VA New Hampshire Vision 2025 Task Force

(Subcommittee of the Special Medical Advisory Group)

Agenda

Wednesday, February 14, 2018 (Day 1 of 2)
8:00 AM – 5:00 PM

Manchester VA Medical Center
718 Smyth Road, Building 1, 1st Floor, Training & Education Room, Manchester, NH

ITEM	Background	Goal of Agenda Item
8:00 AM – 8:30 AM **Welcome/Comments** David Kenney Taskforce Co-Chair & Chairman New Hampshire State Veterans Advisory Committee Jennifer MacDonald, MD Taskforce Co-Chair & Director of Clinical Innovation and Education Facilitator/Alternate Designed Federal Officer: Tom Pasakarnis	Task Force Meeting Jan 9 10 Minutes Fina Task Force Meeting Jan 23 Minutes Final.|	Information
8:30 AM – 9:00 AM **Review Preliminary Report to Special Medical Advisory Committee (SMAG)** **Special Medical Advisory Committee Meeting Update** Jennifer MacDonald, Taskforce Co-Chair David Kenney, Taskforce Co-Chair	SMAG Update Final.docx VA New Hampshire VISION 2025 Task Fo Service Line Options Grid.docx Debrief on meeting with the Special Medical Advisory Committee on February 8, 2018	Information

9:00 AM – 9:30 AM **Focus Group/Survey Update** Lynne Cannavo, VISN 1 Chief of Organizational Performance	Presentation will be provided at the meeting.	Information
9:30 AM – 10:00 AM **Errera Community Center** Debbie Deegan, Director Errera Community Center	Presentation will be provided at the meeting	Information
10:00 AM – 10:15 AM ***Break***		
10:15 AM – 11:45 AM **Discussion of Service Line Reports and Q&A**	Service Line Option Grids are attached to this PDF.	Information/Questions & Answers
11:45 AM – 12:00 PM **Manchester Culture Task Force Update** Lisa Lehmann, MD Acting VISN 1 Chief Medical Officer & Executive Director for VHA National Center for Ethics	Charter will be provided at the meeting.	Information
12:00 PM – 12:45 PM ***Working Lunch***		
12:45 PM – 1:45 PM **Coordination of Services between WRJ and Manchester – Current State** Brett Rusch, Chief of Staff WRJ		Information
1:45 PM – 2:30 PM **Follow up with Service Line Leads from Manchester & WRJ**		Questions & Answers
2:30 PM – 2:45 PM ***Break***		

2:45 PM – 4:00 PM **Facilitated Discussion**		Discussion
4:00 PM – 4:15 PM ***Break***		
4:15 PM – 5:00 PM Discussion/Debrief		Review of day and next steps or other needs identified by members.
5:00 PM **Adjourn**		

VA New Hampshire Vision 2025 Task Force

(Subcommittee of the Special Medical Advisory Group)

Agenda

Thursday, February 15, 2018 (Day 2 of 2)
8:00 AM – 5:00 PM

Manchester VA Medical Center
718 Smyth Road, Building 1, 1st Floor, Training & Education Room, Manchester, NH

ITEM	Background	Goal of Agenda Item
8:00 AM – 8:10 AM **Welcome/Comments** Facilitator/Alternate Designed Federal Officer: Tom Pasakarnis		Information
8:10 AM – 10:00 AM **Facilitated Discussion**		Discussion
10:00 AM – 10:15 PM **Break**		
10:15 AM – 12:00 PM **Facilitated Discussion**		Discussion
12:00 PM – 12:45 PM ***Working Lunch***		
12:45 PM – 2:30 PM **Facilitated Discussion** **Finalize Preliminary Findings**		Discussion/Decision

2:30 PM – 2:45 PM ***Break***		
2:45 PM – 4:00 PM **Facilitated Discussion**		Discussion
4:00 PM – 4:15 PM ***Break***		
4:15 PM – 5:00 PM Discussion/Debrief		Review of day and next steps or other needs identified by members.
5:00 PM **Adjourn**		

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Committee Members	Title/Position	9/13/17	9/25/17	10/3-4/17	10/16/17	10/31 – 11/17	11/13/17	11/29-30/17	12/19/17	01/9-10/18
Jennifer MacDonald, MD, Commitee Co-Chair	Clinical Lead, Office of Innovation & Education									P
Jennifer Lee, MD, Committee Co-Chair	VA Deputy Under Secretary for Health for Policy and Services					P/E	P	P/E	P	
Michael Mayo-Smith, MD, MPH	Network Director VISN 1	P	P	P	P					
David Kenney Committee Co-Chair	Chair of New Hampshire State Veterans Advisory Committee	P	P	P	P	P	P	P	P	P
Stephen Ahnen, MBA	President NH Hospital Association	E	P	P	P	P	E	P	P	P
Craig Coldwell, MD, MPH	Deputy Chief Medical Officer, VISN 1	P	P	P	P	P	P	P	P	P
Edward DeAngelo, MD	Chief of Radiology, Manchester VAMC	P	E	P	A	E/P	A	P	A	P/E
Maj. Gen. Gretchen S. Dunkelberger, U.S. Air Force (Ret.)	Former Air National Guard Assistant to the Surgeon General					P	P	P	P	P
Erik Funk, MD	Staff Cardiologist, Manchester VAMC	P	P	P	P	P	P	P	P	P
Amy Gartley, RN	Nurse Executive, VA Maine Healthcare System	P	E	P	P	P	P	P	P	P
Robert Guldner	NH Disabled American Veterans	E	P	P	P	P	P	P	A	E
Wanda Hunt, PharmD	Pharmacist, Manchester VA MC & President, NA(Local	E	P	P	P	P	P	P	E	P

Michael McCarten, DO	Representative NH Medical Society	P	P	P	P	P	P	E /P	P	P		
Susan MacKenzie, PhD	Medical Center Director, Providence VAMC	P	P	P	P	P	P	P	P	P		
Christine Stuppy	Executive Director, Strategic Planning & Analysis, VACO	P	P	P	P	P	P	P	P	P		

(P) Present (A) Absent (D) Designee (E) Excused

VA New Hampshire Vision 2025 Task Force Minutes – Day One – January 9, 2018

TOPIC	DISCUSSION/DECISIONS	RESPONSIBILITY - FOLLOW UP ACTIONS	TARGET DATE	STATUS
Welcome/Comments David Kenney Taskforce Co-Chair & Chairman New Hampshire State Veterans Advisory Committee Jennifer MacDonald, MD Taskforce Co-Chair & Director of Clinical Innovation and Education Facilitator/Alternate Designed Federal Officer: Tom Pasakarnis	Dave Kenney and new co-chair Jennifer MacDonald opened the meetings and led the group in introductions. Tom Pasakarnis reviewed the guidelines surrounding a public meeting, which are included on the Powerpoint below. Slides for the Screen.pptx Tom Pasakarnis and David Kenny then led the Task Force through a review of the agenda for the next day and the half and the goal. The hope would be that at the end of this face-to-face meeting, the Task Force will have developed and discussed a decision-making matrix that can be applied to the ideas and data brought forth by the Service Line Subgroups and other sources.			

Market Assessment Gerard Benson, Director, Strategic Analysis Service Mark Shelhorse, VISN 6 Chief Medical Officer	VISN 1 North Market FINAL DRAFT 01.08. Christine Stuppy introduced Dr. Mark Shelhorse, who walked the Task Force through the VA's Market Assessment of the North Market. Gerard Benson called into the meeting as a subject matter expert. The overarching themes developed by the group that performed the Market Assessment is that it's a "buyer's market" in the Manchester area; that it is very easy to purchase needed care in the community. However, because of the rural nature of the majority of the North Market, it is important that the VA concentrate on delivering care to Veterans where they need it, either directly or by partnering in the community. The Market Assessment showed that there is an excess of capacity in the community currently. The North Market Assessment looked at White River Junction and Manchester as one unit. One of the differences noted is that WRJ has a strong academic affiliation with Dartmouth, whereas there is no academic affiliation at Manchester. This makes it harder to recruit providers. The team also noted that there was not a high level of interaction between WRJ and Manchester currently, which led to a duplication of services. The presenters then reviewed the Market Assessment recommendations for the future of each service line at Manchester, WRJ, and the New Hampshire and Vermont CBOCs. The importance of telehealth and providing Veterans			

	access to care through novel and innovative means was also discussed. Generally Veterans in the North Market were more satisfied than the national average. In looking at the CBOCs, there are some CBOCs, particularly Portsmouth and Somersworth in New Hampshire, where it makes sense to combine clinics in order to make the CBOC more accessible and offer a greater range of services. The Market Assessment noted an increased demand for acute inpatient mental health services. The recommendations put forth in the Market Assessment are just suggestions and observations. Any decisions made about the future of care in the North Market need to be made at the local level. Discussion with the Task Force members followed. There was consensus that if VA care is offered at a community location (i.e. the hospital within a hospital concept) it needs to be very clearly marked and designated as VA space, and Veterans need to have a clear idea of which services are offered where, and feel as though they are getting care from the VA first and foremost.			
Manchester VAMC Facility Working Tasks Garrett Stumb, Chief of Facility Service Manchester	Manchester VAMC Facilities Working Tas Garrett Stumb presented an overview of the Manchester VAMC Facility working tasks, including the status of			

	several minor construction projects. There are two minor construction projects that are in the design phase; a specialty clinic for audiology and ophthalmology and a clinical services building for urgent care and mental health. Both those projects could potentially go out for construction bid within the year, however, construction is on hold currently pending the decisions of the Task Force. The bid process would likely take 6 months, and then each building would likely take a year and a half to build once bid. There are many functional deficiencies that need to be addressed on the Manchester structure in order to make it functioning and workable for the present and moving into the future. There was discussion about the possibility of finding a new piece of land and building a new structure. The state of the structure at Manchester is not unique across the VISN. There are several construction projects that are nearing completion including a new phlebotomy area, relocation of the Pharmacy, and renovations related to the flood, though some areas affected by the flood have not yet been renovated. Discussion with the Task Force members followed. One idea that came up during this discussion was the creation of a "federal template" for community partnerships that could be used not just by the VA but also by DoD or even HHS if they use community partnerships. The idea of a shared space between DoD and VA – something that has happened in North Chicago and Alaska – was also discussed.			

	Another concern that was discussed was that part of any eventual recommendations that including a new building must also include a routine budget for upkeep so that it is sustainable.			
Facilitated Discussion, Day One, Session One	The first facilitated discussion of the day started with a review of the ground rules and plan for the next day and a half. The conversation began with the facilitators asking the group to articulate the foundational interests and values of the group that must be in place to produce recommendations to the SMAG that are defensible and add value to the Veteran's experience in New Hampshire. There was a discussion about the oversight of the recommendations once they are made and what role (if any) the Task Force may have after April 2018. It was also emphasized that any changes to services must be to services that are made must communicated to Veterans. Veterans must understand what services are available to them, where those services are located, and how to access each service. At the end of the session, the Task Force began to deliver a list of topics about which they required further information, including: - Retention strategies - Opportunities for partnerships within the New Hampshire Community - The Errera Community Care Center in West Haven, Connecticut - Opportunities for partnership with White River Junction - Virtual Care - A review of an earlier presentation on VA Foundational Services			

Brief Presentation/Discussion – The VA and Virtual Care Jennifer MacDonald, MD Taskforce Co-Chair & Director of Clinical Innovation and Education	Dr. Jennifer MacDonald provided a brief overview of virtual care services available to Veterans through the VA. She will make a more thorough presentation during the next Task Force call. One option that is available is home telehealth, were services are delivered to Veterans via VA devices in their homes. The Veterans targeted for these services are the highest acuity Veterans who are experiencing frequent hospitalizations, with the goal of keeping them well and in the home. Another Virtual Care service is Clinical Video Telehealth, which is "point to point" telehealth, in which a VA provider at one location can provide services to a Veteran at another VA location. This helps with the distribution of resources, but has less of an impact on access issues, as providers still only have a limited amount of time to see patients. The VA is constantly trying to increase the ability for Veterans to seek out care virtual when they need it. Another service is VA Video Connect, which connects a provider's device to a Veterans phone. Multiple users can be brought in to the conference; for example, the Veteran's family can participate as well. There is an effort to bring this technology into the VA call centers to better handle Veteran's concerns when they call in. Additionally, the VA is increasingly bring providers into the call center space so they can determine whether a Veteran needs to see a provider in person, or whether they can satisfy the Veteran's needs on the call and then pass that information on to the Veteran's usual provider for follow up. Discussion and question and answer with the Task	Dr. MacDonald – Present on virtual care at the next Task Force meeting	January 22, 2018	Closed

	Force members followed. There were questions about the implementation of some of the above services across VISN 1, which is happening incrementally. Currently, there is a tele-mental health hub in West Haven, CT, that provides services to Manchester and Maine. Another area that the VA is working on currently is eConsults, but this is still in the beginning implementation phase.			
White River Junction Presentation Al Montoya, Director (Acting), Manchester VA Medical Center	WRJ Presentation Al Montoya presented on current services offered and other features of White River Junction. He described the basis of the academic affiliation between WRJ and Dartmouth. He also detailed various outreach activities to community stakeholders, including Coffee with the Congressional representatives and VSOs monthly. Following the discussion on WRJ, Al Montoya led a discussion on how the community partnerships with CMC, Elliot, and Frisbee were set up by Manchester after the flood. It took an executive order from the governor, which has since been codified by the New Hampshire legislature. In the beginning the leadership team from Manchester was at CMC 2 days a week and doing individual follow up calls with Veterans. Responses from Veterans were overwhelmingly positive. A project management team was in place to figure out the differences between VA standards and community standards (i.e. reusable medical equipment processing issues).			

	Leadership at Manchester has developed a "toolkit" that can be used when establishing a community partnership. The biggest limitation to community partnerships is that they can take a lot of time to set up (however, in this case because of the emergent circumstances, part of the process was fast tracked). The Task Force engaged in a facilitated discussion regarding community partnerships following Al Montoya's presentation. The Task Force expressed the importance of Veterans still feeling as though they are receiving their care from the VA, even if it's being provided by a VA provider at a community facility. They also noted the need for a "navigator" within the community facility to help Veterans locate the services they need easily. The Task Force wants any future partnership to be a "two-way street" in that the community partner feels as though they are getting something valuable from the VA. There's also some risk that the VA will become dependent on a community partner who will then move/change/close.			
Facilitated Discussion, Day One, Session Three	To end the day, the Task Force took place in a final facilitated discussion where they developed the values that must underlie any recommendations put forward. They will think on this list for the night, and then tomorrow work on consolidating and refining the list into criteria they will use to "judge" any recommendations put forward by the Service Lines.			

	- Preserving the Mission of the VA - Access – Timely – local/virtual where appropriate - Quality - Satisfaction – Patient experience and staff satisfaction – external and internal customers – feedback, Veteran Buy-In - Maintain VA Standard of Care/ Evidence based standard of care - Feasibility - Prioritization of Foundational Services - High value use of resources - Partners – good partners – don't want to feel isolated from our partners - Innovative and non-traditional - Support the demand for LTSS, prioritizing "choosing home" concept where you can - Leverage or partner rather than build where possible - Consideration is given to geographic locations/demographics/data - Recruitment and retention – is this under feasibility? – provider experience – academic affiliations - Feasibility: recruitment, retention, fiscal, policy and regulations, external forces, cultural change management, time to execute recommendation, sustainability, academic affiliations - Continuum of care of military/Veteran personnel – life cycle of Veteran – ex – guard/corp who flow in and out of the VA as they go in and out of service - Excellence in service to our communities/value to the community – sharing research – expanded education into the community - Exportable - Stakeholder alignment - Veteran Centered Care			

Discussion/Debrief				
VA New Hampshire Vision 2025 Task Force Minutes – Day Two – January 10, 2018				
Welcome/Comments Facilitator/Alternate Designed Federal Officer: Tom Pasakarnis	The Task Force co-chairs and the facilitators welcomed Task Force members and encouraged them to share any ideas as they came up.			
Facilitated Discussion, Day Two, Session One	The Task Force began the day with a reflection on the day before. They discussed the obstacles to building a new building, and the need for any structure to be adaptable as the needs of the Veteran population in New Hampshire change over time. They also discussed the importance of culture and buy in from employees as they move forward with any recommendations. The Task Force reviewed survey responses received via the public-facing NH Vision 2020 Task Force website. These were only preliminary responses, and the survey will be presented to the Task Force again at a later date when more responses have been received.	Maureen Heard and Kristin Pressly – Present future survey results	February 14-15, 2018	Open
Facilitated Discussion, Day Two, Session Two	Task Force members took part in a facilitated discussion to refine and combine the values listed on Day One into a set of criteria to evaluate recommendations put forward by the service lines. The Task Force members developed seven criteria, listed below with a brief description where it was articulated: • Feasibility: innovative; responsible; data driven; "build" and grow • Veteran Centered Care: recognizing changing			

	needs; agility to meet local demographic and population changing needs; seek and employing feedback from Veterans ◦ Potential to Foster Robust Relationships and Partnerships: external and internal; academic; industry affiliations; national; Congressional; professional and clinical at multiple levels ◦ Employee Empowerment ◦ Preserving and Fulfilling the Mission of the VA: trusted care; employee engagement and satisfaction ◦ Timely access to appropriate, evidence-based care: Quality, ability of Veterans to access care when they need it, where they need it, and how they need it; use of technology, community partners, and other resources within the VA ◦ High value use of resources: Emphasis on foundational services; leveraging partnerships to provide Veterans access to other services The Task Force then took part in an informal voting exercise to determine the "weight" of each criterion in their final decision matrix. This exercise will be repeated at the beginning of the next face to face meeting.			
Focus Group Update Maureen Heard, VISN 1 Communications Officer	The Task Force discussed the best ways to engage focus groups once they have new refreshed recommendations.			
Discussion/Debrief **Plusses/Deltas**	Michelle Virshup will work with Dr. Coldwell to compile the criteria into a guide that can be presented to the service line subgroups so they can refresh their recommendations. This document will be presented during the next phone call. At the next face-to-face meeting, the Task Force will receive updated recommendations from the service lines and will begin making decisions about their own recommendations.			

A check in document with the Task Force's guiding principles is due to the SMAG on January 31, 2018. The co-chairs and Tom Pasakarnis will facilitate the creation and delivery of that document.

The Task Force co-chairs will facilitate a trip to the Errera Center in CT, likely the week before the next face-to-face meeting. More information about this trip will be provided on the next phone call.

Plusses
Diversity/makeup of the group
Free flow of ideas
Free conversation
New ideas were generated for community partnerships
Ground rules
Co-chairs
Organized input/accomplishments
Timeline seems less daunting
Time to deliberate
Concrete next steps
Framework/facilitation
Rich conversation
Collegiality
Progress
Patience
Appetite

Deltas
Uncertainty – how to package recommendations going forward
Check in with Manchester employees
Bring stakeholder groups back, maybe in a town hall format

05-FEB-2018

Recorder: Michelle Virshup, Esq.

David Kenney
Taskforce Co-Chair

Date

05 FEB 2018

Jennifer MacDonald, MD
Taskforce Co-Chair

Date

2/6/18

Thomas Pasakarnis, Esq.
Alternate Designated Federal Officer

Date

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Committee Members	Title/Position	9/13/1	9/25/17	10/3-4/17	10/16/17	10/31 – 11/17	11/13/17	11/29-30/17	12/19/17	01/08/18	01/9-10/18	01/22/18
Jennifer MacDonald, MD, Commitee Co-Chair	Clinical Lead, Office of Innovation & Education									P	P	P
Jennifer Lee, MD, Committee Co-Chair	VA Deputy Under Secretary for Health for Policy and Services					P/E	P	P/E	P	P		
Michael Mayo-Smith, MD, MPH	Network Director VISN 1	P	P	P	P							
David Kenney Committee Co-Chair	Chair of New Hampshire State Veterans Advisory Committee	P	P	P	P	P	P	P	P	P	P	P
Stephen Ahnen, MBA	President NH Hospital Association	E	P	P	P	P	E	P	P	P	P	P
Craig Coldwell, MD, MPH	Deputy Chief Medical Officer, VISN 1	P	P	P	P	P	P	P	P	P	P	A
Edward DeAngelo, MD	Chief of Radiology, Manchester VAMC	P	E	P	A	E/P	A	P	A	A	P/E	A
Maj. Gen. Gretchen S. Dunkelberger, U.S. Air Force (Ret.)	Former Air National Guard Assistant to the Surgeon General					P	P	P	P	A	P	P
Erik Funk, MD	Staff Cardiologist, Manchester VAMC	P	P	P	P	P	P	P	P	P	P	P
Amy Gartley, RN	Nurse Executive, VA Maine Healthcare System	P	E	P	P	P	P	P	P	P	P	P

Robert Guldner	NH Disabled American Veterans	E	P	P	P	P	P	P	A	A	E	P
Wanda Hunt, PharmD	Pharmacist, Manches VA MC & President, NAGE Local	E	P	P	P	P	P	P	E	A	P	A
Michael McCarten, DO	Representative NH Medical Society	P	P	P	P	P	P	E /P	P	A	P	P
Susan MacKenzie, PhD	Medical Center Director, Providence VAMC	P	P	P	P	P	P	P	P	P	P	A
Christine Stuppy	Executive Director, Strategic Planning & Analysis, VACO	P	P	P	P	P	P	P	P	E	P	A

(P) Present (A) Absent (D) Designee (E) Excused

VA New Hampshire Vision 2025 Task Force Minutes – January 22, 2018

TOPIC	DISCUSSION/DECISIONS	RESPONSIBILITY - FOLLOW UP ACTIONS	TARGET DATE	STATUS
Facilitator: Tom Pasakarnis **Welcome/Comments** David Kenney Taskforce Co-Chair & Chairman New Hampshire State Veterans Advisory Committee Jennifer MacDonald, MD Taskforce Co-Chair & Director of Clinical Innovation and Education	The next face to face Task Force meeting will take place February 14th and 15th at the Manchester VAMC.			

Telehealth Information Jennifer MacDonald, MD Taskforce Co-Chair	Telehealth Overview - Manchester Task Fo VA Telehealth Services Factsheet - Jennifer MacDonald presented further information on Telehealth within the VA. 50+ specialties and subspecialties have begun to utilize Telehealth, and both users and providers are very pleased. In the next month, providers will be able to utilize "Anywhere to Anywhere" VA Video connections that can allow multiple providers and/or Veterans to participate in the same session. A question was raised about where there is a contingency plan if there is a failure in the system. Dr. MacDonald will follow up with the backup plan. The goal of Telehealth is not to decrease the existing workforce at VAMCs but to augment the existing workforce. In Manchester space needs to be reviewed to support the telehealth program for providers.			
Service Lines – Criteria and Guidance for Options and Recommendations Michelle Virshup, VISN 1 Presidential Management Fellow	Service Lines - Criteria and Guidance Service Line Options Grid.docx The attached criteria and guidance was passed on to the Service Lines. The seven criteria decided upon at the last face to face meeting was included: Veteran			

	Centered Care, Potential to Foster Relationships and Partnerships, Employee Empowerment, Preserving and Fulfilling the Mission of the VA, Timely Access to Appropriate, Evidence-based Care, High Value Use of Resources and Feasibility. The Service Lines will use the attached grid template to "score" each option in relation to the seven Criteria using the following system: 5 = Strongly supports the Criteria 4 = Somewhat supports the Criteria 3 = Neutral towards the Criteria 2 = Somewhat opposes the Criteria 1 = Strongly opposes the criteria Service Lines agreed with the criteria presented and clearly understand where the Task Force stands currently with the timeline.			
Errera Community Care Center Visit Patty Sarni, VISN 1 Health Systems Specialist	Errera Community Care Center.pdf The date agreed to visit the center is February 7th. The agenda currently is that starting at 11AM, there will be a tour of the facility and discussion of services provided. More information will be passed to participants from Patty Sarni.			
Misc. Topics/Discussion Facilitator: Tom Pasakarnis				

06 FEB 2018 Recorder:

David Kenney
Taskforce Co-Chair

Date

05 FEB 2018

Jennifer MacDonald, MD
Taskforce Co-Chair

Date

2/6/18

Thomas Pasakarnis, Esq.
Alternate Designated Federal Officer

Date

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To: Special Medical Advisory Group
From: VA New Hampshire Vision 2025 Task Force Co-Chairs
Date: January 29, 2018
Re: Review of Task Force Process and Concepts

The VA New Hampshire Vision 2025 Task Force ("Task Force") has been convening monthly face-to-face meetings and additional conference calls in its effort to determine the best way forward for VA health care of New Hampshire Veterans.. Initial meetings and calls achieved the aim of gathering relevant information for future decisions. Among the inputs the Task Force received were: 1) feedback from more than 600 Veterans online and via focus groups; 2) reports and recommendations from seven service lines (Medicine, Surgery, Imaging, Geriatrics, Rehabilitation, Primary Care, and Mental Health); 3)the VA Office of Policy and Planning VISN 1 North Market Assessment; 4) six contracted capital asset and master planning options from Ernest Bland Associates; 5) updates from the Manchester VAMC's lead engineer on minor construction plans; 6) national, VISN 1, and North Market-specific statistics and resource options for telehealth.

While outreach on specific topics is ongoing, the Task Force pivoted at its January 2018 meeting to the decisional phase of its charge. Considering the inputs above, Task Force members worked through a series of facilitated exercises and discussion, ultimately identifying seven criteria that will serve as the lens through which potential recommendations are evaluated. By numerical vote, the Task Force also weighted the importance of each criterion; this ranking will be revisited and refined at the next face-to-face meeting in February. A brief description of each criterion is below.

- **Veteran Centered Care**: The Veteran is at the center of any and all care provided by the VA, whether care occurs physically or virtually by VA providers or in the community. Any recommendation put forward must reflect Veteran focus group and online and must be mindful that the needs of the Veteran population in New Hampshire will change over time. Needs of Veterans must be considered first and foremost, without inherent constraints due to bureaucratic process or policy, historical resource limitations, or traditional models of care delivery.
- **Potential to Foster Relationships and Partnerships**: The future of VA care for New Hampshire Veterans is most promising with strong regional partnerships. The Manchester VAMC's ability to foster relationships with national and VISN 1 sites and entities (e.g., White River Junction VAMC and telehealth hubs), Federal partners (e.g., Department of Defense sites and Federally Qualified Health Centers), academic affiliates, and community providers is essential to achieving

the best possible care. Partnerships must be of primary benefit to New Hampshire Veterans.

- **Employee Empowerment**: The ongoing input, specific needs, and professional fulfillment of employees at the Manchester VAMC are of critical importance. The best recommendations will create a sense of pride and excitement for working within and contributing to the facility's future, enhance potential for recruitment and retention, and empower employees to innovate, teach, and develop professionally in ways that elevate morale and improve Veteran care.
- **Preserving and Fulfilling the Mission of the VA**: Veterans must be able to distinguish the care they receive within or through VA as being of exceptional quality and experience. Recommendations should preserve the unique mission of VA and elevate the VA "brand", promoting trust in care and services. The best recommendations will be innovative, placing VA at the leading edge of modern care delivery.
- **Timely Access to Appropriate, Evidence-Based Care**: VA must deliver high quality care to New Hampshire Veterans where they need it, when they need it, and how they need it. Recommendations should incorporate current models and technology with the aim of improving timeliness, convenience, and experience.
- **High Value Use of Resources**: For agility in the setting of changing Veteran needs and system resources over time, recommendations should place an emphasis on VA foundational service and take advantage of established community services to supplement care. VA must be able to sustain a high level of care.
- **Feasibility**: Recommendations must be supported by trend and projection data regarding Veteran's future use of VA care, taking into consideration necessary time, resources, and personnel.

In addition to the criteria above, the Task Force developed a list of concepts of particular interest for service lines to consider. These included: 1) Virtual Care; 2) Opportunities for increased partnership with White River Junction; 3) The Errera Community Care Center (community-based rehabilitation center at VA Connecticut) whole health model; and 4) other innovative opportunities for partnerships in the community. With guidance in the attached document, service lines are now reviewing and refreshing their previously submitted options and recommendations in light of the criteria and concepts of interest.. The Task Force will review these revised options at its February face-to-face meeting and will then begin a decisional process to define recommendations to be submitted to the SMAG. The Task Force expects no further change in timeline of deliverables.

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VA New Hampshire VISION 2025 Task Force Way Forward

To: Service Line Working Groups
From: VA New Hampshire VISION 2025 Task Force
Date: January 19, 2018
Re: Criteria and Guidance for Updated Options and Recommendations

At the January 2018 face-to-face Task Force meeting, Task Force members discussed various ideas and topics that they were interested in receiving more information about from each of the Service Lines. The Task Force requests that each Service Line Subgroup incorporate the four areas of interest into their options and recommendation as appropriate. Further information on two concepts – The Errera Center and VA Telehealth programs – has been included. As was mentioned last week, each group must have input from a subject matter expert at White River Junction when developing their final options and recommendations.

Additionally, members debated and developed criteria to guide their decision-making moving forward. They also brainstormed areas of interest they would like explored in further detail by the subject matter experts in each service line. The seven criteria and four areas of interest outlined below are the lens through which the Task Force will consider proposed options and recommendations. The Task Force requests that each Service Line Subgroup take the following steps:

1. Ensure that you have recruited a White River Junction stakeholder to participate in your group.
2. Review the Four Areas of Interest and review and refresh your subgroup's previous options as appropriate.
3. Use the attached grid template to "score" each option in relation to the seven Criteria using the following system:

   5 = Strongly supports the Criteria
   4 = Somewhat supports the Criteria
   3 = Neutral towards the Criteria
   2 = Somewhat opposes the Criteria
   1 = Strongly opposes the criteria

   We hope that the grid approach will help you compare "Criterion Impact" across your options. All seven are considerations the Task Force considers vital pieces moving forward, and recommendations meeting all criteria are preferred. However, should an option not align with one or more criteria, this will not disqualify the concept.

4. Following the grid, each group is give one page to further explain each option, including their self-evaluation, and any pros and cons considered or other themes. The seven Criteria contain bullets with further context and explanation. You are not expected to speak to each of these sub-bullets in your report, but should only refer to them as necessary and as you find helpful as you summarize each Criterion. The Task Force captured these bullets to help portray the spirit of the Criteria in your group. **The one page limit is a hard limit for each option**. This should be a brief, high-level overview, not an overly detailed proposal. Any data you feel is necessary to support your decision and evaluation can be attached as an appendix.
5. Following the Criteria review, please select a top recommendation from among your options – which may be different than your group's original recommendation. **This should be the first option in your grid**.

Please reach out to Michelle at michelle.virshup@va.gov and Dr. Coldwell at craig.coldwell@va.gov with any questions

Areas of Interest

1. The Errera Center concept

- Are there similar holistic, interdisciplinary, or innovative concepts which could be implemented across multiple service lines?
- Additional information about the Errera Center is enclosed.

2. Opportunities for Collaboration with White River Junction

- This concept is exploratory.
- Consider regionalization of resources and personnel with an eye toward expansion of services and staffing.
- Consider how opportunities for greater partnership and sharing could be achieved with bidirectional augmentation of services and enhancement of professional fulfillment for employees. The aim would not be consolidation, but rather expansion via partnership.
- Are there any concerns or challenges regarding greater integration with White River Junction?

3. Virtual Care

- Consider opportunities within each service line to increase Veterans access to services via telehealth.
- Additional information about current telehealth opportunities within VA is enclosed.

4. Innovative Opportunities for Partnerships

- Consider what innovative partnerships between the Manchester VAMC and internal/ external partners could be created for the benefit of Veterans and employees.

Guiding Criteria

1. Veteran Centered Care

- Does this recommendation **seek** and **employ** feedback from the Veteran population in New Hampshire?
- Does this recommendation consider the changing needs of the Veteran population in New Hampshire over time?
- Does this recommendation have the agility and flexibility to meet local demographic and ongoing population needs?

2. Potential to Foster Relationships and Partnerships

- Does this recommendation encourage VA New Hampshire to foster bilateral partnerships and relationships with:
  - Other VA sites with VISN 1(including Area of Interest 2, White River Junction);
  - Other sites within the VA nationally;
  - Community providers (including Area of Interest 4, Innovative Ideas for Partnerships);
  - Other national providers;
  - Potential Academic affiliations;
  - Congressional representatives;
  - Industry actors and associations;
  - Other stakeholders in the New Hampshire community?
- These should encompass both professional and clinical relationships on multiple levels.

3. Employee Empowerment

- Does this recommendation take into account the **feedback** and **needs** of employees at the Manchester VAMC and related CBOCs?
- Will this recommendation get front line support staff, clinical staff, and providers excited about providing care at the Manchester VAMC and related CBOCs?
- Does this recommendation engage employees on an ongoing basis throughout its implementation?
- Does this recommendation provide the foundation for a future just and innovative culture at the Manchester VAMC?

4. Preserving and Fulfilling the Mission of the VA

- Does this recommendation enable an environment of trusted care felt by everyone (Veterans, providers, employees…) in New Hampshire?
- Does this recommendation distinguish the care received at the VA in New Hampshire as exceptional and unique?
- Does this recommendation encourage employee engagement and satisfaction in their everyday work life?
- Will this recommendation empower the VA to recruit and retain first class employees and providers to serve Veterans in New Hampshire?

5. **Timely Access to Appropriate, Evidence-based Care**
    - Does this recommendation enable the VA to provide Veterans in New Hampshire with high quality care, **when** they need it, **how** they need it, and **where** they need it?
    - Does this recommendation consider the use of available **technology**, **community partners,** and other **VA sites** to allow Veterans to access high-quality care where, when, and how they need it?
6. **High Value Use of Resources**
    - Does this recommendation place an emphasis on the VA's **foundational services**?
    - Does this recommendation consider ways to leverage partnerships and other relationships to allow Veterans access to quality care?
7. **Feasibility**
    - Is this recommendation innovative?
    - Is this recommendation a responsible use of time, resources, and personnel?
    - Does this recommendation provide a path forward upon which future New Hampshire leaders can build and grow?
    - Is this recommendation supported by trend and demographic data?

Time Line

January 19 – Michelle will send instructions on criteria and self-evaluation; Subgroups plan for self-evaluation process

January 31 – Subgroups will email progress updates to Michelle and Dr. Coldwell

February 7 – Deadline to submit drafts of revised Options, Recommendations, and self-evaluation to Michelle and Dr. Coldwell

February 9 – Task Force agenda released, including the final revised options and recommendations from each subgroup

February 14-15 – Next face-to-face Task Force meeting

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Service Line Subgroup Name:
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Recommendation/ Option 1							
Option 2							
Option 3							
Option 4							
Option 5							

Service Line Subgroup Name:
Brief Explanation – Recommendation/Option 1:

Service Line Subgroup Name:
Brief Explanation – Option 2:

Service Line Subgroup Name:
Brief Explanation – Option 3:

Service Line Subgroup Name:
Brief Explanation – Option 4:

Service Line Subgroup Name:
Brief Explanation – Option 5:

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Service Line Subgroup Name: Mental Health Subgroup for Manchester
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: Mental Health services provided through a combination of on-site care and community partnerships	5	5	5	5	5	5	4
Option 2: All Services In House Model	3	2	3	4	2	2	2
Option 3: Contract New Services within the Community	4	5	2	3	2	4	2

Service Line Subgroup Name: Mental Health Subgroup for Manchester
Brief Explanation – Preferred Option: Mental Health services provided through a combination of on-site care and community partnerships

Create a hybrid model of onsite and contracted services, contracting some services out with a focus on leasing space and using VA staff to manage the programs as opposed to contracting for services. Some services would still need to contract out both the service itself and the staffing to give the VA control over the number of beds as the option to use them goes down. In this model the key is to optimize space that can be leased out in the community with VA staff managing the programs. This will give Manchester VA the needed exposure in the community and will keep the program under the auspice of the VA. In this model we'd still need to right-size outpatient space in Manchester to provide the correct level of space for staff.

- ❖ Community Resource and Rehab Center/Errera Like Center, which would incorporate and house a Wellness Center and a MH Intensive Case Management Program. Veterans could enter the new program site to engage in case management services, nutrition, smoking cessation, coffee/social club, a small fitness center, occasional family-style meals, housing resources, art therapy, Primary Care/PCMHI, VJO's Homeless Services Supportive Employment computer center/Job Search area, Storage Space, HPACT, Donations Area, Kitchen and cooking program, Pool, Health and Wellness (Yoga, acupuncture), MOVE. Social Security, Legal Clinics, Pro Bono Lawyer, VBA space. Space for VSO's and Community Partners. Working closely with Physically Therapies, Geriatrics, Primary care and mental health have like-minded ideas going forward with an Errera Center like Model with Whole Health concepts.
- ❖ Networking for Telehealth – Establish a North Market Tele mental Health Network to connect sites, teams and providers. See attached PowerPoint shared by Brad Felker, MD. Train most providers in TMH provision, and then resources are shared across the network to meet needs of Veterans. Network model does not limit treatment options to the staff employed by the hub in the hub and Spoke model. Will need training and CVT resources, an "Air Traffic Controller" to allocate resources. Enhance ability to provide evidence-based psychotherapy to rural populations

"Big Hairy Audacious Goals"

- Animal assisted Therapies
- Child Care Services on site free to Veterans and Parenting Classes/Education
- Intimate Partner Violence –Training availability
- Transportation (VBA)
- Education resource center for continuing education for staff and Veterans, (Broadcast Grand Rounds)
- Training space for residents (Offices with computers)
- Community partner expand Outward bound course (ropes course, team building)
- The ability to ID Providers in the community easier.

Service Line Subgroup Name: Mental Health Subgroup for Manchester
Brief Explanation – Option 2: All Services In House Model

All services would be on site at the Manchester VA. The idea would be that all new services would be **built** on the campus at the Manchester VA. The new services would include the expansion of the existing General MH outpatient clinic, integrating Primary Care Mental Health and a sub-specialty MH outpatient Clinic. The outpatient services would include the newly built Intensive Outpatient Program which would incorporate and house a Wellness Center and a MH Intensive Case Management Program. Veterans could enter the new program site to engage in case management services, MST services, nutrition, yoga, smoking cessation, coffee/social club, a small fitness center, occasional family-style meals, housing resources and art therapy. Inpatient services would include a new on-site 12 bed in-patient/detox unit and a 20 bed Residential Rehabilitation Program (RRTP). And, create Intensive Outpatient Program (IOP) with a 20 bed lodging unit (this is not inpatient it's a place for the veterans to sleep while they complete their 2 week IOP.)

Service Line Subgroup Name: Mental Health Subgroup for Manchester
Brief Explanation – Option 3: Contract New Services within the Community

In this model, at the Manchester VA campus, current services (PCMHI and outpatient) would be maintained and right-sized to meet future workload demand. For MH services that are not currently offered at Manchester VA, the Medical Center would purchase services and space in the community.

Errera Like Center Breakdown of Square Footage

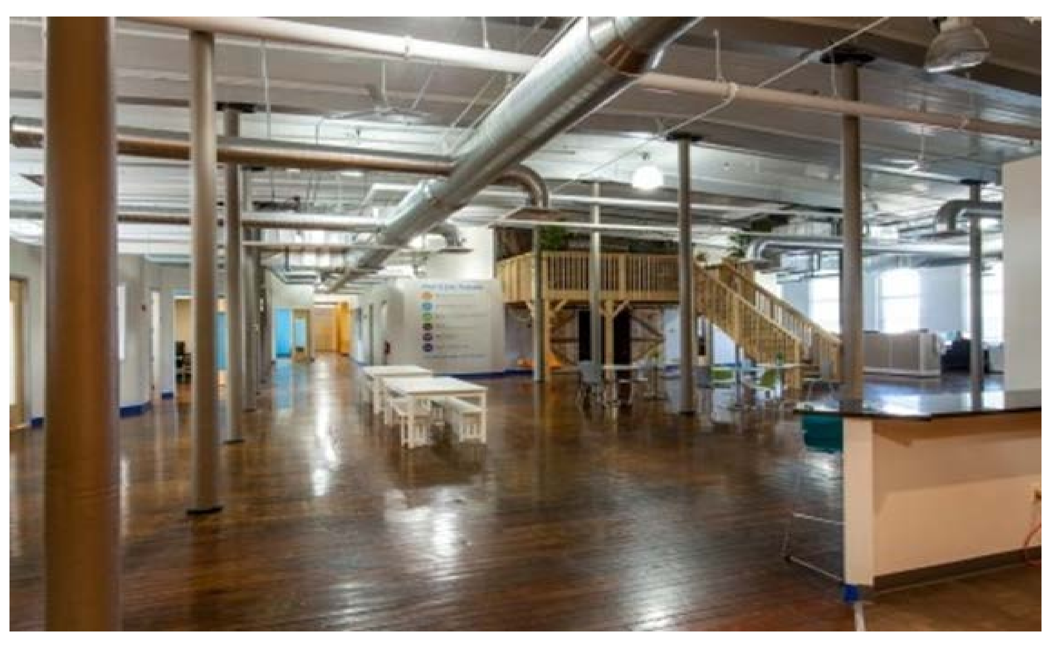
	SF	Number of Rooms	Total Square Footage	Cost of Square Footage	Total Cost
Intrigrated Care	230	7	1610	$15	$24,150
Bathroom	70	7	490	$15	$7,350
Female/Ind Single Room	125	4	500	$15	$7,500
Bathroom	70	4	280	$15	$4,200
Kitchen and Training area	675	1	675	$15	$10,125
Bariatric Bathroom	85	8	680	$15	$10,200
Office space	120	7	840	$15	$12,600
Family room	120	1	120	$15	$1,800
Intake Exam room	120	2	240	$15	$3,600
Consultation	120	1	120	$15	$1,800
Day Room/wellness center	675	1	675	$15	$10,125
Group Room	225	4	900	$15	$13,500
Nourishment room	70	1	70	$15	$1,050
Patient Laundry room	90	1	90	$15	$1,350
Private Toilets	60	2	120	$15	$1,800
Dining Hall	360	1	360	$15	$5,400
Interview Room	120	2	240	$15	$3,600
Toilet Staff	80	1	80	$15	$1,200
Clean Linen Room	60	1	60	$15	$900
Soiled Linen room	60	1	60	$15	$900
Clean Utility Room	80	1	80	$15	$1,200
Crash Cart closet	20	1	20	$15	$300
Recycyeing Room	80	1	80	$15	$1,200
Dictation Room	100	1	100	$15	$1,500
Rectption room	160	1	160	$15	$2,400
Staff Office Space	56	7	392	$15	$5,880
Team Room	240	1	240	$15	$3,600
Resident Trainin Room	300	1	300	$15	$4,500
Med Room	80	1	80	$15	$1,200
Telecommunication	120	1	120	$15	$1,800
Wheel chair/Stretcher	70	1	70	$15	$1,050

House keeping	60	1	60	$15	$900
Oncall Room	80	1	80	$15	$1,200
Toilet/shower Oncall	80	1	80	$15	$1,200
	5061		**10072**	$15	**$151,080**

150 Dow St. Manchester, NH 03101
Office Property For Lease

Rental Rate	$10.00 - $15.00 /SF/Yr	Rentable Building Area	401,802 SF
Min. Divisible	2,500 SF	Year Built	1899
Property Type	Flex	Cross Streets	Commercial St

Two miles from VA Medical Center



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Service Line Subgroup Name: GEC Service Line Subgroup
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: **Expand Community Living Center beds from 41 to 46**	4	5	3	4	3	4	5
Option 2: **Home Based Primary Care / Home Care Expansion to provide services for all Veterans in New Hampshire. Expansions to cover Wolfeboro, Plymouth, Peterborough and gaps within New Hampshire.**	5	5	5	5	4	5	5
Option 3: **Implement Social Work Case Management Model for medically complex vulnerable veterans**	5	5	5	5	4	5	5
Option 4: **Implement GERI MHICM- enhance home care services for Veterans with mental health issues**	5	4	5	5	4	5	5
Option 5: **Expansion of Care in the Community to Support Veterans in the Home Environment and Facility Based Services**	4	5	4	3	4	4	4
Option 6: **Create reservation Center for Respite for streamlined, Veteran centric service**	5	4	4	3	5	4	2
Option 7: **Establish a satellite Senior Center, Wellness Center or Errera Center for New Hampshire Veterans**	5	5	3	5	4	4	4

Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation – Option 1: Community Living Center Expansion from 41 Beds to 46 Beds

The VISN GEC Sub-Taskforce recommends expansion of the Community Living Center (CLC) from 41 Beds to 46 beds based on the Milliman Long Term Care Projection Model. Long Term Care options are limited based on a State Law which limits Community Nursing Home Long Stay Beds and due to staffing concerns reduction of beds at the Tilton State Veteran Home. Manchester Veterans Administration Medical Center contracts/provider Agreements with Community Nursing Homes fluctuates due to quality of care at the Community Nursing Homes. Community Living Centers continue to care for challenging Veterans, whom the community is unwilling to accept. This is feasible due to existing infrastructure on first floor of the main hospital building. This change would enable access to outside common areas and access to solarium for recreational and social activities separate from the dining area.

Note CLC Beds in 2016 is 41 beds vs. 39 beds listed. Table below is based on Bed Days of Care vs. Actual Beds for the projection model.

Other Subacute Beds by Fiscal Year (Fiscal Year) on columns; and Facility (Parent Facility) and Planning Categories (Planning Categories) on rows		FY2016 Modeled		FY2026 Modeled	
		In-House (see notes on data limitations)	Community (see notes on data limitations)	In-House (see notes on data limitations)	Community (see notes on data limitations)
(1V01) (608) M	LTSS - Community Living Center (Long) (Days)	25		29	
	LTSS - Community Living Center (Short) (Days)	14		17	
	LTSS - Community Nursing Home (Long) (Days)		40		61
	LTSS - Community Nursing Home (Short) (Days)		7		10
	Subtotal	39	47	46	71
	FY Total	86		117	

The taskforce also recommends the following functional changes to the Community Living Center:

- Bed Capacity per room (limit 2 beds per room, 1 bed per room is optimal)
- Community Living Center relocated to the ground floor
- Access to gated outside common area
- Dedicated space for social and recreational activities separate from the dining area

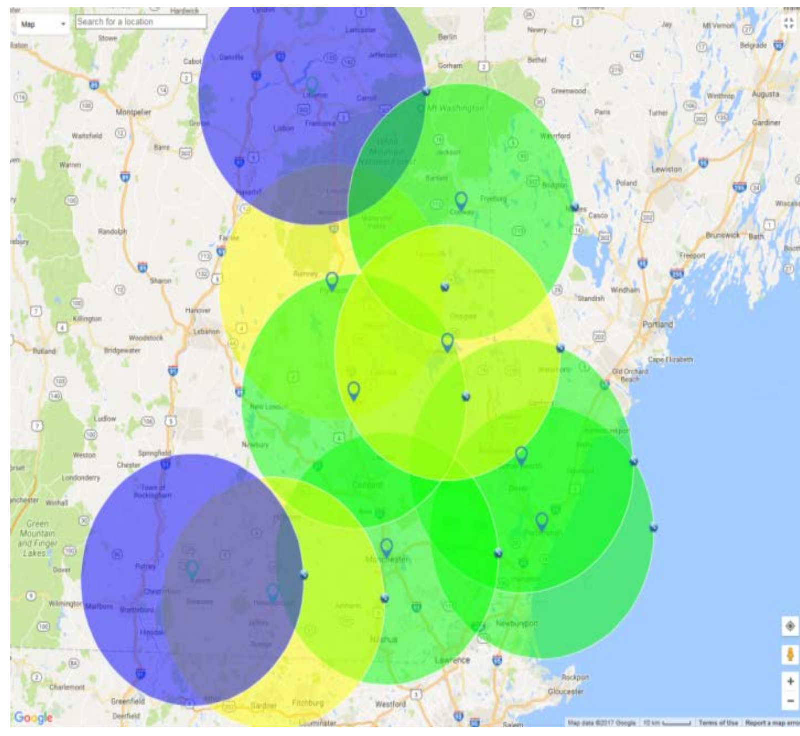
Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation – Option 2: Expand Home Based Primary Care / Home Care to provide services for all Veterans in New Hampshire. Proposed expansions would cover Wolfeboro, Plymouth, Peterborough and gaps within New Hampshire.

Home Based Primary Care (HBPC) PACT cares for Veterans with multiple chronic illness, who are at high risk for poor outcomes such as end of life and frequent hospital admissions. The model is a comprehensive interdisciplinary team providing primary care in the homes of Veterans. Home Based Primary Care reduces Hospitalization, Length of Stay and Emergency Room visits.

HBPC increases primary care access to ensure no Veteran is left behind. HBPC is in line with the Secretary's "Moon Shot- Choose Home" and may incorporate Telehealth to increase access. The New Hampshire HBPC catchment area is served by both White River Junction HBPC and Manchester HBPC.

Below is the current coverage for HBPC by Manchester and White River Junction VA.

Green- current HBPC catchment area
Purple –White River Junction catchment area
Yellow- proposed



HBPC PATIENT LIST FY 17	
Patient Info UPDATED: 9/25/17	
HBPC PROGRAM =	251
Total # of pts MANCHESTER =	93
Somersworth/Portsmouth total # of pts =	86
Tilton total # of pts =	48
Conway total # of pts =	24

Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation – Option 3: Implement Strong Social Work Case Management Model for Medically Complex Vulnerable Veterans
Current Staffing and Veteran Capacity:

Proposed Model: The case management needs of high risk, high cost geriatric patients need to be addressed in multiple areas, as the patient flows through the various spheres of care. Patients and their caregivers often wait until placement or the need for additional care becomes a crisis and they enter through their primary care provider, either VA or Community. Given the VA's current structure it makes the most sense to provide case management in the service areas where the patient is receiving care. This model builds upon current staffing and adds specialty case management at end of life, Non-VA Community Care and increases PACT Social Work. White River Junction Social Work Chief and Manchester Social Work Chief collaborated on the final product. Descriptions are below.

- **Community Care Social Workers**: (3 FTEE) Provide case management of psychosocial needs of geriatric Veterans receiving non-VA care in the community; assure maximum VA benefits; provide inter-agency/facility consultation and support with community providers, home visits to assist with long-term care planning and evaluation; assure Vendor quality of care and Veteran/caregiver satisfaction **Estimated Capacity: 300 - 400 Veterans**

- **PACT Social Work** (7 FTEE additional staff) provide the front-line rapid involvement and case management of the psychosocial needs of Veterans, most of whom are over the age of 65. Long-term care planning; crisis care, engagement of non-VA community care service options, Life sustaining –goals of care conversations would be priorities with this case load. Prioritize with the PACT team the care and management of Veterans with CAN scores over 90**. Estimated Capacity** of a total of 12 PACT Social Workers is **800-1200** Veterans

Service Line Subgroup Name: GEC Service Line Subgroup

Brief Explanation – Option 4:
Implement GERI MHICM- enhance home care services for Veterans with mental health issues

During the listening sessions in Manchester, clinicians in home care voiced concerns regarding the increase and complexity of mental health issues within the population served. Mental Health Intensive Case Management (MHICM) is a successful model within the VA which provides Assertive Community Treatment (ACT), a well-known, evidence based treatment approach for providing intensive case management to persons with Serous Mental Illness.

The Taskforce is proposing a MHICM Program (in collaboration with Mental Health) or a specialized Geriatric MHICM Program (in collaboration with Mental Health) for Veterans to receive care in the home environment. This recommendation is in line with the Secretary's "Moon Shot- Choose Home".

See table below for Percent of Mental Health Illness Diagnosis per HBPC/Home Care Uniques FY 2016:

7%	Schizophrenic
8%	Bi-Polar
45%	Anxiety
54%	Depression
7%	Schizophrenic

Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation - Option 5 - Expansion of Care in the Community to Support Veterans in the Home Environment and Facility Based Services

Expansion of Care in the Community Programs (Non-Institutional Care) maintain Veterans independence in the home vs. facility-based care and supports the “Moon Shot- Choose Home”. Manchester would need to increase market share in Non Institutional Care services in order to meet the National market penetration rate. This can be accomplished utilizing a mix of services below which meets overall Veteran’s needs.

Purchased Care (HM/HHA, Home Respite, Contract Adult Day Health Care, Veterans Directed HCBS) market share penetration.

National 5.9%   Manchester 4.5%

Adult Day Health: (Manchester_ 5 Contracts) A nursing directed health care program that ensures therapeutic orientation and assistance with personal care. This program is for Veterans who need skilled services, case management and assistance with activities of daily living.

Homemaker/ Home Health Aid: A homemaker/ home health aide is a trained person who can come into the Veteran’s home and assist with activities of daily living, including personal care and housekeeping support.

Home Based Primary Care (HBPC): Home based primary care are health care services provided to Veterans in their home. A VA physician supervises the health care team who provides the services. HBPC is for Veterans who have complex health care needs for whom routine clinic care is not effective. The program is for Veterans who need skilled services, case management and help with activities of daily living.

Respite Care: All Veterans are eligible for inpatient and community respite care dependent upon availability. Respite can be provided in home care, Adult Day and inpatient settings. The sum of all respite cannot exceed 30 days per calendar year. All forms of respite must be requested through the Veteran’s VA primary care provider.

Hospice Care: Veterans facing terminal conditions, with less than 6 months to live, are eligible to receive hospice care. Hospice care can be provided in both outpatient and inpatient settings. All Veterans are eligible for inpatient hospice care, provided they meet clinical need for service.

Contracted Nursing Homes: (Manchester - 7 Contracts**)** VA contracts with nursing homes within the community to provide skilled care to eligible Veterans. Veterans are referred to contracted nursing homes for various needs such as hospice care, rehabilitation, long term care and respite.

Veteran Directed Home and Community Based Services (VD-HCBS): This program provides Veterans with a flexible budget, and the means to hire private personal aides to assist with activities of daily living within the home. The budget is determined by a collaborative assessment involving the Veteran, the VD-HCBS Coordinator and Aging Disability and Resource Center staff.

Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation – Option 6: Create reservation Center for Respite for streamlined, Veteran and Caregiver Centric Care

Veteran/Caregiver Dyads currently utilize a system with layers of communication to schedule Veterans for Respite Care. Communication may be disrupted and/or Caregivers may not receive confirmation of approved respite in a timely fashion.

The GEC Taskforce is recommending an option, which would involve new technology/platform to develop a reservation system for respite. This would be comparable to an online booking for hotels and along the same philosophy of the new VA app in which a Veteran may schedule an appointment.

This tool, if recommended by the Taskforce, may need to be developed nationally with identification of pilot sites.

Service Line Subgroup Name: GEC Service Line Subgroup
Brief Explanation - Option 7 - Establish a satellite Senior Center, Wellness Center or Errera Center for New Hampshire Veterans

During listening sessions, it was identified that Senior Centers within the area were often at capacity and Veterans did not have an alternative to meet in a centralized area to socialize, participate in exercise/move like programs, group activities and classes.

The GEC Taskforce recommends a center or common area in which Veterans may attend organized groups or events. This recommendation may be collaboration with Mental Health utilizing the framework of the Errera Center

See brochure below:

CONTACT INFORMATION

VA Connecticut Healthcare System's
Errera Community Care Center
114-152 Boston Post Road
West Haven, CT 06516
Hours of Operation: Doors are open 7:30-4 pm

VA Connecticut Healthcare System's
Errera North @ Newington Campus
555 Willard Avenue
Newington, CT 06111
Hours: please see program page for details

TRANSPORTATION INFORMATION

Yale/VA Shuttle: Operates from 6am-6 pm M-F. Shuttle is scheduled to run every 20-30 minutes.

DAV Transportation: This is a volunteer run transportation service. Please call 203-932-5711 ext. 2612 to discuss eligibility and assistance.

VA Shuttle Bus Schedule (West Haven, Newington and Rocky Hill). Operates M-F only and Veterans must have a valid ID and a scheduled appointment. Please contact VA Transportation @ 203-932-5711 x3182 for specific schedule info.

Updated Jan/2017

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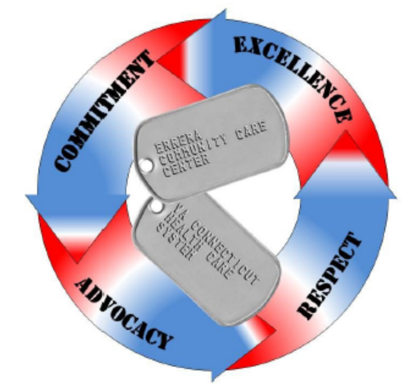
Welcome to:
VA Connecticut Healthcare System's
Errera Community Care Center



Your Guide to
The Programs and Services Available and
Located at Errera CCC & Errera North @ Newington

Please contact programs directly for the most up to date information.

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Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: Expand SPR Services and develop a Whole Health Community Center, including a Regional Amputation Center	5	5	3	4	5	5	4
Option 2: Expand space and staffing for current services to meet future demand at Manchester VAMC	3	3	3	4	5	5	5
Option 3: Expand SPR Services via Additional Clinics and Telehealth Opportunities at CBOCs	4	4	3	4	5	5	3
Option 4: Whole Health Community Center	5	5	3	4	5	5	3
Option 5: Expand SPR services at Manchester VAMC and New Hampshire CBOCs, including telehealth	4	4	3	4	5	5	3

*Please note that the SPRS Subgroup collaborated with the Geriatrics and Mental Health subgroups prior to finalizing this report.

Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Preferred Option: Expand SPR services and develop a Whole Health Community Center, including a Regional Amputation Center

This option aims to increase the provision of rehab services at the New Hampshire CBOCs, specifically the CBOCs located in Tilton and along the Seacoast due to the density of Eligible Veterans residing in these areas. Due to the significant space limitations in the Audiology Clinic at Manchester, as well as the projected increase in demand, offering this service at the CBOCs is recommended.

Additionally, this focuses on providing a Whole Health Community Center at Manchester VAMC. This center should be developed in conjunction with multiple other services lines, to provide an innovative approach to healthcare and wellness care (MH, GEC, Primary care, Pain). The Whole Health Community Center amenities would include: half Olympic-size heated pool; group/multipurpose rooms (note: these could also be used for conference rooms); Veteran common space; gymnasium; locker rooms; computer lab, including My Healthy Vet Portal access; space for a teaching kitchen; and storage. The Whole Health Community Center should also house a state-of –the-art Regional Amputation Center to provide comprehensive, holistic care. (Please use the following reference: https://www.prosthetics.va.gov/asoc/Regional_Amputation_Centers.asp). The center would be run by a Manchester Staff Prosthetist, and utilize significant telehealth to support other VA facilities. A prosthetics lab on site would be included for limb fabrication and fittings. Manchester VAMC is already working closely with the creators of the Luke Arm, and the creation of this amputation center presents the opportunity to expand upon this relationship and provide enhanced amputation services in VISN 1. Recent meetings with Senator Jeanne Shaheen showcased the successes the team has had thus far with cutting edge "pattern recognition" technology – the patient is likely to be the first upper extremity amputee in the country to operate prostheses with this technology bilaterally. The development of this center will create a greater potential for the VA to apply for research grants, as well as promote enhanced collaboration with academic affiliates. The already established partnerships available in the Manchester community make this location ideal for ***continued innovation*** (i.e., DEKA, Mobius Bionics, Next Step Prosthetics). The center would welcome all VISN 1 Veterans, who would be authorized to reside in the on-site rehab lodge for portions of their fittings/trainings.

- New Services
  - Adaptive Sports Clinic (Outpatient Recreation Therapy): requires recruitment of clinical staff and administrative support; purchase of equipment; creation and/or allocation of space
  - Amputee Clinic: recruitment of prosthetist for Manchester (note: Manchester SPRS staff currently rely upon Boston Hub for consult)
  - Blind Rehab: implementation of this service in order to provide more timely care to Veterans
  - Interdisciplinary Amyotrophic Lateral Sclerosis (ALS): provided by SCI/D team
- Expansion of Services
  - Increase provision of Rehab services to better meet the needs of Veterans in the evenings and on weekends
  - Increase staff recruitment and administrative support
  - The finalized space gap analysis will allow the SPRS sub-group to better determine how much space is needed to expand existing services
  - Amputee Clinic to develop into a Regional Amputation Center (see above)
- Telehealth Growth Opportunities
  - Consider general hearing exams. Nationally, the #1 clinic for telehealth is Audiology (Manchester does not currently offer this)
  - One deep positions that might require a physiatrist or prosthetist for example, can be covered with staffing from other sites via telehealth (TBI 2nd level assessments, amputee clinic to improve access at both sites, as examples)
  - Provision of in-home telehealth to ensure continued treatment
- Collaboration with White River Junction VAMC
  - Maintain current relationship with WRJ (i.e., WRJ patients who utilize Community Living Center (CLC) at Manchester will continue to receive care)
  - CARF Program
  - Regional amputee center (RAC) to support WRJVA and other sites in VISN 1 + Northeast
- Partnerships with External Partners
  - Recreation is enhanced through provider agreement partnership with Northeast Passage
- Whole Health Community Center
  - Independent to semi-independent Veteran-driven concept that offers varying types of programming aimed at overall health and wellness. Veterans can select between land-based activities (i.e., gymnasium, group exercise classrooms, etc.) and water-based activities (i.e., pool activities)
  - The second floor of the Wellness Center could be dedicated to the Residential Rehab Lodge that will serve as "dorm-like" housing accompanied by the provision of meals
  - Regional Amputee Center as part of this new build. Requires space, prosthetics lab, and staffing. (see above for details)
- Residential Rehab Lodge co-utilized by Pain and Mental Health
  - Lodging space within the Whole Health Community Center to support intensive outpatient programs and the Regional Amputation Center.

Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Option 2: Expand space and staffing for current services to meet future demand at Manchester VAMC

This option addresses space gaps and staffing shortages that will reduce the VAMC's ability to provide adequate services to all New Hampshire Veterans by 2025. Manchester SPRS staff will continue to refer patients to the community for some services when believed to be more beneficial for the Veteran. The disciplines most likely to utilize community care as an adjunct to address the demand include: acupuncture, chiropractor, and physical therapy.

- New Services
  - Adaptive Sports Clinic (Outpatient Recreation Therapy): requires recruitment of clinical staff and administrative support; purchase of equipment; creation and/or allocation of space
  - Amputee Clinic: recruitment of prosthetist for Manchester (note: Manchester SPRS staff currently rely upon Boston Hub for consult)
  - Blind Rehab: implementation of this service in order to provide more timely care to Veterans
  - Interdisciplinary Amyotrophic Lateral Sclerosis (ALS): provided by SCI/D team
- Expansion of services
  - Increase provision of Rehab services to better meet the needs of Veterans in the evenings and on weekends
  - Increase staff recruitment and administrative support to allow clinicians to work at highest licensure potential
  - The finalized space gap analysis will allow the SPRS sub-group to better determine how much space is needed to expand existing services
- Telehealth Growth Opportunities
  - Consider general hearing exams. Nationally, the #1 clinic for telehealth is Audiology (Manchester does not currently offer this)
  - One deep positions that might require a physiatrist or prosthetist for example, can be covered with staffing from other sites via telehealth (TBI 2nd level assessments, amputee clinic to improve access at both sites, as examples)
- Collaboration with White River Junction VAMC
  - Maintain current relationship with WRJ (i.e., WRJ patients who utilize Community Living Center (CLC) at Manchester will continue to receive care)
  - Expand access into one deep position clinics with telehealth technology btw WRJVA & Manchester (amputee clinic, TBI)
- Partnerships with External Partners
  - Recreation is enhanced through provider agreement partnership with Northeast Passage

Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Option 3: Expand SPR Services via Additional Clinics and Telehealth Opportunities at Community Based Outpatient Clinics (CBOCs)
Option 3 aims to increase the provision of rehab services at the New Hampshire CBOCs, specifically the CBOCs located in Tilton and along the Seacoast due to the density of Eligible Veterans residing in these areas., The patients utilizing the following three services often rely on community care due to the frequency of visits and convenience to their home: Acupuncture, Chiropractor, and Physical Therapy. In addition, due to the significant space limitations in the Audiology Clinic at Manchester, as well as the projected increase in demand, offering this service at the CBOCs is recommended.

- Expansion of Services at Tilton CBOC
    - Add Audiology Clinic
    - Recruit chiropractor for acupuncture and chiropractor
    - Recruit physical therapist(s)
- Expansion of Services in one of the CBOCs located on the Seacoast
    - Add Audiology Clinic
    - Recruit chiropractor for acupuncture and chiropractor
    - Recruit physical therapist(s)
- Expansion of Services in North Conway CBOC
    - Add Audiology Clinic
- Collaboration with White River Junction
    - Expand WRJ CBOCs – Keene and Littleton
    - Physically expand PT and Audiology
    - Develop/allocate for infrequent disciplines
    - Recruit Assistive Technology Specialist to support both WRJVA and Manchester's DME needs
- Integration of Telehealth
    - Connect all of the CBOCs with the medical facility
- Innovative Idea
    - One medical record for both healthcare systems (additional note: Merge interfacility consult onto facility consult page)

Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Option 4: Whole Health Community Center

Option 4 focuses on providing a Whole Health Community Center at Manchester VAMC. This center should be developed in conjunction with multiple other services lines, to provide an innovative approach to healthcare and wellness care (MH, GEC, Primary Care, and Pain). The Whole Health Community Center amenities would include: half Olympic-size heated pool; group/multipurpose rooms (note: these could also be used for conference rooms); Veteran common space; gymnasium; locker rooms; computer lab, including My Healthy Vet Portal access; space for a teaching kitchen; and storage.

- ❖ Whole Health Concept (8 domains of WH)
  - Mental Health
  - Recreation & leisure
- ❖ Wellness Center
  - Independent to semi-independent Veteran-driven concept that offers varying types of programming aimed at overall health and wellness. Veterans can select between land-based activities (i.e., gymnasium, group exercise classrooms, etc.) and water-based activities (i.e., pool activities). Classes and support groups run by various disciplines from many service lines to promote wellness.
  - The second floor of the Wellness Center could be dedicated to the Residential Rehab Lodge that will serve as “dorm-like” housing accompanied by the provision of meals
- ❖ Residential Rehab Lodge co-utilized by Pain and Mental Health
  - Lodging space within the Wellness Center to support intensive outpatient programs
  - This area will serve for housing while Veterans are participating in intensive outpatient programs
- ❖ Integration of Telehealth
  - Provision of in-home telehealth to ensure continued treatment
- ❖ Collaboration with White River Junction
  - CARF program

Service Line Subgroup Name: Sensory and Physical Rehabilitation Services (SPRS)
Option 5: Expand SPR services at Manchester VAMC and at New Hampshire Community Based Outpatient Clinics (CBOCs), including Telehealth
This option addresses space gaps and staffing shortages that will reduce the VAMC's ability to provide adequate services to all New Hampshire Veterans by 2025. Manchester SPRS staff will continue to refer patients to the community for some services when believed to be more beneficial for the Veteran. The disciplines most likely to utilize community care as an adjunct to address the demand include: acupuncture, chiropractor, and physical therapy. This option aims to increase the provision of rehab services at the New Hampshire CBOCs, specifically the CBOCs located in Tilton and along the Seacoast due to the density of Eligible Veterans residing in these areas. In addition, adding Audiology Service to the CBOCs is recommended.

- New Services
    - Adaptive Sports Clinic (Outpatient Recreation Therapy): requires recruitment of clinical staff and administrative support; purchase of equipment; creation and/or allocation of space
    - Amputee Clinic: recruitment of prosthetist for Manchester (note: Manchester SPRS staff currently rely upon Boston Hub for consult)
    - Blind Rehab: implementation of this service in order to provide more timely care to Veterans
    - Interdisciplinary Amyotrophic Lateral Sclerosis (ALS): provided by SCI/D team
- Expansion of Services
    - Increase provision of Rehab services to better meet the needs of Veterans in the evenings and on weekends
    - Increase staff recruitment and administrative support
    - The finalized space gap analysis will allow the SPRS sub-group to better determine how much space is needed to expand existing services
- Telehealth Growth Opportunities
    - Consider general hearing exams. Nationally, the #1 clinic for telehealth is Audiology One deep positions that might require a physiatrist or prosthetist for example, can be covered with staffing from other sites via telehealth (TBI 2nd level assessments, amputee clinic to improve access at both sites *WRJVA & Manchester*, as examples)
    - Connect all of the CBOCs with the medical facility
- Collaboration with White River Junction VAMC
    - Maintain current relationship with WRJ (i.e., WRJ patients who utilize Community Living Center (CLC) at Manchester will continue to receive care)
- Partnerships with External Partners
    - Recreation is enhanced through provider agreement partnership with Northeast Passage
- Expansion of Services at Tilton CBOC
    - Add Audiology Clinic
    - Recruit chiropractor for acupuncture and chiropractor
    - Recruit physical therapist(s)
- Expansion of Services in one of the CBOCs located on the Seacoast:
    - Add Audiology Clinic
    - Recruit chiropractor for acupuncture and chiropractor
    - Recruit physical therapist(s)
- Expansion of Services in North Conway CBOC
    - Add Audiology Clinic
- Collaboration with White River Junction
    - Expand WRJ CBOCs – Keene and Littleton
    - Physically expand PT and Audiology
    - Develop/allocate for infrequent disciplines
- Innovative Idea
    - One medical record for both healthcare systems (additional note: Merge interfacility consult onto facility consult page)
- Assisted Technology Professional to be recruited to support both WRJVA and Manchester

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Service Line Subgroup Name: Primary Care
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: Clinic square footage and design for modern delivery of primary care	5	4	4	5	4	4	3
Option 2: Expanded Telehealth/Tele-Primary Care	5	5	4	4	5	5	4
Option 3: Enhanced pain & opiate management programs	5	5	3	5	4	5	5
Option 4: Veteran and Employee Wellness areas	5	4	5	4	3	3	2
Option 5: Ensure proper staffing per PACT Model to include expanded care team, SW, CPS, RD, PCMHI	5	4	5	4	4	4	4
Option 6: Enhanced access to Choice for Primary Care for rural and remote areas	5	4	3	4	4	4	4
Option 7: Combine Portsmouth and Somersworth CBOCs	5	5	3	4	4	3	4

5 = Strongly supports the Criteria
4 = Somewhat supports the Criteria
3 = Neutral towards the Criteria
2 = Somewhat opposes the Criteria
1 = Strongly opposes the criteria

Service Line Subgroup Name: Primary Care
Brief Explanation – Preferred Option:
Clinic square footage and design for modern delivery of primary care – Current clinic space and design is outdated and not supportive of current needs and functions. Space should be able to provide co-location for appropriate support services and access to technology for virtual care, health education and wellness. In addition, large rooms should be available for group education such as MOVE, Tobacco cessation, physical activity, shared medical appointments and other uses. PACT space design guidance should be followed.

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 2:
Expanded Telehealth/Tele-Primary Care use – Recommend expanding access to medical and surgical specialties, physical therapy, MOVE and smoking cessation and others via telemedicine. Would also recommend expanding use of tele-primary care to improve access to VA primary care services, coverage for smaller sites and broader coverage capability throughout the VISN. Lastly, developing technology so the virtual medical room concept can be spread where the team can hold "visits" with the patient virtually via video while they remain in their home. This will potentially broaden the reach of primary care to more rural areas as well.

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 3:
Enhanced pain & opiate management programs- Access to an integrative pain clinic with complementary and integrative health services: including physiatry, anesthesia, neurology, opioid tapering clinic with clinical pharmacy support, pain psychology, acupuncture, chiropractic care, massage therapy and aquatic therapy. Offer shared medical appointments for chronic pain, consider including Battlefield Acupuncture, incorporate access to yoga and tai chi. Some of these services could be in the community if available but should function fairly seamlessly and treatment plans developed by the interdisciplinary pain clinic.

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 4:
Veteran and Employee Wellness areas – Establish areas for employees to take a break, be refreshed- option to meditate and/or relax, exercise gym, access to health education for veterans and employees. Offer yoga, tai chi for both veterans and employees

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 5:
Ensure proper staffing per PACT Model to include expanded care team, SW, CPS, RD, PCMHI – Aim to establish adequate primary care supports such that there are 1 SW per 4000 uniques, 1 RD per 6000 uniques, 0.33 CPS per 1.0 FTEE provider and 0.33 PCMHI staff per 1.0 FTEE provider.

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 6:
Enhanced access to Choice for Primary Care for rural and remote areas – To ensure veterans in remote/rural areas where there is no CBOC or main facility within a reasonable distance, have access to routine primary care services.

Service Line Subgroup Name: Primary Care
Brief Explanation – Option 7:
Combine Somersworth and Portsmouth CBOCs – Combining two, similarly sized CBOCs in very close proximity will allow for expanded onsite services such as some high demand specialty services and Mental Health while also supporting an expanded tele-medicine access to care.

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Service Line Subgroup Name: Imaging (Radiology)
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: Right Size Staffing and Space	4	4	3	5	5	2	5
CBOC Imaging	5	3	3	5	5	2	3
Multispecialty Ambulatory Care Center	4	3	3	5	5	1	2
Med/Surg Inpatient (Full Service)	4	3	3	5	5	1	1

<u>Service Line Subgroup Name:</u> Right Size Staffing and Space
<u>Brief Explanation</u> – <u>Preferred Option</u>:
This option expands the current staff size and reallocates space to allow the Manchester Imaging department to adjust to current and future needs as well as expanding hours (nights/weekends) to allow for greater flexibility in patient scheduling. Under this options more advanced or critical services such as Interventional radiology IR) could be performed at partner facilities such as White River Junction or Boston. Partnerships for some services such as IR and Mammography could be formed with local community facilities.
PET/CT services could be offered through community and/or VA partners as well as on-site contract mobile services.

- Manchester and WRJ currently have an established process for sharing IR and PET services; however WRJ IR staff is currently at or near capacity. Additional staffing may be needed at WRJ to support a more robust referral program.
- WRJ stakeholders/subject matter experts feel that some basic image guided procedures could be offered at Manchester
- Manchester currently offers mammography services through several community partners, there is potential for more formal arrangements.
- Expansion of PET services may require additional Boston staffing to accommodate the remote reading of these complex exams

Service Line Subgroup Name: **Imaging (Radiology)**

Brief Explanation – Option 2: Community Based Outpatient Clinic (CBOC) Imaging

This option provides for limited imaging services at select CBOC's and can be performed as an augmentation to any of the options presented. This would allow for more patient centric care for the most common imaging exams (General Radiology and Ultrasound). Advanced Imaging (CT, MRI, etc.) would still be performed at the primary medical center or through community partnerships.

Because of the low volumes at CBOCs and the remote nature this options does present some issues with supervision and efficiency that can, with careful planning, be somewhat mitigated.

- The addition of imaging services at the CBOC could also include the WRJ run CBOC's that are physically in New Hampshire
- Since most CBOC's are leased space careful planning is needed to select and install equipment that requires minimal construction and may be easily relocated if needed.
- There is a potential for some advanced imaging to be offered via mobile services contracts. This however would require somewhat expensive construction and site suitability determination.

Service Line Subgroup Name: Imaging (Radiology)
Brief Explanation – Option 3: Multispecialty Ambulatory Care Center (MACC)
The "Right Size Option" may address the needs presented in supporting a MACC. Depending on the final design and hours of operation there may be a need for additional staff and equipment (space). This model does not lend to VA or community partnerships since the goal is to keep the patient(s) in-house under direct observation.

<u>Service Line Subgroup Name</u>: Imaging (Radiology)
<u>Brief Explanation – Option 4:</u> Med/Surg Inpatient (Full Service)
This option provides for 24/7/365 coverage for inpatient medical services. This would require a significant increase in staffing and space to include the provision for around the clock IR coverage. While one of the most patient centric options this would be very expensive and inefficient. This option also does not lend itself to VA or community partnerships due to the complexities of transporting these patients just for an imaging exam or procedure.

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Service Line Subgroup Name: Medicine Service Line
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option: Build a full service Med/Surg Hospital with Enhanced Endoscopy Capability. Full Service Emergency Room.	5	5	5	5	5	5	2
Option 2: Build a new facility on the site of a community partner with direct link to White River Junction.	5	5	5	5	5	5	5
Option 3: On-site Multispecialty clinic with Full Endoscopy capability; more advanced care delivered via Community Partnership (some VA providers working in non-VA setting in existing community space)	3	5	2	4	4	5	2
Option 4: On-site Multispecialty clinic with Full Endoscopy capability and outpatient surgery; more advanced care referred to Community Partners and provided by community clinicians (non-VA employees)	2	5	1	2	3	5	1
Option 5: Strong Boston VA-Manchester VA-White River Junction VA	5	5	3	5	5	5	5

Service Line Subgroup Name: Medicine Service Line
Brief Explanation- Preferred Option - Build a full service Med/Surg Hospital with Enhanced Endoscopy Capability. Full Service Emergency Room.

- Facility would provide intermediate surgery and medical services in a small inpatient (25-30 beds) footprint.
- Limited critical care services through a combination of on site and eICU would be available.
- Would suggest partnering with local hotels to develop Hoptel model.
    - A Hoptel is model by which a hospital and hotel are combined either physically or through the use of local community resources. This is to provide living areas for patients getting radiation therapy or intensive outpatient therapy.
- Full service emergency services could be accommodated in this model. Limited linkages with the community for complex surgical and medical procedures. eICU and Tele-Stroke services in ED
- Strategic alliances with local hospitals and VISN 1 (Boston) for complex care
- Augmented/Advanced use of tele-medicine and Video on Demand
- Dedicated CVT tele-medicine facilities
- In particular, develop a more formalized arrangement with the White River Junction VA:
    - Joint hiring of staff when advantageous
    - Sharing of staff between the two facilities when advantageous (i.e. RN's, ER, Medicine Subspecialty etc.)
    - Sharing of services between the two facilities when advantageous
    - Encourage a closer academic affiliation with Dartmouth Medical School through the current arrangement with WRJ (students, resident and fellow trainees with rotations at Manchester).
- Development of a robust transportation system running regularly between Manchester and WRJ.
    - Executive buses with bathrooms, TV, and WiFi recommended
    - Schedule buses to leave and depart roughly every 1.5 hours from each facility.
    - Buses could transport staff and/or patients

Service Line Subgroup Name: Medicine Service Line

Brief Explanation - Option 2 - Build a new facility on the site of a community partner with direct link to White River Junction.

- This sub option is essentially the same as 1a, however the facility would resemble more of a "hospital within a hospital model" - HIH. In this model the VA would renovate the Manchester facility to provide improved access to outpatient care and then lease new inpatient space from a "local" (preferably within 15 minutes of the current Manchester facility).
- In this option, the health care clinicians would be employed by the VA but there would likely be civilian staff as part of the contract (i.e. lab personnel, Xray techs, RRTs, etc.)

PROS	CONS
1. The public, Veterans and the majority of the Manchester specialty medical staff want a full service Veterans hospital for New Hampshire. 2. Recruitment and retention of needed medical and surgical subspecialties is enhanced by an atmosphere whereby the needed specialists may practice the full scope of their skill set. 3. A full service hospital enhances the possibility of a formal academic linkage which then promotes a culture of continuous improvement. 4. Veterans are cared for in a more vertical model with less interruptions and breaks in their care. 5. The VA has proven its ability to control medical costs much better than the community. When we send patients out in the community we run the risk of losing the economies of scale 6. A full service on site facility does not require considerations of local capacity/willingness to partner of local facilities.	1. Cost. While most options will result in significant capital expenditures, this option will most certainly result in the greatest. 2. Building a new facility does not alone result in improvement, culture change, or guarantee recruitment. 3. Significant logistical hurdles not the least of which will be the interim plan while a facility would be built. 4. Veterans would have to travel to Manchester for services located at the new facility. 5. Potentially duplicates services both in the VISN and the local community (although the latter is of lesser concern to the VA). *less of an issue with HIH* 6. National Surgery Office Infrastructure requirements can be daunting but if tele-medicine were embraced this could be mitigated. 7. Lack of academic residency program to support 24/7 inpatient operations

Service Line Subgroup Name: Medicine Service Line
Brief Explanation – Option 3: On-site Multispecialty clinic with Full Endoscopy capability; more advanced care delivered via Community Partnership (some VA providers working in non-VA setting in existing community space)

- Build a Multispecialty Clinic with Ambulatory Surgery on the Manchester site with integrated outpatient surgical services. Full service endoscopy (EGD, Colonoscopy, Bronchoscopy, Cystoscopy, ENT procedures, etc.) would be offered.
- A full service Urgent Care Center with strategic community alliance for after-hours service.
- Strategic alliances with local hospitals and VISN 1 partners (WRJ, Boston VA) for inpatient admissions, complex surgery, intensive care (non-VA space + VA providers).
- Staffed by VA physicians (e.g. hospitalists, surgeons and selected subspecialties) and strategic coverage by fee/contract inpatient consultant providers.
- Case management would be provided by onsite VA staff
- As noted in option 1 – strong relationship with the White River Junction VA to minimize loss of service to the community or the Choice program.

PROS	CONS
1. Requires less capital expenditures and likely less regulatory hurdles. 2. Provides for the majority of what the local veteran population and public desire. 3. Would be a good model for the VA to potentially under-utilized services in the community. 4. Would embrace a model of veterans receiving primary care at their local CBOC, the more advanced services at this enhanced Manchester site and then more complex care in the community or Boston VA. 5. Still leads to a new facility that allows subspecialists to practice nearly (but not completely) to the full scope of their specialty which aids with recruitment and retention - ability work at the community facility might get some over that hurdle. 6. Easier to implement enhanced ambulatory Manchester services without a full academic affiliation/residency program in place.	1. Local patients still need to travel to other hospitals for complex procedures and simple admissions. The potential for fractured care rises significantly. 2. Permanently limits the growth ability of Manchester. 3. While it may allow for subspecialists to practice mostly to the full extent of their scope it likely will be considered a negative for some in recruitment. 4. Limits potential new academic partnership without inpatient and research facilities. 5. Travel by VA clinicians and staff to the non-VA facility could result in significant inefficiency. 6. Care rendered at the partnered facilities would not be captured by provider productivity databases- ? on how this would affect VA Productivity numbers. 7. VA Clinicians would need a NH license and be privileged at multiple community facilities. 8. Overall a less flexible option. 9. There is no guarantee that community partners want to partner or have capacity to help the VA in a structure that works for the VA.

Service Line Subgroup Name: Medicine Service Line
Brief Explanation – Option 4: On-site Multispecialty clinic with Full Endoscopy capability and outpatient surgery; more advanced care referred to Community Partners and provided by community clinicians (non-VA employees)

- Build a Multispecialty Clinic with Ambulatory Surgery on the Manchester site with integrated outpatient surgical services. Full service endoscopy (EDG, Colonoscopy, Bronchoscopy, cystoscopy, ENT procedures, etc.) would be offered.
- A full service Urgent Care Center with strategic community alliance for after-hours service.
- While Manchester would be staffed by VA employees, the employees at the partnered complex/inpatient facilities would be community based (non-VA space + non-VA providers).
- Case management would be provided by onsite VA staff
- As noted in option 1, we would develop same strong relationship with the White River Junction VA and refer to Boston when appropriate.

PROS	CONS
1. Requires less capital expenditures and likely less regulatory hurdles. 2. Provides for the majority of what the local veteran population and public desire. 3. Would be a good model for the VA to potentially access under-utilized service in the community. 4. Would embrace a model of veterans receiving primary care at their local CBOC, the more advanced services at this enhanced Manchester site and then more complex care in the community. 5. Solves some of the efficiency issues seen with Option #2a. 6. Easier to implement enhanced ambulatory Manchester services without a full academic affiliation/residency program in place.	1. Local patients still need to travel to other hospitals for complex procedures and simple admissions. The potential for fractured care rises significantly. 2. Permanently limits the growth ability of Manchester. 3. While it may allow for subspecialists to practice somewhat to the full extent of their scope it likely will be considered a negative for some in recruitment given that more advanced clinical work is sent out. 4. Limits potential new academic partnership without inpatient and research facilities. 5. While local staffing expenditures would be lower, Community Care expenses would be significantly elevated. 6. VA would be less able to compensate for cost structures of the community and this would likely in the long term be a costly solution. 7. There is no guarantee that community partners want to partner or have capacity to help the VA in a structure that works for the VA.

Service Line Subgroup Name: Medicine Service Line
Brief Explanation – Option 5: Strong Boston VA-Manchester VA-White River Junction VA: We would create a regional partnership between the Boston VA, Manchester VA, and the White River Junction VA. While this to some extent already exists, we would go beyond the normal loose partnerships we have to create a strong and tightly bound entity.

- The VA Boston would be the primary site for tertiary care services
- The WRJ VA would be the primary site for basic inpatient and critical care services
- More formalized arrangement to share trainees between the WRJ and Manchester Facilities
- The existing facilities at the Manchester facility would be analyzed for complete renovation into a multispecialty center that provided ambulatory surgery, basic and advanced GI and pulmonary endoscopy, the full range of imaging services (PET, MRI, CT, nuclear). 24/7/365 urgent care with onsite imaging and lab.
- Strategic partnerships with community facilities for urgent/emergent cases but otherwise every effort would be made to capture veterans at one of the three facilities.
- The strategic partnership would allow for joint hiring of clinical staff between facilities and promote the strengths and current investments of the WRJ and Boston VA facilities.
    - Based on market data it may prove useful to see if increased workload may necessitate some strategic resource expansion at the Boston and WRJ VA facilities as well.
- A robust transportation system (as noted above) would be absolutely required:
    - An emphasis on customer service using executive buses (might be able to get away with an 18-25 passenger size) with bathrooms, WiFi and TV as well as undercarriage storage (to carry mail, supplies, equipment, and patient items such as wheelchairs and scooters). This would be used to provide bidirectional service between the WRJ and Manchester facilities.
        - Would suggest a time table that allows for buses to leave each facility around 0615 for arrival at 0730 and with the last buses leaving the facilities at 1615 for arrival at 1745.
        - Family members could also use the buses to see their loved ones and accompany them to appointments.
    - Travel to Boston would also need to be drastically improved with more comfortable transportation and an 18-passenger mini-bus could be used and would be able to navigate the city of Boston better.
- **Veterans who have become "used" to using the Manchester community hospitals and health care would have to decide on using the VA system or the their own resources for access to the community as most if not all services could be provided in this system.**

PROS	CONS
1. Likely requires significantly less capital expenditures and less regulatory hurdles. 2. Provides for the all of what the local veteran population and public desire. 3. Would allow VISN 1 to fully utilize current capital investments. 4. Would embrace a model of veterans receiving primary care at their local CBOC, the more advanced services at this enhanced Manchester site and then more complex care within the VA system. 5. Improves VISN 1 efficiency by combining underutilized physical and human capital between stations. Extremely easy to implement. Almost a "just do it" as most of the facilities currently exist and other than the Manchester renovation, the augmented transport system is the only other major piece. 6. Veterans receive care within the VA 7. Could cut down on travel pay as the VA would be providing the travel. 8. Allows for subspecialists to get the "best of both worlds" by providing as much as possible at the Manchester site and the doing more advanced care at the WRJ and/or Boston sites. 9. Promotes staff integration and a collegial atmosphere. 10. Sharing of Grand Rounds and CME	1. Travel is still involved but this is not uncommon in rural areas and this case, the VA would be providing for this travel. 2. Permanently limits the growth ability of Manchester. 3. Limits potential new academic partnership without inpatient and research facilities. 4. The system of transportation would be complex and likely require its own department, and repair facilities. 5. Some veterans might not like the change of having to use the VA. This system would not work well if the VA still had to continue the same system of Choice in New Hampshire that it currently allows. 6. Some employees may find the travel a burden – although the VA would be providing this.

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Service Line Subgroup Name: Surgery
Options Grid

	Veteran-Centered Care	Potential to Foster Robust Partnerships and Relationships	Employee Empowerment	Preserving & Fulfilling the Mission of the VA	Timely Access to Appropriate Evidence-Based Care	High Value Use of Resources	Feasibility
Preferred Option/ Advanced ASC @ Manchester with inpatient partnership (VA in non-VA)	4	4	4	4	4	3	3
Option 2: Advanced ASC @ Manchester with inpatient partnership (VA in VA lease)	4	4	4	4	4	3	3
Option 3: Intermediate Full Service Hospital	3	2	3	3	3	1	1
Option 4: Community partnership for surgery/inpatient	3	3	3	3	4	4	4
Option 5: Community lease for surgery/ inpatient	3	3	3	3	4	3	3

Service Line Subgroup Name: Surgery

Brief Explanation – Preferred Option: Build an Advanced ASC on site and set up community partnerships with VA surgeons using Non-VA space for inpatient services.

Rationale: The vast majority (87.5%) of the surgical procedure workload at Manchester is currently outpatient. Less than one third of the outpatient workload that could be accommodated on site is actually done on site. Projections show that outpatient workload is going to continue to increase by as much as 26%. Creating an advanced complexity outpatient facility would allow for accommodation of all the present and projected outpatient workload, and would allow specialties like Urology and Orthopedics to do more advanced procedures, which likely are under-represented in the current data. Feedback from Manchester providers in our listening sessions indicated that there is demand for more advanced outpatient surgery, which they have the skills and desire to perform.

Inpatient services: These would be provided by VA surgeons in community facilities. This would allow VA surgeons to operate at the top of their license and would provide clinical continuity for the patients close to home and would maintain control over quality. This would obviate the need to comply with VA infrastructure requirements that are necessary for any designated VA surgical space. (Option 2.)

Virtual Care: Opportunities exist for Tele-Podiatry, Tele-Retinal, Tele-Wound, Tele-Surgery (pre-op and post-op) and Tele-Pain management. Current limiting factors are equipment, staffing and space at CBOCs.

Leveraging innovative partnerships to provide “Foundational” surgical services: The following services are considered fundamental for overall healthcare and are in high demand at Manchester: Eye care (Ophthalmologic procedures and Optometry), Podiatry (expand to include advanced wound care and surgical Podiatry), ENT, Plastics (depending on what is covered by Ortho), GYN, Ortho (expand to include hand and fingers), Urology, Vascular and General Surgery. It would be expensive and would fragment care to send all of these services to the community. WRJ has demonstrated success with dual paymaster surgeon job sharing that could be adopted by Manchester. This would entail hiring shared part-time clinical FTE with community partners and/or WRJ. That would facilitate scaling staffing needs to VA demand and would allow qualified candidates to practice at the top of their license. This would improve employee satisfaction by allowing employees to retain skills by practicing a variety of complexity cases in the appropriate environment. This has the potential to allow Manchester providers to participate in WRJ academic affiliations.

The other options described, present either huge logistical issues or enormous financial commitments which are not justified by the current or projected workload numbers. Option 1 addresses the majority of the surgical needs within the VA structure and respects the veterans desire to have care close to home while still being fiscally responsible.

Service Line Subgroup Name: Surgery

Brief Explanation – Option 2: Build an Advanced ASC on site and set up community partnerships with VA staff using VA leased space.

Rationale: The vast majority (87.5%) of the surgical procedure workload at Manchester is currently outpatient. Less than one third of the outpatient workload that could be accommodated on site is actually done on site. Projections show that outpatient workload is going to continue to increase by as much as 26%. Creating an advanced complexity outpatient facility would allow for accommodation of all the present and projected outpatient workload, and would allow specialties like Urology and Orthopedics to do more advanced procedures, which likely are under-represented in the current data. Feedback from Manchester providers in our listening sessions indicated that there is demand for more advanced outpatient surgery, which they have the skills and desire to perform.

Inpatient services: These would be provided by VA surgeons in community facilities with physical spaced designated as VA space. This would allow VA surgeons to operate at the top of their license and would provide clinical continuity for the patients close to home and would maintain control over quality. This would allow the VA staff to participate in all aspects of the inpatient care and would facilitate data collection and record keeping. However, there could be a significant cost to ensure the required infrastructure was in place at the community provider setting to meet NSO directive for each level of surgical care provided (Basic, Intermediate or Advanced). Some of the services such as ICU could be provided by contract of the VA designated ward and will not therefore be subject to this directive. Credentialing providers at multiple community partner institutions maybe challenging. It would require a robust transportation system to effectively manage urgent/emergency/intra-op/post-op needs. Contracting costs and implementation are difficult to anticipate.

Virtual Care: Opportunities exist for Tele-Podiatry, Tele-Retinal, Tele-Wound, Tele-Surgery (pre-op and post-op) and Tele-Pain management. Current limiting factors are equipment, staffing and space at CBOCs.

Leveraging innovative partnerships to provide "Foundational" surgical services: The following services are considered fundamental for overall healthcare and are in high demand at Manchester: Eye care (Ophthalmologic procedures and Optometry), Podiatry (expand to include advanced wound care and surgical Podiatry), ENT, Plastics (depending on what is covered by Ortho), GYN, Ortho (expand to include hand and fingers), Urology, Vascular and General Surgery. It would be expensive and would fragment care to send all of these services to the community. WRJ has demonstrated success with dual paymaster surgeon job sharing that could be adopted by Manchester. This would entail hiring shared part-time clinical FTE with community partners and/or WRJ. That would facilitate scaling staffing needs to VA demand and would allow qualified candidates to practice at the top of their license. This would improve employee satisfaction by allowing employees to retain skills by practicing a variety of complexity cases in the appropriate environment. This has the potential to allow Manchester providers to participate in WRJ academic affiliations.

Service Line Subgroup Name: Surgery

Brief Explanation – Option 3: Build a small full service hospital (Intermediate Complexity) on the Manchester Campus.

Rationale: While both current and predicted workload numbers do NOT support the need for inpatient surgery beds, the Medicine service line believes that inpatient medical beds maybe indicated. If this is the case, inpatient beds should be supported by a functional surgical service. A combination of standard and intermediate complexity cases would meet the current surgical needs. Standard complexity designation alone would not justify maintaining a 24/7 inpatient OR presence, with an average of only 2.4 cases per week requiring admission. Even with adding the intermediate cases, the number of required inpatient admissions (6) would be very small and may not justify maintaining a 24/7 inpatient OR and ICU presence.

- Facility would provide **intermediate** surgery and medical services in a small inpatient (25-30 bed) footprint.
- Critical care services must be available and in compliance with NSO directives for intermediate care.
- Strategic alliances with local hospitals and VISN 1 (Boston) would still be necessary for complex surgery.
- Full service emergency services should be present in this model. Linkages with the community for complex emergency surgical procedures would be required.

Virtual Care: Opportunities exist for Tele-Podiatry, Tele-Retinal, Tele-Wound, Tele-Surgery (pre-op and post-op) and Tele-Pain management. Current limiting factors are equipment, staffing and space at CBOCs. The new facility could be built with technological support that facilitates virtual care.

Leveraging innovative partnerships to provide "Foundational" surgical services: The following services are considered fundamental for overall healthcare and are in high demand at Manchester: Eye care (Ophthalmologic procedures and Optometry), Podiatry (expand to include advanced wound care and surgical Podiatry), ENT, Plastics (depending on what is covered by Ortho), GYN, Ortho (expand to include hand and fingers), Urology, Vascular and General Surgery. With an inpatient intermediate facility, it is expected that the vast majority of these services would be provided in the VA. Therefore, partnering with the community would become less essential providing recruitment to VA positions in the various specialties could be accomplished. Partnering with WRJ however, for shared providers, has the potential to bring academic affiliations to the inpatient setting. Providing intermediate inpatient complexity services would improve employee satisfaction by allowing employees to retain skills by practicing a variety of complexity cases in the appropriate environment. This option is best for inpatient continuity of care.

However, the cost to support the infrastructure for intermediate surgery is enormous and would likely far exceed what the cost would be to provide this care in the community. The required resources from other services (Medicine, Radiology, Pathology, etc.) are enormous and also subject to recruitment issues, as we have seen at other intermediate sites across the country. There would be strategic alliances with local hospitals and VISN 1 (Boston, WRJ) for complex surgery.

Service Line Subgroup Name: Surgery

Brief Explanation – Option 4: Use community resources for both ambulatory surgery and inpatient surgery services with VA surgeons using Non-VA designated space. Repurpose existing Manchester OR space for outpatient clinics or other similar functions.

Rationale: The vast majority (87.5%) of the surgical procedure workload at Manchester is currently outpatient. Less than one third of the outpatient workload that could be accommodated on site is actually done on site. Projections show that outpatient workload is going to continue to increase by as much as 26%. Current operating room at Manchester is inadequate to provide all of the outpatient surgical services currently needed. Providing these services on-site at the VA would require the construction of an advanced complexity outpatient facility which would be time consuming and expensive. In the community, there is current available capacity for much of this outpatient procedural surgical need. VA providers may use the community space as any other provider to provide care to Veterans. This would make record keeping and continuity of care difficult, but would allow VA surgeons to provide the full spectrum of outpatient surgical care.

Inpatient services: These would be provided by VA surgeons in community facilities. (Option 1.)

Virtual Care: Opportunities exist for Tele-Podiatry, Tele-Retinal, Tele-Wound, Tele-Surgery (pre-op and post-op) and Tele-Pain management. Current limiting factors are equipment, staffing and space at CBOCs. Repurposing existing space on Manchester campus, would allow better access to virtual care, as current limitations are primarily space and equipment. This would be less costly than building an advanced ASC and would reach patients over a broader geographic area.

Leveraging innovative partnerships to provide "Foundational" surgical services: The following services are considered fundamental for overall healthcare and are in high demand at Manchester: Eye care (Ophthalmologic procedures and Optometry), Podiatry (expand to include advanced wound care and surgical Podiatry), ENT, Plastics (depending on what is covered by Ortho), GYN, Ortho (expand to include hand and fingers), Urology, Vascular and General Surgery. Repurposing the existing facility to expand outpatient non-procedural services, would facilitate access and maintain continuity of care.

For outpatient procedural services, using existing space in the community would be less costly and more timely than building a new Advanced ASC. The pros and cons are similar that seen for inpatient services.

Service Line Subgroup Name: Surgery

Brief Explanation – Option 5: Use leased community resources for both ambulatory surgery and inpatient surgery services with VA surgeons using VA designated space. Repurpose existing Manchester OR space for outpatient clinics or other similar functions.

Rationale: The vast majority (87.5%) of the surgical procedure workload at Manchester is currently outpatient. Less than one third of the outpatient workload that could be accommodated on site is actually done on site. Projections show that outpatient workload is going to continue to increase by as much as 26%. Current operating room at Manchester is inadequate to provide all of the outpatient surgical services currently needed. Providing these services on-site at the VA would require the construction of an advanced complexity outpatient facility which would be time consuming and expensive. In the community, there is current available capacity for much of this outpatient procedural surgical need. VA providers may use the community space as any other provider to provide care to Veterans.

Inpatient services: These would be provided by VA surgeons in community facilities with physical spaced designated as VA space. (Option 1.) This would allow VA surgeons to operate at the top of their license and would provide clinical continuity for the patients close to home and would maintain control over quality. This would allow the VA staff to participate in all aspects of the inpatient care and would facilitate data collection and record keeping. However, there could be a significant cost to ensure the required infrastructure was in place at the community provider setting to meet NSO directive for each level of surgical care provided (Basic, Intermediate or Advanced). Some of the services such as ICU could be provided by contract of the VA designated ward and will not therefore be subject to this directive. Credentialing providers at multiple community partner institutions maybe challenging

Virtual Care: Opportunities exist for Tele-Podiatry, Tele-Retinal, Tele-Wound, Tele-Surgery (pre-op and post-op) and Tele-Pain management. Current limiting factors are equipment, staffing and space at CBOCs. Repurposing existing space on Manchester campus, would allow better access to virtual care, as current limitations are primarily space and equipment. This would be less costly than building an advanced ASC and would reach patients over a broader geographic area.

Leveraging innovative partnerships to provide “Foundational” surgical services: The following services are considered fundamental for overall healthcare and are in high demand at Manchester: Eye care (Ophthalmologic procedures and Optometry), Podiatry (expand to include advanced wound care and surgical Podiatry), ENT, Plastics (depending on what is covered by Ortho), GYN, Ortho (expand to include hand and fingers), Urology, Vascular and General Surgery. Repurposing the existing facility to expand outpatient non-procedural services, would facilitate access and maintain continuity of care.

For outpatient procedural services, using existing space in the community would be less costly and more timely than building a new Advanced ASC. The pros and cons are similar that seen for inpatient services.