a way of achieving a type of external validity. By describing a phenomenon in sufficient detail, a person can begin to evaluate the extent to which the conclusion drawn is transferable to other times, settings, and situations. Babbie (2013) stated that results of any type of research method can be applied to other situations, but transferability is most relevant to qualitative research methods such as ethnography and case studies. Studies based on these research methods are detailed and specific. However, because they often consider only one subject or one group, researchers who conduct such studies seldom generalize their results to other populations. The detailed nature of the results makes them ideal for transferability. This study is not generalizable, which is the act of reasoning that involves drawing broad inferences from observation (Babbie, 2013). This qualitative study was structured to understand an aspect of human experience through the intensive study of a case.

Dependability

In research, dependability is viewed as the ability to duplicate the research study and obtain similar results. Morris (2015) explained that duplicating a research study can only be accomplished if the original researcher provides extensive detail in the design, implementation, effectiveness of the process used, and details of the data collection process. To ensure dependability further, I only recruited participants who were managers that deployed contractors to Iraq or Afghanistan for a minimum of 365 days and explain to them the nature of the research and the intent, and why it is important. Furthermore, to

ensure dependability, *overlapping methods* such as content analysis and interview questions was used. Perhaps by using these techniques, I demonstrated the quality of dependability, by including all the data in the results in a natural form followed by the details of the data collection, interpreting the finding, and reporting the results will ensure future researchers will be able to interpret my research easily, making the approach dependable.

Confirmability

Confirmability refers to the ability of others to confirm or corroborate the findings. Lichtman (2012) wrote that steps must be taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researchers. Because this study was qualitative in nature, the use of content analysis and open-ended interview questions as the technique for data collection was preferred. For documentation, I used data-source triangulation, which, Yin (2014) indicated includes the student and mentor as participants. This step is completed by comparing alternative perspectives and exposing any inconsistencies. Yin (2014) explained that triangulation is an important concept in case study research because an investigation of the phenomenon from different perspectives provides robust foundations for the findings and supports arguments for its contribution to knowledge. I used the data collected from the government managers, company contractor managers, deployment manuals, individual interviews, and the pilot study for the triangulation of data collection. This was accomplished by using member

checking. Traditional quantitative forms of research measure quality in terms of validity. Because the nature of qualitative research is different from quantitative research, these statistical terms are not appropriate.

Ethical Procedures

All Walden Institutional Review Board guidelines for informed consent and confidentiality were followed. Potential participants received an explanation of the purpose of the research, procedures, and outcomes of the study. Participants were given the chance to withdraw at any time during the data-collection process.

To ensure confidentiality, participants' names were not associated with any results of the interviews. Data analysis included only summary information and quotations. Participants all signed their names on the informed-consent form. Data will remain in a locked cabinet in my office for 5 years, and then destroyed by shredding. Electronic media will be erased.

Summary

Chapter 3 included a description of the research to explore ways that contractor managers and government managers can work together to provide healthcare for those contract employees who have been deployed with the U.S. government. This section clarified the purpose and goal of the study and has established the appropriateness of the research design. This section also contains a description of the research design and approach, the study population, data-collection and data-analysis methods, and ethical considerations.

The study took place in a private location on or near a military community. This study focused on contractor managers and government managers experiences in getting information pertaining to physical health and mental health to contractors they deployed to Iraq or Afghanistan, compared to noncombatant military members. Interviews and documentation collection was used to collect data pertaining to the study. Because this area of inquiry is largely understudied, the methods amounted to discovery with the collection of documentation. The focus of this study was not towards generalizing contractors and their struggles to receive assistance, but it is an attempt to provide a basis for further research about the population of civilian veterans returning from war, their untold challenges, and the complications they face regarding obtaining long term healthcare for any injuries they may have suffered while in a combat zone as a contract employee. This research may lead contractor managers to work with the U.S. Government to develop a healthcare mechanism for contract employees who may serve the U.S. in future combat zones. In Chapter 4, I presented the results of this study and the answers to this study's research questions. Also, I presented a description of the qualitative analysis of the data and conclude with a summarization of the answers to the research questions.

Chapter 4: Results

The purpose of this qualitative case study was to explore ways that contractor company managers and government managers can work together to provide healthcare for those contract employees who will be deployed with the U.S. Government. The population for this study was 10 Americans, 10 contractor company managers, and 10 government managers who have been deployed along with noncombatant military members to a combat zone. The sample size was 10 American government managers who provided oversite and approved contractor who deployed to Iraq and Afghanistan and 10 contractor company managers who deployed contractors to Iraq or Afghanistan. Participants' interview responses revealed how critical it may be to have more management processes or a model used by management in providing future contractors with better healthcare management after they return from a combat zone. The overall findings of the research revealed contractor company managers and government managers understand the issues they face with managing healthcare for contractors who they will deploy to Iraq or Afghanistan. Chapter 4 includes the pilot study results from the two contractor company managers and the two government managers, research setting, data collection and analysis, the study results, and the chapter summary.

Pilot Study

A pilot study was conducted where I selected four participants' two contractor company managers who deployed contractors to Iraq or Afghanistan for a minimum of 365 days and two government managers who had oversite and approved contractors to

deploy to Iraq or Afghanistan for a minimum of 365 days, to determine the reliability of the interview questionnaire instrument. I also retained a copy of the letter sent to the four participants, two contractors' company managers, and the two government managers in the pilot study. The pilot study of four participants' two contractor company managers and government managers was conducted using the same procedures as the main research. I met with participants privately on their lunch break, in my home office, and over the phone. Each participant was given a consent form to read over and asked if they had any questions about the consent form or the study. Before starting the interview session, the participants agreed the interview could be conducted via an audio session using a microcassette recorder. Participants understood no one except myself and my chair would have access to the microcassettes. I assured participants all material about this research would be kept locked in a file for 5 years per instructional requirement. All interview questions were asked in the same format as if this was the primary study. The participants confirmed the questions were understandable. The participants were informed that they could add to their responses to the questions, which would have given additional information not possibly mentioned as part of the actual questions. Each participant answered all questions accordingly and was given additional time to provide any additional input. During the interview and after the participants were asked if they understood the study and asked if they wanted to continue, all participants agreed to continue the interview. Upon completion of each interview session, the participants were

informed about when they would receive a copy of the study and asked if any participants had any questions about anything.

The pilot study had no major influence on the main study. The entire process went as planned. The questions were clear and participants confirmed responses related to each question and their experiences with contractors and healthcare management. There were suggestions to add more specifics to Question 1 about possible communication, yet I did not want to change the question and lead the participants in the main study on to a different response.

Research Setting

I conducted the research at public places, over the phone, and in my office for all participants. I conducted the research per an agreement with the participants using their lunch hour, privately, and accommodated their needs. The privacy and attention to participants needs allowed them to be at ease in responding to all questions for the interview. Based on the responses given, there was not any indication that conducting the research at any of these private locations had a negative effect on the outcome of the research.

Demographics

The sample for this study consisted of 20 Americans, 10 contractor company managers who deployed contractors to Iraq or Afghanistan, and 10 government managers who had oversite and approved contractors to deploy to Iraq or Afghanistan for a minimum of 365 days, and who met the criteria to participate in this qualitative study.

The design of the research study brought awareness on how to explore ways that contractor company managers and government managers can work together to provide healthcare for those contract employees who will be deployed with the U.S. Government. The managers indicated that they could benefit from a definitive model or process to be used by management to assist the future contractor company managers and government managers in developing a process or systems to assist contractors. After receiving approval from Walden's Institutional Review Board IRB # 06-08-17-0041021, I invited research participants to take part in my qualitative study, collected and analyzed the data and reached data saturation. Initial contact with potential participants came via a recruitment flier posted in grocery stores, department stores, and religious building and community centers where masses of people congregate. During recruitment, I informed the potential participants of who I am, my school and program, and the reason for contacting them. I then informed the potential participant that they would receive an email with an attached consent form if they were willing to participate in the qualitative study which could be conducted on the phone and local to my surrounding area local to Tampa, Florida, in a private setting. The demographics of the participants varied as to their age, gender, and work status. At the beginning of the study, 33 participants replied to my request to participate in this study. Eight participants were not selected because they did not meet the deployment requirement of 365 days. Five participants were not selected because of personal or professional bias they had against the government agency or the contracting companies they worked with. The scale of men to women and working

or retired members from the contractor company managers and government managers participants was not a factor in this research. Agreements to participants in this study were sent to all 33 potential participants, in which 20 were selected 10 contractors company managers, two women and eight men and ten government managers four women and six men, and all agreed to participate in the study.

Data Collection

I was the primary data collection instrument for this qualitative case study. The data collected for this case study came from the completed interviews of 20 participants and data collected for deployment documents provided to contractors and the secondary source for noncombatant military members came from information gathered from wounded warrior organization websites, religious organization, and the United States Department of Veterans Affairs public websites search. The participants were selected based on the important criteria of their deploying contractors to Iraq or Afghanistan for 365 days. A qualitative case study method was used based on each participant being looked at as single case sixteen participants were interviewed in a face-to-face format and four participants over the phone by asking nine open-ended questions as the research instrument.

All information was annotated in Microsoft Word, which contained the research question and space allowed for participants to give their answers. The interview sessions were conducted by me with participants at a public location and my home office. Each interview session varied in duration from as little as 20 minutes and as much as 35

minutes, while recording all information given by the participants and reading back information given by the participants immediately after each question for clarification and to ensure all information was recorded correctly. Some participants gave additional information not asked in the original interview questions. Each open-ended question allowed for participants to give additional detail to the responses. Once the interviews were completed by participants, time was allowed for participants to give additional detail to the responses. Once completed the interview answers were recorded, coded, and analyzed for themes in the participant's responses to the interview questions.

Data Analysis

I then analyzed the data from the participant's responses to the research interview questions from the Microsoft Word document. Each participant's documents were separated and the data was analyzed individually. Every single document was labeled based on the order each participant was interviewed one through twenty participants this data was saved in a folder uploaded to my computer, password protected and labeled Interviews. The classification of participants interviewed for this case study is as follows:

Table 3

Contractor Company Managers' Breakdown Demographics

Employment	Status	Gender	Age
Participant 1	Employed	Male	51
Participant 2	Employed	Male	33
Participant 3	Retired	Male	55
Participant 4	Employed	Male	49
Participant 5	Employed	Male	42
Participant 6	Retired	Male	52
Participant 7	Employed	Female	37
Participant 8	Employed	Male	43
Participant 9	Employed	Female	44
Participant 10	Employed	Male	29

Table 4

Government Managers' Breakdown Demographics

Employment	Status	Gender	Age
Participant 1	Employed	Male	38
Participant 2	Employed	Female	44
Participant 3	Employed	Male	27
Participant 4	Employed	Male	36
Participant 5	Employed	Female	47
Participant 6	Employed	Male	43
Participant 7	Employed	Male	51
Participant 8	Employed	Male	56
Participant 9	Employed	Male	38
Participant 10	Employed	Female	47

The analysis of data from the interview questions, triangulation of data from the documentation from contractor deployment materials and information provided to

noncombatant military members, being coded looking for themes or patterns consisted of the following keywords:

- Confident
- A universal system
- Basic information
- Consolidation of information
- We do not manage it
- Knowing what they need now
- Keeping track of these contractors after they leave the company
- None
- A central database would help a lot

Table 5

Data Collection Matrix

INTERVIEW QUESTION & CODE	DOCUMENTATION REVIEW CONTRACTORS COMPANY MANAGER	DOCUMENTATION REVIEW NONCOMBATANT MILITARY MEMBERS
What are some of the pitfall your organization has with managing long term health care for contractors who have deployed to a foreign combat	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee DOCUMENTATION	The review of noncombatant military member's documentation revealed an abundance of healthcare *(table continues)* DOCUMTATION REVIEW

INTERVIEW QUESTION & CODE	REVIEW CONTRACTORS COMPANY MANAGER	NONCOMBATANT MILITARY MEMBERS
zone? A universal system		related information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
How does your organization feel about the future management of healthcare for contractors who will return from a foreign combat zone? *Confident*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
What information does your organization provide to contractors after they return from a combat zone? *Basic information*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, assistance, and access for noncombatant military members available

		to them before, during, and after deployment.
How can the information your organization provides be improved in the future? *Consolidation of information*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
How does your organization manage the healthcare issues for contractors after they leave your organization? *We do not manage it*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, *(table continues)*
INTERVIEW QUESITION & CODE	DOCUMENTATION REVIEW CONTRACTORS COMPANY MANAGERS	DOCUMENTATION REVIEW NONCOMBATANT MILITARY MEMBERS
		assistance, and access for noncombatant military

		members available to them before, during, and after deployment.
What are some of the difficulties your organization finds with managing healthcare for contractors in the future? *Knowing what they need now*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
What solution can your organization propose to further manage the healthcare for contractors when they leave your organization now? *Tracking contractors after they leave*	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
What solution does your organization have in place now to ensure healthcare is provided to contractors in	The documentation review from the company confirmed the interview questions and after further	The review of noncombatant military members' documentation revealed an abundance of healthcare related

the future after they leave your organization? *None*	conversation with the interviewee	information, assistance, and access for noncombatant military members available to them before, during, and after deployment.
What process can your organization put in place to manage healthcare for future contractors who may need healthcare services in the near future?	The documentation review from the company confirmed the interview questions and after further conversation with the interviewee	The review of noncombatant military members' documentation revealed an abundance of healthcare related information, *(table continues)*
INTERVIEW QUESITION & CODE	DOCUMENTATION REVIEW CONTRACTORS COMPANY MANAGERS	DOCUMENTATION REVIEW NONCOMBATANT MILITARY MEMBERS
A central database		assistance, and access for noncombatant military members available to them before, during, and after deployment.

Evidence of Trustworthiness

Credibility

All interviews were recorded on microcassette and to eliminate a lengthy time frame there were no further or additional notes taken. I used a journal to ensure data and timelines of the scheduled interview sessions was kept. Also, all personal notes taken during the preparation of the case study are in the journal. I then examined trends and patterns throughout the interview processes by writing down in the form of the frequency of certain terms mentioned by many participants. I crossed checked the data from the interview questions to documentation given by the contractor company manager to contractors and documentation from noncombatant military members from public data sources such as wound warrior facilities, Veterans Administration website, faith services, and veterans' websites.

Transferability

The evidence of this research is not concept based, giving it cause for non-transferability. Healthcare management for contractors who deploy to Iraq or Afghanistan is minimal or nonexistence and to understand the phenomena it must be studied and the evidence collected and analyzed. The guidance in corporations and organization are usually in the form of a model or process used by management to ensure all facets of the management of healthcare are discussed and successful with the contractor's wellbeing in mind.

Contractor company managers and government managers, based on literature review research, have not had such tailored models or processes to guide them in

healthcare management for contractors who will deploy to Iraq or Afghanistan. After reading the literature review in Chapter 2, the study of healthcare management is primarily done on the western military organization and the study on civilians is minimal or nonexistence. The responses to these interview questions indicate what the contractor managers and government managers feel, know, and think about the management of healthcare for these civilians in a combat zone.

Dependability

The dependability of the data from the participants is important, in that the questions were answered in complete honesty. Also, with the hope of management becoming sensitive to the needs of contractors deploying to Iraq or Afghanistan in the future. Understanding the need for an improved systems contractor company managers and government managers and hoping after the interview these managers showing concern on how to improve the management of healthcare for future contractors who may need it after returning from a U.S. deployment to Iraq or Afghanistan.

Confirmability

I also kept a journal with my conclusion concerning the participant responses to the open-ended interview questions. The research finding and the suggestion I mentioned in this case study are prevalent. Below is a list of suggestion mentioned by some of the participants with were pivotal in an expected outcome of the research:

- The contractor company managers who deploy the contractor to Iraq or Afghanistan needs to be involved in the process of implementing a new system for a future contractor who might deploy to Iraq or Afghanistan.

- The government managers who oversee the contract deployment to Iraq or Afghanistan need to be involved in the process of implementing a new system or revamping the current system for managing healthcare for future deployment of contractors to Iraq or Afghanistan.
- Contractors who have been deployed to Iraq or Afghanistan needs to be included during healthcare management discussion between contract company manages and government managers. These individuals know what it means to deploy and could give insight into what future contractors will face with healthcare management issues.

Study Results

I used the themes listed above as part of my research concept in my list of possible items to compare to participant's responses. The themes were critical in a case study that revealed relying factors of contractor company managers and government managers cope with managing healthcare related issues for contractors returning from a war zone. The open-ended questions (see Appendix B) related to the research questions were used in the interview sessions to give each participant a chance to speak openly and share their experience. I reviewed each transcript for the possibility of coding each research question and these themes were chosen because they emerged or 75% of the time this process was completed by highlighting the portion of the response from the interview questions that satisfied the theme from the research questions and for all other items that did not meet the criteria, I marked with an x.

Following is more detailed information on participant responses and a single example to represent the analysis. The participant's alpha-numeric reference is used

based on the highlighted theme listed above. The references are not all inclusive, yet are a confirmation of some relation to the case theory of exploring management practices of the mental health system for contractors.

Theme: Confident

The theme confident, was based on the information provided by participant's thoughts on how the organization feels about the future management of healthcare for contractors who will return from a foreign combat zone. The responses revealed the confidence managers feel about the future of healthcare related management for future contractors. Also, both management team's contractor company managers and government managers shared this sentiment about the confidence.

Contractor company managers and government managers both said they have had multiple meeting with upper management pertaining to managing healthcare services with their executive level managers. Participant 3 of government managers stated that he was in the military and noticed some similarities between where the contractors healthcare management system is now compared to the systems provided to noncombatant military members when he first entered the military to where the healthcare management system for noncombatant military members was when he was honorable discharged from the military.

Participant 3 stated:

I have only been in government contracting for 4 years and have deployed multiple contractors and attended multiple meeting pertaining to this subject. I feel a

good level of confidence when it comes to future healthcare concerns and would be very interested in seeing what happens in the future with contractors and healthcare. With all the turmoil, talk, and movement with healthcare services now I do believe contractors who deploy to Iraq or Afghanistan will have a healthcare system with most of the kinks during the next few years corrected. Developing a healthcare management system for contractors, in the future and issues with managing contractors' healthcare services, in the future are at the forefront of what is relevant to my organization.

Theme: A Universal System

Was a theme the participants discussed in their thoughts of what are some of the pitfall your organization has with managing long term healthcare for contractors who have deployed to a foreign combat zone. The participants do understand the needs and concerns of the contractors. The participants also expressed concern for the potential of developing Participant 1 from contractors` company managers expressed management concerns and a willingness to reach out to contractors before they leave.

Participant 1 stated:

Well, being a member of the management team with responsibility for pushing out contractors to Iraq or Afghanistan or one of the members with that responsibility of deploying contractors I take it personally when it comes to the well-being of contractors. To answer the question what pitfalls do we have I think it's with communication between our organization, other organizations, and the government guys. If we had a better system to communicate with contractors or a consolidated website for contractors to request

medical services or ask a question I think it would increase the output of information to contractors and give contractors some of the access they need or at least some.

Theme: Basic Information

Based on the information provided by participant's thoughts on what information does your organization provide to contractors after they return from a combat zone. The participants were unaware of information provided to contractors but expressed understanding and awareness of the need for this information to be disseminated and or available to contractors. Participant 6 from government contractor managers stated that he was willing and express interest in helping contractors with long term healthcare needs if any.

Participant 6 stated:

Very good question and one that I have asked myself many times. We do not provide any information once they leave because we change jobs, sometimes during a deployment of contractors and so does the contract company managers. These employees change jobs and employers more frequently than we do. I feel contracts who want this information should have it and I am on board with any process that would provide information to contacts after they return from the combat zone. I believe they require it and need it they just do not know how, here, or who to talk to in order to get the information.

Theme: Consolidation of Information

Was a theme based on the information provided by participant's thoughts on how can the information your organization provides be improved in the future. Many of the participants were very enthusiastic about finding a solution to this question. Participant 5 from contractor company managers had a very deep emotion about this question. This was due according to him, being a contractor prior to obtaining a job as a contractor company manager.

Participant 5 stated:

I asked myself that question when I was a contractor, small world, I'm asking myself again as a contractor manager. How can the information get better? There has to be a multitude of answers to some of these questions that can also be answered. The main point too many points is the realization that we need to work together to make this happen. Meaning, the companies, and government need to work together to come up with a process or program that consolidates this information into a location where anybody can receive information.

Theme: We do not Manage it

Was a theme based on the information provided by participant's thoughts on how does your organization manage the healthcare issues for contractors after they leave your organization. Several of the contractor company managers who participated in this study knew of any process for tracking contractors after they leave the organization. Several also stated it was the government's jobs to track contractors and many of the government

managers stated it was the contractor company managers stated it was the duty of the government. All express a need for a system to be developed most alluded to a database, maybe sending out yearly letters or correspondence to keep information updated and current. Participant 7 from contractor company managers made his view clear during the interview.

Participant 7 stated:

As we move forward with decreasing the military presence in these areas we start to hiring contractors to fill these positions. This is good for contractor companies but for the contractors who we deploy, we have to do a better job of keeping up with these contractors after they leave. Once these employees leave the project, which they work on overseas, they stay with our organization just under a different division. Those employees' we can track. The majority of the employees do not go to different division they leave our company these are the individuals we have a problem tracking. I really do not know how to fix the current system my suggestion would be a central tracking system or website or something.

Theme: Knowing What They Need Now

Was a theme based on the information provided by participant's thoughts on what difficulties the organization finds with managing healthcare for contractors in the future. The participants all expressed concern for this topic and all of them, government and contractor managers, stated that tracking contractors is one of the many difficulties they have and will continue to have if they did have a process in place in the future.

Participant 2 from contractor company managers was a project manager for a major contract in Iraq and he stated his concerns about employees having this for the future.

Participants 2 stated:

Wow, I am so excited about this and what we can do about this. I believe if we could create, maintain, and manage a tracking system for these contractors we can better assist them with healthcare needs. The problem is, who will manage the system will be set up another company to perform the tracking of contractors or will we rely on the government, Department of Labor (DOL) or another agency to manage this system for contractors in the future. I think the problem will occur when you try to reach out to contractors who work for different companies, most will not talk to you because they work for a different employer. So, I think the best way to approach this problem would be a consolidated system where either a neutral party controls this process or contract it out.

Theme: None

Was a theme based on the information provided by participant's thoughts on what solution does your organization have in place now to ensure healthcare is provided to contractors in the future after they leave your organization. These views were shared by multiple participants who expressed concerns about future contractors and managing their healthcare related issues. Participant 8 from company contractor managers was previously in charge of multiple contracts spanning from Iraq to Afghanistan managing multiple contractors on different tasks supporting different U.S. military customers and

he stated that the previous management team discussed this topic in detail because of the exodus of military members and influx of contractors in a combat zone.

Participant 8 stated:

When contractors leave our organization, we have no oversite, tracking, status, or anything to do with them. During this interview, I mentioned the previous management team and how they wanted to track contractors for this very purpose. This program was shelved for other priorities, programs, and mission requirements. "Basically, setting up a system for tracking contractors now or in the future was not the priority but it will be soon." With the current up tempo and movement of military members the government will rely more on contractors to fill many noncombat related jobs and with that there needs to be a better system to track contractors not just for healthcare related issues but for all issues they endure in austere environments. With a system in place for contractors now and in the future, we will be better prepared for upcoming deployments, shifting in priorities from the government, and tracking new technologies.

Theme: A Central Database

Was a theme based on the information provided by participant's thoughts on what process can organization put in place to manage healthcare for future contractors who may need healthcare services in the near future. Many of the participants stated this as a major theme for this research question. Participant 4 from government managers, who is a supervisor in his organization stated that he was aware of other agencies keeping this information in a database but was not sure. He also stated that this would not be a

government function alone it should be shared between the government and contracting companies.

Participant 4 stated:

For this system to work we need to work together. The current systems we have is not effective nor will it fulfill what we need to do. Today we have multiple systems for tracking contractors for different reasons none of these systems track healthcare related issues. Really not sure if the contract companies are tracking contract, I would say they are not if asked officially. Moving forward a central database would be ideal but I think the problem and the need to corroborate with contractor managers is due to the upkeep of the system, inputting information, verifying the information and scrubbing for discrepancies. These are key components to ensuring a viable system that will meet the needs of contractors, that works.

Based on the responses from participants above, there were some strong positive and strong negative feelings about the future of healthcare management for contractors in austere environments. Although only one response per participant was selected, the coding and analysis showed more responses between contractor company managers and government managers stating awareness of the need for a healthcare management system for contractors who return from Iraq and Afghanistan. The nine themes used in the analysis showed participants thought and attitudes. I journalized the themes during research of the literature review which proved to be pivotal in the study, and the direction

I hoped participant responses would take. The reference to some participant responses, comparison of documentation from the contractor company managers and the noncombatant military members' documentation was also a pivotal point in the study. During this review of individual participants' response, readers have a better understanding of the data and attitudes of the contractors company managers and government managers. It was also important to be able to chronical and triangulate data from interview questions, documentation from company manager and government managers. These responses are in more depth in Chapter 5 findings.

Summary

The purpose of this qualitative case study was to explore ways that contractor company managers and U.S. government managers can improve management practices to provide short term as well as long term care for future contractor personnel. Chapter 4 included a pilot study, the main study, and data-collection and data-analysis methods. Twenty managers, 10 contractor company managers, and 10 government managers gave insight from their side of managing healthcare services for contractors who will deploy to Iraq or Afghanistan. Chapter 4, data analysis focused on contractor managers and government managers' experiences in providing information pertaining to healthcare management services to contractors who deployed to Iraq or Afghanistan for a minimum of 365 days compared to noncombatant military members. As stated in earlier chapters this area of inquiry is largely understudied. In Chapter 4, I presented the results of this study and the answers to this study's research questions. The description of the data

collection involving time frame for data collection, descriptive and demographic characteristics of the sample, and descriptions of the representation of the sample is off the population, of the population, and a detailed analysis finding was discussed in Chapter 4.

In Chapter 5, I include more in depth about the complete findings of the study and suggestions and ideas to possibly assist management as they work to revamp, modify, or create a healthcare management system for contractors who will deploy to Iraq or Afghanistan.

Chapter 5: Discussion, Conclusion, and Recommendations

Contractor personnel working in a combat zone, deployed with the United States military, have no direct engagement with the enemy, carry no weapons, and yet, they are still exposed to the same environment as their noncombatant military counterparts. The U.S. government has programs in place to assist noncombatant military members during and after deployment; however, the contractor is not authorized to use these programs. The purpose of this qualitative case study was to explore ways that contractor company managers and U.S. government managers can improve management practices to provide short term as well as long term healthcare for future contractor personnel. The objective was to analyze how contractor company managers and government managers can improve the future system provided to contractors in receiving short-term and long-term healthcare that may be needed because of injuries received during their employment in a combat zone. I asked 20 American participants, 10 contractor company managers and 10 government managers, open-ended interview questions to address the research questions and review of contractor company HR information that they disseminate to contractors before they deploy them to Iraq or Afghanistan and review of documentation given to noncombatant military members. I conducted a qualitative analysis case study with two additional sources of data for methodological triangulation, which was critical in examining theories that were critical in examining theories that contractor company managers and government manager's engagement in providing a revamped system, a new system, or a consolidated system for contractors who will deploy to Iraq or Afghanistan.

Data obtained from this individual study conducted on the notion that exploring ways that contractor company managers and U.S. government managers could improve management practices to provide short term, as well as long term healthcare for future contractor personnel who may deploy to a war zone, was analysed individually using data analysis from three different sources on providing healthcare management for contractors provided truth and impact the reader because of their real life context and the emphasis placed on a lived experience. Yin (2015) stated that the abundance of context in qualitative studies since the setting of the study involves the everyday lives of different people regarding how their past or current circumstances. Yin stated five distinctive features which were evident in this study:

1. Studying the meaning of people's lives, in their real-world roles.
2. Representing the views and perspectives of people labeled throughout the research, as the participants in the study.
3. Explicitly attending to and accounting for real-world contextual conditions.
4. Contributing insights from existing or new concepts that may help to explain social behavior and thinking.
5. Acknowledging the potential relevance of multiple sources of evidence rather than relying on a single source alone (p. 11).

Overall, the 20 Americans 10 contractor company managers and 10 government managers varied in their experiences, feelings, and behaviors in dealing with managing

healthcare for contractors who they deployed or had oversight over, to Iraq or Afghanistan.

Interpretation of Findings

The responses given by the contractor managers and government managers during the taped sessions in addition to, the analysis of two other data sources interpreted by the participants yielded additional codes recognized during the review of the data. A recorded list based on the emerging themes and patterns from the triangulation of data from the interview questions, analysis of predeployment documentation given to contractors from contractor company manager compared to the documentation received by noncombatant military members, not mentioned in the preassessment of possible codes found is represented in Table 5. The new all-inclusive table of codes and code definitions in where the bulk of the research finding confirmed portions of the literature review, as well as alignment with the theory. Richards (2015) stated that data analysis and triangulation gives your data more depth into the code definitions, based on observation and progression into the research because of the attention to detail and perspectives of the participants. Recoding refined my categories and placed more depth into the code, definitions, based on observation progression into the research because of the attention to detail and perspectives of the participants.

Table 6

Recorded List of Patterns Codes and Definitions

Code	Code Definition
Training	Implies that contractor company managers and government managers will need to be training on the new system.
Preventing Failure	Implies that all organizations need to use lessons learned from past system implementation success and failures to ensure a successful implementation.
Coordination	When a new system is implemented, company managers will have to coordination with other managers located in Iraq and Afghanistan as well as other government agencies to ensure contractors and all interested parties know of the new system existence.
Cross platform implementation	All organizations need to implement the same or similar process, system, or operating capabilities.
Ownership of the system or process	At what point does any organization hand off the responsibility of the contractors to

the gaining organization. When does the government get involved?

As stated earlier in the study most of the research and information and access to healthcare for returning Americans from war was conducted for military members. Ginter (2012) stated that the DoD has developed long range strategic management of healthcare since the 1950s. From my case study, all 20 American participants: 10 contract company managers and 10 government managers expressed major concern of there being a need for a healthcare management system for contractors returning from Iraq or Afghanistan. Several of the participants from the government management team and contractor management team stated that new polices or procedures may have to be adopted to better provide a healthcare management system for future contractors. Several participants from the contractor managers and government managers expressed concerns during and after the interview about having to an increased their work function if a new healthcare management system was implemented. These concerns were not limited to just work load but also included issues or training, ease of use of a new system, and monetary compensation. Contractor company managers and government managers involved with the modification of the current system or implementation of the new system stated they would prefer a more hands on approach to the change in the organization. Ginter (2012) explained that when modifying healthcare systems, the culture of change and understanding in an organization needs to start at higher management discussions with the critical level management addressing the initial planning and accountability.

Training was one of the major theme mentioned by a majority of the contract company manages and government managers. Several expressed interests on who would provide the training on the new system, where would the training take place and on what platform would the training take place, (e.g. would the training be at a conference, online, or individual). In addition to, what level of training will be needed for each iteration of this system? Ginter (2013) stated that training programs have little value unless complemented with modern technology and management tools. Many of the participants after conducting the interview stated training as one of the key components when implementing a new system and indicated that based on the training received by the contractor company managers and government managers the outcome of the new system would be received with little to no resistance.

Preventing failure is also key in implementing change in a modified healthcare system which Ginter (2012) suggested is critically based on an organization history on past change implementation. The contractor company managers and government participants involved in this study confirmed both organizations need to communicate with each other about any change or upgrade to the current systems. Previous discussions about system change were done internally and did not include any other contracting company or government agency. The contractor company managers and government managers did explain that before this study they had little understanding about the disparity of information, services, and assistance available to contractors' vs noncombatant military members. Previous communication about healthcare related

services or any conversation was only minimal or nonexistence. Contractor company managers and government managers also referred to the Department of Labor and their role in providing healthcare to deployed contractors; however, this insurance is provided by the contractor company and provided to contractors while deployed the issue, explained to the participants, during the interviews, was for healthcare related services after they leave the organization and for future contractors.

Coordination was also identified as a major theme if a new system is implemented. Both sets of participants' contractor company manager and government manager stated that coordination between the company managers and government managers located in the United States and Iraq or Afghanistan need to coordinate their efforts to ensure a more streamlined approach if a new system is implemented. Ginter (2013) determined that development of a new healthcare system has become the responsibility of key managers, usually the chief executive officer (CEO), but the entire management team is responsible for strategy development and its management. All participants understand also that the new system implemented needs to include the deployed contractor in the equation and understand the system needs to ease contractor frustration for a contractor who may require healthcare related services if needed.

Another issue mention by the contractor company managers and government managers was cross platform implementation, uniformity of a new system. Ginter (2013) stated that to implementing a new system requires:

- Strategic alternatives – If the first implementation of a new system is not conducive then alternatives needed to be identified.
- Identify unique cultures of an organization during the planning states – different companies have different cultures which have an influence on the style of and participation in strategic planning.
- Identify the stakeholders and who will work with third party companies – Most organization defer healthcare to an outside organization and have little control over healthcare plans or policies.
- Identify a viable system that has the provisions needed to for your organization – society and its values place special demands on healthcare organizations.

The organization contractor company managers and government managers need to implement the same system. This will ensure uniformity across the board and cut training time, retrain time, and downtime. Understand that different contractors have different backgrounds having a system with noticeable similarities will ensure that contractor company managers and government managers are able to disseminate information easily and disseminate the same information when communication to contractors on where they can get information for healthcare if needed.

Ownership is also identified as one of the key components to a new system success. Contractor company management teams from different companies and government managers from different government agencies develop strategies, plan

differently and foster different mission, vision, and valuable tools. Ginter (2013) stated that organizations run into trouble as if there is no ownership of the plan or the task associated with it. A significant number of the participants discussed the need for ownership of the new system '*having a bellybutton'* was identified as a key component for a system to be integrated. Some organizations have to have oversite of the new system and make the final decision as to what the final system will look like, which provisions will be finally implemented, and what will be added later. Understanding the new system will not simply be an extension of the organization current system but a consensus of all interested parties and their desired outcome for a future contractor who may need healthcare related services.

Limitation of the Study

The limitation of this qualitative case study was finding contractor company managers and government managers willing to speak to me. This limitation would have had a definite effect on obtaining needed saturation for assessment of how contractor company managers can improve management practices in the system provided to contractors in receiving short-term and long-term healthcare that may be needed because of injuries received during their employment in a combat zone. There were 33 participants who responded to the email invitation to participate in the research study.

Another limitation was difficulty in getting participants to communicate and not be biased about the companies or government agencies they work for while deploying contractors or overseeing the deployment of contractors to Iraq or Afghanistan. Each

participant was comfortable enough to speak with me on the phone, in a public location, and my home office.

A further limitation of this study was the deployment documentation given to contractors by the contractor managers and government managers having access to this information. I could collect all information need to complete the study from public access for the noncombatant military members but not the contractor deployment documentation given by the contractor manages who deployed the contractors to Iraq or Afghanistan. This limitation would have had a definite effect on obtaining needed saturation for assessment of how contractor managers provided healthcare for contractors, if needed. The contractor managers directed me to open source non-company proprietary locations where I obtained the contractor deployment documentation. Also, this research did not rely solely on deployment documentation but also used interview questions from contractor company managers and government managers. Also, all participants approved to have their interview response recorded via a microcassette recorder.

Recommendations

From this study, contractor managers who deploy contractors to Iraq or Afghanistan and government managers who have oversite and approve contractor deployment to Iraq or Afghanistan for a minimum of 365 days can take several actions based on the results of the research. There are three change models recommended for implementation for use for the contractors' managers and the government managers to potentially implement. The three models assessed from the literature review as possible

models to use in the case of my research, The Lewin model, evidence based management theory, and customer service theory. The nature of this issue requires that the change management take place for the managers of the contractors (unfreezing and freezing model); the modified system or new system implementation (evidence based theory); and the contractors in the future (customer service theory). All three areas must be addressed to facilitate a successful change model.

Lewin Model

The first change management model introduced by Lewin in 1947, described a three stage process of unfreezing and freezing to preparing employees for change and assisting them through change completion. A brief recap of the model explains how the first stage prepares the mind for a change; the second stage is the actual change, which is a transition; and the third stage takes the employee back to their comfort zone before the change happens. The seven phases to come about because of these three states are:

1. Setting up for success by starting with the result in mind.
2. Creating urgency by identifying early resistance and negative behaviors, and addressed accordingly.
3. Shaping the future of the organization by sharing all aspects of the change with all employees, and possibly printing vision statements to hang throughout the departments.
4. Implementing the change, the new process, and the additional skills to do a good job.

5. Support the shifting by once again identifying any resistance or negative behaviors, now that actual implementation has taken place.
6. Sustain momentum by reinforcing positive behaviors, and the employees show small milestones and recognizing in group meetings the progress made.
7. Stabilize the environment which is the capstone of the process, and the result of the permanent change of job (Lewin, 2000).

The Evidence Based Model

Another possible strong recommendation for the participants is to use evidence based management theory approach coined by Sackett in the 1990's, which he defined as the conscientious, explicit, and judicious use of current best evidence in making decision about the healthcare of the individual patient (Straus & Sackett, 2000). Straus and Sackett (2000) indicated that this was the most helpful way to answer a question because it is self-correcting. Evidence-based management (EBM) bases managerial decisions and organizational practices on the best available scientific evidence. When implementing EBM contractor managers' companies and government manager organizations could work within small working groups of managers trying to determine how to improve job processes, conduct comprehensive and objective survey, collect data; to determine if a new process is creating the environment needed or if further research is needed. (Straus & Sackett, 2000) stated that using EBM an organization would collect *n* number of responses, the data could be assessed revealing the conclusion to be either signification or

insignificant to future management decision. One of the main goals of EBM is backing up decisions with sound scientific reasoning and this process of thinking would be ideal when dealing with the current management of healthcare for contractors by the contractor company manager verse that provided by the military to noncombatant military members. Also, given the nature of the current research on this subject, which is minimal (Layard & Clark, 2014) explained that EBM has evolved to minimize the gap that exist between research and practice.

Customer Service Theory

A third theory that is very relevant and would be a good process for the contractor management and government managers is customer service theory (CST). Lucas (2014) explained that one of the key tenants of customer relations is to keep your customer happy. In designing a new system or modifying the current one to service future contractors who may need healthcare, in the future the contractor company managers and government managers need to know their audience. Lucas used a hierarchy of customer service model to identify steps contractor company managers and government managers can use to assist when considering a new system or modifying the current one. The model consists of several steps.

The first step of Lucas' (2014) change management model is *meeting unrecognized needs.* To meet unrecognized needs the contractor company managers and government managers must learn more about the need of the contractors deploying to

Iraq and Afghanistan developing a certain intuition about the need for better management of their healthcare needs if any. This can be accomplished by

1. Interacting with contractor
2. Build on what you learned
3. Engage them in conversation
4. Take the time to get to know their need so you can better manage the individual

Lucas stated that unrecognized needs are often not articulated, so contractor company managers and government managers must take an active approach.

The second step of Lucas' (2014) model is *meets desires*. To facilitate this need, contractor company managers and government managers must figure out exactly what processes are required to create, modify, or consolidate a new healthcare management system for a contractor who may need assistance if needed. Contractor company managers and government managers can use analytic tools and predictive modeling software to help them make sense of customer data, measure emotional responses, quantify customer requirement and response accordingly. Lucas stated that managers who deal directly with employees probably have a good idea of what the contractor's needs are and should be involved early in the process.

The third step is *meets expectations.* Contractor company managers and government managers can meet expectation with current customer service model. By optimizing transaction, having the answers to contractors' queries, and providing a decent

level of service. Lucas (2014) explained that many organization are starting to implement this step into processes to meet these simple customer need.

My recommendation is for the contractor company managers and government managers to seek out a proven model used in reengineering or creating a healthcare management system, which would incorporate some or all phases of the three change management models recommended. The U.S. Veterans Administration uses a model that I believe would provide the contractor company managers and government managers a base model to build on. The Veterans Administration (2012) stated that healthcare should be veteran-centric and calls this process a patient centered healthcare model. The Veterans Administrations healthcare delivery model is based on:

- Personalized, proactive and patient driven
- Team healthcare
- Continuous improvement
- Data driven, evidence based
- Value
- Prevention and population health (Veterans Administration, 2012).

The model utilizes what the Veterans Administration is called the veterans choice program. The Veterans Administration (2012) described the choice program as veteran access to healthcare through a comprehensive network of community based providers and augments the VA ability to provide specialty impatient and outpatient healthcare services to veterans in large cities and remote rural areas. In addition to, the Veterans Choice

model, I would also suggest that the contractor company managers and government managers implement a healthcare insurance system that is available throughout the United States and the territories. These healthcare plans are called multi-state insurance plans and are managed by the Office of Personnel Management (OPM). Under this program OPM contracts with private healthcare providers to offer high quality, affordable healthcare options. These healthcare plans are broad and accepted at many hospitals in the United States. Multi-State insurance plans must include the follow categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn healthcare
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision healthcare

If the contractor company managers and government managers implement a model similar to the Veterans Administration choice program and a multi-state insurance plan they would be able to modify or create a new system similar which would allow the two

organization a tool to better manage healthcare for future contractors who will deploy with the U.S. military and may require healthcare related services. It is imperative for management to follow all phases of the change process or model they chose to navigate their organization's change (Lucas, 2014). Contractor company managers and government managers who participated in this study admitted to some form of the process being needed to assist contractors with healthcare needs if any. The majority expressed concern for a better system for contractors and admitted the lack of effort toward creating a solution. The process looked good on paper, yet the reality of it taking place may take some time and critical planning.

The view of contractor company managers and government managers for a need and a desire to provide a healthcare management system was very positive. Since the participants all sided with a positive view it is a strong indication of a more detailed analysis, which could take place by contractor company managers and government manager upper management teams.

Implication for Positive Social Change

Participants gave examples of how they would change the current system or adopt a new system for contractors being deployed to Iraq or Afghanistan in the future. Several participants depicted large group management meeting to discuss the change management or conferences to facilitate the training for the new system and stated the real reason for coming would be lost in the crowds of contractor company managers and government managers pushing their own agenda. Several participants also stated that

smaller sessions would only become grip sessions since contractor company managers and government managers have no real decision making authority, or some have an unwilling to give top level management the information being discussed in this study because, as stated by some of the participants about top management, they are only concern with the bottom line. Feeling of job loss and increased work assignment brought agitation and frustration, while others welcome the need to help facilitate a new system for contractors returning from Iraq or Afghanistan and needed a healthcare management system; all signs of negative and positive social change with the contractor company managers and government managers.

Top level management from contractor company manager and government managers are responsible for making decisions that affect an entire organization which involves any form of major administrative change. They should take strong consideration of the human side of change from the participants on this study or any other middle managers from the contractor company manager or government management organization. Business processes management will be inevitably a part or any change within an organization. The contractor in the future will be affected by the change and contractor company managers and government managers need to understand all components of the change and its direct relational effect to future contractors who will inherit the new system for managing healthcare. A managerial decision from the contractor company managers and government managers should include the contractor needs in all aspects of the change by using communication and training, as well as

providing process and tools for managers to effectively lead change amongst their contractors who are deployed and, for this case study, in the future. Lucas (2014) stated that good change management should listen to employees encourage their input and suggestions, develop corrective action program and the conclusion of celebrating small and large success throughout the change implementation. The key to overall positive social change is communication. More than 80 percent of participants who participated in this study stated communication as one of the key components in effectively implementing a change.

Methodology Theory and Practice

Qualitative case study research in which each participant was considered an individual case, based on the method of focused interview to obtain data proved to be effective in explaining the theory or the study. The use of triangulation of data patterns and codes according to Lucas (2014) in the research helps established a correspondence between two or more categories of text. It becomes important in showing the relationship. Participants' data shows the analysis of how codes related to each response to a interview question. Patterns were drawn to form the level of relationship for the response to guide us in how important these major codes of what is available to contractor verse what is available to noncombat military members and the need for a system implementation upgrade.

Yin (2015) stated qualitative research allow researchers to get a deeper understanding of complex issues revealed in research. The participants from the

contractor managers and government managers showed a snippet of these issues and the relative factors affecting the healthcare management needs for a contractor who will deploy to Iraq or Afghanistan. This social research through in-depth interviewing where each participant was separate case study, has the potential of using exact information from the transcripts to analyze future the thoughts, ideas, concerns, of the participants in how management can explore ways that contractor company managers and government managers can work together to provide healthcare for those contract employees who will be deployed with the U.S. Government.

Conclusions

The qualitative holistic case study analysis using open-ended interview of 20 American participants: 10 contractor company managers who deployed contractors to Iraq or Afghanistan for 365 days and 10 government managers who had oversight of the contractors for the 365 days they were deployed to Iraq or Afghanistan. My hypothesis on contractor company managers and government managers need to provide a better healthcare management system for contractor returning from Iraq or Afghanistan has proved correct. The literature review dates to the Roman Empire to the present war in Iraq and Afghanistan for the bases on the importance of assisting for healthcare related issues. The participants exhibited strong concerns for future contractors and a need for a healthcare system for contractors who may return from Iraq or Afghanistan and may require management of their healthcare services. The participants stated that before a new system could be implemented or the current system upgraded, effective communication

before, during, and after the change needs to happen. The participants also noted that training would be a factor in developing a new system or modifying the current system. The most important aspect for the company contractor manages and government managers for the contractors would be a show of concern and commitment during all phases of implementation including discussion with current contractors who are deployed to Iraq or Afghanistan or recently returned from any of the current combat zones. These discussions will help managers of contractors' gain a better understand into what is needed for future contractors who may deploy to Iraq or Afghanistan and may need assistance with managing their healthcare. As stated earlier in this study most of the research on healthcare management in a combat zone has been done on noncombatant military members with little to no data on U.S. civilians in a war zone. After conducting this research, I am confident there is hope as contractor company managers and government managers can continue to explore ways that contractor company managers and government managers can improve management practices to provide short term as well as long term healthcare management system for future contractor personnel.

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Appendix A: Permission to Use

Hello,

My name is Gary Williams. I am a doctoral student with Walden University. I would like to use some of your material for my dissertation. Your paper is title: Qualitative Research: Why use theories in qualitative research?

BMJ 2008:337:a949 doi: 10.1136/bmj.a949

Reply:

Of course. I hope the paper is helpful to your thesis

Hi Gary,

I reached to the GAO staff concerning your request and he stated the following:

While I don't see the same numbers on page 8 as those provided by Gary, those numbers come from, according to CRS, CENTCOM's Quarterly Contractor Census Reports.

Reply:

Gary can cite to the CRS report (which has been updated since then), contact the author, Moshe Schwartz directly, or he can view the census reports online at http://www.acq.osd.mil/log/PS/CENTCOM_reports.html.

Thank you! Pat

Hello,

My name is Gary Williams and I am a doctoral student at Walden University. I apologize for sending this email from my work but I have limited bandwidth at my location. I request permission to use charts and documentation located on your website. The charts are listed below in HTML format for your review.

Figure 1. Breakdown by job performed by contractors in area of

responsibility.

Reply:

Hi Gary,

All of our information on our website is in the public domain, so you have permission to use it.

Best,

Setareh Kamali, MPS

Hello,

My name is Gary Williams and I am a doctoral student at Walden University. I apologize for sending this email from my work but I have limited bandwidth at my location. I request permission to use charts and documentation located on your website. The charts are listed below in HTML format for your review.

Rates of Post-Traumatic Stress Disorder in the General Population: National Comorbidity Study.

	Males	Females
One lifetime incident	60.7%	51.2%
Four or more incidents	10.0%	6.0%
Lifetime rates of PTSD	7.8%	7.8

Note. From *Home,* National Institute of Mental Health, 2009, Bethesda, MD: Author. Reprinted with permission.

Reply:

Dear Gary

Thank you for your email and for clarifying your request. You may quote from the article

but please ensure you include a full reference and a link to the original article.
I hope your dissertation proposal goes well.
With kind regards
Lucy Alexander

Hello,
My name is Gary Williams and I am a graduate student with Walden University.
I would like to permission to reuse your material for my dissertation
proposal.
Below is the information of your journal:
The British Journal of Psychiatry (2005) 186: 473-475 doi:10.1192/bjp.186.6.473
Of course you can quote. I hope the paper is helpful to your thesis

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Hello,
My name is Gary Williams. I am a doctoral student with Walden University. I would like to use some of your material for my dissertation. Your paper is title: Qualitative Research: Why use theories in qualitative research?

BMJ 2008:337:a949 doi:10.1136/bmj.a949

Appendix B: Interview Questions

Interview Questions

1. What are some of the pitfall your organization has with managing long term healthcare for contractors who have deployed to a foreign combat zone? (RQ1)
2. How does your organization feel about the future management of healthcare for contractors who will returned from a foreign combat zone? (RQ1)
3. What information does your organization provide to contractors after they return from a combat zone? (RQ1)
4. How can the information your organization provides be improved in the future? (RQ2)
5. How does your organization manage the healthcare issues for contractors after they leave your organization? (RQ2)
6. What are some of the difficulties your organization find with managing healthcare for contractors in the future? (RQ2)
7. What solution can your organization propose to further manage the healthcare for contractors when they leave your organization now? (RQ3)
8. What solution does your organization have in place now to ensure healthcare is provided to contactors in the future after they leave your organization? (RQ3)

9. What process can organization put in place to manage healthcare for future contractors who may need healthcare services in the near future? (RQ3)

Appendix C: Transcripts from Participants

Transcripts from Participants

Contractors Company Managers

Theme: Keeping track of these contractors after they leave the company

Was a theme based on the information provided by participant's thoughts what solution can your organization propose to further manage the healthcare for contractors when they leave your organization now. This question gave many of the participants a pause and made them think about a solution. Many had ideas and thoughts on how to track participants and what process to put in place. The real question many stated was how to track, who will track or maintain the information, and how long will companies and the government keep this information? Participant 1 from the contractor company managers had a very unifying message for all organizations.

Participant 1 stated:

Well, being a member of the management team with responsibility for pushing out contractors to Iraq or Afghanistan or one of the members with that responsibility of deploying contractors I take it personally when it comes to the well-being of contractors. To answer the question what pitfalls do we have I think it starts with communication between our organization, other organizations, and the government guys. If we had a better system to communicate with contractors or a consolidated website for contractors to request medical services or ask a question I think it would increase the output of

information to contactors and give contractors some of the access they need or at least some. Unfortunately, now we are not equipped to facilitate that at this time.

Participant 2 stated:

In order to assist contractors when they leave the organization we would have to have some type of tracking system similar to the one we use to recruit contractors. However, this one would be to track contractors after they leave our company. I believe by modifying a system that we already have would be a better option than to develop a new one.

Participant 3 stated:

A system that doesn't expire would be great for these guys and girls who we deploy overseas in a war zone. The problem with keeping track of contract is the need to track them. For example, if we use contractors now we have a need for a system to manage them. If that changes in the future, then we will reduce the contractor footprint in a war zone and essentially eliminate the need for them. The problem with the second approach is this, we will forget about them, upkeep of the system will become second nature and the need for a system will fade into nothing. What we need is a system that will not be forgotten I believe this could be done if this system is monitored by the government and maintained by the government with contractors just inputting data only.

Participant 4 stated:

We can do many things to assist contractors with the management of their healthcare needs. I do not think we should be the only one's tracking contractor as they are employed by the contractor company and the government so I believe it should be a dual approach where we both maintain a system for these individual contractors.

Participant 5 stated:

As managers or contractor, we need a better process or methodology to keep track of these employee's after they move to other companies or leave the government contracting arena all together. The system in place now only moved these contractors to a residual file after they leave and only activates if they are rehired.

Participant 6 stated:

Like the military members who leave the military and are able to contact the Veterans administration and they manage the former military members healthcare needs after they leave the military. The contractors need a similar system. I believe if you apply the model from the veteran administration the company managers and government managers would have a system similar that would effectively give them what they need.

Participant 7 stated:

If we only collect contact information it would not answer this question or the mail when it comes to managing healthcare for contractors. We need a process, identifier, or a database to house information on contractors that will not change. That being said, cell phone number, house address, and names change so I don't know how we can do it.

Participant 8 stated:

Where can I start, we can do multiple things to manage the healthcare of contractors when they leave our company. One, we can send postal mail to their home of record yearly. Two, we can send an email address we have on record. Three, we can keep some personal identifiable information on file. The problem arises when contractors change their names, close email address, or move.

Participant 9 stated:

I have no idea how we can manage their healthcare after they leave. They are no longer our problem. This issue should be resolved from a top down approach meaning, the corporate level managers need to devise a plan to assist these temporary employees with a program for managing their healthcare.

Participant 10 stated:

I think to start we should keep a database for the contractors to track them. Also, in addition to this database we need to reach out to the contractors yearly to keep our information updated.

Theme: Consolidation of information:

Was a theme based on the information provided by participant's thoughts on how can the information your organization provides be improved in the future. Many of the participants were very enthusiastic about finding a solution to this question. Participant 5 from contractor company managers had a very deep emotion about this question. This

was due according to him, being a contactor prior to obtaining a job as a contractor company manager.

Participant 1 stated:

Well, first I know all we provide in the onboarding is medical information, 401k information, and information for company e.g. history, executive staff, and our vision for moving forward. To assist these contractors with managing healthcare I do not know. I can give a few suggestions as to how it can be done but I'm not confident my suggestion would make it to the decision makers. Humbly, I hope the system in place today gets better.

Participant 2 stated:

In the future we can add information about healthcare management to the packages we give the contractors when they deploy. Before we do that, we will have to fix the issue with healthcare management and only after we have a better system we can change the methodology and process we use for contractors. Hopefully this lead to a better system and will give the contractors what they need.

Participant 3 stated:

I would modify what we have now making is scalable to what we will need in the future. I think if we had studied this subject during WWI/WWII we would have a better understanding of this issue and what issues contractors are having with healthcare management.

Participant 4 stated:

In many ways the information we provide can be improved. We provide little to no information about healthcare after the employees leave the company. The only medical information we provide is related to COBRA insurance, which is for people who are unemployed. Most of the individual who leave our organization usually move to another company.

Participant 5 stated:

I asked myself that question when I was a contractor, small world, I'm asking myself again as a contractor manager. How can the information get better? There are a multitude of answers to this question and many point to a realization that we need to work together to make this happen. Meaning, the companies and government need to work together to come up with a process or program that consolidates this information into a location where anybody can receive or retrieve healthcare related information.

Participant 6 stated:

Information can be improved by consolidating information for all contractors and keeping it updated. I hope this will make the information more accessible and hopeful make healthcare management better for contractors.

Participant 7 stated:

By creating an organization that keeps contractors' data, tracks contractors, and sends out yearly correspondence. I think we can reach more contractors. All we provide is out processing documentation that explains healthcare, insurance, and corporate proprietary information.

Participant 8 stated:

I have no idea how to address this question or where to start. First, we need to identify what our shortcoming are with the current system and build from there. Second, we need to inform and education our staff on the new system. Third, we need to plan for continuity by having redundancy build into the plan of action. I feel this will help the contractors in the future.

Participant 9 stated:

We can improve information by working with other companies that deploy contractors and the government to develop a system to house this information.

Participant 10 stated:

By creating a better system where information is shared between contracting companies and government agencies. This I think will improve healthcare management for contractors in the future. Also, fixing the issues with the current system, making it mandatory for all to use this will also help with the management of healthcare for contactors.

Theme: We do not manage it

Was a theme based on the information provided by participant's thoughts on how does your organization manage the healthcare issues for contractors after they leave your organization. Several of the contractor company manager who participated in this study did not know of any process for tracking contractors after they leave the organization. Several also stated it was the government's jobs to track contractors and many of the

government managers stated it was the contractor company managers stated it was the duty of the government. All express a need for a system to be developed most alluded to a database, maybe sending out yearly letters or correspondence to keep information updated and current. Participant 7 from contractor company managers made his view clear during the interview.

Participant 1 stated:

From my understanding we do not track contractors after they leave. We have no reason to do this. After participating in this study, I now know there is a need to do so.

Participant 2 stated:

We manage them badly I guess because we do not keep track of contactors after they leave our organization. They are not our problem and therefore not on our radar. Now I see that is not the correct answer after taking this survey.

Participant 3 stated:

Well to honestly answer your question I have to say we don't track them. Until I participated in this study I did not understand the severity in managing healthcare for contractors.

Participant 4 stated:

I know we provide nothing other than out processing paperwork with information pertaining to when the healthcare will end and government deployment information for example, access to government email and information.

Participants 5 stated:

I know we track contractors who we believe we may rehire. Other than that, we don't track then for anything after we out process them the file is closed and they are considered former employees.

Participants 6 stated:

We don't track contractors after they leave our company. We do keep their information in case we rehire them. From this information we could probably create a system for tracking contractors. From here we could share this information with other companies that do business with the DoD deploying them to a war zone.

Participant 7 stated:

As we move forward with decreasing the military presents in these areas we start to hiring contractors to fill these positions. This is good for contractor companies but for the contractors who we deploy we have to do a better job of keeping up with these contractors after they leave. Once these employees leave project, which they work on overseas, they stay with our organization just under a different division. Those employees' we can track. The majority of the employees do not go to different division they leave our company these are the individuals we have a problem tracking. I do not know how to fix the current system my suggestion would be a central tracking system or website or something.

Participant 8 stated:

The system we have now only keeps a small amount of information on contractors. In order for us to facilitate a system for tracking contractors we would need

to work with other companies and the government to modify the system they have now or create a new one.

Participant 9 stated:

We do not have a mechanism in place to manage the healthcare of contractors after they leave our company. We do keep certain documentation on past employees but most of this information has a deletion date which is usually 3 to 12 months.

Participants 10 stated:

This will require a lot of time that I do not have and resources from other departments to help facilitate a major undertaking like tracking former employees after they leave. We are not equipped to perform this at this time.

Theme: Knowing what they need now

Was a theme based on the information provided by participant's thoughts on what are some of the difficulties your organization find with managing healthcare for contractors in the future. The participants all expressed concern for this topic and most or all of them, government and contractor managers stated that tracking contractors is one of the many difficulties they have and will continue to have if they did have a process in place in the future. Participant 2 from contractor company managers was a project manager for a major contract in Iraq and he stated his concerns about employees having this for the future.

Participant 1 stated:

We are missing a process for conducting this. This process would have to be adopted by all or multiple contracting company and signed off by the government.

Participants 2 stated:

Wow, I am so excited about this and what we can do about this. I believe if we could create, maintain, and manage a tracking system for theses contractors we can better assist them with healthcare needs. The problem is, who will manage the system, will they create another company to perform the tracking of contractors or will we rely on the government, Department of Labor (DOL) or another agency to manage this system for contractors in the future. I think the problem will occur when you try to reach out to contractors who work for different companies, most will not talk to you because they work for a different employer. So, I think the best way to approach this problem would be a consolidated system where either a neutral party controls this process or contract it out.

Participant 3 stated:

I can identify several issues we have keeping information on contractors after they leave, a system for housing this information, and someone to management this health system.

Participant 4 stated:

A willingness to do it is one of the problems. Before I did this study, I did not understand or realize the necessity for a healthcare management system. Second tracking these contractors would be key. Because we are talking about future contractors we have time to develop a system or modify a current one.

Participant 5 stated:

One issue I see is with knowledge of what contractors need for healthcare management. Meaning, what we can manage, where will the information be held, and what data do we keep.

Participant 6 stated:

Tracking contractors will be an issue unless we create a system or modify one that we have now. The Veterans Administration has the model we can use and if we based our model on the one used by the VA we should be at a good starting point.

Participant 7 stated:

Keeping information on contractors after they leave is one major issue we have. We do not have a system in place at this time to manage healthcare for contractors in the future. The only way to achieve healthcare management would be to model it after a system already on the market today and modify that system to fit our needs.

Participant 8 stated:

Keeping information on contractors is one thing we can do to manage healthcare for contractors after they leave. What information, I think we should keep information on home of record and next of kin. These two items I think we can use to keep track of these contractors after they leave our organization.

Participant 9 stated:

Several things come to mind, keeping a system to track contractors is one thing we can do. Second, start conversation now with other companies and government managers to develop a system in the future.

Participant 10 stated:

Keep contract with contractors after they leave is one thing we can do. This will better facilitate managing a healthcare system for them. Also, we need a better system for tracking contractors and we need other agencies to use the same system so we can have continuity for the system being utilized.

Theme: None

Was a theme based on the information provided by participant's thoughts on what solution does your organization have in place now to ensure healthcare is provided to contactors in the future after they leave your organization. These views were shared by multiple participants who expressed concerns about future contractors and managing their healthcare related issues. Participant 8 from contractor managers was previously in charge of multiple contracts spanning from Iraq to Afghanistan managing multiple contractors on different tasks supporting different U.S. military customers and he stated that the previous management team discussed this topic in detail because of the exodus of military members and influx of contractors in theater.

Participant 1 stated:

This is something we need to look into as we have nothing at the moment.

Participant 2 stated:

We provide nothing to contractors after they leave the war zone.

Participant 3 stated:

Nothing that I'm aware of. We only give information about unemployed insurance options when they leave Iraq or Afghanistan. They only take this option if they are receiving unemployment.

Participant 4 stated:

We provide no services for contractors after they leave the war zone.

Participant 5 stated:

When contractors inform us that that intend to terminate employment while in Iraq or Afghanistan we out process them. After out processing the contractors we provide documentation for unemployment insurance. We provide nothing else for contractors relating to healthcare management services.

Participant 6 stated:

We provide no healthcare management services after the contractor leaves Iraq or Afghanistan.

Participant 7 stated:

We provide no healthcare management services to the contractors after they leave Iraq or Afghanistan.

Participant 8 stated:

When contractors leave our organization we have no oversite, tracking, status, or anything to do with them. During this interview, I mentioned the previous management team and how they wanted to track contractors for this very purpose. This program was shelved for other priorities, programs, and mission requirements. “Basically, setting up a system for tracking contractors now or in the future was not the priority but it will be soon.” With the current up tempo and movement of military members the government will rely more on contractors to fill many noncombat related jobs and with that there needs to be a better system to track contractors not just for healthcare related issues but for all issues they endure in austere environments. With a system in place for contractors now and in the future, we will be better prepared for upcoming deployments, shifts in priorities from the government, and tracking new technologies.

Participant 9 stated:

We do not provide any healthcare management services to contractors after they leave our organization while deployed to Iraq or Afghanistan.

Participant 10 stated:

Our organization provides no healthcare management services to contractors once they inform the management team of their intent to terminate employment while in Iraq or Afghanistan.

Theme: A central database

Was a theme based on the information provided by participant's thoughts on what process can organization put in place to manage healthcare for future contractors who may need healthcare services in the near future. Many of the participants stated this as a major issue and should be a priority or one of the first milestones accomplished if a reengineered system was created or a newer one created. Participant 4 from government managers, who is a supervisor in his organization stated that he was aware of other agencies keeping this information in a database but was not sure. He also stated that this would not be a government function alone it should be shared between the government and contracting companies.

Participant 1 stated:

From a contractor prospective we could take the information we have not consolidate into a central database and build a healthcare management system from the data we already have. This healthcare management systems can be tested on current contractors who are deployed to Iraq or Afghanistan and use for future contractors who will deploy to Iraq or Afghanistan.

Participant 2 stated:

If contractors company manages and government managers can work with current contractors and build a healthcare management system for future contractors based on data collected by contractors' company manager, government managers, and current contractors.

Participant 3 stated:

We can implement processes that retains current contractor's data after they terminate employment and leave Iraq or Afghanistan. This process will allow us to build a central database and from that database we can start to create a healthcare management system for contractors.

Participant 4 stated:

For this system to work we need to work together. The current systems we have is not effective nor will it fulfill what we need to do. Today we have multiple systems for tracking contractors for different reasons none of these systems track healthcare related issues. Really not sure if the contract companies are tracking contract, I would say they are not, if asked officially. Moving forward a central database would be ideal but I think the problem and the need to corroborate with contractor managers is due to the upkeep with the system, inputting information, verifying the information and scrubbing for discrepancies. These are key components to ensuring a viable system that will meet the needs of contractors, that works.

Participant 5 stated:

I can think of many processes we can put in place to assist contractors in the future with healthcare management services. However, we need to build a system based on information we have today. We need to start to collect data from current contractors deployed to Iraq or Afghanistan. From this data of currently deployed contractors we can

work with current contractors to build a database and system to manage healthcare services for future contractors.

Participant 6 stated:

I think if we build a database centralize it and make it mandatory for all companies' government and contractors company, who deploy contractors to Iraq or Afghanistan we could use this process to build a healthcare management system for contractors to use in the future.

Participant 7 stated:

One process we can put in place is to build a central database based on current deployed contractor in Iraq or Afghanistan. Use the lessons learned from the currently deployed contractors in Iraq or Afghanistan and build a better healthcare management system for future contractors.

Participant 8 stated:

To assist future contractors who will deploy to Iraq or Afghanistan we can implement a process today which captures all contractors' data for current contractors deployed to Iraq or Afghanistan. We can take the data from current deployed contractors and build a healthcare management system for future contractors who will deploy to a war zone.

Participant 9 stated:

One process we can put in place is to take the lessons learned from current deployed contractors to Iraq or Afghanistan. Take that information work with other

contractors' companies, government managers, and current contractors to build a healthcare management system for future contractors.

Participant 10 stated:

Several processes come to mind that can be done to assist future contractors with healthcare management. The one that stands out to me is to develop a healthcare management system today based on needs of current contractors deployed to Iraq or Afghanistan. By using the knowledge, situation, and feedback from current contractors we the company managers and government manages can take this data centralize it on a mainframe somewhere and use the lessons learned to develop a healthcare management system for future contractors.

Theme: Confident

Was based on the theme from information provided by participant's thoughts on how your organization feels about the future management of healthcare for contractors who will return from a foreign combat zone. The responses revealed the confidence managers feel about the future of healthcare related management for future contractors. Also, both management team's contractor company managers and government managers shared this sentiment about the confidence. Contractor company managers and government managers both said they have had multiple meeting with upper management pertaining to this very subject. Participant 5 of contractor company managers stated that he was very enthusiastic about the future or healthcare management for contractors in a war zone.

Participant 1 stated:

After participating in this study, I know I feel a bit more confident about the future of healthcare management for contractors who will deploy to Iraq or Afghanistan. Knowing what we need to do and the pitfall facing our civilians at war we can now start to plan and prepare for this daunting task.

Participant 2 stated:

Taking this survey and listing to the ins and outs the contractors facing now helps me get a mental picture of what the future contractors who will deploy to Iraq or Afghanistan will need from a healthcare management system. I now know what direction we need to move it and have nothing for the upmost confidence in our team to fine a healthcare management system that will give our future contractors what they need.

Participant 3 stated:

My outlook if bright when it comes to build or creating a healthcare management system for future contractors. Based on what we now know and understand I believe we can provide what future contractors' needs based on what we learn today.

Participant 4 stated:

I believe confident is the work I would use when I think about the future of healthcare management for future contractors. If we take the time and involve current contractors and managers from both government and company we can develop a healthcare management system that can be used by future contractors who deploy to a war zone.

Participant 5 stated:

I have a very positive outlook when it comes to future healthcare management for contractors who will deploy to Iraq or Afghanistan. If we use the lessons learned from current contractors deployed to a war zone. Take the information develop from the information collected from contractors currently in Iraq or Afghanistan, and develop a healthcare management system for future contractors from that data.

Participant 6 stated:

When I take into account the information I gained from participating in this study I feel confident about the future of healthcare management for contractors who will deploy to Iraq or Afghanistan. If we document the issues with providing this service to current contractors deployed to a war zone and use this information to develop a new system for future contractors we could, in my opinion, develop a great healthcare management system for future contractors.

Participant 7 stated:

I feel uncertain after participating in this study. We need a clear starting point to build a system for future contractors and we do not have one. We have to lockdown a process or a methodology now and I, before this study, did not know we had issues with providing healthcare management for future contractors. We need to take some kind of action to resolve this.

Participant 8 stated:

The future of contractors' healthcare management looks good to me. After participating in this study, I believe we can take the data collected and use the historical information and build a healthcare management system for contractors who will deploy to Iraq or Afghanistan in the future.

Participant 9 stated:

I feel confident about the future of healthcare management services for future contractors who will deploy to Iraq or Afghanistan. If we bring more and more attention to the issues facing contractors today it will hopefully build momentum for creating a robust healthcare management system for future contractors who will deploy.

Participant 10 stated:

I'm a bit confident after participating in this study about the future of healthcare management services for future contractors who will deploy to Iraq or Afghanistan.

Theme: A universal system

Was a theme based on the information provided by participants thoughts on what are some of the pitfall your organization has with managing long term healthcare for contractors who have deployed to a foreign combat zone. Both contractor company managers and government managers stated that a universal system for healthcare management for contractors who will deploy to Iraq or Afghanistan in the future is a key component in providing universal healthcare management for future American contractors deployed in a war zone. Participant 6 from the contractor company managers stated that there are too many out of the box healthcare system to choose from and that

contractors who will deploy need a more specialized one. Government and contractors' managers need to discuss the way forward.

Participant 1 stated:

Some pitfalls are a universal healthcare system, a directional way forward or how do we proceed in developing a healthcare management system, and historical knowledge of the situation (have we tried this before, if so where is the data? After we answer all these questions I believe we can then start to develop a system for managing healthcare for future contractors who will deploy to Iraq or Afghanistan.

Participant 2 stated:

Notable pitfalls are a universal system, a clear understanding on what is required to create, maintain, and scalability for a healthcare management system for contractors who will deploy to Iraq or Afghanistan in the future. If we can answer these questions we will have a better understanding as to what type of healthcare management system will be required in the future.

Participant 3 stated:

One pitfall I can see is that contractors today do not have a universal healthcare management system. If we can develop a system today we can use this management system which we will work all or most of the bugs out for contractors in the future.

Participant 4 stated:

The main pitfall is to provide a healthcare management system to future contractors who will deploy to a war zone. The issue surrounding providing a healthcare

management system for contractors who will deploy is what we know about the issue, how much coverage and for what, and who will manage the healthcare management system.

Participant 5 stated:

To offset the pitfalls that are facing future contractors who will deploy to Iraq or Afghanistan we have to develop a system based on what we know today. We need to involve current contractors and get input from them on what type of management healthcare system is required and build the requirement based on contractors input. From here we can consolidate the data in a central database.

Participant 6 stated:

Many of the pitfalls has to do with information, storing the information, and type of information needed to create a healthcare management system for future contractors. First, we need to collect data from current contractors. Second, we need to let current contractors deployed to Iraq or Afghanistan to communicate to company managers and government managers what issues they have and how we can help. Third, we need to build a healthcare management system based on data collected and information given from the currently deployed contractors in Iraq or Afghanistan.

Participant 7 stated:

To fix many of the pitfalls we need to develop a central database for all contractors currently deployed to Iraq or Afghanistan. From this we can centralize the

data and create a healthcare management system for future contractors who may deploy to Iraq or Afghanistan.

Participant 8 stated:

I can think of many pitfalls however, to overcome many of them I believe to assist the contractors in the future who may need a healthcare management system we should utilize the resources we have today. We need to collect as much data from current contractors as we can. Consolidate this data in a central database and from that database build a healthcare management system for future contractors who may require healthcare management services, if needed.

Participant 9 stated:

Well, to fix many of the issues we have with providing management of healthcare services for future contractors who may deploy to Iraq or Afghanistan we need to consolidate all the data and build a healthcare management system from the data collected from current contractors who are deployed to Iraq or Afghanistan.

Participant 10 stated:

Many of the pitfalls associated with managing healthcare services for future contractors who may need assistance are rooted in the historical knowledge about this issue. We have no historical knowledge so we need to start collecting this data from current contractors who are now deployed to Iraq or Afghanistan. From that point we could build a healthcare management system which can be used by future contractors.

Theme: Basic information

Was a theme based on the information provided by participant's thoughts on what information does your organization provide to contractors after they return from a combat zone. The participants were unaware of the abundant of information the government managers needed to provide to contractors but expressed understanding and awareness of the need for this information to be disseminated and or available to contractors. Participant 3 from company contractor managers stated that he was willing and express interest in helping contractors with long term healthcare needs, if any.

Participant 1 stated:

Once contractors inform the management team or their intent to leave Iraq or Afghanistan we provide limited information about healthcare management. We provide an out processing checklist this check list has information pertaining to medical insurance for unemployed Americans. In addition to, insurance information we provide flight information for them to fly back to the United States. Where to turn in military equipment (military ballistic helmet, vest, gas mask) and company documentation and company computer, laptop, mobile phone, and other items or equipment.

Participant 2 stated:

The information we provide has nothing to do with managing healthcare services after they leave Iraq or Afghanistan. We provide limited/basic information about unemployed medical coverage, when out medical coverage will expire, and how to demobilize from Iraq or Afghanistan.

Participant 3 stated:

When contractors notify us of their readiness to leave the war zone and terminate employment we provide basic information to the contractor, no information pertaining to a healthcare management system. The information we provide is basic we only provide information about unemployed healthcare, how to transition out of Iraq or Afghanistan, and where to turn in company equipment or military equipment.

Participant 4 stated:

After contractors inform us that they are terminating employment while in Iraq or Afghanistan, we provide limited information to contractors pertaining to when benefits will expire (for our company), where to go to purchase your airline ticket to transition back to the United States, and where to turn in military equipment.

Participant 5 stated:

We do not provide any information about management of healthcare services. We provide basic information when contractors state they are leaving Iraq or Afghanistan.

Participant 6 stated:

We provide basic information to contractors when they inform us of their intent to terminate employment while in Iraq or Afghanistan.

Participant 7 stated:

Basically, once we are notified that the contractor is terminating employment we provide basic information in reference to leaving Iraq or Afghanistan and how and where to turn in military and corporate equipment and documents.

Participant 8 stated:

Once notified we out process the contractors by providing basic information relating to turning in equipment, medical insurance coverage, and where and how to purchase airline ticket to leave Iraq or Afghanistan.

Participant 9 stated:

When contractors terminate employment, we provide information to contractors pertaining to out processing from Iraq or Afghanistan.

Participant 10 stated:

Once notified of the contractors' intention to terminate employment we notify corporate and start the process for moving the contractors back to the United States. The individual contractor is given an airline ticket, instruction on when, where, and how to turn in government equipment and company equipment and paperwork.

Transcripts for participants

Government Managers

Theme: None

Was based on the theme based on the information provided by participant's thoughts on what solution does your organization have in place now to ensure healthcare

is provided to contractors in the future after they leave your organization. Participant expressed mixed emotion about this topic and most wanted to understand a timeline for implementing a system. Participant 2 from the government managers had very deep feeling about this topic and provided some insight.

Participant 2 stated:

I want to get a better understanding about the needs of the contractor in a combat zone. Until this questioner I only looked at contractors as commodities and not as people. After going through this study, I realized we have to treat them as we do our own people. In developing a system, we need to first identify what information we need to keep in order to reference when the contractor attempts to make contract. Meaning how do we identify them e.g. social security number or employee ID number, etc. This will not be an overnight process and will take some time to develop.

Participant 1 stated:

None, we have nothing at this time. Good question though something needs to be done. We know the need for contractors is only going to increase.

Participant 3 stated:

None that I know of, reach back for contractors is not available at this time

This is a contractor issue but needs to be worked by both sides of the equation contractor company managers and government managers. I do not know how to do it I just know it needs to be done and quickly. I think the problems that we are facing are who will control the system and what information will be included.

Participant 4 stated:

None, reach back for contractors is not available at this time

Contractor issue not government. Government cannot fix everything. However, if the government is getting involved to fix this issue then we will more than likely leave the system in place that is currently their now and modernize it to fit today's contractor's needs.

Participant 5 stated:

None, reach back for contractors is not available at this time. Not saying it's not needed just not available. I am not high enough on the food chain to make anything happen. I would like to suggest that we move slowly as if we move with our hair on fire we will and have miss something.

Participant 6 stated:

None, contractors need a way to contract the companies after they leave. Knowing it is needed should be the priority for these companies.

Participant 7 stated:

None, from my understanding this process is controlled by the contractor management team and we only provide deployment orders, housing, and medical for emergencies while deployed. These emergencies consist of loss of sight, limb, or life and anything else is handled while not in a combat zone.

Participant 8 stated:

None, we only deal with deployment to and from the location. We also leave the healthcare and feeding of the contractor to the contractor management team.

Participant 9 stated:

None, I have heard this question before but never paid any attention to answering it until now. I think it is a subject that should be approached but with caution. We as government have a specific role to play if a system is implemented and I would need to understand that role before I suggested a course of action.

Participant 10 stated:

None, I don't believe we have a dog in this fight. However, after completing this study I understand we have a group of Americans who may need assistance with healthcare and we the contractor managers and government management need to do a better job of managing it for them.

Theme: Confident

Was based on the theme based on the information provided by participant's thoughts on how your organization feels about the future management of healthcare for contractors who will return from a foreign combat zone. The responses revealed the uncertainty managers feel about the future of healthcare related management for future contractors. Also, both management team's contractor company managers and government managers shared this sentiment about the uncertainty. Contractor company managers and government managers both said they have had multiple meeting with upper

management pertaining to this very subject. Participant 3 of government managers stated that he was in the military and notices some of the pitfalls.

Participant 1 stated:

After taking this study and listening and now have a better understand and grasp on the subject. I can only guess where the future of healthcare for contractors is going. With what my organization is doing and with our priorities I do not see this being an issue for me or anybody I work with here. This is a higher issue and needs to be taken to higher management, because I feel a bit of uncertainty when it comes to this subject.

Participant 2 stated:

I really do not know what the future of healthcare for contractors returning in the future is, I'm uncertain if it will change but feel positive that if we keep talking about the current status of not having a system we will eventually create one.

Participant 3 stated:

I have only been in government contracting for 4 years and have deployed multiple contractors and attended multiple meeting pertaining to this subject. I feel a good level of uncertainty when it comes to future healthcare concerns and would be very interested in seeing what happens in the future with contractors and healthcare. With all the turmoil with healthcare I do not think contractors and issues with managing contractors' healthcare services, in the future are at the forefront of what is relevant with my organization. I think contractors will have some remnants of healthcare in the future

however, the current system in place now is the system we have is good, bad, or indifferent we do not know if it will be better or worse, we hope it is better.

Participant 4 stated:

From a government point of view, I believe this is not on our radar as a talking point or even a discussion for implementation. I'm uncertain if we will even use a system created for contractors that is not managed by the government.

Participant 5 stated:

The future of contractor and healthcare will be tied to the mission the U.S. Government had working in a war zone. Uncertainty is the word that comes to mine. Depending on what we do as the government will determine how and what we do with healthcare for contractor in the future.

Participant 6 stated:

The future of contractors in a war zone is uncertainty. I want to believe it will get better if we, government managers and company contractor managers start implementing a new system or a better system.

Participant 7 stated:

Future contractors in a war zone is so entwine with the mission of the military. Personally, I see a need for more contractors in the future with the increase of military deployments and missions. With this I have a lot of uncertainly when it comes to a system for contractors relating to healthcare and the management of a systems for them. Honestly, I wouldn't know where to start.

Participant 8 stated:

The future management of healthcare for contractors is a frustrating and complicated scenario to fathom. The future is uncertain and will remain that was until we can have decided where the military will be in the future.

Participant 9 stated:

Contractor future healthcare management is a scare subject and an important one that needs to be addressed. This issue will not be resolved by the government alone we will need to involve managers from contractor company and outside independent think tanks who have dealt with the issues of migrating healthcare management or implementing a new one.

Participant 10 stated:

I think the future of contractors' healthcare management will fall in line and be similar to what the government provides to its employees. Now the systems used is based on old technology and the government is slow to upgrade current systems or extremely slow to implement a new system. Sometimes the government overlooks certain systems. I think this is one that got overlook and needs to be addressed.

Theme: Basic information

Was a theme based on the information provided by participant's thoughts on what information does your organization provide to contractors after they return from a combat zone. The participants were unaware of the abundant of information the government managers needed to provide to contractors but expressed understanding and awareness of

the need for this information to be disseminated and or available to contractors. Participant 6 from government managers stated that he was willing and express interest in helping contractors with long term healthcare needs, if any.

Participant 1 stated:

We give the contractors an out briefing from our organization when they leave our organization. I can only assume all organization provide the same. When it comes to healthcare management we do not provide services and believe this would be a higher level problem with resolution coming from upper management.

Participant 2 stated:

We out process the contractor and provide basic information about insurance, where to turn in equipment issues by the government. The equipment ranges from a bullet proof vest, helmet, chemical gear, cell phone, or a military vehicle.

Participant 3 stated:

We don't provide anything to contractors because they usually leaving the company they are working for in Iraq or Afghanistan and move to other companies. After receiving a notice of termination, I send the individual an off boarding package which explains when the benefits will end e.g. common access card, SPOTs, and medical insurance.

Participant 4 stated:

We only provide basic information to contractors most of the information comes from the company managers. The information we provide pertains to leaving Iraq or

Afghanistan; current threats, and where to turn in equipment common access card (ID card issues by the DoD).

Participant 5 stated:

We only provide basic information to contractors after they leave Iraq or Afghanistan. This information is only issues once they express interest to leave Iraq or Afghanistan and the contracts the contractors is currently working. We provide information to contractors that will assist them in turning in equipment, leaving Iraq or Afghanistan, and being unenrolled in SPOTs.

Participant 6 stated:

Very good question and one that I have asked myself many times. We do not provide any information once they leave because when they change jobs, they pick up a new government manager. These employees change jobs and employers more frequently than we do. I feel contracts who want this information should have it and I am on board with any process that would provide information to contacts after they return from combat zone. I believe they require it and need it they just do not know how, where, or who to talk to in order to get the information.

Participant 7 stated:

Upon notification from the contractor that they plan to terminate employment while deployed to Iraq or Afghanistan we provide basic information on how to demobilize. This information is given to every contractor that leaves this job and contains

information on being taking out of spots, insurance, and turning in equipment that belongs to the government.

Participant 8 stated:

When contractors inform the government management team of their intent to leave Iraq or Afghanistan we provide information which will start the process for out processing from Iraq or Afghanistan.

Participant 9 stated:

We provide information when they inform us that are planning to leave this job. When then inform the contractors on where to turn in government issued equipment and when they will be taking out of SPOTs.

Participant 10 stated:

After notification of the intent to leave the contractor is given out processing documentation which has instructions on where to turn in government equipment and SPOTs information.

Theme: Consolidation of information

Was a theme based on the information provided by participant's thoughts on how can the information your organization provides be improved in the future. Many of the participants stated that consolidation of information as a key component in improving the current system and the start to creating a better system for future contractors. Participant 9 from government managers stated that he was enthusiastic about creating a healthcare

management system and would like to be part of the government team working on that management system.

Participant 1 stated:

I think if we consolidate information we have now pertaining to healthcare management for contractors returning from Iraq or Afghanistan we could build a system for contractors returning taking the lessons learned from today and the healthcare management system now and build a better system for the future contractors.

Participant 2 stated:

Place information under the same umbrella will truly enhance the contractors experience with healthcare management in the future.

Participant 3 stated:

If we put information in a central database and build a healthcare management system based on contractors need I think this will give the contractors' company managers and government managers a good starting point for developing a healthcare management system for contractors who return from Iraq or Afghanistan in the future.

Participant 4 stated:

Placing data in a single database would start the ball rolling when it coming to creating a healthcare management system for contractors leaving Iraq or Afghanistan in the future.

Participant 5 stated:

Working with contractors' companies and government agencies to develop a system now keeping that information in a database and requiring all organization that deploy contractors to Iraq or Afghanistan to use that system will, in my opinion, gives contractors a healthcare management system in the future. If you start using a consolidated healthcare management system today you can work through issues with that system remediate those issues and develop a system that will give contractors a healthcare management system based on trial and error.

Participant 6 stated:

To resolve the problem with healthcare management of contractors in the future we have to fix the issue today. To fix the problem with healthcare management today we the government managers and contractors' managers need to move all the data to one location and develop a system from that data.

Participant 7 stated:

I think if we improve the system today used by contractors for healthcare management we can arbitrarily create a better system for future contractors who leave Iraq or Afghanistan with healthcare management needs.

Participant 8 stated:

Government managers and contractors' managers need a better understand of what contractors leaving Iraq or Afghanistan need for healthcare management. The starting point would be to gather as much data needed to understand the issues place this

data in a central location, computer, system, or database. Take this data and build a system that contractors in the future can use for healthcare management.

Participant 9 stated:

In order to help contractors in the future with healthcare management we need to create a system today. From this healthcare management system, we can learn, modify, revamp, and tweak it into a modern healthcare management system for future contractors who leave Iraq or Afghanistan and need healthcare management.

Participant 10 stated:

Developing a consolidated system for contractors who deploy to Iraq or Afghanistan healthcare management is the main ingredient to developing a healthcare management system for contractors in the future. Government managers and contractors' company managers can work together today on the current system and mold that systems using the processes that makes sense and getting rid of the processes that do not.

Theme: Keeping track of these contractors after they leave the company

Was a theme based on the information provided by participant's thoughts what solution can your organization propose to further manage the healthcare for contractors when they leave your organization now? This question gave many of the participants a pause and made them think about a solution. Many have ideas and thoughts on how to track participants and what process to put in place. The real question many stated was how to track, who will track or maintain the information, and how long will companies

and the government keep this information? Participant 6 from the government managers had a very unifying message for all organizations.

Participant 1 stated:

After contractors notify the government management team of their intent to leave Iraq or Afghanistan we input termination information into our database which starts the out processing process. During these procedures contractors are released from our system and we have no more control of them. To answer your question what can we do we can start a system that tracks contractors after they leave. I think this would fulfill that basic requirement.

Participant 2 stated:

I think if we could maintain contact information on contractors after they leave the war zone in Iraq or Afghanistan it would help us and them by providing reach back for healthcare management.

Participant 3 stated:

Maintaining updatable contract information on contractors after they leave Iraq or Afghanistan would help us to manager a healthcare system for them. By maintaining contact, we can better assist the contractor in guiding them to a facility to use based on where they are located in the United States.

Participant 4 stated:

If the contractors or a representative for the contractors is able to contract us after they leave our organization it would help us to manage the contractors' healthcare. By

maintaining this continuity with the contractors, we would be in a better position to assist them with healthcare management.

Participant 5 stated:

To start the process of managing healthcare we need to maintain contract with these contractors after they leave Iraq or Afghanistan.

Participant 6 stated:

Tracking contractors is a starting point for creating a healthcare management system. By consolidating information on contractors who deployed to Iraq or Afghanistan we can build a system for healthcare management for future contractors.

Participant 7 stated:

To betting help future contractors with healthcare management after they leave Iraq or Afghanistan we have to start by tracking contractors today. We have to build a reliable healthcare management system today the starting point is a database with contractors' information.

Participant 8 stated:

Start tracking contractors today. We would also have to work with other organization government and contractors company managers to determine what, where, and how to track contractors after they leave Iraq or Afghanistan and need healthcare related services.

Participant 9 stated:

Once a contractor stated his/her intent to leave we need to collect data on that individual. From this data we can use this information if/when they contract us for healthcare management. Because, now we have no way of identifying these individuals.

Participant 10 stated:

The only was contractors can reach back to use after they leave Iraq or Afghanistan is to give us the employee ID number. Most do not remember that number or have misplace it. To offset this, we need a better system for tracking them. Maybe sending correspondence yearly by having the contractors give us a mailing address this will help us with tracking them. Management of healthcare for contractors who deployed to Iraq or Afghanistan should be developed now to assist those in the future.

Theme: Knowing what they need now

Was a theme based on the information provided by participant's thoughts on what are some of the difficulties your organization find with managing healthcare for contractors in the future. The participants all express concern for this topic and most or all of them, government and contractors' managers stated that tracking contractors is one of the many difficulties they have and will continue to have if they did have a process in place in the future. Participant 4 from government managers was a project manager for a major contract in Iraq and he stated his concerns about employees having this for the future.

Participant 1 stated:

Understanding what they need is very difficult. Before this study I did not understand the problem and that their system was either not as good or nonexistence. That being said, now we need to collect data, test cases, and look into the problem to understand what they need.

Participant 2 stated:

Understanding the problem is a major difficulty. I did not know we have an issue with healthcare management for contractors. Because of that I really do not understand what they need, what they are lacking, and where I need to assist with healthcare management.

Participant 3 stated:

Identifying the needs of the contractors who have deployed to Iraq or Afghanistan is keep to managing healthcare for them in the future.

Participant 4 stated:

Realizing the need of the contractors is a hard subject for us government managers because we only contact contractors once we are notified that they are deploying to Iraq or Afghanistan and after they decide to leave the war zone. So, we need to know what they need in order to assist them with healthcare management needs.

Participant 5 stated:

Knowing what they need is a pivotal point in managing the healthcare needs for contractors who will deploy to Iraq or Afghanistan.

Participant 6 stated:

Understanding the needs of contractors.

Participant 7 stated:

Knowing what they need is a must to getting contractors who leave Iraq or Afghanistan and need healthcare management.

Participant 8 stated:

Contractors needing a healthcare system need to inform us what they need. I did not understand the issue until I starting this study and now wonder what we have to do to catch up to what contractors who leave Iraq or Afghanistan need from a healthcare management system.

Participant 9 stated:

To get a better understand of what contractors who leave Iraq and Afghanistan need in the future from healthcare management we need to know what their needs are today.

Participant 10 stated:

Understanding what contractors who leave Iraq and Afghanistan needs are today is a major theme in knowing what their healthcare needs will be in the future.

Theme: A central database

Was a theme based on the information provided by participant's thoughts on what process can organization put in place to manage healthcare for future contractors who may need healthcare services in the near future. Many of the participants stated this as a major theme for this interview question. Participant 2 from government managers, who is

a supervisor in his organization stated that he was aware of other agencies keeping this information in a database but was not sure. He also stated that this would not be a government function alone it should be shared between the government and contracting companies.

Participant 1 stated:

If the data on contractors who deployed to Iraq or Afghanistan was housed in a central location it would be easily accessible for government managers, contractor company managers, and contractors, who deployed to Iraq or Afghanistan.

Participant 2 stated:

If we start collecting information on current contractors who are deployed to Iraq or Afghanistan for 365 days we can build a database to house all the data for all American contractors. This process will allow current leadership to build a healthcare management system from the current data and by working with contractors who are now deployed to Iraq or Afghanistan, government managers, and contractors' company managers, developing a user friendly healthcare management systems for future contractors.

Participant 3 stated:

One process would be to centralize all contractors who have deployed data in a central location. From here we can work with other agencies and build a healthcare management system for contractors who will deploy in the future.

Participant 4 stated:

This is not something we as government managers can do alone we need to work with contractor company managers and contractors who are deployed to Iraq or Afghanistan, to develop a healthcare management system for contractors who will deploy in the future to Iraq or Afghanistan.

Participant 4 stated:

If government managers and contractor company managers' work with current contractors who are deployed to Iraq or Afghanistan we can develop a healthcare management system for future contractors. If we collect data on current deployed contractors who are in a war zone, consolidate the information, refine the data we can build a system based on input from contractors who are deployed to Iraq or Afghanistan, government managers, and contractor company managers.

Participant 5 stated:

Centralizing the data in the first step in building a futuristic healthcare management system for contractors who will deploy to Iraq or Afghanistan.

Participant 6 stated:

First, we need to get input from current contractors who are deployed to Iraq or Afghanistan. This data can be used to figure out what contractors, who are deployed to a war zone need from a healthcare management system. Second, the data collected from the initial collection of data from contractors who are deployed to a war zone can be consolidated in a central database. Third, take the input from steps one and two and build a healthcare management system for future contractors who will deploy to a war zone.

Participant 7 stated:

Placing the information for contractors in a central digital library and building a system from that data would be a process you can use to create a healthcare management system for contractors in the future.

Participant 8 stated:

If the information for current contractors is placed in one location for everyone to use. Consolidate the data and build a healthcare management system for contractors who deploy to Iraq or Afghanistan in the future.

Participant 9 stated:

We would need to collect all information from all American contractors who have deployed to Iraq or Afghanistan. Send out a survey to all the American contractors and ask for input on what they required for a healthcare management system, what they need, and how they would like it delivered. From this government managers and contractor managers can develop a healthcare management system for contractors who will deploy to a war zone in the future.

Participant 10 stated:

If our government organization and contractors company managers can consolidate information for all American contractors who have deployed to Iraq or Afghanistan and create a database. Use this database to build a healthcare management system for future contractors who will deploy to a war zone.

Theme: We do not manage it

Was a theme based on the information provided by participant's thoughts on how does your organization manage the healthcare issues for contractors after they leave your organization. Several of the contractor company manager who participated in this study knew of any process for tracking contractors after they leave the organization. Several also stated it was the government's jobs to track contractors and many of the government managers stated it was the contractor company managers stated it was the duty of the government. All express a need for a system to be developed most alluded to a database, maybe sending out yearly letters or correspondence to keep information updated and current. Participant 2 from government managers made his view clear during the interview.

Participant 1 stated:

Our organization does not manage contractors after they leave Iraq or Afghanistan. We coordinate with the government managers and our corporate office in the United States to recovery all propriety corporate information.

Participant 2 stated:

Once we are notified that the contractor wants to leave the war zone we coordinate with the government managers and our internal management team to out process the contractors from Iraq or Afghanistan.

Participant 3 stated:

We do not manage any healthcare services for contractors once they leave our organization. We do however, work with the contractor management team to out process, purchase airplane ticket back to the United States, archive government email (.mil)

Participant 4 stated:

We do not manage any aspect of healthcare for contractors after they depart Iraq or Afghanistan. Once we are notified we out process from the war zone and have no further contract with the contractor.

Participant 5 stated:

Contractors who inform the contractors' management team and government managers or their intent to terminate employment while in Iraq or Afghanistan receive no healthcare management service from our company.

Participant 6 stated:

As contractors move in and out of Iraq or Afghanistan we the government managers and contractor company managers, manage every aspect for the contractors coming into and out of the war zone. After they terminate employment we out process and have no further contract with the contractor after they leave Iraq or Afghanistan.

Participant 7 stated:

Once the contractor tells the management team we coordinate with both parties government and contractor company management to out process the contractors. After we out process the contractors from the war zone we do not manage healthcare services for the contractor.

Participant 8 stated:

We manage no aspect of healthcare for contractors after they terminate employment in Iraq or Afghanistan.

Participant 9 stated:

We do not manage healthcare or any other service when the contractor leaves Iraq or Afghanistan.

Participant 10 stated:

When we get notified by email or in person that the contractor wants to terminate employment in Iraq or Afghanistan we out process the contract redeploy the contractors to the Unites States and have no further contract with the contractor unless they redeploy to Iraq or Afghanistan.

Theme: A universal system

Was a theme based on the information provided by participants thoughts on what are some of the pitfall your organization has with managing long term healthcare for contractors who have deployed to a foreign combat zone. Both contractor company managers and government managers stated that a universal system for healthcare management for contractors who will deploy to Iraq or Afghanistan in the future is a key component in providing universal healthcare management for future American contractors deployed in a war zone. Participant 1 from the government managers stated that there are too many healthcare systems out there to choose from and government and contractors managers need to discuss the way forward.

Participant 1 stated:

I can name a few pitfalls that we need to address and fix in order to manage long term healthcare for contractors who will deploy to Iraq or Afghanistan. The main one, I think, is with a universal healthcare management system. There are way too many healthcare management systems to choose from. Contractors who deploy to Iraq or Afghanistan redeploy to the United States and scatter across the United States. Because of that we cannot use the system based in one state in the United States for example, New York for contractors who redeploy from Iraq or Afghanistan to a different state in the United States for example, the state of Texas.

Participant 2 stated:

To assist contractors who will deploy to Iraq or Afghanistan with long term healthcare management we need to consolidate services that we have now move to a healthcare management system that can be utilized by all contractors, government agencies, and contractors company manages.

Participant 3 stated:

I believe we need a universal healthcare management system. Also, model the system after a known system that works for employees who are spread over the United States or on different continents. Third, include contractors who are deployed in the decision on what system to use. The contractors who are deployed will know what future contractors will need.

Participant 4 stated:

If contractors who will deploy had a universal healthcare management system it would alleviate a major pitfall for contractors who will deploy to a war zone.

Participant 5 stated:

Providing long term healthcare management for contractors who will deploy is riddled with many pitfalls. Different processes from different contractor's company managers and government managers when it comes to healthcare, money, locations, corporate deployment documents and government deployment documents depending on which government agency the contractors deploy to Iraq or Afghanistan with. The starting point will be to unify a healthcare management system and from that base spread out other processes and unify them also.

Participant 6 stated:

If contractors today had a universal healthcare management system it would benefit future contractors.

Participant 7 stated:

Many of the pitfalls for contractors who will deploy to Iraq or Afghanistan can be attributed to not have a universal healthcare management system. Companies that deploy contractors and government agencies have this in place. I believe if we developed the same for deploying contractors it could alleviate many of the pitfalls associated with providing a healthcare management system.

Participant 8 stated:

Providing a universal healthcare management system would eliminate many of the pitfalls associated with contractors who will deploy to Iraq or Afghanistan.

Participant 9 stated:

Contractors now have a major pitfall one is a universal healthcare management system. If we the government managers and contractor company manager could develop and provide a universal healthcare management system to current contractors who are deployed to Iraq or Afghanistan this system could eliminate pitfalls for future contractors who will deploy to a war zone.

Participant 10 stated:

Providing a universal healthcare management system is a good starting point to fixing many of the pitfall for future contractors. If they had a healthcare management system like the one provided to merchant marines, air line pilots, and people who work on cruise lines I believe it would fix many of the issue they face today.