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14. ABSTRACT

The Department of Veteran Affairs (VA) established the Capital Asset Realignment for Enhanced Services (CARES) program in 2000 to improve its efficiency. As part of CARES, the VA proposed closing the Waco, TX hospital and dispersing its services elsewhere. Currently, the VA has established a system to seek stakeholder input to ensure veterans' needs are being met and ensure the success of CARES. All organizations have stakeholders, which influence every issue and attempt to align the organization with its own goals. As such, they must be recognized and evaluated for their potential to support or threaten the organization. A stakeholder analysis was conducted to ascertain the external environment and ultimately be incorporated into the strategic plan for the Waco Medical Center.

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Graduate Management Project

for

Capital Asset Realignment for Enhanced Services (CARES) for the Waco Veteran Affairs Medical Center (VAMC): A Stakeholder Analysis

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the requirements for the Administrative Residency in

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Abstract

The Department of Veteran Affairs (VA) established the Capital Asset Realignment for Enhanced Services (CARES) program in 2000 to improve its efficiency. As part of CARES, the VA proposed closing the Waco, TX hospital and dispersing its services elsewhere. Currently, the VA has established a system to seek stakeholder input to ensure veterans' needs are being met and ensure the success of CARES. All organizations have stakeholders, which influence every issue and attempt to align the organization with its own goals. As such, they must be recognized and evaluated for their potential to support or threaten the organization. A stakeholder analysis was conducted to ascertain the external environment and ultimately be incorporated into the strategic plan for the Waco Medical Center.

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Introduction

Conditions that Prompted the Study

During World War I, the Public Health Service operated a system of hospitals to treat returning veterans. In 1921, these hospitals were transferred to the newly established Veterans' Bureau (presently renamed as the Department of Veteran Affairs) and by the early 1990s the VA had grown into the nation's largest health care system. In 1995, the VA began to transform its health care system to align with that of the private sector. That is, from a hospital based inpatient model, to a health maintenance organization model. Prior to this transformation, about half of all veterans lived more than 25 miles from a VA hospital, and about 44 percent of those admitted lived more than 25 miles away. A key feature of this conversion involved the development of community-based, integrated networks of VA and non-VA providers that could deliver care to veterans in a more proximal fashion. These networks became known as Veteran Integrated Service Networks (VISN)(GAO, 2003).

Today, the VA operates over 800 delivery locations nationwide, including over 600 community-based outpatient clinics and 162 hospitals. The VA organized this delivery model by establishing 21 VISNs. Each network includes a management office that is responsible for making basic budgetary, planning, and operating decisions concerning the delivery of health care to its veterans.

By shifting inpatient care to more inexpensive primary care settings, and consolidating duplicative services to maximize

economies of scale, the VA significantly improved the efficiency and effectiveness of its health care delivery system. Needless to say, these strategies significantly reduced inpatient utilization. Consequently, the VA now has excess inpatient capacity at many locations. To illustrate this point, the VA operated about 73,000 hospital beds in fiscal year 1995 and by 2001 utilization continued to decrease to about 16,000 hospital beds per day (GAO, 2003).

In conjunction with declining inpatient utilization, the VA operates a massive and aged infrastructure. Currently, the VA has most of its resources dedicated to costs associated with its existing hospitals and other infrastructure, including clinical and support staff (GAO, 2003). That is, a large portion of funding is allocated to utility and maintenance costs for older buildings, which in some locations may only be partially full. This can also lead to difficulties in appropriately staffing these facilities. In recent years however, the VA has made an effort to realign its capital assets, primarily buildings, to produce needed efficiencies.

In October 2000, the VA established the CARES program. The CARES recommendations were developed after an extensive study by an independent CARES commission charged with examining optimum solutions for cost, quality, and access standards across all VA health care sites. The VA first conducted a pilot CARES study of one regional health care network, VISN 12, which covers the Chicago area, Wisconsin and the Upper Peninsula of Michigan. A formal CARES analysis has been proposed for each network. These

initiatives are designed to analyze projected inpatient and outpatient demand, determine current capacity, identify duplicate services within the same catchment area, and verify current and future beneficiary access needs (GAO, 2003).

As part of CARES, VA Secretary Principi established the Federal Advisory Committee Act (FACA). This act created committees to provide advice in the selection of a plan to implement CARES. The VA will appoint an outside contractor as a consultant to complete these studies and plans for market areas in each VISN. The contractor's duties are to develop and evaluate options for the location and delivery of health care services to veterans. This will include currently enrolled and projected beneficiary populations. The plan will also identify options for divesting or leasing any current or future underutilized property in order generate savings and revenues that could be applied to the VA's health care mission.

In contrast to the consultant, the Federal Advisory Committee (FAC) is tasked with ensuring a thorough and fair evaluation of stakeholder recommendations on how to best implement CARES. The FAC must guide the contractor's scope of work to meet the demands from various stakeholders. In particular, the FAC must follow four defined stages. The first and most important is to "provide advice regarding stakeholder issues as the study of potential business plans begin at each site" (Department of Veterans Affairs, 2004). Of all the CARES sites, the VAMC, Waco, TX, is considered one of the most contentious (FAC Conference Call, December 8, 2004).

The Waco VAMC has been a multi-VISN referral facility for long-term chronically mentally ill patients and a national referral facility for blind rehabilitation. In addition, it currently operates inpatient services for nursing home patients and has a 20-bed Post Traumatic Stress Disorder (PTSD) residential rehabilitation program. The Waco VAMC is an old, large and sprawling hospital campus built in 1932 on 127 acres. Currently, it operates 109 beds, most of which are for psychiatric patients. The VA estimates it costs 12 to 15 million dollars per year to operate and maintain this campus. To complicate things, this campus has been recently added to the National Historic Register. This area also experiences considerable difficulty recruiting specialists. At present, when patients require acute care needs the VA must immediately transfer them to a nearby civilian hospital (Department of Veterans Affairs, 2003).

The Waco VAMC reports having 17,000 enrolled veterans, 94 percent of which are outpatients. The remaining 6 percent are inpatients. Only 20 percent of those enrolled reside in the Waco service area (Department of Veterans Affairs, 2003). Accepting the notion that modern day medicine has invalidated the need for institutionalizing many psychiatric patients has prompted the VA to contend the old Waco facilities and property are no longer required. The CARES draft plan recommended closing the facility and transfer the 109 beds to the VA hospital in Temple, TX, located 35 miles away. To maintain continuity of care, the plan suggested treating more psychiatric patients as outpatients in a

residential care setting, or with contract services in the Waco community. In either case the Waco facility would not be needed. The plan further recommended transferring about 30 nursing home patients to the Temple VAMC and contracting out the remaining patients to non-VA nursing homes near Waco: Referring blind rehabilitation patients to other VA medical centers with blind rehabilitation treatment programs, treating more PTSD veterans through the use of telemedicine, and establishing a community based outpatient clinic in the Waco area (Department of Veterans Affairs, 2003).

Problem Statement

The VA needs a system of strategic management planning to confront these challenges to obtain and sustain competitive advantage. The GAO (2000) identified several weaknesses in the CARES methodology. In particular, they suggested that stakeholders remain too heavily involved in decision-making roles. However, many of these stakeholders may have vested interests in maintaining the status quo. Stakeholder participation as decision-makers on such committees could bias the market studies and ultimately the CARES project. VA stakeholders are a diverse group with competing interests. It is logical to assume they will oppose some changes they believe are not in their or their organization's best interest. Despite this, it is essential to involve stakeholders in an advisory role in CARES. Stakeholders can provide valuable perspectives on the evaluation criteria for selecting the optimum solution as well as the best practices for implementing them. In addition,

stakeholder input could enhance their understanding of the CARES process and help foster confidence in the realignment decisions are fair and fact-based. The FAC must develop a process of balancing the competing demands of stakeholder interests and the VA's desire to deliver effective and efficient health care in the face of increasingly scarce fiscal resources.

Literature Review

Strategic management is an externally oriented philosophy of managing an organization. It is used to link strategic thinking and analysis to organizational action. This process provides an ongoing structure for rationally thinking about the plans and actions of an organization. The overall goal of strategic management is to effectively position the organization within its changing environment. This process involves several elements such as the organizational setting, situational analysis, strategy formulation, strategy implementation, and strategic control. Simply put, strategic management is essential for guiding leaders of health care organizations (Ginter, Swayne, & Duncan, 2002).

P. S. Bronn and C. Bronn (2002) contend that a firm's strategic orientation is a complex function of many factors that are both internal and external to the organization. Convoluting this fact, these factors interact with each other creating an environment characterized by uncertainty, casual ambiguity, and the presence of multiple stakeholders. This scenario in conjunction with the formulation of the organization's mission, vision, values, and goals, comprise the elements of the

situational analysis. The influences and context from these three processes must be understood before any strategy can be formulated. P. S. Bronn and C. Bronn further argue managerial attempts to exert control over these forces have resulted in a wealth of models and prescriptions for performing the many functions of strategic management. The external environment, in particular, is often the most difficult to gauge.

Due to the complexity and degree of change within the health care industry, external influences on an organization can be profound. As such, health care managers need a method for scanning the external environment to prepare for unforeseen opportunities or threats. Once these issues are identified, managers must determine which ones are the most relevant to the organization, evaluate their impact, and incorporate them into a strategy. This process is referred to as external environmental analysis and is an integral part of the situational analysis (Ginter, Swayne, & Duncan, 2002).

An external environmental analysis is the process by which an organization crosses the boundary between itself and the external environment in order to identify and understand changes that take place outside the organization. These changes represent both opportunities and threats. It is important that managers understand them and respond appropriately before they affect their organization. To be successful, organizations must effectively scan, monitor, forecast, and assess information. This fundamental issue will lead to the success or failure of the organization (Ginter, Swayne, & Duncan, 2002). Several

different analytical tools and techniques may be used in an external environmental analysis. The technique selected can vary depending on organizational characteristics such as the size of the organization or complexity of the issue and/or market (Ginter, Swayne, & Duncan, 2002).

The results of the external environmental analysis directly influence the development of the organization's mission, vision, values, goals, and internal analysis. In the end, this shapes the strategy itself and the organization's ability to create and sustain competitive advantage within the health care industry (Ginter, Swayne, & Duncan, 2002).

Today's continual and turbulent transformation of health care has resulted in higher expectations from the general public, patients, and special interests groups alike. Specifically, the growth of public interest and advocacy organizations has resulted in demands for a higher level of accountability on the part of politicians and government agencies. Often times, decision makers are required to make difficult tradeoffs among objectives from varying stakeholders. The ensuing controversies usually force management to defend their decisions under intense public scrutiny (Gregory & Keeney, 1994). Consequently, there is substantial pressure on these decision makers to identify key stakeholders in their organization and develop appropriate strategies for managing them (Fottler, Blair, Whitehead, Laus, & Savage, 1989).

Blair, Fottler, and Whitehead (1996) define a stakeholder as any individuals, groups or organizations with a stake in the

decisions and actions of an organization and who attempt to influence those decision and actions. Clarkson (1995) defines stakeholders as persons or groups that have or claim ownership, rights, or interests in a corporation and its past, present, and future activities. Other definitions include actors who have an interest in the issue under consideration, who are affected by the issue, or have an active or passive influence on the decision-making and implementation process (Varvasovszky & Brugha, 2000). They can include individuals, organizations, and different individuals within an organization, and networks of individuals and/or organizations.

Stakeholders exert an influence on every issue by attempting to affect those decisions and actions in order to sway the organization to meet its needs and priorities. Some stakeholders impact strategy by demanding to be included in the planning, while others may have their interests considered by management indirectly (Ginter, Swayne, & Duncan, 2002). Clarkson (1995) distinguishes a difference between primary stakeholders, those essential for the survival and wellbeing of an organization, from secondary stakeholders, those with which the organizations interacts but are not needed for survival. An organization does not choose it stakeholders, rather, they chose themselves. Typically, stakeholders decide to protect their interests on an issue-by-issue basis. That is, their degree of supportiveness is contingent on the exact issues at hand (Blair & Buesseler, 1998).

All organizations have stakeholders. Stakeholder analysis has become one technique to attempt to manage them. A stakeholder analysis can be generalized as an approach for generating knowledge about these actors to understand their behavior, intentions, and interests. This tool is also important for ascertaining the resources and influence stakeholders bring to bear on the decision-making process of an organization. In health care, stakeholder analysis had been promoted as a tool for an organization to achieve specific advantages and goals as they relate to strategic alliances, either to carry out short-term objectives or for projecting into the distant future (Varvasovszky & Brugha, 2000). For the purpose of this paper the use of the term stakeholder analysis is synonymous with stakeholder management.

The primary purpose of stakeholder management is to transform the complex relationships that exist in and between organizations and the external environment into a logical, systematic framework that can be communicated and acted on. Rather than searching for ways to close the organization from their external environment, stakeholder management attempts to control these relationships. This integration serves as a strong strategic management tool. Stakeholders are an integral aspect of this management technique because they represent the relevant environment that potentially benefit or threaten the organization (Blair & Fottler, 1990). Effective stakeholder management enhances an organization's overall strategy and can

contribute to developing and/or maintaining sustained competitive advantage.

Stakeholders can be classified as internal, external, and interface. Internal stakeholders are those who operate within the organization. External stakeholders operate outside the organization, while interface stakeholders consist of a mixture of both categories. Some of these stakeholders consistently wield a great deal of power, others may only influence specific issues, while others have little or no power. Stakeholders must be recognized and evaluated for their potential to support or threaten the organization and its competitive goals. The desires of these constituencies may dramatically affect the organization (Fottler, Blair, Whitehead, Laus, & Savage, 1989). These desires have been labeled as the "stakeholder's bottom line" (Blair & Fottler, 1990).

Successful methods for managing key stakeholders are becoming more important in health care management. Balancing competing interests is the basic problem of administration, and the ability to satisfy changing stakeholder preferences over time could be argued as a way to assess organizational effectiveness (Savage, Taylor, Rotarius, & Buesseler, 1997). The need to understand how stakeholder groups and the issues of each are started, the importance of key issues, and the willingness of groups to expend resources related to these issues were first identified by Freeman (1984). A growing body of literature in the United States has demonstrated the use of stakeholder analysis. Dymond, Nix, Rotarius, & Savage (1995) used a

stakeholder analysis to identify the most important medical group practice stakeholders that played a major role in shaping delivery networks. Blair, Buessler, Stanton, and Whitehead (1989) used this method to aid physician executives in coping with an uncertain environment. Topping and Fottler (1990) examined how stakeholder analysis can revitalize health maintenance organizations (HMO) while Whitehead, Blair, Smith, Nix, and Savage (1989) observed how an HMO is strategically vulnerable to its stakeholders. Blair, Rock, Rotarius, Fottler, Bosse, and Driskill (1996) investigated the link between stakeholder analysis and strategic planning with medical group stakeholders, including integrated delivery networks and discovered their stakeholders shifted categories over time. They argued the need for continual analysis. Savage, Taylor, Rotarius, and Buessler (1997) studied of stakeholders and determined they greatly influence the organizations type of physical governance structure.

To manage stakeholders, health care leaders must be involved in a continuous process of internal and external assessments. They must look to those external, internal, and interface stakeholders who are likely to influence decisions. At this point a critical diagnosis of whether the stakeholder intends to threaten or cooperate with the organization should be made (Blair & Whitehead, 1988). Looking at the potential threat of stakeholders is similar to developing a worst-case scenario and protects managers from unpleasant surprises. A stakeholder's threat to the organization is based on its power relative to

that organization. Power can be defined as the organization's dependence on the stakeholder. That is, the more dependent the organization is on the stakeholder, the more powerful the stakeholder becomes (Blair & Whitehead, 1988).

Determining the potential for cooperation is similar to understanding threats, except this potential is viewed as a best-case scenario. The stakeholder's dependence on the organization and its relevance to any particular issue facing the organization determines their potential for cooperation. In direct contrast with threat, the more dependent the stakeholder is on the organization, the more likely it is to cooperate with them (Blair & Whitehead, 1988).

These two dimensions map stakeholders into a diagnostic framework and serve as a summary measure of stakeholder information from multiple factors. Using these two dimensions, Blair and Fottler (1990) characterized four types of health care stakeholders: mixed blessing, supportive, non-supportive, and marginal.

In addition to identifying and diagnosing stakeholders, Blair and Fottler (1990) also proposed generic strategies to correspond with the aforementioned categories. These generic stakeholder management strategies include: collaborate with mixed blessing stakeholder, involve supportive stakeholder, defend against non-supportive stakeholder, and monitor marginal stakeholder. Stakeholders are not likely to remain complacent and allow themselves to be managed. Powerful stakeholders are likely to try to manage the organization equally as much as

organizations will try to manage them. This fact makes a proper diagnosis, whether to threaten or cooperate with an organization, vital to its future.

Purpose

The purpose of this project is to conduct a stakeholder analysis as a means for assessing the external environment of the Waco VAMC CARES project. To do so, it will be necessary to identify the major groups and individuals who have a stake in Waco VAMC. These groups may be internal, external, or both to the VA. Once these major players are identified, their stance to the proposed changes in the health care delivery system for the Waco VAMC will need to be diagnosed. These findings may be used at a later time in combination with an internal assessment and the VA's mission, vision, and values, to develop a situational analysis. Eventually, this will be used to develop adaptive strategies for the VA's Waco, TX market. However, a complete situational analysis will not be conducted for the scope of this project. A thorough analysis of an organization's internal environment is conducted by assessing numerous variables such as workload, capacity, total enrollment, and relative costs to provide specific services. Since the Waco VAMC has known it was targeted for closure, there has been speculation the data does not meet the accuracy required to perform a comprehensive analysis (J. C. Coronado, personal communication, December 8, 2004).

Although specific adaptive strategies cannot be developed from this analysis, this methodology does allow for the

formulation of generic strategies that can be used to assist in anticipating stakeholder reactions. It will also be used to identify potential strategies to increase support for the project among the various stakeholders.

Methods and Procedures

To gain insight into the CARES process for the Waco VAMC it will be necessary to identify the major stakeholders and gain an understanding of their stake in the hospital. Hospital executives do not have time to consider all possible stakeholders so it is important for them to focus on the more important ones (Varvasovszky & Brugha, 2000). Being able to determine which players are most relevant to a particular issue is an important first step.

To accomplish this analysis, it will be necessary to assess select members of VA management within VISN 17. The data were collected using a matrix of each issue proposed under the VA's CARES draft plan for the Waco VAMC market area. Specifically, the issues outlined in the draft plan are: To close the Waco VAMC and transfer the inpatient beds to the VAMC in Temple, TX, treat psychiatric patients within other Waco community hospitals or treat them as outpatients within VA facilities, transfer nursing home patients to the VAMC in Temple, TX, refer blind patients to the nearest blind rehabilitation unit, and to treat primary care patients in the nearest VA community-based outpatient clinic. The assessment will require the participants from VISN 17 management to identify the internal, external, and interface stakeholders associated with each of the

aforementioned issues proposed in the VA's CARES draft plan for the Waco VAMC market. In addition, it will require a brief list of the stakeholder's sources of power, and to quantify their perception of each stakeholder's power and which issue they view as critically important using a seven-point Likert scale.

This is the preferred method for this project. According to Varvasovszky and Brugha (2000) the analyst or team may make judgments or scores using structured tools such as a Likert scale. Also, it may be appropriate to take secondary sources of data, such as published opinions of a stakeholder's stance into consideration during the assessment. All of these sources will be taken into deliberation while attempting to determine the stakeholders' potential to threaten or cooperate with the VA.

Varvasovszky and Brugha (2000) further stated, resources and time constraints determine whether an individual or a team should conduct the analysis or even by an individual analyst working with the support of selected key informants and/or a supervisor. Judgment is critical, particularly as qualitative data are analyzed and quantified, a team approach can provide a more balanced analysis and can compensate for and minimize individual biases and question untested assumptions.

Analysts can be insiders and/or outsiders. Insiders are defined as personnel directly involved in the project, management question, or policy studied and understand the organization and its cultural context, whereas outsiders do not. Insiders can sometimes hold strong opinions about stakeholders or an issues potential outcome. On the other hand, the outsider

can play a valuable role as an independent auditor. A team consisting of both can allow for outsiders to draw on the cultural and contextual insights of insiders while conversely allow insiders to perceive how their assumptions may be biasing the analysis (Varvasovszky & Brugha, 2000). Taking this philosophy into consideration in order to reduce bias, the VISN 17 management team consisted of both insiders and outsiders.

Previous research using stakeholder analysis techniques utilized structured or semi-structured interviews of stakeholders to collect data. However, if the analysis is around a pre-determined direction such as the implementation of a defined policy or project the use of qualitative interviewing may be curtailed early on or dispensed with altogether (Blair & Buessler, 1998; Blair, Fottler, & Whitehead, 1996; Blair, 1996; Daake & Anthony, 2000; Dymond, Nix, Rotarius, & Savage, 1995; Fottler, Blair, & Whitehead, 1989). This concept is applicable since the VA published its draft plan to include finite, specific intentions with regard to the Waco VAMC and the primary stakeholders are relatively known.

For the purpose of this project, it is important to note the need to forgo interviewing relevant stakeholders for the Waco VAMC CARES proposal. Often times it is important to involve stakeholders in the assessment process to build trust and enable them to correct inaccurate reporting. However, feedback is not always beneficial since it may influence or alter a stakeholders position toward the issues at hand, thereby reducing the utility of the analysis. This is particularly true if stakeholders are

in a position to influence or control the outcome, especially if the preliminary assessment is not favorable to them. Due the contentious, political nature of the CARES process, coupled with the fact that the Waco VAMC FAC consists of stakeholders themselves, the process of conducting interviews would likely influence the outcome. For similar reasons it was important for the VISN 17 team to be as small as possible and be void of any participants from the Waco VAMC or its senior management from the Central Texas Health Care System in nearby Temple, TX. Varvasovszky and Brugha (2000) liken this plausible outcome to the Hawthorne effect, whereby analysts themselves change the outcome of the study.

The information will be collected and summarized into a stakeholder issue matrix. As proposed by Blair and Fottler (1990) this document will be used to diagnose stakeholders on two dimensions: their potential to threaten or to cooperate with the CARES process. From this diagnosis, stakeholders will be classified into four categories: supportive, mixed blessing, non-supportive, or marginal. Lastly, each categorized stakeholder will then be "fitted" with a corresponding generic strategy for managing them as it relates to the CARES project. These generic stakeholder management strategies include: collaborate with mixed blessing stakeholder, involve supportive stakeholder, defend against non-supportive stakeholder, and monitor marginal stakeholder.

Results

The issues proposed in the VA's Draft CARES plan were summarized in stakeholder issue matrix in Table 1.
This matrix relates the proposed changes with the relative importance to each stakeholder. The stakeholders perceived to view the CARES initiatives the most critically were United States Congressional delegation, the VA, Waco community, labor unions, non-physician professional staff and Veteran Service Organizations. Alternatively, those stakeholders who perceived to view it least critically consisted of non-Waco veterans and the state of Texas.

In addition, stakeholders were listed with their sources of power and overall power to influence the CARES process in Table 2. The stakeholders perceived to possess the most power include the United States Congressional delegation and the VA, each with a score of 7. Conversely, those perceived to have the least power were non-Waco veterans and the State of Texas each with a score of 1.
As a result of this research, a stakeholder map was created in Figure 1 to visualize the relationship among stakeholders to the Waco VAMC.

Table 3 contains a matrix summarizing the diagnosis of each stakeholder on the likelihood to threaten or cooperate with the VA. Lastly, Table 4 summarizes the corresponding generic strategies recommended for managing each stakeholder. The strategies are derived from their respective category associated with their diagnosis from Table 3.

Table 1: Stakeholder Issue Matrix for Waco VAMC CARES draft plan

	Issue				
Stakeholder	Transfer inpatients to Temple, TX	Psychiatric patients in Waco or as outpatient	Transfer nursing home to Temple, TX	Treat primary care at nearest CBOC	Transfer blind to nearest blind unit
Congress	7	7	7	7	7
VA leadership	7	7	7	7	7
VISN 17 leadership	5	5	5	5	5
Central TX leadership	7	5	7	5	7
Academic affiliation	6	6	6	2	6
Waco veterans	4	5	7	4	7
Waco community	7	4	7	4	7
Non-physician staff	7	7	7	7	7
Non-Waco veterans	1	1	1	1	1
Texas government	1	1	1	1	1
Labor union	7	4	7	4	7
VSO	7	7	7	5	7

7-Critically important to stakeholder
5-Somewhat important to stakeholder
1-Not very important to stakeholder

Table 2: Sources of Power for Waco VAMC Stakeholders

Stakeholder	Sources of Power	Overall Power Level
Congress	Exert political influence Control Budget	7
VA leadership	Possess formal control Establish policy	6
VISN 17	Influence use of resources Enforce policies	4
Central TX	Controls operation Administers budget	3
Academic affiliation	Administers patient care Influence standards of care	2
Waco veterans	Influence public perception	3
Waco community	Influence public perception	3
Non-physician	Possesses critical skills Control support services	2
Non-Waco veterans	Influence public perception	1
Texas government	Influence federal officials Control medical schools	1
Labor union	Influence elected officials Influence employees	3
VSO	Influence elected officials Influence veteran perceptions	2

7-Very strong power
5-Moderate power
1-Very little power

Figure 1: Key Stakeholders in Waco VAMC CARES initiative

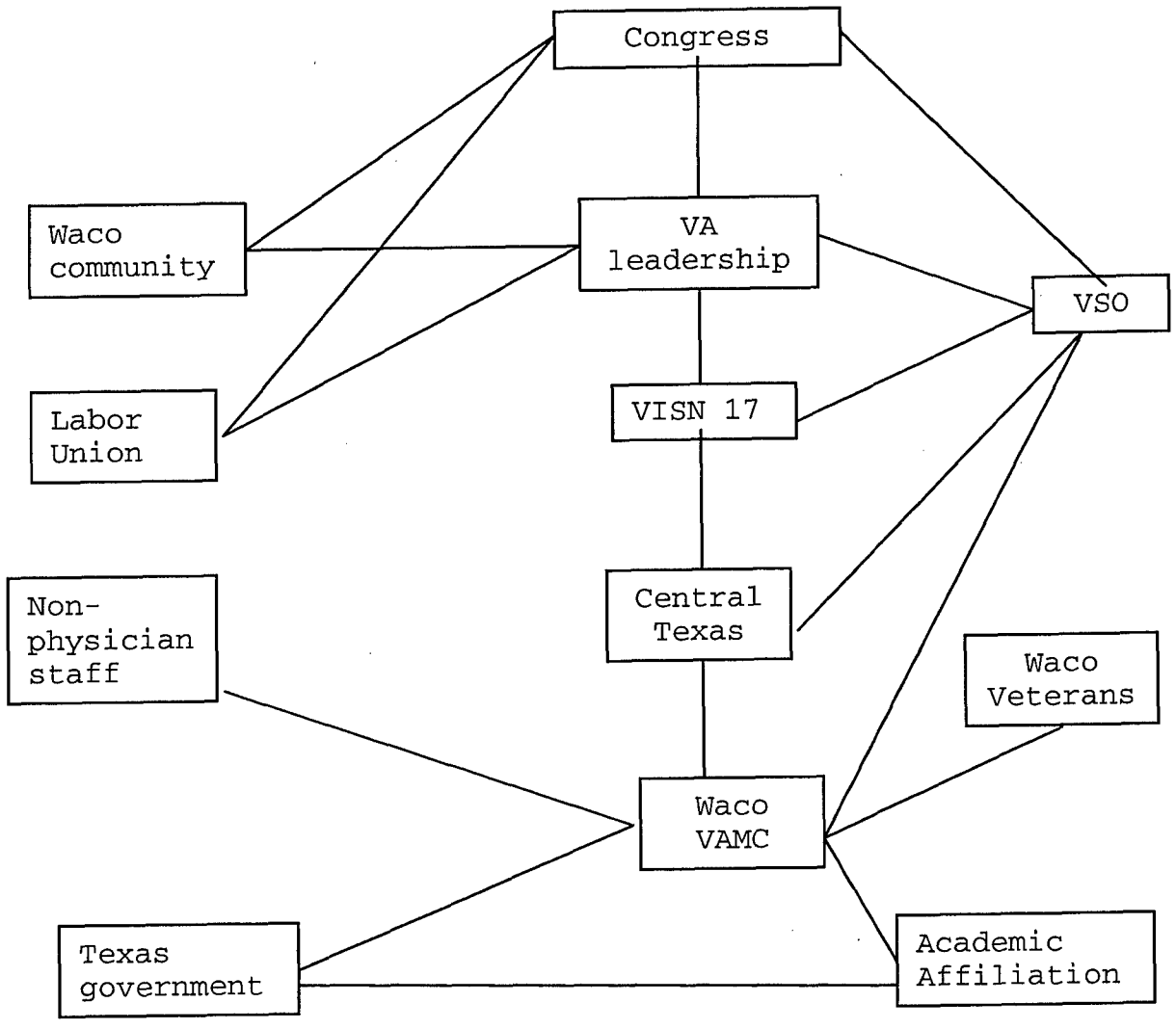

Table 3: Diagnostic Typology of Waco VAMC Stakeholders

Stakeholders potential to cooperate with the organization		Stakeholders potential for threat to organization: High	Stakeholders potential for threat to organization: Low
	High	**Mixed blessing stakeholder** Congress Central Texas	**Supportive Stakeholder** VA leadership
	Low	**Non-supportive Stakeholder** Labor Union Waco Community Non-physician staff Waco veterans VSO	**Marginal Stakeholder** VISN 17 Academic affiliation Texas government Non-Waco veterans

Table 4: Generic Stakeholder Management Strategies

		Stakeholders potential for threat to organization	
		High	Low
Stakeholders potential to cooperate with the organization	High	**Collaborate** Congress Central Texas	**Involve** VA leadership
	Low	**Defend** Labor Union Waco Community Non-physician staff Waco veterans VSO	**Monitor** VISN 17 Academic affiliation Texas government Non-Waco veterans

Discussion

Health care organizations do not relate to one or a few stakeholders on any given issue, rather, they must learn to manage a portfolio of stakeholders (Blair, Fottler, & Whitehead, 1996). Stakeholder analysis is an approach for generating knowledge about actors to understand their intentions, interests, and relationships with other actors to assess their influence and control of resources on decision makers for any given issue or policy. It also aims to evaluate and understand stakeholders from the perspective of an organization, or to determine their relevance to a project or policy. In health management, stakeholder analysis has usually been advocated as a tool for an organization to achieve specific advantages and goals by identifying potential allies and building alliances or mitigating potential threats. It may also be carried out to inform strategic planning for a specific short-term objective, or as a periodic exercise in scanning the external environment by focusing either on the present or more distant future. Frequently, the organization, rather than a specific venture, is the focus of the analysis and the purpose is to predict changes in the relative importance of stakeholders, identify new or upcoming ones and decide on what strategies to use in managing them (Varvasovszky & Brugha, 2000).

However, this paradigm does not directly relate to the scope of this project. It is not the Department of Veteran Affairs, or the degree of their presence within the Waco, TX market that is

the focus of this study. This project examined the specific venture of the CARES process as it relates to the Waco VAMC and its stakeholders, and not as these stakeholders may relate to the VA at the national level or within different markets.

Stakeholder supportiveness or non-supportiveness affects whether its power is used, and to what extent. As it relates to this project, a stakeholder analysis was conducted to diagnose key stakeholders and generate generic strategies. The significance and justification of each category, their assigned stakeholders, and associated strategies for managing them need to be understood. In turn, this will drive the organizations overarching strategic posture toward the CARES process.

Mixed blessing stakeholders will play a pivotal role in the success of CARES. The most important of which is the United States Congressional delegation since they possess the most power and are critically engaged in CARES activities. Because of this, it can be expected that all other stakeholders who view CARES as critically important to their organization will attempt to exert great influence on them, especially those with little or no sources of power of their own.

The Central Texas System leadership is also projected to fall into this category. They are faced with the difficult position of simultaneously needing economies of scale between their two hospitals at Waco, TX and Temple, TX while also having to balance any potential political backlash if the plan is accepted. Consequently, if the political context becomes too volatile or has already become decidedly unfavorable toward the

VA, it can be expected that the Central Texas Health Care System will shift to a non-supportive position and try to influence VA Central Office to abandon or greatly modify the CARES draft plan for the Waco, TX market. The generic strategy for this typology is to collaborate with mixed blessing stakeholders. This strategy will be challenging for the CARES process.

The stakeholders that should be perceived as the most dangerous to the VA are those categories as non-supportive stakeholders. Some of these include: labor unions that are likely protecting their stake to maintain employment levels, the Waco community who is at risk to lose a large number of local jobs, and non-physician staff that do not want to transfer out of the area or risk losing their federal employment status and subsequent pensions. Waco veterans and Veteran Service Organizations (VSO) were also listed as non-supportive, although it could be argued they are not as uniformly opposed. Most veterans (patients) opposed shifting services because it is often perceived as a loss of service or even degradation in quality of care. Many veterans are distrustful of the federal government and belief that if a foothold on care is lost more will follow. Because of this, VSOs will echo these sentiments since the veterans themselves are their constituents. If the VA can establish a successful marketing campaign to demonstrate that care will not be lost and quality can be improved significantly as a result of CARES, it may be logical to move these two stakeholders from non-supportive to supportive category. However, other non-supportive stakeholders may

recognize this and attempt to influence veterans and their VSOs to campaign for their own agendas.

Not all VSOs are the same. Each seeks to identify their organization within a niche of veterans. Since the Waco CARES plan greatly affects blind rehabilitation and mental health it can be anticipated that the Blind Veterans of American and the Vietnam Veterans of America, respectively, to be the most outspoken and non-supportive of the CARES plan. The associated strategy is to defend against non-supportive stakeholders by attempting to reduce the dependence that forms the basis of the stakeholder interest. This may include offering alternative ways for maintaining jobs in the Waco area, or agreeing with the labor union to systematically shift employees to Temple over time and slowly reduce it through natural attrition to name a few.

Currently, the VA leadership is considered the sole supportive stakeholder. In an ideal setting all stakeholders would be supportive because they endorse the organizations goals and actions. As previous mentioned, the Waco campus is inefficient and the VA wants to recoup the capital for improving services in other areas of VA care. To manage this stakeholder category it is recommended to involve supportive stakeholders. Since this plan was developed by the VA this is already occurring. As previously mentioned other organizations may later be reclassified to become supportive stakeholders. The strategy to involve stakeholders that are wavering will increase the likelihood of transitioning them to a supportive stance.

Lastly, this analysis diagnosed several stakeholders as marginal stakeholders. Marginal stakeholders can be considered fairly neutral. Although they potentially have a stake in the organization and its decisions they are generally not relevant to the organization. For example, the Texas government will likely have little concern in this matter since it doesn't involve any potential cost shifts from the federal level to them. In addition, this issue does not involve a state run nursing home. The only link to the state government is their relationship with academic medical schools. The affiliated medical school may also have mixed reactions within their own organization as they have had difficulty recruiting specialty physicians to the Waco area. However, since the recommended changes involve sending patients to nearby Temple, TX the medical school will not be greatly affected.

Similar arguments could be made for veterans who receive care outside of the Waco market. A shift in care back to Temple could potentially impact access standards for existing veterans in Temple, but it is not likely to be too substantial since the plan accounts for expanding inpatient capacity at Temple. Also, few veterans are likely to see a direct impact from the revenues generated if Waco closed since those funds will likely be dispersed across all VA cost centers.

Lastly, this analysis proposes the VISN 17 leadership is also likely to be a marginal stakeholder since total services are not proposed to be added or subtracted, rather, to be realigned within the same system. The leadership will be content

to follow the guidance from VA Central Office and not risk any unnecessary political battles. The final generic strategy is to monitor marginal stakeholders, in essence to "let the sleeping dogs lie." This category is unlikely to help or hinder the organization as long as they have no reason to take action. It may be helpful to directly task managers with actively monitoring these stakeholders to ensure their ambivalent state is being maintained.

It should be noted, the term stakeholder analysis encompasses a variety of different methodologies for analyzing stakeholders and is not considered a single tool. The purpose, time dimension of interest, context of the analysis, the degree to which the issues were defined and stakeholders identified will determine the best approach and how the tools are used. The use of structured data collection approaches in the health management literature, e.g. Delphi technique, where respondents are asked to quantify the current and future influence of various stakeholders has been attempted to replace or be used in conjunction with previous intuitive qualitative techniques. However, the policy environment, the context of the analysis, stakeholder interests, positions, alliances and influence are subject to change and stakeholder perception can also change. The political context of policy making is frequently unstable and can be subject to sudden, unexpected transformations. Notably, if the time frame of a prospective analysis is too long or study results are not applied in a relatively short period of time, especially in a complex or unstable setting, the relevance

of the analysis to manage the future decreases rapidly. The development of health policy or of politically charged projects is a complex process. The use of overtly structured methods may not adequately capture its many nuances (Varvasovszky & Brugha, 2000).

This context is especially true of the CARES process. Although a more rigid and empirical study could have been conducted they posed severe limitations due the extreme dynamic and politically contentious nature of CARES proposals. Rigid models often require the need for ceteris paribus, that is, to assume certain variables are constant and unchanging in order to study the research variable of interest. This condition could never be truly met for the sake of this project because of its ever-changing context. For example, Secretary Principi resigned following the Presidents first term, a new director was appointed to the Central Texas Veterans Health Care System which oversees the Waco VAMC, and the mayor of Waco, TX, and appointed member of the FAC, had deceased. These changes have possibly changed the external environment since the onset of this project and other changes are likely to continue.

In addition, as Varvasovszky & Brugha (2000) state, for empirical models to be effective they require immediate prospective action. This circumstance could not be met for this study. Currently, the contracted consultants have not been issued a statement of work to begin their research and planning thereby leaving an unknown timeline for completion. Upon its undertaking this process will exceed one year. Moreover, the

scope of this project relates to a finite context within the situational analysis of strategic planning and is not intended to be a stand-alone tool for drafting, implementing, and managing the CARES initiatives. The VA's mission, vision, values, and goals, along with information from the internal environment will also greatly influence the outcome of the situational analysis and possible reduce any attempts at empiricism within the external environment.

Lastly, it is important to note the Waco FAC does not possess approving authority for forthcoming consultant's draft plan. Rather, this plan will be taken under advisement by the Secretary of the VA for deliberation on the final policy. Thus, a more practical tool for ascertaining stakeholder positions and negotiating at the local level was needed, which competing empirical models could not provide. Although more rigid models could offer stronger reliability and validity of data, due to some of the aforementioned conditions such as time constraints for implementation and even influencing stakeholder actions itself, these models would have been impractical and yielded little actual value to this project.

In addition to being a practical tool, this assessment lends itself to review necessary ethical implications in working with stakeholders. Strong consideration to ethics needs to be taken into account when using a stakeholder management strategy since it delineates a preferred manner in dealing with other persons or groups in ways that significantly affect them. The core essence of delivering health care involves moral issues and

choices. It requires the need to balance the values of business and health, which will become exceedingly more complex as technological advances, economic constraints, and the numbers of stakeholders continually increase. Blair and Fottler (1990) highlight that the stakeholder management concept is highly regarded among health care leaders because it reflects what managers actually do. Despite this general support, there are caveats. This approach could be used to manipulate stakeholders so that their needs are only considered in so far as the degree necessary to induce their contributions to the organization (Blair & Fottler, 1990). It is imperative that VA leadership interacts with their stakeholders in such a manner as to reflect their core values while attempting to understand their stakeholder's goals and priorities. In addition, it will be necessary to develop an implementation strategy that simultaneously attempts to meet their needs as well as the VA's.

Conclusion

The CARES initiative will be one of the largest restructurings in the VA health care system's history. It calls for the modernization of VA facilities, expansion of outpatient services and other service delivery improvements. CARES will ensure that VA health care services are delivered in modern facilities that provide accessible state of the art health care and the effective use of VA campuses with unused space.

CARES is the VA's response to the dynamic challenges in their health care delivery system. These challenges are a result of many factors including the migration of veterans, increasing

average age and patient acuity of VA beneficiaries, a substantial shift from inpatient to outpatient care, and increased patient travel and waiting times.

Those who fail to plan, plan to fail. Stakeholder input is vital within the VA's environment. The FAC must ensure the plan developed by the private consultants adequately address all issues relative to CARES. To do so, their plan must be built on reliable information.

Managers in organizations might argue that the concept of stakeholders represents nothing new, since managers must deal with such individuals or groups regularly. However, the benefit is its potential to organize and manage these complex relationships systematically to align with the organization's strategies in such a way as to maximize benefits and minimize the damage from the external environment. When stakeholder management is properly performed it is almost invisible because the involved stakeholder is content with the relationship that exists with the organization. Within this context, stakeholder' contributions are maximized with minimal inducements, and the stakeholder has no reason to threaten or harm the organization (Blair & Fottler, 1990).

A stakeholder analysis will serve as a useful tool in the information gathering stages of the strategic plan for Waco VAMC. Stakeholders should be viewed as partners who create value through problem solving that result in a corporate community (Ginter, Swayne, & Duncan, 2002). However, the FAC must be cautious not to allow key stakeholders to sabotage or influence

the process outside of the VA's vision. As such, a means of identifying all the players and their stakes will reveal useful generic strategies to the VA's overall CARES plan development.

References

Blair, J. D. & Buessler, J. A. (1998). Competitive forces in the medical group industry: A stakeholder perspective. *Health Care Management Review*, 23 (2), 7-27.

Blair, J. D. & Buessler, J. A., Stanton, S. Y., Whitehead, C. J. (1989). Stakeholder issues for the physician executive. *Physician Executive*, 15 (3), 9-14.

Blair, J. D. & Fottler, M. D. (1990). *Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders*. San Francisco, CA: Jossey-Bass.

Blair, J. D. Fottler, M. D., & Whitehead, C. J. (1996). Diagnosing the stakeholder bottom line for medical group practices: Key stakeholders potential to threaten and/or cooperate. *MGM Journal*, March/April, 40-50.

Blair, J.D. & Whitehead, C. J. (1988). Too many on the seesaw: Stakeholder diagnosis and management for hospitals. *Hospitals and Health Services Management, 33 (2), 153-156.*

Blair, J. D., Rock, T. T., Rotarius, T. M., Fottler, M. D., Bosse, G. C. & Driskill, J. M. (1996). The problematic fit of diagnosis and strategy for medical group stakeholders-including IDS/Ns. *Health Care Management Review*, 21 (1), 7-28.

Bronn, P. S. & Bronn, C. (2002). Issue management as a basis for strategic orientation. *Journal of Public Affairs*, 2 (4), 247-258.

Clarkson, M. E. (1995). A stakeholder framework for analyzing and evaluating corporate social performance. *Academy of Management Review,* 20 (1), 92-117.

Daake, D., & Anthony, W. P. (2000). Understanding stakeholder power and influence gaps in a health care organization: An empirical study. *Health Care Management Review,* 25 (3), 94-107.

Department of Veterans Affairs. (2004). Charter for the advisory committee for CARES business plan studies. (Available from the Department of Veterans Affairs, 810 Vermont Ave NW, Washington D.C. 20420).

Department of Veteran Affairs. (2003). *Draft national CARES plan*. Retrieved October 1, 2004, from Veteran Affairs Web site: http://www1.va.gov/cares/docs/VISN17MarketPlan.pdf

Dymond, S., Nix, T. W., Rotarius, T. M., & Savage, G. T. (1995). Why do key integrated delivery stakeholders really matter? Assessing control, coalitions, resources, and power. *MGM Journal*, November/December, 27-38.

Fottler, M. D., Blair, J. D., Whitehead, C. J., Laus, M. D., Savage, G. T. (1989). Assessing key stakeholders: Who matters to hospitals and why? *Hospital and Health Services Administration*, 34 (4), 525-546.

Freeman, R. E. (1984). *Strategic Management: A Stakeholder Approach.* Marshfield, MA: Pitman Publishing.

Ginter, P. M., Swayne, L. E., & Duncan, W. J. (1998). *Strategic Management of Health Care Organizations*. Malden, MA: Blackwell Publishers, Inc.

Gregory, R. & Keeney, R. L. (1994). Creating policy alternatives using stakeholder values. *Management Science*, 40 (8), 1035-1048.

Savage, G. T., Taylor, R. L., Rotarius, T. M., & Buessler, J. A. (1997). Governance of integrated delivery systems/networks: A stakeholder approach. *Health Care Management Review*, 22 (1), 7-20.

Topping, S. & Fottler, M. D. (1990). Improved stakeholder management: The key revitalizing the HMO movement. *Medical Care Review*, 47 (3), 365-393.

Varvasovszky, Z. & Brugha, R. (2000). How to do (or not to do)…A stakeholder analysis. *Health Policy and Planning*, 15 (3), 338-345.

Varvasovszky, Z. & Brugha, R. (2000). Stakeholder analysis: A review. *Health Policy and Planning*, 15 (3), 239-246.

U.S. General Accounting Office. (2000). *VA is struggling to address asset realignment challenges* (GAO No. GAO/T-HEHS-00-91). Retrieved October 1, 2002, from U.S. General Accounting Office Web site: http://www.gao.gov/new.items/he00091t.pdf

U.S. General Accounting Office. (2003). *Improved planning needed for management of excess real property*. (GAO No. GAO-03-326). Retrieved October 1, 2004, from U.S. General Accounting Office Web site: http://www.gao.gov/new.items/d02434.pdf

U.S. General Accounting Office. (2003). *Key management challenges in health and disability programs*. (GAO No. GAO-03-756T). Retrieved October 1, 2004, from U.S. General

Accounting Office Web site:

http://www.gao.gov/new.items/d03756t.pdf

Whitehead, C. J., Blair, J. D., Smith, R. R., & Savage, G. T. (1989). Stakeholder supportiveness and strategic vulnerability: Implications for competitive strategy in the HMO industry. *Health Care Management Review,* 14 (3), 65-76.