

Running Head: Capital Asset Realignment

U.S. Army - Baylor University

Graduate Program in Healthcare Administration

Case Study of the Capital Asset Realignment for Enhanced
Services as Applied to the Wyoming VA Healthcare Market

14 November 2003

Kurtis N. Mayer, Chief of Facilities (138)

Department of Veterans Affairs Medical Center

1898 Fort Road

Sheridan, Wyoming 82801

Report Documentation Page			Form Approved OMB No. 0704-0188		
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 14 NOV 2003		2. REPORT TYPE Final		3. DATES COVERED Jul 2002 - Jul 2003	
4. TITLE AND SUBTITLE Case Study of the Capital Asset Realignment for Enhanced Services as Applied to the Wyoming VA Healthcare Market			5a. CONTRACT NUMBER		
			5b. GRANT NUMBER		
			5c. PROGRAM ELEMENT NUMBER		
6. AUTHOR(S) Kurtis N. Mayer			5d. PROJECT NUMBER		
			5e. TASK NUMBER		
			5f. WORK UNIT NUMBER		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Department of Veterans Affairs Medical Center 1898 Fort Road Sheridan, Wyoming 82801			8. PERFORMING ORGANIZATION REPORT NUMBER		
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) US Army Medical Department Center and School Bldg 2841 MCCS-HRA (US ArmyBaylor Program in HCA) 3151 Scott Road, Suite 1412 Fort Sam Houston, TX 78234-6135			10. SPONSOR/MONITOR'S ACRONYM(S)		
			11. SPONSOR/MONITOR'S REPORT NUMBER(S) 38-03		
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release, distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT The Department of Veterans Affairs has embarked on a sweeping initiative to align capital assets with patient demand in order to improve access, quality, and cost effectiveness of care to veterans now and in the future. This study documents the first four steps of the nine-step Capital Asset Realignment for Enhanced Service (CARES) process as it applies to the Sheridan market area. This process involved establishing a communication plan and leading teams that analyzed and validated data and developed a strategic plan for the Sheridan market. The outcome of the study suggests that improving access to levels prescribed by CARES standards is possible but very expensive in a highly rural market. However, improving access through conscientious strategic planning is possible and practical. The CARES process is an accelerated program that relies heavily upon data and projections. Data validity, expedience, and political pressure may affect the outcomes. Nonetheless, CARES is a sound and dynamic process for improving the cost, quality, and access of the care delivered to our nations veterans.					
15. SUBJECT TERMS Capital Asset Realignment for Enhanced Services (CARES)					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT UU	18. NUMBER OF PAGES 81	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

Abstract

The Department of Veterans Affairs has embarked on a sweeping initiative to align capital assets with patient demand in order to improve access, quality, and cost effectiveness of care to veterans now and in the future. This study documents the first four steps of the nine-step Capital Asset Realignment for Enhanced Service (CARES) process as it applies to the Sheridan market area. This process involved establishing a communication plan and leading teams that analyzed and validated data and developed a strategic plan for the Sheridan market. The outcome of the study suggests that improving access to levels prescribed by CARES standards is possible but very expensive in a highly rural market. However, improving access through conscientious strategic planning is possible and practical. The CARES process is an accelerated program that relies heavily upon data and projections. Data validity, expedience, and political pressure may affect the outcomes. Nonetheless, CARES is a sound and dynamic process for improving the cost, quality, and access of the care delivered to our nation's veterans.

Table of Contents

Introduction	2
Overview of the CARES Process	2
Conditions that Prompted Study	3
Local Conditions	5
Statement of the Problem	7
Unique Market Characteristics	9
Purpose	10
Literature Review	10
Background	10
Consensus Building	11
Communications	12
Strategic Planning within a Team	13
Methods and Procedures	14
Communications	14
CARES Teams	15
Data Analysis Team	15
CARES Market Planning Team	18
Validity	20
Strategic Planning	22
Market Plan Development	23
Planning Initiatives	23
Non-planning Initiative Workload Gaps	25
Findings and Utility of Results	28

Mental Health Data	29
Planning Initiative Resolution	30
Conclusions	31
References	34
Appendix A	37
Appendix B	51

List of Tables

Table 1	The CARES 9-Step Process	3
Table 2	Data Validation	19
Table 3	Miles and Travel Time Guidelines by Population Density and Type of Care	24
Table 4	Workload and Cost Calculations for Access Gaps	27

Introduction

Overview of the CARES Process

The Department of Veterans Affairs (VA) operates the largest integrated healthcare system in the country consisting of 172 hospitals and over 800 community-based outpatient clinics. Originally designed to treat veterans of the first two world wars, the VA created a system of inpatient hospitals that has become outdated and expensive to maintain. Initial decisions for the location of VA hospitals were often driven by politics or availability of vacant government facilities rather than consideration for patient access.

The Capital Asset Realignment for Enhanced Service (CARES) process was born of necessity to address an aging infrastructure built for decades old healthcare practices. The intent of CARES is to provide a data driven, comprehensive process for critically examining all VA assets, comparing them to projected veteran needs, and creating strategic plans for modifying the system so that the physical structure of the VA complements its strategic mission. CARES defines assets as land, buildings, and medical services owned or controlled by the VA.

The CARES process is divided into nine steps. The scope of this graduate management project was to document the first four steps of this process as they apply to the Sheridan Wyoming

market. Table 1 describes the nine-step CARES process.

(Department of Veterans Affairs, 2002)

Table 1

The CARES 9-Step Process

CARES Step	Description
1	Develop Markets and Sub Markets as the Planning Unit for Analysis of Veterans Needs
2	Conduct Market Analysis of Veterans' Healthcare Needs
3	Identify Planning Initiatives for Each Market Area
4	Develop Market Plans to Address Planning Initiatives
5	VA Central Office Review and Evaluation
6	Independent Commission Review
7	The Secretary Department of Veterans Affairs Decision
8	Implementation
9	Integration into Strategic Planning Process

Conditions that Prompted the Study

Changing population demographics and healthcare practices have modified the way healthcare is delivered throughout the country. Further, population migration continually alters access to healthcare geographically. With a stationary infrastructure, these changes have left substantial gaps in service in some geographic areas and excess capacity in others. Long hospital stays and chronic mental health inpatient services

have given way to outpatient treatment and residential rehabilitation. (Fortney, 2002)

To respond to these changes, the VA has moved toward treating veterans closer to the communities in which they live. Dr. Kenneth Kizer, former Undersecretary for Health, created this movement with his "Prescription for Change." (1996) Primary to his plan was the creation of community based outpatient clinics that would provide modern outpatient treatment in local communities. The improved access to care created by this movement has been a substantial benefit to VA beneficiaries, but the initiative has left many VA inpatient hospitals with large amounts of space in excess of local need.

Since Korea and Vietnam, no widespread military conflict has emerged to produce large numbers of injured veterans. Because of this, most veterans are older and populations of eligible veterans are declining. Among the younger veterans are substantial numbers of females. This has further strained a system designed for a large number of male veterans.

Although all of the above issues contributed to the inevitability of VA's capital asset realignment, the ultimate catalyst was the 1999 General Accounting Office (GAO) report on VA capital asset planning and budgeting. In this report, the GAO predicted that by fiscal year 2000, one quarter of all VA expenditures would go to expenses generated by building

ownership. Over 40% of VA buildings are more than 50 years old, and over 200 were constructed prior to 1900. (General Accounting Office, 1999)

Also at issue in the CARES process was the large amount of vacant space prevalent throughout the VA and the potential for sharing this space with other federal partners, particularly the Department of Defense.

Local Conditions

Fort Mackenzie, now the Sheridan VA Medical Center, was established as a military post by the War Department in 1898. (McDermott, 1998) The campus consists of over 60 structures on nearly 300 acres framing the historic Fort MacKenzie parade ground. Most of the main buildings and housekeeping quarters were constructed between 1906 and 1908. The conversion of the historic fort to a modern healthcare facility has been, and continues to be, an awkward transformation.

The Sheridan VA operates as part of a Veterans Integrated Service Network (VISN) that covers most of Wyoming, Montana, Colorado and Utah. The VISN is divided geographically into markets. The Sheridan Wyoming market captures the majority of Wyoming counties and includes the Sheridan VA Medical Center and its four community based outpatient clinics. The Sheridan Wyoming market will be referred to as the Sheridan market for

purposes of this paper. The CARES market map for the Sheridan market is included at Appendix A1 on page 49.

Clearly, if modern healthcare architects were to design a facility to meet the current and future needs of the veterans within the Sheridan market area, plans would be far different from the layout of the existing Fort MacKenzie facility. However, one can make a case for the efficiency and the efficacy of care provided by this medical center and its functionality within the VISN structure. Costs per unit of workload at the facility have improved remarkably over the past few years. They now compare favorably to other similar facilities and are in line with national VA averages.

The Sheridan VA completed a clinical addition in 1990. It serves as the cornerstone for medical and ancillary services and is the only truly modern architectural element of the Sheridan VA Medical Center. All other buildings supporting healthcare, such as mental health, residential rehabilitation, and long-term care, have been modernized through remodel within the last decade. Although modernization has been extensive, the effectiveness of the construction has been mitigated by physical constraints driven by structural layout and historic concerns. The entire facility is listed on the National Register of Historic Places and plans must undergo review and approval by

state and national offices of historic preservation before substantive exterior modifications can be made.

The Sheridan VA Medical Center maintains an inpatient program consisting of 22 acute and sub-acute medical beds, one medical intensive care bed, 46 acute and sub-acute psychiatric beds, 50 nursing home beds, and 27 psychiatric residential rehabilitation treatment program beds that provide treatment for serious mental illness, post traumatic stress disorder, and substance abuse. In addition to inpatient services, more than 85,000 outpatient visits in medicine and mental health were recorded during 2002 at Sheridan and community-based outpatient clinics in Casper, Riverton, Powell and Gillette, Wyoming.

Statement of the Problem

The problem addressed by this study was to support the local CARES process by developing a CARES communication plan and planning statement (Appendix A) followed by a strategic plan (Appendix B.)

The first step, the communication plan, supported the CARES goal of fostering a transparent process that encouraged stakeholder participation. The CARES process relied heavily upon the input of stakeholders at all levels and the inclusion of stakeholder groups throughout the process. To facilitate and document this, a national mechanism was established for gathering and addressing this input. The local process must

keep all stakeholders engaged throughout the transformation so they may better understand and accept changes that may result from these initiatives. Properly engaging stakeholders reduces misunderstanding and resistance to change should the process yield substantial requirements for change. To this end, a communication plan was developed and a Market Planning Team was assembled. The team was comprised of a diverse group of stakeholders and management officials who participated fully throughout the entire process. This participation enabled the team to better understand the intent of the process. Substantial concerns or recommendations were recorded and forwarded to the VA Central Office. The central CARES Committee, in Washington, D.C., recorded this feedback for the purpose of utilizing the information in future decision-making.

Strategic planning was the second step in addressing the problem. A market plan was developed that addressed planning initiatives¹ tailored to the Sheridan market. Although planning initiatives were created centrally, the local facility was charged with developing strategies for implementation. VISNs

¹Planning initiatives are generalized directions that address gaps or overlaps in service and are the product of overall data analysis at the national level.

then incorporated all local market plans into the overall VISN plan and forwarded it to VA Central Office for review.

This study addressed the question: How will the Sheridan VA Medical Center and Clinics best serve the needs of veterans in the Sheridan Wyoming market, now and in the future? The strategic plan provides the answer.

Unique Market Characteristics

A confounding element throughout this study was the application of standardized evaluation and planning criteria, developed for large metropolitan areas, to a highly rural healthcare setting such as the Sheridan market. Most planning initiatives developed by VA Central Office had to meet certain thresholds to be formally considered in the CARES process. One example of such a threshold is that the catchment area of the clinic must contain 1,600 enrolled veterans in order to open a community based outpatient clinic addressing a gap in access. (Department of Veterans Affairs, 2002) This is a relatively small number in most urban areas; however, in sparsely populated locations such as Wyoming and Montana, adhering to this threshold would mean no access to VA care across huge geographic areas. The metropolitan planning criteria were not considered acceptable to our market area or to our stakeholders.

Purpose

The purpose of this study was to apply the first four steps of the CARES process to the Sheridan market in a way that ensured the initiative addressed local concerns and stakeholders' issues and converted planning initiatives into appropriate strategic plans. (Longest, Radich & Darr, 2000) This was accomplished through local data validation, communications with market stakeholders and central CARES coordinators, and strategic planning that addressed future needs of the local market and the VISN.

Literature Review

Background

Although the CARES process is new to the VA, leadership has created a culture of rapid change over the last decade. At the foundation of this study were two works of Kenneth Kizer, "Vision for Change: A Plan to restructure the Veterans Health Administration" (1995) and "Prescription for Change: The Guiding Principles and Strategic Objective Underlying the Transformation of the Veterans Healthcare System" (1996). These works precipitated a dramatic change in the way care is provided to this nations veterans.

Once Kizer implemented his plan to streamline the healthcare delivery process and treat more veterans closer to where they lived, a large disparity between healthcare

facilities and healthcare demand became apparent. Shifting from an inpatient model to outpatient treatment left the VA with hospital infrastructure in excess of need. The General Accounting Office (GAO) highlighted this issue in its report "VA Health Care Capital Asset Planning and Budgeting Need Improvement" (1999). Even prior to the GAO findings, the VA Office of Inspector General identified problems in aligning capital assets to meet the VA mission (1998). With the evidence mounting on the need to realign the VA infrastructure, VA Secretary Anthony Principi launched "Capital Asset Realignment for Enhanced Services" (CARES). This initiative set into motion recommendations from previous studies and added the dimension of encouraging VA staff, veteran service organizations (VSOs), unions, and outside healthcare professionals to participate in the architecture of the realignment.

Consensus Building

The CARES process relied heavily upon multi-disciplinary teams to pass information, create ownership, and build consensus. Participation by each member of a group was paramount to producing a plan that would be widely accepted. Gaining consensus from the local CARES team was a very important element in the local process. The team process satisfied two goals of the VA and the CARES process by 1) collecting input, aggregating concerns, and jointly developing final planning

documents, and 2) ensuring stakeholders understood the process and the direction it would take them. It is important to note that the team-based approach to this issue was of far more value in addressing the second point than the first. The planning document would have been essentially identical had it been produced by staff alone. In fact, Cassard, Weisman, Gordon, & Wong (1994) recognize that in some situations, team-based approaches are not necessarily superior to other methods. However, producing the planning document within a team of stakeholders ensured that everyone understood the process, was engaged in the decision making, and felt ownership for the directions chosen.

Communication

Communication at its simplest level can be modeled as a *sender* providing a *message* to a *receiver*. (Rakich, Longest and Darr, 1992) In this model, the message is encoded by the sender and decoded by the receiver with feedback provided from the receiver to the sender. The communication process is only effective when the receiver gets the message that the sender intended. (Shortell and Kalunzi, 2000)

Shortell and Kalunzi (2000) suggest that the most important impact a healthcare organization will make on its community will be in fulfilling health enhancing activities. The VA hospital, however, provides these services for only a limited segment of

the population. Additionally, the Sheridan VA operates a large business in a very small community. Therefore, it may be more correct to assume that the most important impact that the VA has on the local community is economic in nature. This said, the business community and public sector became important stakeholders and were included in all communication channels.

Communication is most effective when it takes a multimedia approach (Longest, Radich & Darr, 2000). Face-to-face meetings that used hand-outs and projected presentations were combined with mailings to provide the bulk of the information for the CARES process. Additionally, computer WEB-based information with links to national information pages was used extensively and updated regularly. Locally, the CARES WEB-site provided an e-mail link over which questions could be submitted to the local VA staff.

The process of producing the planning document was perhaps the most powerful communication tool used. Because of the multi-media approach and open discussion, clarity was achieved in the delivery of the message and feedback was facilitated.

Strategic Planning within a Team

For purposes of developing strategies within a team, Ansoff (1988) identified two types of external environments- those that are relatively predictable and those that are turbulent. Teams generally work best when they are formed around specific tasks

(Lighter and Fair, 2000). By narrowing the focus of the group activity to predictable, data driven processes, more direction and control of the group was obtained. That said, it is important not to oversimplify the goals of the group and create short sighted expectations. Kurt Lewin (1947) described change as stages of unfreezing, changing, and refreezing. This description may be too simplistic and implies that there is a discrete beginning and end. "In reality, change is best characterized as an ongoing dynamic journey in which a sequence of events unfolds over time." (Fried and Johnson, 2002, pg. 226) In this framework, the expectations of a final outcome were replaced by the selection of a general direction.

Methods and Procedures

Communications

The first step in the process was to develop a communication plan for addressing stakeholders' concerns and gaining participation from stakeholders. Controlling the national CARES process from the local market area was not possible, and controlling the outcome in the form of planning initiatives was tenuous at best. However, controlling the local process, keeping stakeholders engaged, and reacting conscientiously to the outcomes of the process ensured that the intent of the CARES process was preserved and the Sheridan

market remained a strong and viable component of the VA healthcare system.

The communication plan outlined a multi-media approach to developing interest and sharing information with veterans, employees, state and local elected officials, and community leaders. (Longest, Radich & Darr, 2000) This plan was developed and implemented locally; however, certain outreach information was collected in a national "roll-up" for purposes of tracking outreach activities and ensuring stakeholder comments and concerns were addressed at the national level. This outreach information was also used throughout the process to counter attacks from groups concerned that they had no opportunity for input into the process.

CARES Teams

Two local teams analyzed raw data produced by VA Central Office and consultants from Milliman U.S.A. They were the Data Validation Team and the CARES Market Planning Team. They transformed the data into useful information and developed a strategic plan to align local services with expected demand.

Data Validation Team

The Data Validation Team reviewed all baseline data used for projections and analyzed the projections to ensure applicability to local situations. (Austin & Stuart, 1998) Data used for many of the CARES projections were based on a model

developed by the Milliman Group. A broad database derived from the medical industry combined with trends and predictions about specific populations the VA serves to forecast use patterns within the VA. (Milliman USA, Inc., 2002) These data were considered along with average utilization rates and treatment patterns to predict geographic demand for services.

The Data Validation Team was formed as soon as the first data became available. The team compared data pertaining to facility condition, space utilization, and clinical inventory to local experiences and observations. These data were based primarily on information provided by the medical center, which simplified validation. Main issues encountered were related to how local data were categorized and how they would consistently compare with data submitted by other VA facilities. Definitions were not available for many of the data fields leading to significant inconsistencies among reporting facilities. In the absence of definitions, the strategy was to strive for consistency among the hospitals in the network. Two of the main (and most troublesome) data sets were the clinical inventory and the space and functional database. Although these data sets would be used in the national database for decision-making purposes, no instructions were provided for assuring consistency. Therefore, much of the input was subjective.

Population projections and demand models were even more difficult to validate due to assumptions made in the complex modeling that formed the basis of the data. The assumptions most in question related to rates at which new veterans would be added to the system and future eligibility. These concerns came to light when Secretary Principi closed new enrollment to priority eight² veterans and proposed higher co-payments to other categories of veterans. This change in enrollment required demand assumptions to change and all data to be completely recalculated. Additionally, Milliman had to predict world behavior and congressional decision-making for input into these models. The validity of these projections will be tested over time.

Centrally developed demand forecasts with little or no local input or control made local validation more difficult. Central Office allowed no changes to the forecasts due to local input unless egregious errors were identified.

As a check of validity, the group questioned what the data would be used for and how the data would be refined over time.

²Priority eight veterans earn more money than a geographically based income threshold, have no service-connected disabilities, and are not being treated for a service-connected condition.

Most of the CARES data is dynamic and will undergo continual year-to-year refinement. Therefore, the team validated data that reasonably described current conditions and made logical projections. The data validation team accepted all data and produced the results in Table 2.

CARES Market Planning Team

The purpose of the Market Planning Team was to develop strategies for meeting projected workload demand and aligning facilities within the framework established by the CARES process. The Market Planning Team accomplished these strategies by utilizing CARES data, using local experience in serving the Sheridan market, and by assuring input from stakeholders.

The first order of business was to develop and present a draft market plan to the CARES Market Planning Team. Meetings were held after each major data revision and accompanying change in the market plan. A total of four meetings occurred over four months, culminating in the development of the final market plan. The local Market Planning Team endorsed the Sheridan Market Plan and forwarded it to the VISN for inclusion in the overall VISN CARES Plan. The Sheridan Market Plan is included as Appendix A.

Table 2

Data Validation Table

Data	Method	Outcome
Affiliations	Comparison to listed affiliates	Valid
Research	Comparison to research activities	Valid
DSS Unit Cost	Comparison of DSS Unit cost data to actual cost data	Not valid. No consistency can be found between known data and DSS unit cost data.
FY01 Actual Workload Output and Input	Comparison to gains and losses worksheet	Valid
FY01 Market Penetration	Comparison to local calculations	Valid
Station and CBOCs	Simple review	Valid
Access by market and county	Not tested	
FY01 Beds Day of Care	Comparison to gains and losses worksheet	Valid
FY01 Outpatient Clinic Stops	Comparison to gains and losses worksheet	Valid
List of DoD Facilities		Not applicable for the Sheridan Market
Market Definitions	Review of assumptions	Valid
Special Populations	Validated at VISN level	Unknown
Maps	Simple review	Valid
Market Rational	Validated at VISN level	Unknown

Veterans' service organizations contributed the primary input into the market planning process. Their constituencies were primarily interested in adding a VA access point to serve a gap in the far eastern portion of Idaho and the far western counties of Wyoming. This input was included in each iteration of the market plan and created some complication in dealing with the Sheridan market. The main issue was that most of the counties comprising the gap our market proposed to serve were not within the Sheridan market area (see the market map at page 49). To provide this service, the market boundaries would have to be redrawn to assign responsibility for the area to a single market. Secondarily, to open a new clinic several conditions must be met including a threshold of 1,600 veterans enrolled within the standard commuting area. (Department of Veterans Affairs, 2002) In a highly rural setting such as Western Wyoming the population is too sparse to meet this threshold. In fact, three of the four community-based outpatient clinics in the Sheridan market would not meet this threshold if proposed today. For these reasons, the Market Planning Team decided to address the population threshold issue by establishing a satellite of an existing clinic rather than creating a new one.

Validity

Data analysis and validation were other major components in the process. Consultants working for the VA produced, and

continue to produce, a great deal of data. The contractors extracted data from VA databases and other sources and reported the information back to the markets. Concerns with this type of process include the method by which the data are retrieved and the accuracy of the data pulled. Opportunity for error abounds. Errors may include consistency errors in the base data, collection errors, and reporting errors at several different levels. These errors lead to questions of validity. (Austin & Stuart, 1998) Interpreting the results also proved problematic as the contractor did not present the data in a form familiar to the department and added confusion by manipulating the data for standardization.

Another difficulty with data validation was political influence on the acceptability of some data. Although CARES embraced the principles of a data-driven, transparent process, data that suggested change that may negatively effect large, influential markets were dismissed. Long term and inpatient mental health data were dropped from the CARES study in this manner. This is demonstrated in the study of the mental health projections later in this paper.

Workload and population projections were based on a complex formula that accounted for demographic trends, use patterns of veterans, illness patterns, and related mortality and morbidity. This formula used possible scenarios (predictions) of the

likelihood and severity of armed conflict possibly leading to increases in veteran enrollees within the VA system.

For purposes of this study, the projections were accepted and the data on which those projections were based considered valid. This was done with full knowledge the data are numerically invalid. However, given the assumption that data quality will improve over time, the construct and criterion-related measures are sound and validity will improve as the reliability of the data tightens. (Cooper & Schindler, 2000)

Strategic Planning

Strategic planning was the final element of this study. A long-term, local strategic plan was in place and had effectively improved the viability of the Sheridan market. The local CARES Market Planning Team drew upon this past strategy in order to develop a market plan that would address CARES initiatives and coordinate services with the rest of the VISN resources. This plan incorporated Milliman data, local market experience, and input from local veterans' service organizations and stakeholders to chart a course for serving veterans in the market area. Planning initiatives assigned to the Sheridan market fit within the framework of current strategic planning with no unanticipated changes prescribed. The mission of the Sheridan market also experienced no substantive change resulting from planning initiatives.

Market Plan Development

The purpose of the Sheridan Market Plan was to describe how the local market would correct issues identified by CARES national planning initiatives³. Also identified in the CARES plan were non-planning initiative⁴ workload gaps. The Sheridan market had two planning initiatives and a number of non-planning initiative workload gaps.

Planning initiatives

CARES planning initiatives suggested the Sheridan market would have two significant gaps in service. One in the area of access to care and the other in outpatient specialty care capacity.

The access gap, which relies on current population and workload data only, raises two issues. First, a large portion of western Wyoming contains small populations of veterans living

³Planning initiatives identify gaps or overlaps in workload that meet thresholds set by CARES. These are mandatory action items to be addressed.

⁴Non-planning initiative workload gaps identify gaps or overlaps in workload that do not meet thresholds set by CARES. These are recommendations and corrective action is not mandatory.

further from primary care services than was contemplated by CARES; see CARES guidelines on miles and travel time in Table 3. Second, only small portions of the Sheridan market are within CARES standard travel distances to full-service hospital care. (Table 3) The Sheridan VA hospital does not provide surgical services; those services are generally obtained from the Denver, Salt Lake City, or Cheyenne VA Hospitals.

Table 3

Miles and Travel Time Guidelines by Population Density and Type of Care

Type of Care	Urban	Rural	Highly Rural
Primary Care	30 minutes 6 miles	30 minutes 20 miles	60 minutes 60 miles
Specialty Ambulatory Care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Extended Care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Inpatient hospital care	60 minutes 12 miles	90 minutes 60 miles	120 minutes 120 miles
Tertiary hospital Care	3-4 hours if available	3-4 hours if available	Community Standard

The outpatient specialty care gap was based on projected workload derived in the Milliman study. These data predict the Sheridan market will need to add capacity for 12,120 clinic

stops⁵ in FY2012 (an 83% increase over current demand) and 8,838 clinic stops for FY2022 (an increase of 60% over current demand.) It is interesting to note the number of expected clinic stops falls well short of the threshold criterion of plus or minus 30,000 clinic stops. (Department of Veterans Affairs, 2002) The reason the outpatient specialty care gap became a planning initiative, even though it failed to meet the volume threshold, is that the Central Office CARES Team accepted the argument of the local CARES Market Planning Team for a threshold exception for highly rural areas.

Non-planning Initiative Workload Gaps

Workload gaps that were identified by CARES, but did not meet CARES thresholds, included inpatient medicine, inpatient surgery, inpatient psychiatry, and outpatient mental health. These gaps involved such low volumes that they were not considered in the Sheridan Market Plan. Outpatient primary care, however, was of adequate volume to warrant attention. Projections indicated there would be a negative gap (indicating excess capacity) of 12,332 clinic stops in FY2012 and 17,046 in FY2022.

⁵CARES defined a clinic stop as a visit to a single clinic. An outpatient visit may contain more than one clinic stop. (Department of Veterans Affairs, 2002)

The data supporting the planning initiatives and non-planning initiative workload gaps were disaggregated to assign the workload components to the Sheridan VA hospital and each of its four community-based outpatient clinics. Demand data was downloaded from the national CARES portal (<http://vssc.med.va.gov>) and placed in a spreadsheet for easier manipulation. Data and calculations from this spreadsheet are included as Table 4, which shows current workload and projected workload demand in fiscal years (FYs) 2003, 2012, and 2022 for each county in the Sheridan market and subtracts that demand which was within the standard commuting distance to an existing access point. Simple mapping techniques were used to estimate the demand assigned to each access point. These maps appear at appendices A2 and A3. The resulting workload represents the total workload to be purchased to satisfy access distance standards. Once workload calculations were made, costs were derived using estimates from the CARES Cost Calculator. (VSSC/tas:12-9-2002) CARES Cost Calculator data are included in the calculations of table 4.

The culmination of this analysis is the Sheridan Wyoming CARES Market Plan that was endorsed by local stakeholders through the CARES Market Planning Team. (Appendix A) This document was used to communicate how the Sheridan market would address planning initiatives to the VISN.

Table 4

Workload and Cost Calculations for Access Gaps

CARES Category	Baseline Fee	Baseline In-House	Baseline Total	FY03 Model	FY12 Model	FY22 Model
Medical	78	2508	2586	3987	4017	2691
Sheridan						
Medical	19	1510	1529	1919	1854	1202
Difference	59	998	1057	2067	2163	1489
\$Cost			\$1,701,770	\$3,328,523	\$3,482,115	\$2,397,044
Casper	45	513	558	970	990	690
Riverton	14	253	267	707	815	570
Sheridan	0	232	232	390	358	228
Total						
Medical	59	998	1057	2067	2163	1489
\$Casper			\$898,380	\$1,561,801	\$1,593,688	\$1,111,240
\$Riverton			\$429,870	\$1,138,783	\$1,311,530	\$918,128
\$Sheridan			\$373,520	\$627,939	\$576,897	\$367,675
\$Medical Contract Costs			\$1,701,770	\$3,328,523	\$3,482,115	\$2,397,044
CARES Category	Baseline Fee	Baseline In-House	Baseline Total	FY03 Model	FY12 Model	FY22 Model
Surgical	87	1495	1582	1456	1516	1015
Sheridan						
Surgical	69	410	479	215	175	103
Difference	18	1085	1103	1241	1341	912
\$Cost			\$3,265,983	\$3,674,628	\$3,970,021	\$2,701,165
Casper	14	203	217	367	384	268
Riverton	4	409	413	340	419	296
Sheridan	0	473	473	534	538	348
Surgical						
Contract	18	1085	1103	1241	1341	912
\$Casper			\$642,537	\$1,087,249	\$1,137,085	\$793,355
\$Riverton			\$1,222,893	\$1,006,353	\$1,240,498	\$876,479
\$Sheridan			\$1,400,553	\$1,581,026	\$1,592,439	\$1,031,331
\$Total			\$3,265,983	\$3,674,628	\$3,970,021	\$2,701,165
\$Total Contact Cost			\$6,531,966	\$7,349,256	\$7,940,043	\$5,402,330

Findings and Utility of Results

This project determined a logical plan for aligning Sheridan market resources to provide the best care to veterans now and for the next 20 years. The communication process ensured stakeholders had the opportunity to understand and provide input through every step of the process. This transparency proved to be valuable in gaining stakeholders' trust and confidence. Strategic planning provided the link between centralized planning initiatives and implementation of the CARES program to provide high quality healthcare service to more veterans closer to where they live.

The study suggested there is a high cost associated with delivering an acceptable level of access to a population in a highly rural area. Many of the services the Sheridan market must provide under CARES standards, including all tertiary and surgical services and most specialty care, must be purchased. To provide all services in-house at the small volumes realized in this market would be impractical. Full implementation of this market plan would also result in loss of workload for referral centers, within the VISN. Because of these two factors, it is likely this market plan will be only partially implemented and that the limited access to healthcare inherent in highly rural markets will continue to exist. However, even the partial implementation of this plan will improve access and

lead to a likely increase in veterans' satisfaction within the Sheridan market.

A substantial amount of frustration was injected into the process with several schedule changes and one major data change. The data change occurred in mental health inpatient projections and happened for the political reasons explained below.

Mental Health Data

Utilization and access inequities are two of the main problems within the VA Healthcare System that the CARES process was designed to address and correct. There is a wide diversity in utilization rates of inpatient mental health services throughout the country. Varying levels of access to mental health services may partially explain these geographical use patterns since there is better access to mental health hospital services in urban areas than in rural and highly rural settings.

The CARES process set out to normalize these use patterns by realigning access to these services throughout the country based on nation-wide averages for demand for these services. As a result, many rural hospitals would be required to enhance mental health inpatient services, while large urban facilities would be required to dramatically cut back. Because of the negative impact these changes would make to large, influential facilities, VA Central Office dropped the average use patterns in favor of traditional geographic use patterns. This political

move eliminated one formal planning initiative for the Sheridan market and characterizes one of the major challenges to rural health care; access to specialized services.

Planning Initiative Resolution

As discussed earlier, the National CARES Team identified workload gaps with two formal planning initiatives for the Sheridan market. These were gaps in access to services including primary and hospital care, and a gap in capacity for specialty outpatient care services. The Sheridan CARES Market Planning Team addressed the primary care gap by proposing an access point in western Wyoming. Addressing the hospital service gap was slightly more involved and consisted of proposing contract arrangements for civilian hospital services in the three largest communities in the market area. By providing hospital care in these three communities based on an access area of 120 miles around each access point, CARES standards could be met.

The Sheridan Market Planning Team similarly modeled outpatient specialty services on a contract basis with community providers throughout the market. At the main hospital in Sheridan, where both outpatient specialty care and primary care are delivered, the outpatient specialty care gap coincided with an excess in outpatient primary care services. The Sheridan Market Planning Team therefore proposed to accommodate the

expected growth in specialty services by converting primary care space to outpatient specialty care space. The modification would be by space assignment and associated scheduling only, rather than by facility construction. This would minimize capital costs associated with the shift in care and allow for a seamless conversion over the timeframes covered in the CARES process. Specialty care demand that could not be met at the Sheridan VA facility would be provided by contract in the community. Overall cost projections for these services are found in the Sheridan Market Plan. (Appendix A, Figure A1) The disaggregated workload and cost information is illustrated in Appendix A, Figures A2 through A8.

Conclusion

The CARES initiative is providing a data driven process to realign the capital infrastructure of the VA to meet the demands of its customers, both now and in the future. Although this process is not immune to data uncertainty and political influence, it marks the best effort to date to objectively evaluate the VA system and chart a clear direction for change. Deliberate involvement of stakeholders and interest groups has provided an atmosphere of relative transparency in the Sheridan market that may aid in the acceptability of the final results due for presentation in the fall of 2003.

The execution of the first four steps of the process for the Sheridan market demonstrated that providing acceptable access to healthcare in a highly rural region is difficult and expensive. However, the process also highlighted the effectiveness of strategic planning in minimizing gaps in healthcare access and maximizing value in healthcare delivery. The Sheridan VA Hospital and community based outpatient clinics are well positioned for continuing quality care to Wyoming veterans.

Although the principals of the study were sound, the process was plagued with several recurring problems that may compromise the utility of the final outcome. First, data gathering techniques were inconsistent to a point that comparisons based on some data were considered numerically invalid. Secondly, political pressure applied by influential VISNs curtailed the application of parts of the process. Also, the speed at which the process progressed resulted in confusion and ridiculously short turn-around times for data gathering and reporting, which further compromised validity. Finally, CARES planning criteria set standard thresholds for travel distances to points of care while creating enrollee thresholds for establishing new clinics. In sparsely populated areas, these thresholds are impossible to meet, ensuring access to care in highly rural areas will be substandard.

Despite these shortcomings, CARES is providing the first comprehensive, forward-looking initiative to ensure future viability, efficiency, and continued excellence in VA healthcare. Over time the CARES process should help build a better healthcare system for veterans of this nation.

References

- Austin, C., & Boxerman, S. (1998). Information systems for health services administration (5th Ed.). Chicago: Health Administration Press.
- Ansoff, H. (1998). The new corporate strategy. New York: John Wiley & Sons
- Cassard, S., Weisman, C., Gordon., D. and Wong, R. (1994). The impact of unit-based self-management by nurses on patient outcomes. Health Services Research, 29, 415-433
- Cooper, D., & Schindler, P. (2000). Business research methods (7th ed.). New York, NY: McGraw-Hill/Erwin.
- Department of Veterans Affairs (2002). Capital asset realignment for enhanced services guidebook-phase II (2nd Ed.). Washington, DC: Veterans Health Administration.
- Department of Veterans Affairs (2002). Handbook for Market Plan Development (Draft). Washington, DC: Veterans Health Administration.
- Fortney, J. C., Borowsky, S. J., Hedeem, A. N., Maciejewski, M. L., Chapko, M. K. (2002). VA Community-Based Outpatient Clinics: Access and Utilization Performance Measures. Medical Care. 40 (7), 561-569.
- Fried B., Johnson, J. (2002) Human resources in healthcare, managing for success. Washington, DC: AUPHA Press

- Lewis, K. (1947). Frontiers in group dynamics. Human Relations.
1, 5-41.
- Gapenski, C. (2001). Understanding health care financial
management (3rd Ed.). Chicago: Health Administration Press.
- General Accounting Office. (1999). VA health care capital asset
planning and budgeting need improvement (GAO Publication
GAO/T-HEHS-99-83). Washington, DC.
- Ginter, P., Swayne, L., & Duncan, W. (1998). Strategic
management of health care organizations (3rd ed., Rev.)
Malden, Massachusetts: Blackwell Publishers, Inc.
- Kizer, K. (1995). Vision for change: a plan to restructure the
veterans health administration. Washington, DC: U.S.
Government Printing Office.
- Kizer, K. (1996). Prescription for change: the guiding
principles and strategic objective underlying the
transformation of the veterans healthcare system.
Washington, DC: Veterans Health Administration.
- Lighter, D., Fair, D. (2000). Principles and methods of quality
management in health care. Maryland: Aspen Publishers, Inc.
- Longest, B., Rakich, J., & Darr, K. (2000). Managing health
services organizations and systems (4th ed.). New York:
Hamilton Printing Company.
- McDermott, J. (1998). Fort mackenzie: a century of service 1898-
1998. Casper, WY: Endeavor Books.

- Milliman USA, Inc. (2002). Department of veterans affairs fy03 enrollee health care projection model update, fiscal years 2002 through 2022. (Contract # GS-23F-8025H). Washington, DC: Department of Veterans Affairs.
- Office of Inspector General. (1998). Evaluation of VA capital programming practices and initiatives (VA Report No. 8R8-A19-061). Washington, DC: David Sumrall.
- Rakich, J., Longest, B., & Darr, K. (1992) Managing Health Services Organizations (3rd ed.). Baltimore: Health Professions Press.
- Shortell, S., & Kalunzi, A. (2000). Health care management organizational design and behavior (4th ed.). New York: Delmar.
- Weissert, S., & Weissert, W. (1996). Governing health: the politics of health policy. Baltimore: The Johns Hopkins University Press.

Appendix A

CARES Market Plan

Sheridan Wyoming Market, February 6, 2003

Planning Initiatives

The Sheridan Wyoming market has two CARES planning initiatives. The first initiative identifies and addresses a gap in providing access to outpatient and hospital services throughout the Sheridan market. The second identifies and addresses a gap in providing specialty outpatient services at the Sheridan VA. This plan addresses access issues, planning initiative gaps⁶ and non-planning initiative gaps⁷.

Access

Guidelines regarding access to healthcare services within established travel distances have not been met for primary care or hospital care. Tertiary care available at the Denver and Salt Lake City Medical Centers satisfies CARES standards requiring that tertiary care is available within the VISN.

Primary Care Access

⁶ See note 3, *supra* at page.

⁷ See note 4, *supra* at page.

The maximum acceptable travel distance for primary care in a highly rural area is 60 miles. Given this standard, 67% of the veterans within the Sheridan market live within that distance of VA primary care.

The distribution of existing clinics serves the market well, with the exception of the far western portion of the market in Teton County. There is an adjacent access gap in two eastern Wyoming counties within the Western Rockies market, Lincoln and Sublette. A graphical representation of this concept displays existing and proposed access points. (See Appendices A1, A2 & A3, beginning on page 49.)

This plan proposes that the VISN redraw market boundaries to provide a logical geographical service area in which better access will be provided. By adding Lincoln and Sublette counties to the Sheridan Wyoming market and by creating a primary care access point in Afton, Wyoming, the primary care access percentage will improve and exceed the CARES threshold for the Sheridan market. The Western Rockies market primary care access percentages will also increase under this model. The VA Central Office will provide exact primary care access numbers. A primary care access point in the Afton, Wyoming area can be created by developing a satellite clinic in conjunction with one of the established community based outpatient clinics.

Hospital Care Access

The maximum acceptable distance a veteran must travel from his or her residence for hospital care in a highly rural market is 120 miles. Given this standard, 34% of veterans in the Sheridan market are within access standards for hospital care.

To exceed CARES access standards (65%), the Sheridan market could provide care in several communities within the market. This would require the VA to purchase care from community hospitals. By providing this type of arrangement in the communities of Sheridan, Casper, and Riverton, the largest population centers would be covered and the access percentages would dramatically increase.

Using the projected demand for hospital and surgical care by county, the CARES Market Planning Team modeled projections for volume and cost of contract care at the access points listed above. (Figure A1) This model assumes all hospital and surgical care from the counties within standard access distances to the Sheridan VAMC currently being provided at the Sheridan VAMC will continue to be provided in-house. Demand that falls outside of the Sheridan travel area, and demand within the Sheridan VAMC travel area currently referred elsewhere will be purchased in the local community. Cost for medical and surgical workload projections was estimated using the DVA confidential cost

worksheet (VSSC/tas: 12-9-2002) for converting workload in bed days of care (BDOC) to cost in dollars.

With no consideration for inflation, contracting for these services would result in a cost of \$8 million in year 2004, rising slightly through 2006 and then dropping off to \$5.4 million by 2022. (See figure A1)

The VA Central Office will supply the exact data for percentage improvements in access to hospital care for the Sheridan market. These figures are estimated to exceed the CARES threshold of 65% for hospital care.

Access to tertiary hospital care

The newest model for tertiary care states that a market meets access standards if tertiary care is available within VISN 19. (DVA, 2002) Tertiary care is available at both Denver and Salt Lake City. Therefore, 100% of the veterans in the Sheridan market are within the guideline for access distance to tertiary care.

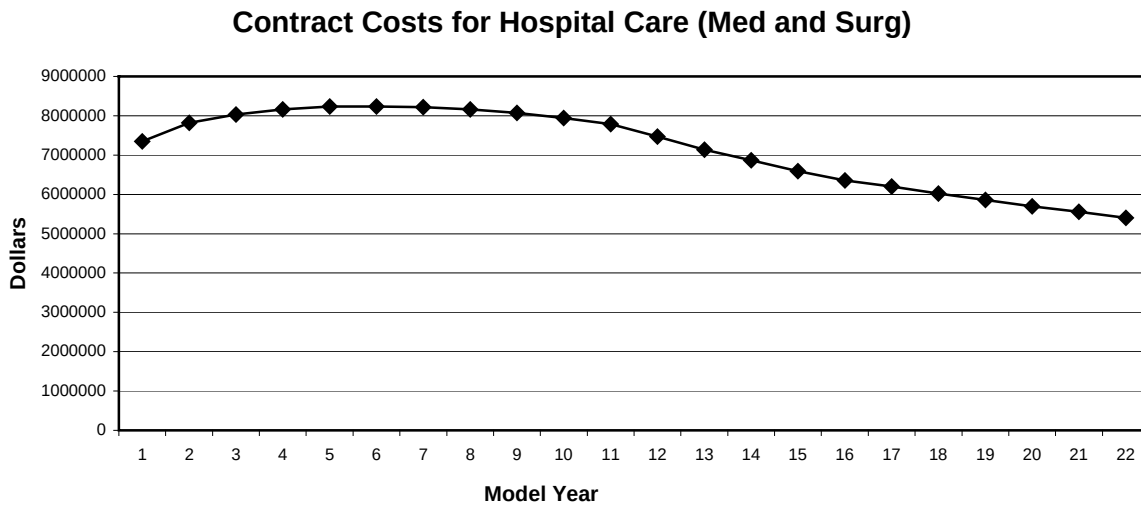


Figure A1 By providing hospital care through contracts in local communities within the Sheridan market, we would expect annual expenditures as shown. This chart shows the expected cost of all contracted hospital care, both medical and surgical, for this market. Costs are not adjusted for inflation.

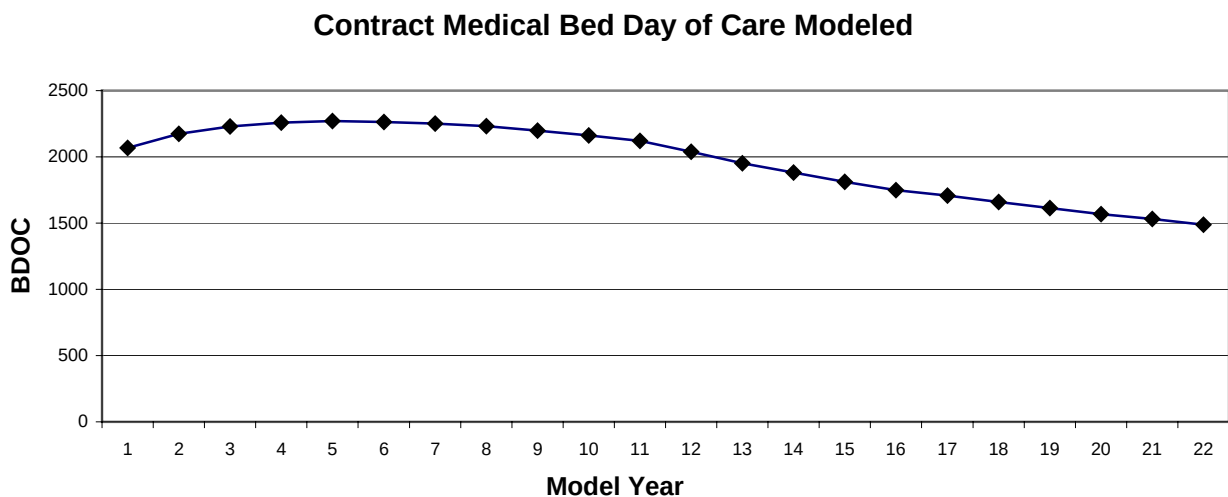


Figure A2 CARES projections for the medical portion of hospital care that would need to be contracted in the Sheridan, Wyoming market.

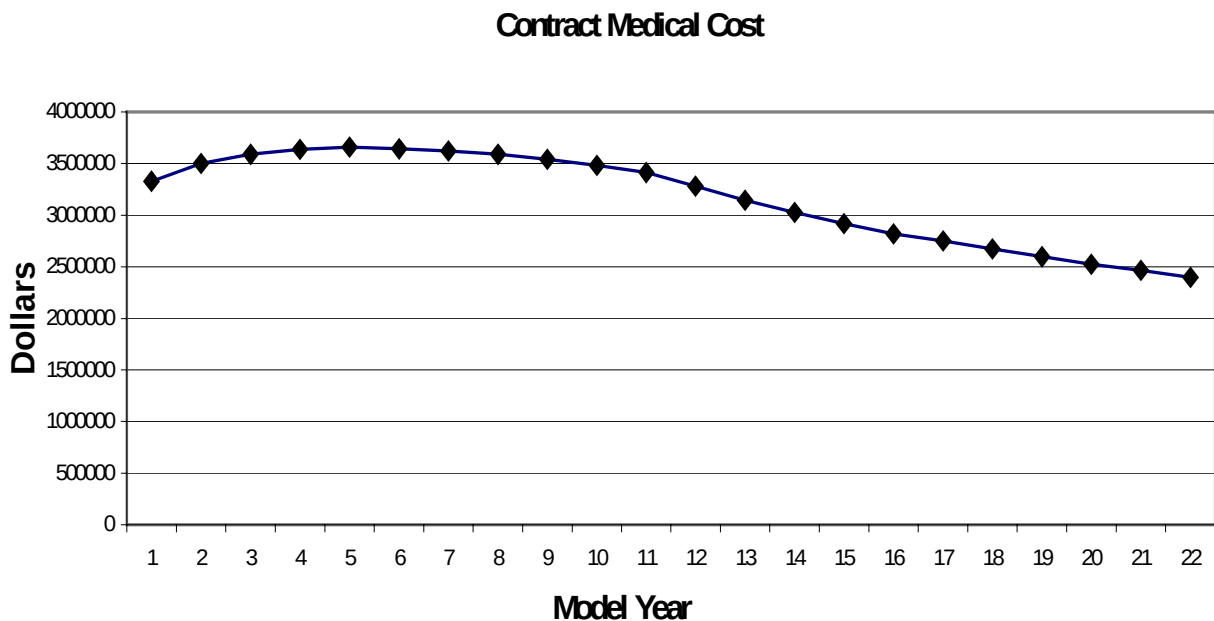


Figure A3 Projected costs for the medical portion of hospital care that would need to be contracted in the Sheridan, Wyoming market.

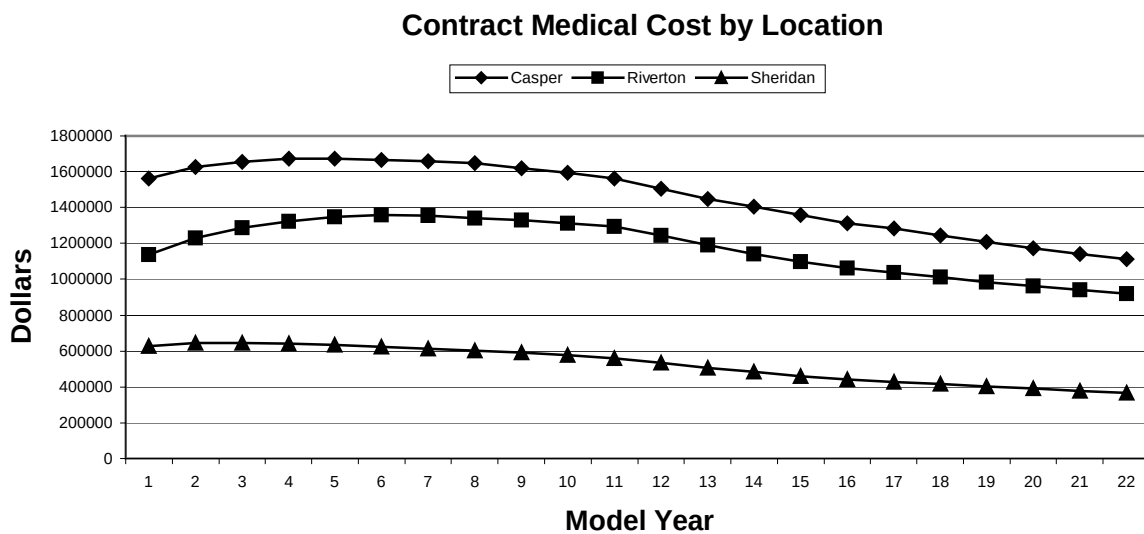


Figure A4 The medical portion of the hospital costs are modeled by location of access point.

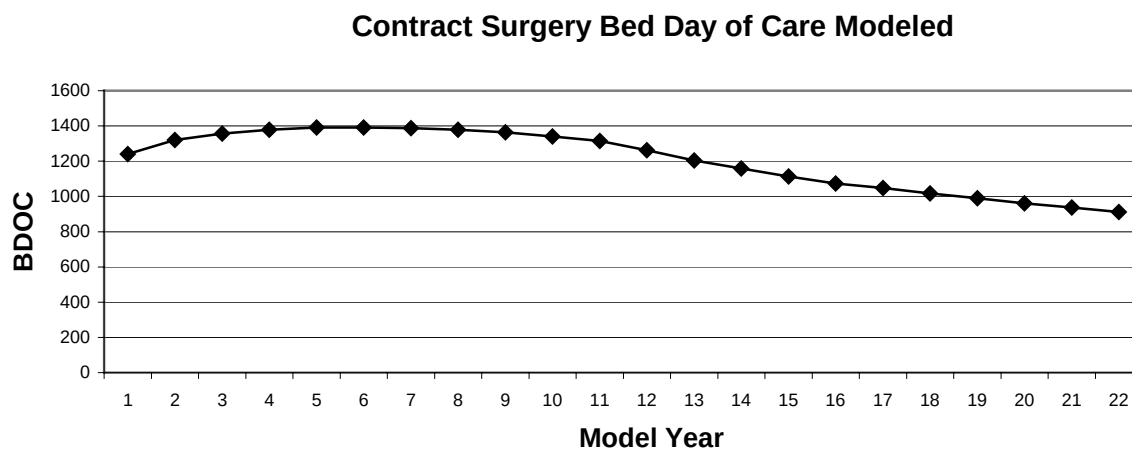


Figure A5 The surgical portion of the contract hospital workload projections are shown.

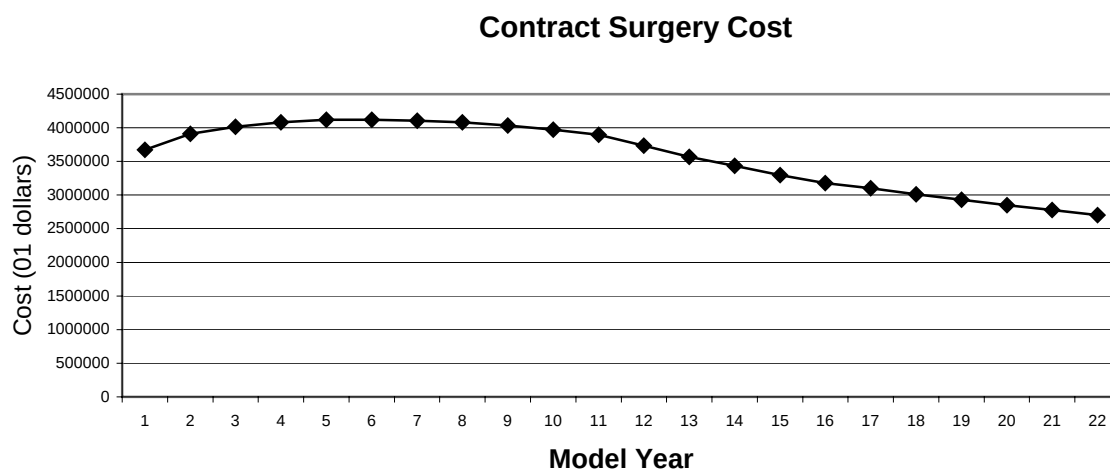


Figure A6 The surgical portion of the contract hospital cost are shown.

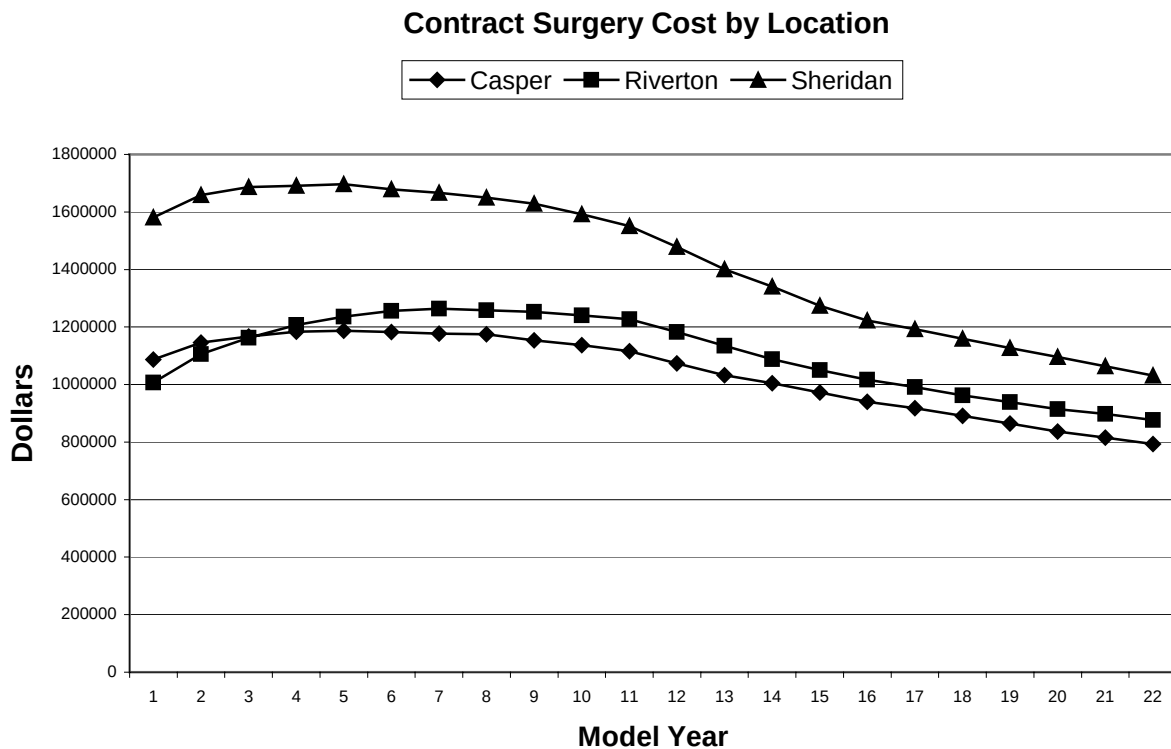


Figure A7 The surgical portion of hospital costs are modeled by location of access point.

Access to mental health services

The Sheridan VA serves as the mental health referral facility for VISN 19. Although mental health planning initiatives have not been developed, the Sheridan market will maintain its focus on mental health and continue to support VISN needs for inpatient mental health services and adapt to further changes in mental health demand projections.

The Sheridan market proposes to convert one of its core buildings (bldg. 6) into residential substance abuse treatment to expand the capacity of the current program by 13 beds. This

will better serve the needs of VISN 19 by providing capacities that will help meet VA Central Office mandated capacities for special populations. Currently, the program operates at 95.7% occupancy.

CARES Non-planning Initiative Workload Gaps

Inpatient Medicine

Although percentages appear substantial, raw workload numbers are small and can be managed within existing system flexibility.

Inpatient Surgery

Although percentages appear substantial, raw numbers are insignificant. The Sheridan VA is not a surgical hospital and surgical numbers reflect only follow-up care and minor ambulatory surgery.

Outpatient Primary Care/Outpatient Specialty Care

Outpatient primary care and outpatient specialty care were considered together because projected excesses in capacity for primary care services were balanced by gaps in outpatient specialty care. Only in FY 2022 is an aggregate excess in services evident. This would equate to an approximate eleven patient visits per-day decrease or approximately two visits per day, per clinic. The current system has the flexibility to accommodate this level of change over 20 years.

Specialty care would be purchased locally to support the increasing demand. By using current workload as a baseline and the model projections for determining marginal demand, projections for the cost of supplementing specialty care services have been created. These costs would start at approximately \$3.0 million in year 2004 and rise slightly before beginning, in 2008, to fall to a low of \$1.8 million in 2022 (see figure A8.)

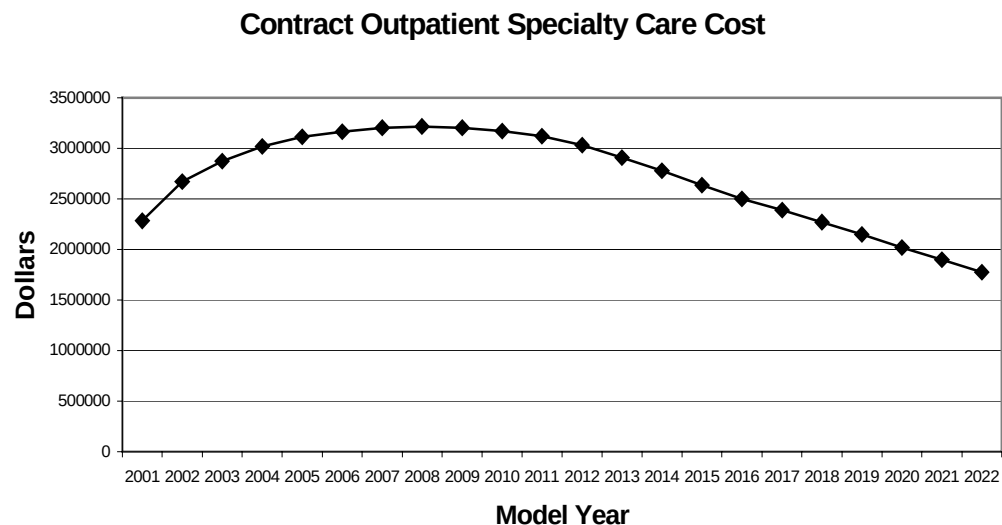


Figure A8 The cost of outpatient specialty care to meet projected demand is shown.

Outpatient Mental Health

Projections indicate that demand for outpatient mental health services will fall off beginning in FY 2022. Again, this drop, based on population-based figures, would roughly equate to five patients per day, spread among several clinics. The

Sheridan market has the flexibility in its current system to adapt to these changes over a 20-year period.

Other Issues

Vacant Space

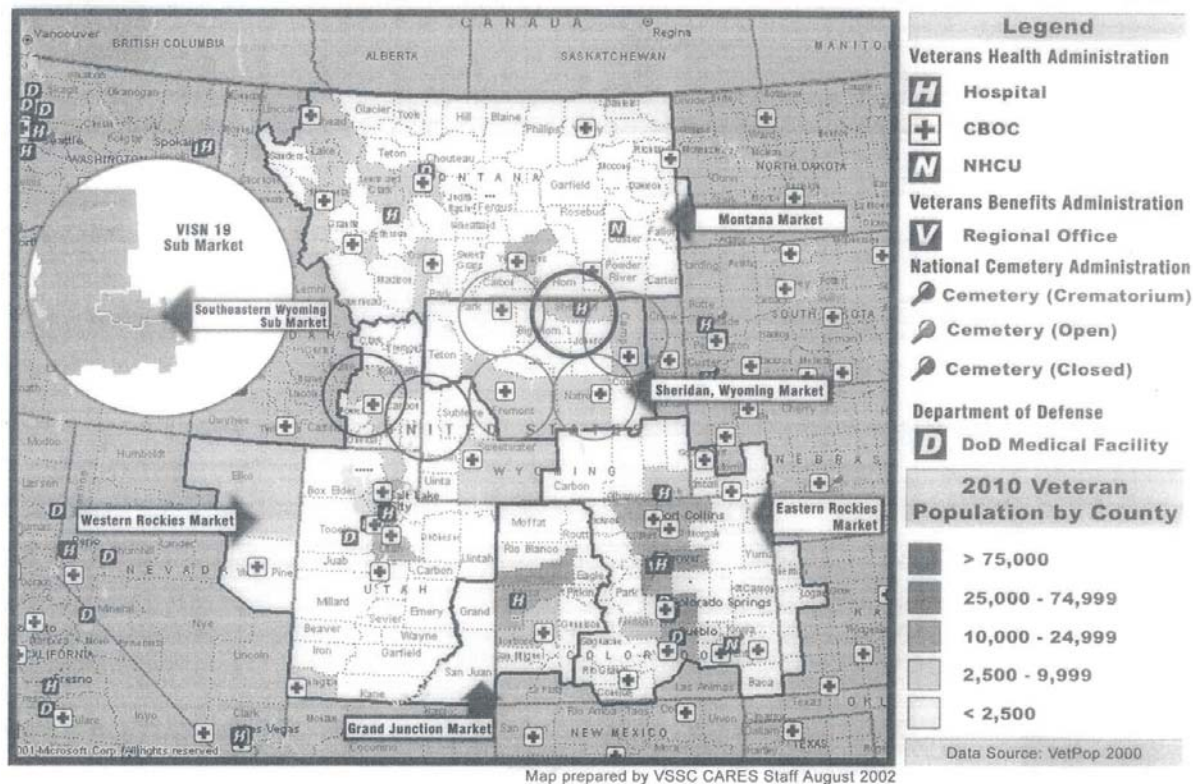
Sheridan currently is executing a comprehensive centralization plan that is reducing vacant space and moving medical center functions to the central core of the facility. This plan exceeds requirements established by CARES.

Lead Based Paint

Sheridan has lead based paint in quarters and in most buildings. Most patient care areas have been subject to interior remodeling with total lead abatement. Lead abatement is currently under way for the exterior of several buildings. The presence of lead-based paint in the facility will have no impact on the provision of care.

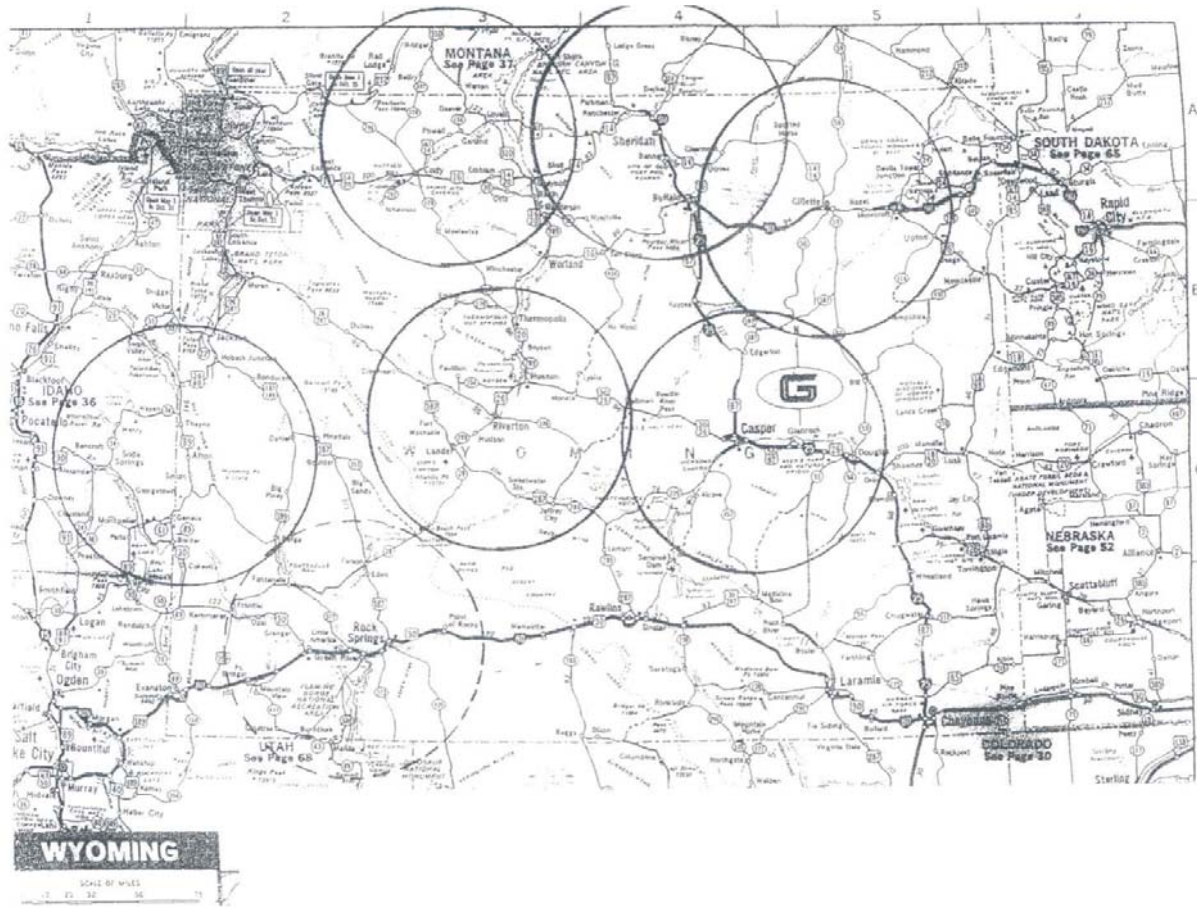
Appendix A1

VISN 19 CARES Market Map Projected 2010 Veteran Population by County



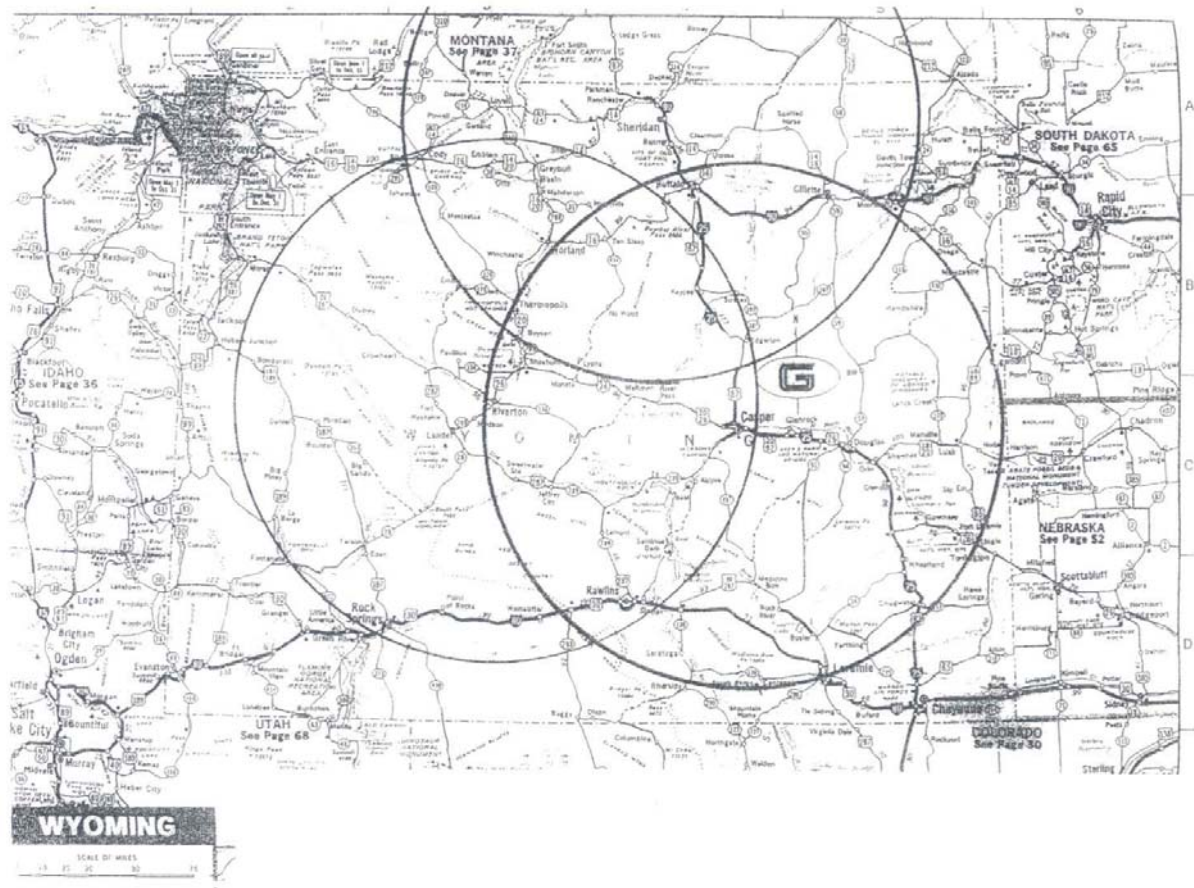
This map shows the Sheridan market with the Sheridan VA Medical Center access area (bold circle) and its four Community-based outpatient clinics (light circles.) The circles approximate a 50-mile travel area for access to primary care. The shaded circle illustrates the gap that would be filled by placing a CBOC in Afton, Wyoming. Boise, Idaho is shown in black.

Appendix A2



This map was used to graphically estimate the percentage of veterans within the 50-mile primary care access area in the Sheridan market. Note the proposed Afton clinic is shown to identify an access gap. Rock Springs is also shown and is an access point in an adjacent market.

Appendix A3



This map graphically estimates the area within commuting distance to hospital care, assuming access points were developed in Sheridan, Casper, and Riverton.

Appendix B

U.S. Army - Baylor University
Graduate Program in Healthcare Administration

VA Sheridan Market Strategic Plan

September 2003

Kurtis N. Mayer, Chief of Facilities
Department of Veterans Affairs
1898 Fort Road
Sheridan, Wyoming 82801

Executive Summary

The Sheridan VA, as part of the Rocky Mountain Veterans Integrated Service Network (VISN), is undergoing strategic realignment as part of a national Capital Asset Realignment for Enhanced Services (CARES) initiative. The Sheridan market offers high quality healthcare services to veterans of Wyoming and provides mental health referral services to the entire VISN. In order to continue robust inpatient services and improve access to outpatient and specialty care, the Sheridan market has analyzed environmental influences and established strategic direction.

An assessment of the market and industry was completed and mission and vision statements were reviewed. A SWOT analysis demonstrated that the Sheridan market has strengths and opportunities that outweigh its weaknesses and threats. A SPACE analysis recommends that the Sheridan market is in the "conservative quadrant" which suggests specialization, market development, product development and vertical integration. The Sheridan market needs to examine these alternatives and decide the best options for further expansion. In aggregate, these analyses recommend the Sheridan VA use adaptive strategies and place emphasis on specialization and market growth.

Table Of Contents

Background	55
External Environmental Analysis	55
Technological	55
Political/Regulatory	56
Economic	56
Competition	57
Porters Analysis	58
Stakeholders Analysis	60
Internal Environmental Analysis	63
Mission and Vision	63
SWOT Analysis	63
Evaluation of Strategic Alternatives	66
SPACE Profile	66
Strategic Plan	66
Directional and Adaptive Strategies	66
Market Entry Strategies	67
Positioning Strategies	67
Operational Strategy - Implementation Plan	68
Marketing	68
Information Systems	68
Research and Development	69
Finance	69
Human Resources	69

Culture	70
Structure	70
Facilities and Equipment	70
Ethical and Social Responsibility	71
Strategic Control	71
References	73
Appendix B1 - Stakeholders Analysis	74
Appendix B2 - SWOT Analysis	75
Appendix B3 - SPACE Analysis	76

Background

The Capital Asset Realignment for Enhanced Services (CARES) process, for the Sheridan market area was presented in the body of this study. This strategic plan applies principles outlined by Ginter et al. (1998) to support strategic initiatives proposed by the CARES Market Planning Team. This plan was framed by the CARES planning initiatives and will therefore be focused on outpatient specialty services and access to care.

External Environmental Analysis

Technological

The increased use of technology in the healthcare industry has had a huge impact on health services. Computer technology has rapidly replaced old sources of information and has made sharing of information faster and simpler. The VA has been a leader in the development and application of electronic medical record systems. Within the VA, the Sheridan VA Medical Center has been at the forefront of implementation and utilization of electronic medical record.

The Sheridan VA and associated outpatient clinics have also been very active in remote diagnostics and examination. Currently all diagnostic images from the Sheridan VA are read remotely at the VA in Denver, CO. Mental health examinations are routinely conducted by video teleconference allowing

practitioners at the Sheridan facility to expand services to the community-based clinics without traveling.

Additional services such as electronic home health monitoring are currently being piloted and may prove useful in reaching even more veterans in the Sheridan Market.

Political/Regulatory

As a public entity, the VA relies on politics and public funding for its very existence. Additionally, the VA is regulated by the same standards that govern private health care organizations. The VA maintains Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation and abides by a wealth of regulatory requirements from several regulatory agencies.

Public policy controls access to the VA for beneficiaries. Changes in eligibility can have a dramatic impact on access to care for veterans and can change the demand this access places on the system.

Economic

The VA receives its budget from discretionary sources. As such, the VA budget changes every year and can vary greatly depending on competing needs and political influence.

Healthcare in general is in a continuing state of change, with pressure to provide more efficient and effective services. The VA is not immune to this pressure and has undergone major

change in the last 5 years due to budgetary constraints and internal restructuring. (Kizer, 1996)

The CARES process will further dictate restructuring and will drive physical reconfiguration with its focus on capital asset realignment. (Department of Veterans Affairs, 2002) The result of broad efforts to re-engineer an antiquated system will be intense competition for limited dollars to implement proposed change. As this initiative becomes a component of an already uncertain budget, the VA must remain as flexible as possible to survive the nearly certain fluctuations in funding.

Competition

The VA has a base of beneficiaries that seek care from the VA for one of two reasons. Either the veteran prefers the VA to other options due to cost or quality of care, or the VA is the only access to care that is available. In the Sheridan market, a large number of the VA beneficiaries come to the VA by choice. This forces the VA to compete with other healthcare providers to provide high quality care and control costs.

Eligibility has an effect on the necessity for competition between the VA and other healthcare providers. Generally, those who have the greatest amount of choice in healthcare options hold the lowest levels of eligibility. Therefore, the more restrictive the government is with VA eligibility, the less direct competition the VA will be subjected to.

Competition also exists within the VA among medical centers and networks. In some cases, performance incentives in the way of additional funding are awarded to facilities that provide the most productive or efficient care delivery.

PORTERS ANALYSIS

A Porter's approach⁸ to assessing the level of competitive intensity within this health care delivery area (Ginter, Swayne, & Duncan, 1999) was conducted to help identify the forces driving the competitive market. Although the VA does not compete directly with private and public healthcare delivery systems, its successful operation depends on these competitive forces. The analysis demonstrates that competitive pressure is secondary to internal forces, such as providing service within a larger healthcare system, and supports an overall conservative approach to strategic planning.

Threat of New Entrants - Low

The threat of new entrants into the provision of care to veterans is low. Demographically, the VA cares for lower income

⁸ A Porter's approach is an assessment of competitive intensity that measures external competitive pressure for the purpose of shaping strategic planning.

individuals, a market in which healthcare organizations have difficulty making money.

Intensity of Rivalry Among Existing Organization - low

Rivalry among existing players is substantial but not critical to VA's existence. The costs of switching are low if consumers have the means, such as insurance or money, of doing so. However, those that can afford to obtain care from other than the VA contribute very little to the overall budget and would have little effect on overall VA solvency.

Threat of Substitute Products or Services - Low

The threat of substitutes in the market for VA healthcare is low. Technology may improve access to care and eligibility may change the availability to some users, but forecasts suggest demand will remain strong for the next 20 years. (Milliman USA, Inc., 2002)

Bargaining Power of Customers - Low

The bargaining power of consumers is relatively low considering that a substantial portion of VA customers does not pay for services. The remaining paying consumers have no effective mechanism with which to apply bargaining pressure other than through political channels.

Bargaining Power of Suppliers - Medium

The VA has been very successful in negotiating the best available rates for goods and services. It has used tools, such

as the contracts of GSA and other agencies to obtain fair pricing for the things it needs to do business. Although isolated suppliers may be able to influence pricing for scarce supplies or services, the prescribed procurement practices of the government help to ensure that the best available prices are obtained.

Stakeholder Analysis

A stakeholder analysis illustrates the reciprocal relationship between an organization and other related entities (Ginter, Swayne, & Duncan, 1999, p. 64). Internal and external stakeholder groups identified as being critical to the strategic goals of the Sheridan market are listed in Appendix B1 and are discussed briefly herein.

Employees of the organization are critical internal stakeholders and hold significant strategic power in the organization. The Sheridan market invests heavily in training and support for its employees and enjoys a stable workforce. The availability of state-of-the-art equipment and advanced practices keeps many employees engaged.

The American Federation of Government Employees Union, Local 1219, represents the non-supervisory work force. It can be troublesome when management attempts to make rapid changes that may impact employees. However, government unions have

limited power and lack the tools to block changes that they may see as a threat to its constituents.

Regulatory agencies monitor nearly every aspect of hospital business. The JCAHO accredits the Sheridan VA Medical Center. Additionally, many government agencies regulate aspects such as pharmaceuticals, hazardous waste disposal, boiler emissions, water treatment, medical devices, occupational health and safety, and laboratory practices. Although burdensome, adhering to these regulations ensures that focus is given to safety and environmental stewardship and adds credibility to the organization.

Suppliers make up a broad category of organizations that provide materials and services to the Sheridan VA market. The rural nature of the Sheridan market makes access to some products and services more difficult than in metropolitan areas. The market overcomes this, however, by applying the considerable purchasing power of the VA and federal government. Technological improvements and the speed of nation-wide deliveries are helping to close the gap between rural and urban supply chains.

Veterans' service organizations play a critical role in providing service to veterans. They serve as veterans' advocates at the medical center and lobby for them at the state and federal levels. The American Legion is the most active

veterans' service organization in the Sheridan market and has been a strong supporter of the Sheridan VA mission.

The local community, including private businesses and local government, benefits from having a large governmental organization in the area. The Sheridan VA supports the local tax base through employee payrolls, and it expends substantial amounts of money on goods and services in the community. In isolated instances, however, the VA has moved in-house services that were once purchased in the community. Some in the community interpreted this action as threatening.

Education collaborations help support programs at the local community college. The Sheridan market is active in providing training opportunities for nursing and dental career fields. Educational collaboration also includes limited graduate medical education and student internships to support university medical education programs.

Taxpayers ultimately pay for all services provided by the VA. As a steward of the taxpayers' money, the VA must ensure the effectiveness and efficiency of care provision supports the conservative goals of those that are paying. The VA measures costs for the purposes of benchmarking to support further improvements goals and to compare itself with others. The Sheridan Market has done very well to control unit costs and to reduce overhead contributing to those costs.

INTERNAL ENVIRONMENTAL ANALYSIS

Current Mission and Vision Statements

The current mission, vision, and value statements for the Sheridan market are listed below:

MISSION- Sheridan VA Medical Center including its community-based outpatient clinics provides access to a full continuum of quality healthcare to veterans. We are the referral site for mental health services in the Rocky Mountain Network. Care is provided in an environment that respects and supports the needs of veterans. We are committed to serve our community.

VISION- We will be the healthcare provider of choice. We will provide timely and convenient access to quality, cost effective, patient-focused health care. We will be the leader in the use of information management technology. We will be recognized as the employer of choice in our community. We will foster a continuous learning environment for our staff.

VALUES- As a successful organization we value: Trust, compassion, respect, communication, integrity, teamwork, commitment, accountability, safety, and excellence.

SWOT Analysis

Analysis of strengths, weaknesses, opportunities, and threats is used within the framework provided by the mission and

vision of the organization and suggests strategic alternatives that will best serve the organization. The SWOT matrix is displayed as Appendix B2.

Strengths

The major strengths of the Sheridan market include its focus on high quality mental health services and high ratings in patient satisfaction. The market enjoys relatively low turnover and a dedicated staff willing to meet challenges and adapt to change. The market is at the forefront of the VA for implementation of the electronic medical record and remote diagnostics and treatment. Through its parent network, patients have access to a full continuum of health care services.

Weaknesses

The weaknesses of the Sheridan market stem largely from its roots as a cavalry fort (McDermott, 1998) and from the rural nature of its location. Although a full continuum of health care services is available through the Sheridan market, hospital, tertiary, and specialty services must be procured locally or veterans must be referred to larger VA hospitals making care less than seamless. Additionally, the market's success in attracting patients has resulted in a high penetration rate that will limit further growth.

Opportunities

The opportunities for the Sheridan market are somewhat limited due to its location. However, small steps can continue to be made to improve access to care and expand services that the market already specializes in, such as mental health and outpatient residential treatment. Other opportunities include contracting for services not currently provided locally and gaining revenues by renting excess space and selling medical services.

Threats

The outpatient programs established throughout the Sheridan market, and at the Sheridan VA Hospital, are subject to very little threat. The greatest threat for the Sheridan market is in its inpatient program at the Sheridan VA Hospital. Here, a reduction in mental health referrals could result in a corresponding loss in inpatient demand. Currently, the Sheridan VA specializes in a continuum of mental health services that supports the entire network. The loss of this specialty mental health tract could jeopardize an otherwise robust inpatient and outpatient-residential program. It is imperative that the Sheridan VA maintains its value to the network as a referral center for it to remain a viable inpatient hospital.

Evaluation of Strategic Alternatives

SPACE Profile

The strategic position and action evaluation (SPACE) analysis is provided in Appendix B3 and is used to determine the appropriate strategic posture for the organization. An overall analysis finds the organization to be in the conservative quadrant as indicated in the SPACE matrix (Appendix B3). The analysis reinforces a conservative strategic posture that focuses on reducing costs, protecting competitive products, and gaining entry into more attractive markets (Ginter, Swayne, & Duncan, 1999, p. 227).

Strategic Plan

Directional and Adaptive Strategies

The Sheridan market's main adaptive strategies are vertical integration and stabilization. Vertical integration will apply primarily to outpatient and specialty services markets whereas stabilization will apply to inpatient and residential mental health programs.

Market development will be of some value in communities within the market where penetration rates are still relatively low. There are still broad geographic areas in the market that are generally underserved. One such area is the Riverton, Wyoming community-based outpatient clinic that could serve a Native American veteran population if it can overcome cultural

barriers to market entry.

Integration, primarily vertical, is very important to the continuing success of the organization. The Sheridan market has demonstrated gaps in outpatient and specialty care throughout. Even if these can be closed, i.e. if services can be provided by referral to larger VA medical centers, the access is burdensome to the patient and far from seamless. The vision for the Sheridan market is to provide a continuum of care and that will require providing local access to outpatient and specialty services, and to hospital care.

Market Entry Strategies

Market entry strategies focus primarily on development of underserved markets, and establishing access points to a full continuum of care throughout the market. Specific interest lies in reducing the travel requirements that limit the ability of veterans to easily access care. If access points are added, market share will very likely grow.

Positioning Strategies

The Sheridan market will position itself as a high quality and efficient provider of a continuum of health care services with particular specialties in mental health.

Operational Strategy–Implementation Plan

Marketing

The VA has a prohibition on actively marketing for services because of an overwhelming demand in some areas of the country. Marketing in the Sheridan market is still done through work-of-mouth and through outreach to special populations such as Native Americans. Even without formal marketing, informal approaches have resulted in continued growth at each access point in the market.

Internal marketing is also necessary at the network level to maintain and grow a robust inpatient and outpatient residential referral service that makes the Sheridan market especially valuable to the entire network.

Information Systems

The Sheridan market relies heavily on high-speed communications at several levels. Locally, the facility fully utilizes an electronic medical record system and bar-code medical administration system. Regionally, all community based outpatient clinics are connected to the Sheridan VA for real-time information sharing and tele-psychology. Network-wide information is shared real-time and links have been established for tele-radiology. Globally, finance and personnel systems and communication links exist that connect all VA hospital via an intranet system.

In total, the VA operates one of the most advanced clinical computer network in the world, giving it a huge advantage in the provision of consistent care. Additionally, the data that are captured on this system are used to provide timely quality improvement and effective patient safety enhancements.

Research and Development

Research and development is a very small part of the operation of the Sheridan market. However, research will remain a key element in developing relationships with university partners and is providing staff development and satisfaction.

Finance

The Sheridan market continues to exhibit strength in managing within an appropriated budget. Although the source of VA funding is discretionary on a national level, the Sheridan market has expanded impressively while controlling overall costs. Continued sound financial management and focus on the efficiency of care delivery will be a key component in the continued viability of the Sheridan VA Medical Center and the Sheridan market.

Human Resources

The Sheridan market maintains a stable workforce in an environment that can be tumultuous. Union-management relation issues have created a deterioration of the local culture. That said; the Sheridan market has also seen tremendous growth, high

quality indicators, innovative care delivery, and workforce stability. Therefore, although Union-management issues can be troublesome, they do not appear to be hampering the success of the operation. Substantial effort is being made to improve internal culture with the results yet to be seen.

Culture

In executing a strategy of expansion by contracting for outpatient and specialty care, management needs to address cultural issues. All strategic alliances must be carefully crafted to ensure that the overall mission and vision of the organization are shared across all aspects of the market.

Structure

The VA is a huge organization with complexities that are exacerbated by myriads of political and financial uncertainties. This structure must be clearly defined and communicated to all levels of the organization to ensure an understanding of the make-up and goals of the overall organization. In order to stay on the task of meeting the vision of the organization, this structure should be reevaluated at each period of growth to ensure cohesiveness in operations.

Facilities and Equipment

Facilities and equipment are adequate for the type of care provided in the Sheridan market. Although not ideal for health care delivery, the Sheridan VA has been extensively remodeled

and has preserved a historic character that suites its mission. Throughout the market, clinics are provided that meet the needs of the care delivered. No further physical expansion is anticipated or immediately required. Equipment is state-of-the-art in areas of diagnostic imaging and supports the operation well. Recurring equipment budgets have been, and are anticipated to continue to be, adequate to meet demands.

Ethics and Social Responsibility

The Sheridan market best meets its social and ethical responsibilities by ensuring seamless healthcare to those who depend upon it. It is also important to advance the social good of the organization by maintaining a forward-looking perspective that follows not only the requirement for efficiency but also recognizes the ethical importance of expanding into areas that have significant social value.

Strategic Control

Strategic control for the Sheridan market will be executed using three types of mechanisms: data management mechanisms, management mechanisms and conflict resolution mechanisms. Data management mechanisms require the evaluation of the strategic management processes, resources, and performance measures (Ginter, Swayne, & Duncan, 1999, p. 433). The Sheridan market will need to utilize both accurate and timely information systems from the internal organization and external environment.

Management mechanisms within the Sheridan market must permeate all levels of the organization, so that employees know and understand the overall goals and objectives of the organization and subscribe to its mission and vision. Performance appraisals and bonuses should be tied to attainment of organizational excellence.

Conflict resolution mechanisms to be used will include task forces, process action teams, committees, and management retreats. These strategic control mechanisms will increase overall communication and understanding of the organization. The goals of these mechanisms are to assist networking and teambuilding in the organization.

References

Department of Veterans Affairs (2002). Capital asset realignment for enhanced services guidebook-phase II (2nd Ed.). Washington, DC: Veterans Health Administration.

Gapenski, L. (2001). Understanding healthcare financial management (3rd ed.). Chicago, IL: AUPHA Press.

Ginter, P., Swayne, L., & Duncan, W. (1998). Strategic management of health care organizations (3rd ed., Rev.) Malden, Massachusetts: Blackwell Publishers, Inc.

Kizer, K. (1996). Prescription for change: the guiding principles and strategic objective underlying the transformation of the veterans healthcare system. Washington, DC: Veterans Health Administration.

McDermott, J. (1998). Fort mackenzie: a century of service 1898-1998. Casper, WY: Endeavor Books.

Milliman USA, Inc. (2002). Department of veterans affairs fy03 enrollee health care projection model update, fiscal years 2002 through 2022. (Contract # GS-23F-8025H). Washington, DC: Department of Veterans Affairs.

Appendix B1 – Stakeholder Analysis

Stakeholders	General Purpose	Nature of the Relationship
Employees	To provide the highest quality of service to the department and customers	Good- Currently focusing on training and development. State of the art systems and quality service keep employees engaged. Most employees are covered under collective bargaining agreements (Unions)
Regulatory Agencies – Food and Drug Administration, Joint Commission on Health Care Organizations, Inspector General	Necessary to maintain hospital accreditation and prove the quality of its product to customers and taxpayers	Very Good – All VA hospitals are JCAHO accredited and have processes for working with regulatory agencies
Suppliers	Provide materials and services to ensure delivery of health care services	Good- Government has substantial bargaining power and tools to obtain goods and services at fair prices
Veteran Service Organizations	Represent the veterans obtaining care at VA facilities and lobby issues to Congress	Very Good- Local VSOs support the facilities of the market and exert political pressure to support funding
Veterans	To provide valued health care services to end users that meet current needs and anticipate future needs	Good- Quality of service is high and patient satisfaction is similar to other health care providers
Local Community	Exchange resources and provide mutual support	Very Good- Largest payroll and major purchaser of goods and services supports a small community
Education collaborations	Provides teaching opportunities for medical professionals	Very Good- Have productive collaborations with multiple teaching institutions
Tax payers	Provide a valuable service for a reasonable price	Uncertain- The discretionary nature of VA funding makes value difficult to understand for the taxpayer

Appendix B2 – SWOT Analysis

Strengths	Weaknesses
*Focus on mental health *Specialty services in residential substance abuse *Backing of VSOs *Good market penetration *Great location *Solid infrastructure *High customer satisfaction *Efficiency in care delivery *History of strong financial stability *Strong leadership *State-of-the-art equipment *Electronic medical records	*Old facility *Heavy overhead due to large and aged facility *Limited continuum of care *Rural location *Limited growth potential
Opportunities	Threats
*Continue to grow as mental health referral site for network *Take advantage of CARES funding to enhance facilities *Expand into geographic areas currently underserved in market *Contract with other hospitals for hospital and tertiary services *Centralize operation and gain revenue from leased buildings *Sell more services to the community *Expand teaching and research programs	*Changes in eligibility *Loss of network referral status if others in network expand service locally *Failure to meet regulatory requirements or JCAHO accreditation *Loss of patient base if more services are offered in local communities *Increases in costs of goods and services, particularly pharmaceuticals *Disruptions due to union activity *Reductions in budget

Appendix B3 – SPACE Analysis

Factors Determining Environmental Stability										
Technological Changes	5	Many	0	1	2	3	4	5	6	Few
Rate of inflation	3	High	0	1	2	3	4	5	6	Low
Demand variability	2	Large	0	1	2	3	4	5	6	Small
Price range of competing products/services	2	Wide	0	1	2	3	4	5	6	Narrow
Barriers to entry into market	3	Few	0	1	2	3	4	5	6	Many
Competitive pressure	3	High	0	1	2	3	4	5	6	Low
Price elasticity of demand	5	Elastic	0	1	2	3	4	5	6	Inelastic
	-4.3									
Factors Determining Industry Strength										
Growth potential	1	Low	0	1	2	3	4	5	6	High
Profit Potential	1	Low	0	1	2	3	4	5	6	High
Financial stability	4	Low	0	1	2	3	4	5	6	High
Technological know-how	5	Simple	0	1	2	3	4	5	6	Complex
Resource utilization	5	Inefficient	0	1	2	3	4	5	6	Efficient
Capital intensity	1	High	0	1	2	3	4	5	6	Low
Ease of entry into market	5	Easy	0	1	2	3	4	5	6	Difficult
Productivity, capacity utilization	4	Low	0	1	2	3	4	5	6	High
	3.3									
Factors Determining Competitive Advantage										
Market share	5	Small	0	1	2	3	4	5	6	Large
Product quality	5	Inferior	0	1	2	3	4	5	6	Superior
Product life cycle	1	Late	0	1	2	3	4	5	6	Early
Product replacement cycle	3	Variable	0	1	2	3	4	5	6	Fixed
Customer/patient loyalty	5	Low	0	1	2	3	4	5	6	High
Competition's capacity utilization	4	Low	0	1	2	3	4	5	6	High
Technological know-how	5	Low	0	1	2	3	4	5	6	High
Vertical Integration	5	Low	0	1	2	3	4	5	6	High
	-4.1									
Factors Determining Financial Strength										
Return on investment	5	Low	0	1	2	3	4	5	6	High
Leverage	3	Imbalanced	0	1	2	3	4	5	6	Balanced
Liquidity	5	Imbalanced	0	1	2	3	4	5	6	Balanced
Capital required/capital available	5	High	0	1	2	3	4	5	6	Low
Cash flow	4	Low	0	1	2	3	4	5	6	High
Ease of exit from market	1	Difficult	0	1	2	3	4	5	6	Easy
Risk involved in business	3	Much	0	1	2	3	4	5	6	Little
	3.7									
			1	2	3	4				
			FS	IS	ES	CA				
			3.7	3.3	4.3	4.1				

Appendix B3 - SPACE Analysis

