

A New Medical District in Austin, Texas: A Study of Implementation

By

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Applied Research Project

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Submitted to the Department of Political Science
Texas State University-San Marcos
In Partial Fulfillment for the Requirements for the Degree of
Masters of Public Administration

Summer
2013

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Abstract

Purpose: The purpose of this research is two-fold. The first is to explore the obstacles to the successful implementation of a new medical district composed of a University of Texas medical school and a teaching hospital in Austin. The second purpose is to explore the strategies to overcome those obstacles to implementation.

Method: This research uses two working hypotheses, each composed of three sub-hypotheses to explore the threats to and solutions for the implementation of the new medical district in Austin. A limited case-study method is used to assess the hypotheses, which are tested through focused interviews with those identified as responsible for the implementation process of the medical district.

Findings: The results indicated an adequate level of support for the working hypotheses. Primary and secondary recommendations are provided based on the results of the study along with suggestions for further, future research. However the results should be considered with caution because this is a qualitative study, based on the verbal reports of nine individuals, and is limited in external validity.

About the Author

Kathryn Ward graduated with a Bachelor of Arts from the University of Texas at Austin in 2010 where she majored in both political science and history, and was a member of the Phi Alpha Theta Honor Society. Ms. Ward graduated magna cum laude with a Masters in Public Administration from Texas State University. Ms. Ward is passionate about healthcare policy and non-profit organization management. She currently lives in Austin, Texas.

Acknowledgements

I would like to thank Dr. Patricia Shields for her invaluable guidance throughout the applied research project process. Additionally I would like to thank my parents, Joan and Gilbert Douglas, and Kenneth and Melinda Ward. Their unwavering love and support helped me throughout my entire academic career, to them I owe everything. Finally, to my shining star, R.P., who helped me find my way throughout this entire process and back home again, this project would not have been possible without you. Thank you all from the bottom of my heart.

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Chapter I: Introduction

The Patient Protection and Affordable Care Act (Obamacare) became law in 2010. This landmark health reform law was passed in response to public demand for access to affordable healthcare services. The Act enables millions of previously uninsured Americans to access affordable health insurance. The Congressional Budget Office estimates that the legislation will provide insurance to an additional 32 million Americans by the year 2019 (Elmendorf, 2010, 9). This enhanced access to health insurance, along with an aging and growing population, is expected to increase the demand for healthcare service providers.

Hofer et al. (2010, 69), estimate that an additional 566 – 923 primary care physicians will be needed by 2019 in Texas in order to keep pace with the rising demand. Primary care physicians are generally the entry point into the healthcare delivery system thus, an adequate supply of these physicians is needed in order to meet the anticipated increased demand due to Obamacare (Hofer, et. al, 2010, 70). The Institute of Medicine defines primary care as:

The provision of integrated accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs... practicing in the context of family and community (Grumbach, 2007, 6).

According to a Seton Family of Healthcare commissioned study, Travis County is projected to face a shortage of 770 primary care physicians by 2016 (Jacob, 2012, 1). Compounding this shortage, Austin residents with serious illnesses such as cancer are unable to access necessary specialized healthcare services in Central Texas. These patients must travel

outside of Austin for life-saving, research-based treatments, wait longer for appointments, and/or use costly emergency rooms for basic care (Conway, 2010, 4).

Research Purpose

The healthcare provider shortage is projected to worsen and can only be addressed long-term by expanding the output of physicians from US medical schools (Cooper, 2004, 711). An effective way to decrease the provider shortage and increase access to healthcare services is to develop a new medical district, composed of a research-intensive medical school and a cutting-edge teaching hospital, in Travis County. This medical district should expand graduate medical education and improve access to services. The school is to be named The University of Texas Dell School of Medicine. In November 2012, Travis County voters approved Proposition 1, an increase in property taxes from 7.89 cents to 12.89 cents per \$100 (UT-Austin, 2012). This increase will provide \$35 million per year in tax dollars that will be combined with UT-Austin's resources to help fund the construction and operation of new medical school buildings needed to establish the new district. This district can be thought of as a new medical teaching facility as well as a new healthcare service provider for the Austin-area.

Historically, the implementation process of publically-funded projects in Austin has been problematic. The City of Austin describes these problems as including: political opposition; disagreements with contractors; higher than expected costs; staffing limitations; and difficulties acquiring land and right of ways (Coppola, 2012). Despite voter-approval, the medical district has opposition such as, Austin's large, private healthcare and hospital provider, Saint David's Healthcare. David Huffstutler, President, and CEO of Saint David's explained the opposition to the project: "We are very supportive of bringing a medical school to Austin... But we do not

believe that this is the appropriate way to fund it” (Saint David’s Healthcare, 2012). This history indicates some common obstacles that may be encountered in this project.

The stakeholders responsible for implementing the new medical district aim to avoid the common pitfalls of project development in Austin. The purpose of this research is two-fold. The first is to explore the obstacles to the successful implementation of a University of Texas medical school and a teaching hospital. The second purpose is to explore the strategies to overcome those obstacles to implementation.

Public Administration Relevance

The lack of access to healthcare services and life-saving treatments is an important public administration issue. Publically-funded hospitals and health clinics are the primary providers of healthcare services for many lower-income, uninsured, or underinsured individuals (Judd and Swanstrom, 2004, 340). This will continue to be the case despite Obamacare. Though access to affordable healthcare has been expanded, not everyone may choose to purchase adequate health insurance. This means that some of the community’s citizens are dependent on city and county resources for healthcare, which puts pressure on the city and county administration. These residents are provided “safety-net” healthcare services by Austin’s public sector.

Implementation and Public Administration

Implementation is a relatively young field in public administration (Winter, 2003, 220-221). Pressman and Wildavsky define implementation as, “to carry out, accomplish, fulfill, produce, complete” (Pressman and Wildavsky, 1984, xxi). Implementation is thus, an on-going

process with steps, rather than a destination. Bardach (1977, 2), provides a helpful conceptualization of this process:

Whatever else it is, a policy- or program-implementation process is an assembly process. It is as if the original mandate... that set the policy or program in motion were a blueprint for a large machine that was to turn out... healthier older people, or better-educated children, or more effective airplanes... This machine must sometimes be assembled from scratch. It can sometime be created by overhauling and reconstituting an order, or preexisting, machine. Putting together the machine and making it run is, at one level, what we mean by the “implementation process”. “Implementation problems”... are specific to the assembly activities that constitute some “implementation process”.

The study of implementation can be a valuable tool for public administrators when executing new projects, programs, and policies, like the medical district.¹ According to Alan Werner (2004, 2), the core mission of implementation research is to describe, assess and explain what is happening and to document how a program operates. Implementation research is helpful because it documents the process, which can be used to identify and address mistakes and missteps.

Chapter Summaries

Chapter two discusses the setting of the medical district. It highlights the basic population and demographic statistics. The chapter also presents the projected costs and benefits of the new medical facility. In chapter three, the scholarly literature on the implementation process is reviewed. The chapter identifies the potential threats to implementation as well as potential strategies to overcome those obstacles. A summary of the conceptual framework is presented at the end of the chapter. The research methodology used to assess the implementation process for

¹ For an example of a Texas State University Applied Research Project that explores the implementation process see Joseph Scanio (2006).

the new medical district is described in chapter four. It examines some of the advantages and disadvantages of the research method used. The chapter also discusses the operationalization of the conceptual framework. The results of the study are provided in chapter five. The responses to the focused interviews are presented. Conclusions and recommendations based on the results are provided in chapter six. It discusses the possible bias associated with the study. Chapter six concludes with suggestions for future research.

Chapter II: Setting

Chapter Introduction

Austin provides a beneficial and complementary setting for the medical district. This chapter discusses how the city and its population will benefit from the district. In addition, it describes the setting in which the implementation process of the medical district will unfold. Understanding the context of this process should provide insights into future problems. Images of what the proposed medical district will look like are provided in Image 2.1 and 2.2 below.

Image 2.1: The Proposed Medical District, Looking South toward the State Capitol Building



Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

Image 2.2: Final Build-out: Future Medical Program UT Austin Future Academic and Research Buildings



Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

The proposed medical district will require massive investment and will ultimately double the size of the UT-Austin campus from its current 40 acres, to 80. The images presented here are of buildings that will have to be constructed, some of which in the places where other structures, like the Frank Erwin Center, currently stand. The UT-Austin campus is located in downtown Austin. In order to understand the context in which the new medical district will be implemented the basic demographic statistics should be considered.

Demographics of the Austin/Travis County Area

Map 2.3: Austin, Texas

Source: Texas Tech University Center for Geospatial Technology



Map 2.4: Travis County, Texas

Source: Wikimedia Foundation



Austin is the State Capitol, and is located in the heart of Central Texas. Austin lies within the Travis County jurisdiction, as shown in Maps 2.3 and 2.4 above, highlighted in yellow and red respectively. According to *The Regional Healthcare Partnership Plan*, (Central Health, 2012, 47), Travis County has 1,024,266 residents. Of that, an estimated 842,592 people reside within the Austin City Limits (U.S. Census, 2010). The community has a high educational attainment rate. Over 40% of Travis County adults have a bachelor's degree or higher, compared to just 26% of Texas adults (U.S. Census, 2010).

Austin has several institutions of higher education including the State's flagship research university, The University of Texas at Austin (UT-Austin). Such institutions contribute to the County's high educational attainment rate. A workforce with high educational achievement could provide the knowledge, skills, and expertise needed to fully implement the medical school at all levels. In addition to the available educational resources, the medical district should benefit from the city's healthcare resources.

Existing Hospitals

Austin is home to large, established hospitals that already have research initiatives in place, along with thousands of knowledgeable staff members who could enhance the implementation process of the medical district. For example, the Seton Healthcare Family (Seton), the largest healthcare provider in Central Texas, is currently conducting research in neuroscience, pediatrics, and trauma (Seton, 2013). Seton values collaboration because it brings together scientists, physicians, entrepreneurs, and venture capitalists to, “help create and enhance tomorrow’s economy and quality of life for Central Texas” (Seton, 2013).

Seton has partnered with UT-Austin for the medical district. This is appropriate because Seton has experience operating the University Medical Center Brackenridge (UMCB), which trains residents from the UT- Southwestern Medical School, located in Dallas (Seton, 2013). Over time, UMCB has become outdated and inadequate to accommodate the healthcare needs of the growing population. A new medical district should provide needed supplemental service to the community.

Benefits for the Austin/Travis County Area

The medical district should directly benefit the community. For example, according to the *Community Health Assessment: Austin/Travis County, Texas* (City of Austin, et. al., 2012, 39), cancer is the leading cause of death for Travis County residents, just above heart disease. Currently, there are only few places to get research-based cancer treatment. Generally, a cancer diagnosis would involve traveling to research hospitals outside of Austin, if it is financially

possible. Lower-income residents, and those who are under- or uninsured, may not have the resources to travel outside of the community for healthcare.

Teaching hospitals provide 71% of the charity care in the U.S., acting as healthcare safety nets, serving those who are under-insured or uninsured (Seton, 2013). Obamacare should reduce, though not eliminate, the uninsured population, as more people should have access to healthcare they can afford, increasing the demand for healthcare services in the Austin-area. As such, healthcare capacity needs to be increased to keep up with demand. In addition to the social benefits, expanding healthcare capacity with the new medical district will provide significant economic benefits to the community.

Projected Economic Impact

The medical district should have a significant, positive economic impact on the community. The Perryman Group, Texas-based economic research and consulting firm, published a report on the impact of this project. According to the Perryman Group report (2007, 41), the medical district is projected to generate gains in business activity through operations, research, student spending, and spin-off firms in related industries. Specifically, the medical district is projected to generate more than \$2.3 billion in annual spending in the regional economy and over 19,000 new jobs (2007, 6).

According to the UT-Austin (2013, 35), the city has the opportunity to develop an innovation district near the new medical campus. Such capacity and technical resources would provide UT-Austin with the chance to translate research into products and businesses. Despite the benefits, it is necessary to address the costs of implementing the medical district.

Costs to the Austin/Travis County Area

According to The University, (UT-Austin, 2013), the construction of the first phase of the medical school portion of the new district, is projected to cost \$334,500,000. Phase I of development includes: the construction of new educational, administrative, research, and medical office buildings; a parking garage; and a new teaching hospital (2013, appendix). Financing for the project has been committed from several sources. The University of Texas System has allocated the funding for the construction of the medical school campus, operating costs, faculty recruitment, and support (UT-Austin, 2012). Seton has committed the construction a new teaching hospital that will replace UMCB (UT-Austin, 2012). Travis County property tax payers will provide funds towards the school's operating expenses. Additional funding is expected from the philanthropic community. Thus far, the Michael and Susan Dell Foundation, has donated \$50 million to the project (UT-Austin, 2012). Some support is expected from the State, but the medical district will not be dependent on funding from the Texas Legislature. According to the National Academy of Sciences (2012, 10), state appropriations for research universities, like UT-Austin, have declined by 25% over the past 20 years. As such, the new medical facility cannot rely solely on legislative funding.

A New Healthcare Education Model

Traditionally, healthcare service delivery has been fragmented across several government and non-profit agencies. For the past 18 years, safety net care in the county has been split between local government and Seton's non-profit facilities. Primary care has been the responsibility of a government entity, either Central Health or the City of Austin. Central Health was created in May 2004 by a vote of Travis County residents as a political subdivision of the

State of Texas, not a part of Travis County Government. Central Health does not directly provide services rather, it contracts with a variety of providers to meet the health care needs of eligible residents (Central Health, 2013). Central Health owns University Medical Center Brackenridge (UMCB) which it leases to Seton. Inpatient and outpatient hospital care is provided by Seton, under contractual arrangement, at UMCB (Central Health, 2013, 3). This approach is not systematically coordinated and resulted in fragmentation. This system divided the two major healthcare players, both of whom acted semi-autonomously. Such an approach is insufficient and inefficient instead, a new sustainable and integrated model for the medical district is needed.

According to Central Health, the new model to be used in the Central Texas case is characterized by the integration of healthcare service delivery. This should improve care coordination and create a more sustainable safety net system (Central Health, 2013, 8). The new healthcare service delivery model combines education, industry, philanthropy, charity, and community resources into a coordinated system. The health professionals educated at the Dell School of Medicine will be directly involved in service provision, spending their residencies training at Seton's new teaching hospital. This multi-disciplinary approach represents a changed vision of healthcare service delivery and medical education.

Table 2.5: Healthcare Model Comparison

Traditional Healthcare Education Model	Integrated Healthcare Education Model
<ul style="list-style-type: none">• Segmented by college/discipline.<ul style="list-style-type: none">○ For example, liberal arts and biological sciences colleges function independently of each other.• Funding determined by state legislature via a formula.	<ul style="list-style-type: none">• Based on synergies among existing UT schools, programs, and assets.<ul style="list-style-type: none">○ For example, the existing UT-Austin schools of engineering and social will be working with the medical program.• Funding based on public-private partnerships via contractual agreement.• Integration and expansion of existing healthcare and biomedical infrastructure.

The Vision of the Medical District

The vision of the medical district is specified in UT-Austin's, *Medical District Master Plan*. According to the University:

The medical district will be a compact, dynamic, urban setting that nurtures innovation, collaboration and community. It will be developed through a partnership between UT Austin, Seton Healthcare (Seton), and Central Texas Healthcare (Central Health), and will contain the University's planned new medical school and medical research building, as well as a new teaching hospital and medical office building. The vision for the district is founded on an innovative idea for medical education that integrates healthcare, teaching, and research within an interdisciplinary setting, taking full advantage of adjacent university resources (2013, 5).

The new model is based on synergies among UT-Austin's existing schools like: nursing; engineering; social work; and pharmacology (UT-Austin, 2012). The medical school is projected to be completed by July of 2016 (UT-Austin, 2013, appendix). The teaching hospital is expected to be completed along the same timeline. The non-binding, but important, *Letter of Intent*

between Central Health and Seton, describes the integrated healthcare delivery system as „dependent upon several components“. This includes, “...the creation, funding, construction, and operation of a medical school and safety net hospital located in Travis County” (2013, 1-2).

Chapter Conclusion

This chapter discussed the context in which the medical district will be located. Understanding the setting of the process should afford a better awareness of the implementation problems the project may encounter, allowing for better solutions to be developed. Basic population and demographic statics of the area were highlighted. The projected costs and benefits were presented. In addition, the resources available in Austin were discussed. The chapter introduced a new, integrated healthcare delivery and medical education model. The chapter concluded with the vision the stakeholders have for the new medical district. The next chapter reviews the scholarly literature on implementation and applies it to this case.

Chapter III: Literature Review

Chapter Purpose

This chapter reviews the scholarly literature on program implementation as well as the key factors that affect the implementation process. The research goal is achieved through a set of working hypotheses designed to explore the factors that could impact the implementation of the medical district. The working hypotheses aim to identify both the potential threats, and strategies to mitigate such threats to the process. The literature helps identify areas for concern and ways to address potential problems. The working hypotheses framework is used to develop interview questions for the stakeholders responsible for implementing the new medical district.

Implementation Defined

Implementation research can be helpful to the stakeholders responsible for bringing the medical district to fruition. Alan Werner asserts (2004, 2), that the core mission of implementation research is to describe, assess, and explain what is happening; to document how a program operates. Implementation should be thought of as an ongoing and systematic process. The study of policy implementation emerged in the 1970's and has evolved through different models over time.

Implementation Models

Implementation research originated with Pressman and Wildavsky's seminal implementation case-study, *Implementation: How Great Expectations in Washington are dashed in Oakland*, originally published in 1973. The study sparked debate over the issue of joint action in the implementation process. It analyzed the implementation of federal-local Economic Development Administration programs in Oakland, California (1984, 90). Their model, "complexity of joint action", asserts that: the implementation of new programs and policies are negatively related to the number of participants and decision points involved in the process (Pressman and Wildavsky, 1984, 90).

Pressman and Wildavsky: A Critique

According to O'Toole (2003, 238), Pressman and Wildavsky's (1984), model is now considered flawed because it contradicts an abundant body of real-world evidence on joint action (O'Toole, 2003, 238). There are many examples where complex policy/program implementation has become routine, thus contradicting the Pressman-Wildavsky model. Medicare and Medicaid are examples of complex programs functioning with a multitude of other players. These programs are administered by the federal and state government, and services are provided by public and private healthcare providers in the local community. This paradox is illustrative of the role context plays in implementation. In some cases, the involvement of multiple actors with diverse interests can lead to failure. Yet, in other cases, additional actors can increase the chance of successful implementation (O'Toole, 2003, 239).

Top-Down Implementation Model

Two schools of thought have emerged from the evolution of implementation research: top-down and bottom-up (Matland, 1995, 146). This study explores the early stages of implementation which are inherently hierarchical, and characterized by the top-down approach. In top-down models the top-level policy designers (legislators) are the central actors controlling the implementation process, (Matland, 1995, 146). Pressman and Wildavsky provided the first top-down model in which a program was directed from the highest-level. Top-down implementation provides an applicable model for the new medical district because the project in the stages of early implementation, and is being directed by high-level officials. According to Winter (2003, 241), the newer top-down implementation is more optimistic than the model offered by Pressman and Wildavsky, and it adds a long-term perspective. Exploring the successes and failures of past project or program implementation can provide insights needed to bring the new medical district to reality.

Failed Implementation

According to Winter (2003, 221), previous studies indicate that there are many barriers to, and factors that can increase the chance of, successful implementation. Alexander, (1989, 463), argues that the Pressman-Wildavsky model is a special case which is unrepresentative of the implementation process in general. Yet, their groundbreaking study still offers some critical insights into problems that may be encountered. To Pressman and Wildavsky (1984, 90), failed programs are characterized by: contradictory criteria [of success], antagonistic relationships among participants responsible for implementation, and an elevated uncertainty about even the

possibility of success. Pressman and Wildavsky describe a program or project as a failure if the results do not achieve the goals (Pressman and Wildavsky, 1984, 211).

Alexander (1989, 463), asserts that the implication of the Pressman-Wildavsky study is that implementation models should be clearly matched to the specific context in which they operate. Those responsible for the medical district can learn from other failed projects by recognizing some of the common pitfalls that delay or diminish new programs. This study uses working hypotheses, developed from the literature reviewed, as a framework to explore the both potential implementation problem and solutions to those problems.

Conceptual Framework

According to Shields and Tajalli (2003, 315), a conceptual framework provides coherence to empirical research and are used to connect all aspects of inquiry. Shields and Tajalli, present five conceptual frameworks each linked to a corresponding research purpose (Shields and Tajalli, 2003, 317). This study assesses a project that is still in the preliminary stages so the research purpose used is exploratory, and uses the “working hypothesis” conceptual framework.² According to Shields and Tajalli (2003, 320), Working hypotheses are a provisional means to advance further inquiry, but like formal hypotheses they are still statements of expectations that cannot be proven but will either be supported, or failed to be supported, by evidence. In this case, exploratory research is used to identify potential obstacles to the implementation of the new medical district and ways to overcome them. To achieve this purpose a set of working hypotheses were devised which are composed of sub-hypotheses. Through this conceptual framework, empirical data is collected and the hypotheses tested.

² For other Texas State University Applied Research Projects that use the working hypotheses see Ruiz (2010), Douglas (2011), Irle (2011), and Painter (2013).

Since this study is not interested in explanation or causality the exploratory study purpose is preferable. Thus, a comprehensive set of formal hypotheses is unnecessary. Working hypotheses are a starting point, which can be more fully examined through future studies. According to Shields (1998, 202), “working hypotheses enable and focus evidence collection. They are particularly useful in qualitative research”. The literature (for example: Anglin, 2001; Pressman and Wildavsky, 1984; Winter, 2002), revealed some common barriers to any type of new project implementation. Broadly defined, such problems include resource constraints and diverse or divergent perspectives among those responsible for the implementation process. Potential implementation problems and possible solutions to those problems are used to construct working hypotheses. The working hypotheses are used as the basis for interviews with stakeholders responsible for implementing the medical district.

Threats to Implementation (WH 1)

Identifying possible obstacles and potential problems can assist in devising strategies to move past barriers. Though all the constraints to cannot yet be foreseen; there are common obstacles to any type of program implementation, including: resource shortage, lack of coordination, and poor planning (Pressman and Wildavsky, 1984, 212). Mazamania and Sabatier, (1983, 21), assert that there are three factors, each composed of multiple variables that drive the implementation process: tractability of the problem; the statute’s [law/mandate] ability to structure the process; and effects of political variables.

There are also more-nuanced barriers that lie within the structure of the community and administration (Anglin, 2011, 109). For example, political issues such as Saint David’s, public opposition to Proposition 1; it is not known what their next actions toward the medical district

may be. In addition to identifying such barriers, stakeholders must also consider community assets.

According to Blakley and Bradshaw, (2002, 49), in order for local projects to succeed in the new global economy communities must understand how to identify and mobilize their assets, without waiting for assistance from a federal program. Austin has a wide range of assets, for example, UT-Austin, a highly- educated workforce, and vibrant non-profit sector, and technological industries. There is diversity among these assets thus, stakeholders must work to bring agreement and cohesion to the project.

Bardach, (1977, 37), asserts that in order for the implementation process to succeed it must be understood as a:

Process of assembling numerous and diverse program elements... these elements are in the hands of many different parties, most of whom are in important ways independent of each other. The only way such parties can induce others to contribute program elements is through the use of persuasion and bargaining.

The stakeholders responsible for the medical district are operating within a complex, dynamic, and inter-connected setting. Bringing the medical district to reality involves a varied set of players working together within the community and a tight budgetary climate. Therefore, one would expect:

WH 1: *Those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation.*

Financial Resource Limitations (WH 1a)

One of the three driving factors of the implementation process identified by Mazamania and Sabatier, (1983, 21), is the ability of the state to structure the process. This factor is affected by the initial allocation of financial resources. Mazamania and Sabatier, (1983, 26) state, “the initial policy decision establishes the general level of funding. An inadequate level can doom a program before it begins. Conversely an adequate level can help, but not guarantee, that program gets off to a decent start.”

For example, according to Matland (1995, 162), the World Health Organization’s program to eradicate small pox was successful because it was provided with the necessary resources to continue active implementation until the disease was eliminated. Conversely, a similar federal program to contain tuberculosis was de-funded in the 1980’s, once the the number of cases began to decrease. As a result, there has been a resurgence of tuberculosis since the 1990’s along with the emergence of a drug-resistant strain of the disease (Matland, 1995, 162).

Money is needed for any project, as Roland Anglin, (2011, 11), states the, “lack of capital and access to capital prevent meaningful wealth building and economic development”. Without proper resources there is no way to build, staff, operate, or maintain the medical district. There are multiple dimensions of financial capital resources required for implementation, including fiscal assets, land, and operating costs. The medical district will require billions, and as such, the traditional medical education and healthcare service delivery funding models are inadequate for successful implementation.

Traditionally, public research universities received nearly two-thirds of their revenue from the state, but that has dropped significantly (Lewis and Hearn, 2003, 1). Stakeholders cannot solely rely on state funding to implement the medical district. The new medical district will be operating within the context of a new economy, and must have differently approach to revenue generation. Blakley and Bradshaw, (2002, 175), offer a solution, project financing as opposed to funding. Financing involves the flexible use of existing assets. For example, rather than relying on the Texas Legislature to appropriate money for the project, stakeholders must leverage existing, community assets. Therefore, one would expect:

WHI a: Financial resource limitations are a threat to successful implementation.

Human and Social Capital Resource Limitations (WH 1b)

Successful program implementation is not limited to financial resources; it also requires human and social capital resources. Another of the variables that affects the implementation process as identified by Mazamanian and Sabatier (1983, 34), involves the commitment and leadership skills of the implementing officials. This variable can be thought of as a type of human capital. According to Ostrom (2009, 18), human capital involves the properties of individuals. Specifically human capital refers to the skills and knowledge of individuals or groups of individuals, which can increase future benefits (Ostrom, 2009, 21). Sarrides and Stengos (2009, 4) assert that human capital includes: the quality of the education of a community; the general health of the workforce; and both formal and informal training. To successfully implement the medical district, human capital resources are needed. For example, such resources include a range of educational skills and technical skills. Another dimension of human resources needed to achieve the vision of the medical district is social capital.

Social capital should be thought of as value of relationships among members of a group. According to Ostrom, (2009, 17), social capital resources are those available to members of a social network. Generally, such resources can be accessed by all of the members of a group. Nahapiet (2009, 205), states: “social capital theory focuses on the value of social connections... firms well-endowed with social capital create competitive advantage through better access to opportunities, options and resources through their relationships”. This theory can be extended to the public and non-profit sectors as a way to maximize efficiency and quality of projects.

It is important to note that social capital is not inherently good or bad. Bull and Frate, (2003,145), argue that social capital can facilitate or hinder access to additional social, economic, and, political resources depending on the context in which it operates. For example, because social capital refers to human relationships, it could take the form of trust or distrust, depending upon the circumstances. There are multiple players responsible for implementing the medical district. The types of social capital resources needed for this project include trust and positive or fruitful working-relationships among all the diverse stakeholders involved. Yet, when dealing with human relations, neither trust nor effective partnerships can be taken for granted. These take effort, time, and commitment to build. Therefore, one would expect:

WH1 b: Human and social capital resource limitations are a threat to successful implementation.

Diverse Goals among Participants (WH 1c)

The implementation of the new medical district involves multiple participants, all of whom have different perspectives, interests, and backgrounds. To Pressman and Wildavsky

(1984, 90), antagonistic relationships and agreement breakdowns were common among failed programs (Pressman and Wildavsky, 1984, 90). Disagreement can emerge for various reasons. For example, agreement can breakdown if participants feel such pressure as: direct incompatibility with their other obligations; preferences for some programs over others; simultaneous commitments to other projects; dependence on others; and differences of opinion on leadership and organizational roles (Pressman, Wildavsky, 1984, 100).

According to Clingermayer and Feiock (2001, 13), mutual obligations and outcomes among all the parties participating in the implementation process, must be aligned and coordinated (Clingermayer, Feiock, 2001, 13). Coordination among participants is needed for effective collaboration, which a critical component of project development (Anglin, 2011, 18). Collaboration involves working together in many, various ways (Bardach, 1998, 8-9). However, collaboration cannot eliminate basic underlying conflicts that may arise among participants (Bardach, 1998, 17). According to Lachapelle (2008, 54), “situations viewed through conflicting lenses tend to be antagonistic”. Thus, conflicts among stakeholders can lead to antagonistic relationships, which can breakdown agreements and doom a project to failure.

There are multiple stakeholders responsible for the implementation of the medical district, each with unique perspectives, values, and missions. Stakeholders include: the University of Texas System, UT-Austin, Seton, Central Health, Travis County, the City of Austin, and the CCC. The multiplicity and diversity of the goals among stakeholders can threaten the implementation process. Therefore, one would expect:

WHI c: *Diverse goals among participants are a threat to successful implementation.*

Strategies to Overcome Potential Threats to Implementation (WH 2)

Past implementation failures can be used strategically to develop ways to overcome common threats to implementation of the medical district. For example, Pressman and Wildavsky (1984, 90), argued that failed programs are characterized by contradictory criteria of success and antagonistic relationships responsible parties. Mazamania and Sabatier (1983, 22), identified additional variables that can threaten the implementation process, such as financial and non-financial resource constraints. Once the threats to implementation have been identified, strategies can be developed to overcome them.

According to Bardach, (1977, 254), when implementing a new policy the consideration of resources allocations and rule design are critical for success. For example, the stakeholders responsible for the medical district represent diverse organizations. The creation of a shared, clear vision was identified as a strategy that can be used to align diverse players. Anita Pankake (1998, 27), asserted that a clear vision with defined goals is a prerequisite for successful program implementation. A clear vision helps determine the future state of a program and the benefits that are associated with it (Pankake, 1998, 30). This can help protect against agreement breakdown and mistrust because all of those involved have a mutual understood result to work towards. The creation of clear vision with defined goals can be accomplished through strategies such as mission statements, a stated shared vision, or the development of explicit purpose and desired outcomes (Pankake, 1998, 27). Therefore, one would expect:

***WH2:** Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation.*

Provision of Financial Resources (WH 2a)

The literature, such as Matland (1995) and Mazamania and Sabatier (1985), revealed that fiscal resource shortages can threaten implementation. Fiscal assets include financial resources, land, buildings, and costly equipment (Chen et. al., 2009, 66). For example, one strategy to overcome resource constraints is public-private partnerships.

The medical district is a public-private partnership between the University of Texas, Seton, and Central Health. Public-private partnerships, or P3's, are defined by the National Council for Public-Private Partnerships as, "the investment of a locality's capital and other resources, leveraged with those of a private entity or another public entity to achieve a significant benefit that could not otherwise be achieved" (Philips, et.al., 2004, 14). Bardach (1998, 8), asserts that such collaboration increases public value, such as increased efficiency, effectiveness of equity and joint-activity, which creates possible new sources of value through pooled resources (Bardach, 1998, 8-9). In addition to allowing for more financial resources, P3's also provide enhanced knowledge, skills, and expertise (Considine, Giguere, 2008 45) which increase the human and social capital resources available. If well designed, public-private partnerships should provide stakeholders the necessary fiscal resources to implement the medical district. The partnerships between the University of Texas, Seton, and Central Health should alleviate the dependence on legislative appropriations for the funding of the new medical district. The stakeholders will need strategies to achieve a new funding model that should overcome financial problems. The stakeholders will need strategies to achieve this end. Therefore, one would expect:

WH 2a: Those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations.

Provision of Human and Social Capital Resources (WH 2b)

O'Toole, (1996, 150-62), asserts that inter-organizational implementation needs both the cooperation and coordination of multiple institutional actors. Collaboration is one strategy to address resource limitations. Collaboration with organizations from other sectors can provide access to significant additional resources that otherwise would not have been available to the public sector. Specifically, public-private collaboration can provide an integrated approach to addressing specific issues or dimensions of a problem, in order to promote the best possible solutions (Considine, Giguere, 2008, 3). Furthermore, according to Anglin (2011, 18), collaboration across sectors is a vital component of community development. Social capital for example, is enhanced by norms of cooperation and respect among collaborators, which can produce future benefits (O'Toole, 2003, 240).

However, according to Bardach, (2000, 4), collaboration is not possible without a culture of trust, pragmatism, and a consensus building process. Bardach states that these do not just appear, rather: "it takes time, effort, skill, and a mix of constructive personalities who are around long enough to build effective relationships" (2000, 4). For example, working groups and committees representative of stakeholders are strategies that can be used to build the social capital necessary for the medical district.

Therefore, one would expect:

***WH 2b:** Those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations.*

Reconciling Diverse Goals among Participants (WH 2c)

The literature such as Pressman and Wildavsky (1984) and Lachapelle (2008) identified different, often conflicting goals and perspectives among responsible parties as threats to the implementation process. For example, conflicting goals can lead to antagonism and agreement breakdown which could erode the commitment and collaboration needed for the implementation process.

According to Guess (1985, 576):

Inefficient project execution is largely a product of failure to understand the history of role conflict and incentive structures used by project participants.... The historical conflict process creates opportunities for an appropriate oversight strategy. Where these results are recognized, project results may be improved.

Guess (1985, 583), identifies strategies to address conflict that can be applied to the implementation of the new medical district including:

...project managers-designers should guard against...the tendency to innovate for innovation's sake and to shroud tasks in excessive complexity... designers of multi-year capital projects should first build up internal capacity for technical oversight...

Putnam (2010, 333), identifies three strategies that can transform disputes, "differentiate conflicts, alter conflict framing, and enact collective sense making."

According to Clingermayer and Feiock (2001, 13), local politics involves making deals such as coalitions, contracts, and public-private partnerships. It is crucial that the expectations of mutual obligations and outcomes among all of the participating parties are aligned. Coordination between participants can help formulate a clear and unified vision with defined goals. Teisman and Klijn (2002, 197), “the achievement of the goals of each individual actor requires activities by the other actors; mutual adjustment is an important prerequisite [for coordination].” Pressman and Wildavsky (1984, 133), characterize coordination between participants as, “mutually supportive policies or actions that are not contradictory, with participants that contribute to a common goal.”

Therefore, one would expect:

WH 2c: *Those responsible for implementing the new UT medical teaching facility can identify strategies to address the problems of diverse goals among participants.*

Summary of the Conceptual Framework Table

Like all new projects, the medical district is bound to encounter some problems that threaten to diminish or delay its implementation. This research uses two working hypotheses to explore the threats to and strategies for the implementation process of the district. Both of the working hypotheses are composed of sub-hypotheses, which are used to enhance the meaning and specificity of the major hypotheses. These hypotheses will be operationalized and tested in the following chapter.

The working hypotheses and supporting literature are summarized in Table 3.1, The Conceptual Framework Table. To reiterate, working hypothesis 1 asserts: Those responsible for

implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation. Working hypothesis 1 is further refined by sub-hypotheses 1a, 1b, and 1c as follows: Working hypothesis 1a asserts: Financial resource limitations are a threat to successful implementation. Working hypothesis 1b asserts: Human and social capital resources limitations are a threat to successful implementation. Working hypothesis 1c asserts: Diverse goals among participants are a threat to successful implementation.

Working hypothesis 2 asserts: Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation. Working hypothesis 2 is refined through sub-hypotheses 2a, 2b, and 2c as follows. Working hypothesis 2a asserts: Those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations. Working hypothesis 2b asserts: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations. Working hypothesis 2c asserts: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the problems of diverse goals among participants.

Chapter Summary

The scholarly literature on program implementation was reviewed in this chapter. The chapter identified potential threats to the medical district as well as strategies to mitigate those threats. The working hypotheses and corresponding sub-hypotheses were presented. The chapter concluded with the conceptual framework table, which provides scholarly support for the research purpose. The following chapter describes the research methodology used to test the working hypotheses.

Table 3.1: Conceptual Framework Table

Working Hypothesis	Literature
WH 1: Those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation.	Anglin, 2011 Bardach, 1977 Blakley, Bradshaw, 2002 Mazamania, Sabatier, 1983 Pressman, Wildavsky, 1984
WH 1a: Financial resource limitations are a threat to successful implementation.	Anglin, 2011 Blakley and Bradshaw, 2002 Lewis, Hearn, 2003 Matland, 1995 Mazamania, Sabatier, 1983
WH 1b: Human and social capital resources limitations are a threat to successful implementation.	Bull, Frate, 2003 Nahapiet, 2009 Mazamania, Sabatier, 1983 Ostrom, 2009 Sarrides, Stengos, 2009
WH 1c: Diverse goals among participants are a threat to successful implementation.	Anglin, 2011 Bardach, 1998 Clingermayer, Feiock, 2001 Lachapelle, 2008 Pressman, Wildavsky, 1984
WH 2: Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation.	Bardach, 1977 Mazamania and Sabatier, 1983 Pankake, 1998 Pressman, Wildavsky, 1984
WH 2a: Those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations.	Bardach, 1977 Bardach, 1998 Chen et. al., 2010 Considine, Giguere, 2008 Philips, Scott, Leavitt, 2004
WH 2b: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations.	Anglin, 2011 Bardach, 2000 Considine, Giguere, 2008 O'Toole, 1996 O'Toole, 2003
WH 2c: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the problems of diverse goals among participants.	Clingermayer, Feiock, 2001 Guess, 1985 Pressman, Wildavsky, 1984 Putnam, 333 Teisman, Klijn, 2002

Chapter IV: Research Methodology

Chapter Introduction

This chapter describes the research methodology used to assess the threats to the implementation process of the medical district, as well as the potential strategies to overcome such threats. It discusses how the conceptual framework is put into operational terms through empirical research. The advantages and disadvantages of the research method are highlighted.

Research Method

Exploratory studies aim to develop relevant hypotheses and propositions for additional inquiry (Yin, 2009, 9). This study explores the potential problems to and solutions for the implementation process in Austin. Most of the case studies in the literature, such as Pressman and Wildavsky's (1984), *complexity of joint action model*, are not as exploratory as this more preliminary case, because they sought to determine causes of implementation failures and success. This study identifies variables that could affect the implementation process of the medical district in Austin, but does not assert causality of the failure or success of the process.

The limited case study research method used along with a single-site approach. According to Yin (1982, 39), single-site implementation studies examine the experiences of stakeholders vested in a single project.

There are two units of analysis used in this study, the individual level and the whole case level. In-person interviews are used to address the research purpose by exploring the possible obstacles to project implementation. The key organizations involved in creating and

implementing Austin’s new medical district are used to identify possible interviewees. The organizations are identified in Table 4.1 below.

Table 4.1: Key Organizations Responsible for Implementing the Medical District in Austin

Organization	Implementation Responsibility
Travis County	Funding through property taxes; Represented via Central Health.
Central Health	Lease land for new hospital to Seton; Fund healthcare services through Seton.
Texas State Legislative Staff	Spurred project forward and provided support for the vision of the new medical district.
The University of Texas System	Provide funding for the construction and operation of the Dell School Medicine.
The University of Texas at Austin	Operate the Dell School of Medicine.
The University of Texas Southwestern Medical School (UTSW)	Operate in conjunction, collaboration, and according to the new medical district; currently provides residents to UMCB (the current teaching hospital).
Seton Healthcare Family	Provide funding for the construction and operation of a new teaching hospital to replace UMCB; Currently provides safety-net healthcare services through partnership with UTSW at UMCB.
Seton-UTSW Clinical Research Institute	Expand UTSW’s world-class research programs to the Austin area; Operate in collaboration with the new medical district.

Operationalization of the Conceptual Framework

The working hypotheses and their corresponding sub-hypotheses are tested through the use of focused interviews. Table 4.2, The Operationalization Table, outlines how the conceptual framework is put into operational terms for this study. The conceptual framework is divided into three sections, each of which connects the working hypotheses to the inquiry process. Each section contains three columns. The first column reiterates the working hypotheses and sub-

hypotheses. The second column identifies the data that interviews that should elicit in order to test the hypotheses. The third column specifies what type of evidence is needed to support the corresponding hypotheses.

Table 4.2: Operationalization Table

Working Hypotheses	Assessment Method/ Informant ID	Research Question/Evidence
WH 1: Those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation.		
WH 1a: Financial resource limitations are a threat to successful implementation.	Interview Question (I) - (Stakeholder organizations) I-1: What are the ideal financial resources needed to successfully complete/operate the medical teaching facility? How does that compare to reality? What could stop us from making that happen?	Financial Resource Shortage Informants identify potential threats to successful implementation. Informants show that fiscal capital resources are needed for successful implementation. Informants can explain how resource shortages can impede implementation.
WH 1b: Human and social capital resources limitations are a threat to successful implementation.	Interview Question (I) – (Stakeholder organizations) I-2: What are the ideal kinds of skills, people and organizations that should be available to make the medical teaching facility a reality? How does that compare to what is really available? I-3: What are the ideal types of social networks that should be available to make the medical teaching facility a reality? How does that compare to what is really available?	Human and Social Capital Resources Informants show that human capital is needed for successful implementation and explain why. Informants show that social capital is needed for successful implementation and explain why.
WH 1c: Diverse goals among participants are a threat to successful implementation.	Interview Question (I) – (Stakeholder organizations) I-4: Who is responsible for bringing the medical teaching facility to fruition? I-5: What are the consequences of any conflicts?	Divergent Perspectives among Participants Informants show that conflicting views among participants can diminish successful implementation.

	I-6: Do you think these people/organizations have a compatible vision for the medical teaching facility? Why? Why not?	
WH 2: Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation.		
WH 2a: Those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations.	<p>Interview Question (I) – (Stakeholder organizations)</p> <p>I-7: How might any financial threats to successful completion of the medical facility be overcome?</p> <p>I-8: How successful would the following strategies be:</p> <ul style="list-style-type: none"> ➤ <u>Public-private partnerships</u> Describe any public-private partnerships that are responsible for bringing the medical teaching facility to fruition. What is the relationship like among the participants of such partnerships? ➤ <u>Interagency Collaboration</u> How do the various entities work together to achieve the vision of the medical teaching facility? 	<p>Financial Capital Informants can identify strategies to address the potential financial threats to successful implementation.</p>
WH 2b: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations.	<p>Interview Question (I) (Stakeholder organizations)</p> <p>I-9: How might any non-financial threats to successful completion of the medical facility be overcome?</p>	<p>Human and Social Capital Informants identify strategies to overcome human and social capital threats to implementation.</p>

<p>WH 2c: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the problem of diverse goals among participants.</p>	<p>Interview Question (I) (Stakeholder organizations)</p> <p>I-10: How are any problems arising from diverse goals or conflicts addressed?</p> <p>I-11: Describe any strategies Austin could use to align the goals and objectives across participants responsible for the medical teaching facility.</p>	<p>Conflict Resolution Informants identify strategies to overcome problems arising from diverse goals or conflicts.</p>
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Summary of the Operationalization Table

Working hypothesis 1a asserts that inadequate fiscal, human and social capital resources are obstacles to implementing the medical district. The evidence needed to support or not support this sub-hypothesis is identified in column three as: *agreement among informants that fiscal, human, and social capital resource shortages are obstacles to implementation; informants can explain how resource shortages can impede implementation*. To achieve the research purpose, the working hypotheses are operationalized with the use of focused interviews.

Interview questions I-1 through I-6 are used to collect evidence on working hypotheses 1, 1a, 1b, and 1c. In order to address working hypothesis 1a, which asserts that inadequate fiscal, human and social capital resources are obstacles to implementing the new facility, question I-1 asks stakeholders: “What are the ideal financial resources needed to successfully complete/operate the medical district? How does that compare to reality? What could stop that from happening?”

Working hypothesis 1b, which asserts, that human and social capital resources limitations are a threat to successful implementation, is addressed by interview questions I-2 and I-3.

Interview questions I-2 and I-3 respectively ask: “What are the ideal kinds of skills, people and organizations that should be available to make the medical teaching facility a reality? How does that compare to what is really available?” “What are the ideal types of social networks that should be available to make the medical teaching facility a reality? How does that compare to what is really available?”

Working hypothesis 1c, diverse goals among participants are a threat to successful implementation, is operationalized through interview questions I-4 and I-5, and I-6. Interview questions I-4 and I-5 respectively ask: “Who is responsible for bringing the medical teaching facility to fruition?” “What are the consequences of any conflicts?” Interview question I-6 asks: “Do you think these people/organizations have a compatible vision for the medical teaching facility? Why or why not?”

Focused Interviews

Focused interviews are used in this study. The interview questions are semi-structured and open-ended. Interviewees are treated as informants. To Yin (2009, 107), informants go beyond answering only what was explicitly asked and offer their insights into an issue and can initiate access to corroboratory or contrary sources of evidence. However, because interviews are qualitative in nature, they are subject to bias, poor recall, and inaccurate or poor articulation. As such, they must be considered as “verbal reports” only (Yin, 2009, 108). These verbal reports are the basis of this inquiry, but do not assert causality.

The interviews took place from March 1, 2013 through May 20, 2013. Each interview lasted approximately thirty to forty-five minutes. Of the nine interviews, eight were given in-person and one was over the phone. Informants interviewed in this study include the following: Texas State Legislative staff; Central Health leadership; UTSW Medical Center leadership; Seton leadership; Travis County management; UT-Austin faculty and leadership; UT-System leadership; and Seton/UTSW Clinical Research Institute leadership. The initial questions for each working hypothesis and for the focused interviews are specified in Table 4.2: The Operationalization Table. These questions were meant to stimulate discussion. Further questions in the interviews took into account the informant's response and the focus of the working hypothesis.

Sample

According to Johnson (2010, 129), snowball sampling is appropriate when researchers do not know who to include and rely on others to tell them. Non-random snowball sampling is used for this case. The possible problems of bias would be minimal in this case because it is not intended to establish causality. Snowball sampling is a way to obtain early or preliminary information in which relationships established by one respondent help locate additional people to interview. At the end of each interview, each informant is asked who else they thought should be included in the inquiry process, which leads to additional informants included in the sample.

According to Johnson (2010, 138-139), the potential for non-sampling errors, which refer to problems with how data was collected, is part of the research process. In this case non-sampling errors could emerge from the interview questions and responses. In order to minimize non-sampling errors the exact same interview questions are given to each informant. Not every

informant answered each question, though most did. This was either due either time limitations or the informant's lack of knowledge or information needed to provide an answer.

External validity refers to generalizing the results of a study to a larger population (Johnson, 2010, 78). Johnson asserts that because case-studies are qualitative and small in scope, they are weak in terms of external validity. This case is purely exploratory with the goal to simply discover "what is going on out there". Though external validity is problematic with qualitative research, it is not an issue in this case because no causality is being asserted (Werner, 2004, 39). Rather, this case reports what people with multiple perspectives view as obstacles to implementation.

Support Criteria

The evidence collected is gauged on the following scale of support: strong support; adequate support; or limited support. The determination of support is subjective, and is made based on the author's knowledge of the subject matter. For example, strong support would mean that for these informants, responses supported the relevant working hypotheses. For a determination of strong support, there is preliminary evidence that those engaged in the process could identify barriers to implementation and strategies to overcome those barriers. The concrete barriers and strategies identified by the respondents should inform the implementation process in useful ways. Evidence assigned as strong support indicates multiple informants identified the same threats or strategies and they could discuss these things in depth.

Evidence deemed as adequate support, indicates some support for the relevant working hypothesis. The primary difference between strong and adequate support is the expectation of

findings. For example, strongly-supported expectations are frequently verified, whereas adequately-supported expectations are verified less frequently.

Evidence assigned as limited support, indicates partial, or no support of the relevant working hypothesis. The primary differences between adequate and limited support are frequency and depth. If the hypothesis is partially supported or not supported at all, it is deemed to have limited support.

Human Subjects Protection

This exploratory research uses in-person and phone interviews, which require human subjects, and as such potential ethical issues must be addressed. Social scientist, Earl Babbie (2004, 64-68), asserts that the main areas for ethical concern in social research include: voluntary participation; harm to the participants; anonymity/confidentiality; and deception (Babbie, 2004, 64-68). To ensure voluntary participation and to prevent any semblance of deception, all interviews contain a full description of both the research purpose and how the findings of the research would be used.

To address the issue of confidentiality, only the researcher has access to individual responses, and responses are not publicly disclosed. Participants did not have to answer any questions that they felt uncomfortable with. The identities of participants are known only to the researcher. No names were disclosed publicly by the researcher. Audio recordings of the interviews are made only if the informant agreed in advance. This assurance of confidentiality was included in writing at the beginning of the interview. Participation in the interview was completely voluntary, and refusal to respond to the interview involves neither penalty nor loss of

benefits to those contacted. This research project was approved for exemption by the Texas State Institutional Review Board on February 19, 2013 (EXP2013R2055). A copy of the exemption certificate is found in Appendix A.

Chapter Summary

This chapter discussed the research methodology used in this study. The limited case-study method along with semi-structured interviews, were used to operationalize the conceptual framework. The advantages and disadvantages of this qualitative methodology were highlighted. The stakeholders in the project implementation process were identified. The interview questions asked in this study were provided in conjunction with the working hypotheses that they sought to test. The chapter presented Table 4.2, the Operationalization Table and concluded with the human subjects protection used in this study. The following chapter presents the results developed through this study.

Chapter V: Results

Chapter Purpose

This research has a dual purpose. First, it explores the various threats to the implementation of a medical district in Austin. Second, it explores potential strategies that may be used to overcome such threats. This chapter summarizes the results collected from this study.

This case uses two major working hypotheses (WH 1 and WH 2) in order to assess the data collected through focused interviews with medical district stakeholders. Working hypotheses 1 and 2 respectively assert that those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation; and that those responsible for implementation can identify strategies to overcome potential threats. The results indicate that the stakeholders have identified potential implementation problems as well as solutions to those problems. Some threats were considered more problematic than others, and some strategies identified were applicable to multiple threats.

Potential Threats to Implementation (WH 1)

WH 1: *Those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation.*

This study identifies three potential threats that could diminish or delay the implementation of the medical district. Financial resource limitations are the first. The second pertains to human and social capital resource limitations. The third involves diverse goals among those responsible for the implementation process.

Financial Resource Limitations (WH 1a)

Working hypotheses 1a is tested through interview question I-1 which asks:

I-1: What are the ideal financial resources needed to successfully complete/operate the medical teaching facility? How does that compare to reality? What could stop us from making that happen?

One informant responded that the medical school portion of the district should have a total annual budget of \$100 million, approximately \$60 million of which will be provided by the UT System combined with an estimated \$35 million generated from Travis County property taxes. The remaining \$40 million budgeted, is to be used for the extension of the clinical part of the medical school, as it builds out and engages the community. The informant went on to state:

In reality, funding gaps need to be addressed. There is uncertainty with the new healthcare law. We are not certain how current projections or plans will change and that could lead to [funding] gaps, the realities that take hold from the plan to actual costs. We are anticipating that there will be gaps.

Another informant responded that there is, “never enough, [and] will always need more financial resources”. Not all of the informants felt that financial resource limitations were a threat to the medical district. For example, one informant stated:

If all of the funding sources are maintained, that is what is required to operate. We would not have announced the establishment of a medical school without having a firm notion that the required money is available. Around 2017, the first session of the first matriculation, additional funding will be provided with formula funds for students.

This response indicates the will to make do with the budget available, while the rest of the informants indicated more funding uncertainties. Four of the informants identified financial

resource limitations as a potential problem for the implementation process. Only one of the informants asserted that financial resource limitations were not a threat to the medical district implementation. As such, working hypothesis 1a is determined to have adequate support.

Human and Social Capital Resource Limitations (WH 1b)

Working hypothesis 1b is tested through interview questions I-2 and I-3. Interview question I-2 asks the following:

I-2: What are the ideal kinds of skills, people and organizations that should be available to make the medical teaching facility a reality? How does that compare to what is really available?

The interview responses focus on the role of the human element needed for the new medical district. One informant indicated that the project is all about people because it “will need research faculty, clinicians, administration, and a variety of professionals”. When asked how the needed human and social capital resources compared to what is available the same informant replied, “The stage is set and the talent is there”, contradicting the notion of a human and social capital resource shortage, and failing to support working hypotheses 1b. This sentiment is echoed by one other informant who identified the need for:

...Creative innovative individuals that think outside the box, and are not afraid to try something new, while remaining within the guidelines of accreditation. In reality, we have a lot of this (I.E. creative, innovative individuals) in Austin. UT-Austin is a huge campus and people are “coming out of the woodwork”. Medicine and education needs an inter-disciplinary, inter-professional, team-training approach.

However, one informant did identify a resource gap, responding:

There is a shortage [of necessary skills, people, and organizations]. There is a lack of easily accepted expertise in many aspects required for the medical school because there is limited medical school experience in Austin and there are not many people that come from a medical school/clinical research program.

Another informant asserted that the medical district will need:

A huge list of a heterogeneous group of people including teachers, researchers, clinicians, and financial and administrative services.... There will be national searches for the faculty. The biggest constraint is the housing market.

Working hypothesis 1b is further tested through interview question I-3 as follows:

I-3: What are the ideal types of social networks that should be available to make the medical teaching facility a reality? How does that compare to what is really available?

One informant specified that the vision of a new multi-disciplinary model of healthcare education must be: team-oriented; community-based; include various levels of providers; and offer primary, specialty, and ambulatory care. The informant asserted that many of these resources are currently available in Texas and stated, “The social networks are already in place”.

Another informant identified a gap and potential threat, responding:

Ideally, there are needs to be a relationship with Saint David’s, which would further strengthen the medical community.... In reality, we have everything, except a partnership with Saint David’s, already in place.

The interviews reveal potential human and social capital resource limitations that could threaten the implementation process. Interview responses indicate that a wide array of different types of people, skills, expertise, and organizations are needed to implement the new medical district. However, the responses were evenly divided between supporting WH 1b and failing to

support it. Thus, based on responses to interview questions I-2 and I-3 working hypothesis 1b, which asserts human and social capital resource limitations are a threat to implementation, is found to have adequate support.

Diverse Goals among Participants (WH 1c)

Working hypothesis 1c is tested through three interview questions, I-4, I-5, and I-6.

Interview question I-4 asks the following:

I-4: Who is responsible for bringing the medical teaching facility to fruition?

One informant described the context from which the project emerged, as the “perfect storm”. According to the informant:

In 2004-2005, Galveston was considering Austin as a place for its UTMB medical student residents. Then Hurricane Ike hit [seriously damaging Galveston, including its medical campus], and UTSW (based in Dallas) began a residency program in Austin, partnering with Seton at UMCB. Texas State Senator Kirk Watson, brought the medical district project together and strongly advocated for it. The economic decline put the project on hold for a few years, but now the economic recovery has enabled it to proceed.

Those ultimately considered to be responsible for the new medical district were identified by most informants as: UT; Seton; and Central Health. All nine of the informants identified UT as responsible. Seven of the informants identified Seton as additionally responsible. Five of the informants believed that Central Health was also responsible.

Working hypothesis 1c is further tested through interview question I-5 is as follows:

I-5: What are the consequences of any conflicts (between those responsible for bringing the new medical teaching facility to fruition)?

Informants asserted that there will be unintended consequences but none of them are considered “life-threatening” to the project. One said that the relationship between UTSW and Seton will probably change. In addition the UTSW residents currently at training at UMCB will likely be transitioned to residents from the Dell School of Medicine.

Another informant indicated that the primary consequences of conflict will be disconnect and duplication. While another specified the consequences of conflict as, “delay, inefficiencies, and loss of scope or purpose.”

Working hypothesis 1c is further operationalized through interview question I-6 which assesses stakeholders’ goals for the project, and asks:

I-6: Do you think these people/organizations have a compatible vision for the medical teaching facility? Why/Why not?

Eight of the nine informants interviewed felt that there was a compatible vision for the new medical district. One informant described that vision as one that, “will improve the quality of healthcare, provide healthcare based on need, and care for the uninsured and under-insured.”

Another informant described the vision as:

A research intensive community-based medical district with a multi-disciplinary approach [to healthcare education]... achieved through extensive in-patient and out-patient experiences, strong community involvement, and an emphasis on the full spectrum of research, from basic science to translational research, such as clinical trials.

Not all of the respondents thought that the visions are compatible. One informant asserted that although the visions are not shared, they are not mutually exclusive. The informant explained:

There is a natural tension between UT's mission, to produce highly-educated individuals and Seton's mission, healthy human beings. Both of these missions are necessary, and both are positive, but they have different areas of focus and different vantage points.

Interview responses suggest that there may be diverse goals among the participants responsible for the implementation of the medical district. Informants agree that any collaborative effort involving multiple entities, as the new medical district should, are inherently conflicted. However, this does not necessarily mean that the goals are divergent or mutually-exclusive. Rather, it is natural that some conflicts will emerge due to diverse goals simply because multiple players are involved.

Based on the interview responses to questions I-4, I-5, and I-6, working hypothesis 1c, diverse goals among participants, is found to have adequate support. Therefore, because sub-hypotheses 1a, 1b, and 1c are found to have adequate support, the overall working hypothesis 1, that those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation, is determined to have adequate support as a whole.

Table 5.1: Results for WH 1

WH1: Those responsible for implementing the new UT medical teaching facility recognize that there are potential threats that could diminish its successful implementation.		
WH1a: Financial resource limitations are a threat to successful implementation.		
Evidence	Finding	Level of Support
Interviews	Identification of financial shortages as a problem.	Adequate
WH 1b: Human and social capital resource limitations are a threat to successful implementation.		
Evidence	Finding	Level of Support
Interviews	Identification of social and human capital resource shortages as a problem.	Adequate
WH 1c: Diverse goals among participants are a threat to successful implementation.		
Evidence	Finding	Level of Support
Interviews	Identification of diverse goals among stakeholders as a problem.	Adequate

Strategies to Overcome Threats to Implementation (WH 2)

WH 2: *Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation.*

This study uses focused interviews to explore strategies that can overcome the potential threats to the implementation of the new medical district. Strategies are identified in this study can be used to overcome financial resource shortages, human and social capital resource shortages, and the problem of diverse goals among those responsible for implementation.

Strategies to Overcome Financial Limitations (WH 2a)

Working hypothesis 2a is tested through interview questions I-7 and I-8. Interview question I-7 aims to identify strategies to address financial limitations and asks the following:

I-7: How might any financial threats to the successful completion of the medical facility be overcome?

One informant asserted: “To get the needed funding, the healthcare model must be changed, from focusing mainly on sick care to include wellness and ambulatory [outpatient] care.” According to the informant, the traditional model is based on government funds given directly to Central Health, which then allocates funds to Seton. However, it is Seton rather than Central Health that assumed the financial risk for providing safety net healthcare services. According to the informant, the old model, “does not work”. Conversely, the new model would provide government funding directly to those accepting the risk, which should rebalance the financial risk model of safety net healthcare service provision.

Informants interviewed indicated that the traditional public medical education funding model, which depends on the Texas Legislature for funding, is inadequate for Austin’s new medical district. A new funding model is needed for sustainable medical district financing and is identified by multiple informants as a broad strategy that can be used to overcome the financial threats to implementation. Specifically, the informants argued for a new funding model based on a public-private partnership between UT, Seton, and Central Health for finances. The informants identified communication, commitment, and trust, as strategies that should be used in order for the partnership to function effectively. These findings provide evidence that the stakeholders have identified some potential strategies to overcome the financial threats to implementation.

Working hypothesis 2a is further tested through interview question I-8 as follows:

I-8: Describe any public-private partnerships that are responsible for bringing the medical teaching facility to fruition. What is the relationship like among the participants of such partnerships? What about interagency-collaboration? How do the various entities work together to achieve the vision of the medical teaching facility?

All nine of the informants described the relationship as a public-private partnership composed of the UT- Austin, the UT System, Central Health, and Seton. The respondents emphasized the role of steering committees and working groups in which stakeholders are represented. Collectively, these groups must come up with agreements and find common ground. For example, the “Master Agreement” and other contracts and arrangements, specify which entity is responsible for what, both in terms of funding and outcome.

Based on the responses to interview questions I-7 and I-8, working hypothesis 2a, those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations, is found to have adequate support. Strategies identified include: public-private partnerships, communication, trust building, and a new funding model.

Strategies to Overcome Human and Social Capital Limitations (WH 2b)

Working hypotheses 2b explores strategies to overcome human and social capital limitations. Working hypothesis 2b is tested through interview question I-9 as follows:

I-9: How might any non-financial threats to successful completion of the medical facility be overcome?

The majority of the respondents identified communication as a key strategy that can be used to overcome threats to the implementation of the medical district. One informant stated that

problems of trust can be overcome by communication, forthrightness, and transparency. Another stressed the role of trust and trust-building as strategies to overcome non-financial threats to implementation. According to the informant, “trust requires effective communication, open-dialogue, and transparency”.

This sentiment was echoed by another informant, asserting that, “the negotiation of partners is the key to ensure that they are all in agreement”. Four of the informants asserted that if negotiations breakdown, there will be big problems. Another stated that, “it is very important to keep everyone involved from the beginning”. However, these strategies are somewhat vague and the stakeholders are still working towards more concrete strategies to enhance trust, communication, and negotiation. For example, one informant identified bringing the private hospital provider in Austin, Saint David’s, into the partnership in the future as a strategy. The informant elaborated that this is because medical schools tend to be affiliated with more than one hospital system in order to enhance greater student expertise.

Interview responses reveal strategies that may be used to overcome human and social capital resource limitations. Informants noted the role of the public-private partnerships, in terms of bolstering the necessary skills, expertise, people, and organizations required to bring the new medical district to reality. Cultivating strong working relationships and trust among those involved is another key strategy necessary for the implementation of the medical district. Thus, based on the responses to interview question I-9, working hypothesis 2b, those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations, is found to have adequate support.

Strategies to Address the Problem of Diverse Goals among Participants (WH 2c)

Working hypothesis 2c is tested through interview questions I-10 and I-11. Interview question I-10 asks the following:

I-10: How are any problems arising from diverse goals or conflicts addressed?

The informants identified open communication and dialogue as a strategy to overcome conflict. One asserted that the diverse goals among the participants can be reconciled through negotiation. The informant asserted that a series of high-level documents will be created that contractually define the relationships.

Another informant responded that there will be big issues arising from the diverse schools in the academic campus. For example, the colleges of natural science, chemistry, molecular biology, pharmacy, nursing, and engineering, all have their own interests. According to the informant, “the key to success is to create synergies among these programs with the medical district, by building joint-programs and using a multi-disciplinary approach to medical education”.

Working hypothesis 2c is further tested through interview question I-11 as follows:

I-11: Describe any strategies that could be used to align the goals and objectives across participants responsible for the medical teaching facility.

Again, the informants identified communication as a strategy. Another emphasized the importance of keeping all of the participants involved. There will be town hall and open meetings held in order to keep the community informed and engaged in the implementation

process. According to the informant, such meetings should include a communications team composed of Seton, the UT System, and UT - Austin. Such meetings should communicate the vision, goals, and projected outcome of the new medical school and hospital. The informant emphasized the importance of communicating one message going forward.

Another informant stressed the importance of intentional conversation between the partners. According to the informant, when there is a divergence from the goals, the diverse stakeholders should be brought together to discuss the problems and find commonality in areas that are aligned. This strategic planning together will help to ensure that the various stakeholders do not work against each other.

One respondent asserted that the key to the success of this project is to build programs that mount excitement around a multi-disciplinary approach. As these programs are built, exciting education and research programs will be interfaced with programs linked to the new medical school. For example, cancer research at the school will be interfaced with cellular microbiology, pharmacology, computational science (which maximizes the speed and depth of data), translational research, and patient-care programs. According to the respondent, these will be built in a way that is driven by UT's supporting faculty.

Interview informants nearly all agree that conflicts arising from diverse goals are inevitable, yet they are also relatively easy to reconcile. Informants emphasized the importance of communication and open dialogue, through committees and working groups involving those responsible for implementation, as strategies to overcome the threats from diverse goals and conflicts. It is crucial that those involved all feel that they have a voice. One respondent asserted foundational legal contacts are a crucial strategy. Thus, working hypothesis 2c, those responsible

for implementing the new UT medical teaching facility can identify strategies to address the problem of diverse goals among participants, is found to have adequate support.

Sub-hypotheses 2a, 2b, and 2c are each determined to have adequate support based on the responses to interview questions. As such, the overall working hypothesis 2, those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation, is deemed to have adequate support as a whole.

Table 5.2: Results for WH 2

WH 2: Those responsible for implementing the new UT medical teaching facility can identify strategies to overcome the potential threats to its successful implementation.		
WH 2a: Those responsible for implementing the new UT medical teaching facility can identify strategies to address financial limitations		
Evidence	Finding	Level of Support
Interviews	Identification of strategies to address the potential financial threats to successful implementation.	Adequate
WH 2b: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the human and social capital resources limitations.		
Evidence	Finding	Level of Support
Interviews	Identification of strategies to overcome human and social capital threats to implementation.	Adequate
WH 2c: Those responsible for implementing the new UT medical teaching facility can identify strategies to address the problem of diverse goals among participants.		
Evidence	Finding	Level of Support
Interviews	Identification of strategies to overcome problems arising from diverse goals or conflicts.	Adequate

Chapter Summary

This chapter provided the results of this limited case study. This exploratory study used focused interviews as sources of evidence. The overall results indicate an adequate level of support for the working hypotheses. Strategies identified through interviews include: communication; open dialogue; trust building; public-private partnerships; working groups and steering committees. The following chapter provides some recommendations and conclusions based on these results.

Chapter VI: Recommendations and Conclusions

Chapter Purpose

The purpose of this research is two-fold. The first purpose is to explore the potential threats to the implementation process of the new medical district in Austin. The second purpose is to explore the potential strategies that can be used to overcome the potential threats. The threats to implementation along with the strategies to address such threats are identified in the literature review and are tested through focused interviews with relevant stakeholders. This chapter provides recommendations and conclusions based on the results of this study.

Recommendations

This study reveals that any new project, such as the new medical district, faces potential implementation problems. Focused interviews with stakeholders adequately support the existence of possible threats to implementation. The threats identified include:

- Financial resource limitations.
- Human and social capital resource limitations.
- Problems arising from diverse goals among implementation facilitators.

The literature is used to identify potential strategies to address such threats. The strategies identified are tested through focused interviews with stakeholders. The interview responses adequately support the existence of possible strategies that can be used to overcome the threats to the implementation process. Strategies identified include:

- Communication and open dialogue between those responsible for implementation.
- Public-private partnerships.
- Contractual agreements.
- Trust building.
- Working groups and committees representative of the multiple entities charged with implementation.

Primary and secondary recommendations are developed based on the results of this study and are provided as follows.

Primary recommendations:

- Stakeholders should embrace new multi-disciplinary models of healthcare education and service delivery.
- Stakeholders should use the strategies identified in this study including:
 - Communication and open dialogue between those responsible for implementation.
 - Public-private partnerships.
 - Strengthened accountability through the use of contractual or legal agreements.

- The cultivation of trust through inclusive working groups and committees.
- Finding areas of agreement as a starting place for negotiations when conflicts emerge.

Secondary recommendations:

- Other jurisdictions should consider this case as an innovative approach that may be used in order to adapt to the dynamic economic and technological environment in which they operate.
- Stakeholders should work together in groups and committees to develop more concrete, specific strategies.

The results of this study must be interpreted with caution because of reflexivity and question bias (Yin, 2009, 102). According to Yin (2009, 102), reflexivity is a weakness of the interview process, that occurs when the response given is what the interviewer wants to hear. Interviews may be biased due to poorly articulated questions, response bias, or inaccuracies due to poor recall (Yin, 2009, 102). In addition, more time was spent on some questions than others, which could have limited the responses. These weaknesses should be considered when assessing the results of this study.

Future Research

The primary suggestion for further research is to incorporate more stakeholders into the sample. Due to limitations of scope and time, this study was unable to include all of the potential stakeholders. For example, Saint David's, Austin's other major healthcare provider, should be included in future research. The role and perspective of the community should also be included.

The secondary suggestion for future research is to expand upon this study in order to apply the results to other new development projects, both in Austin and other jurisdictions, within the context of each individual project/program.

Conclusion

The results of this study revealed that there are potential threats to the implementation of a new medical district in Austin. In addition to these threats, strategies were identified that can be used by the stakeholder in order to overcome potential obstacles. Understanding what the possible implementation problems are is the first step toward developing solutions. Focused interviews indicated that the stakeholders responsible for the implementation process have compatible visions for the medical district. By adhering to the strategies identified, they should be able to overcome both the financial and non-financial threats to implementation in order to bring the full vision of the medical district to reality.

Chapter Summary

This chapter provided recommendations and conclusions based on this implementation study. It addressed possible biases and provided suggestions for future research. The results indicate that several potential threats to successful implementation likely do exist. The interviews revealed that the stakeholders responsible for the medical district have identified strategies that may be used to overcome threats and bring the new medical district to fruition.

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Phase I Medical District:



Dell Medical School Program:

Education and Administration Building
Research Building
MOB Phase 1
Parking Structure (1,000 spaces)
Chilling Station (Potential)

Teaching Hospital and MOB Program:

Hospital (220 beds)

Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

Phase II: Future Medical District Program



Psychiatric Hospital (120 beds)
Cancer Center and MOB Phase 2
Parking Structure (500 spaces)
Travis County Medical Examiner's
Office Expansion

Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

Final Build-out: Future Medical District Program UT Austin Future Academic and Research Buildings



Parking Structures (2)
Future Housing

Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

Existing Illustrative with Planning Boundary



UT-A Campus Boundary —

Medical District Planning
Boundary —

Source: The University of Texas at Austin Medical District Master Plan, Spring 2013

The proposed Medical District, looking South toward the Texas State Capitol building



Source: The University of Texas at Austin Medical District Master Plan, Spring 2013