# 1 - Status Quo

	Manchester		orkload and ctions				
			Manchester	CI	TC*	Non-Manches	ter VA Data**
	Specialty	2015	2025	2015	\$		
			Clinic Stops			T	
	Amb: Nuclear Medicine	428	493	227	45%		
	Amb: Radiation Therapy			131	100%		
	Amb: Radiology	17569	19521	3412	16%		
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Outpatient (Ambulatory)							
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### **Option Summary**

References

Currently offering most demanded diagnostic services (No PET/CT). Staffing levels are adequate for workload if there are no absences due to leave or attrition. Reading capacity could be supplemented with in-VISN teleradiology. Increased workload will most likely result in poor performance measures and delays in access.

Resource Impacts	ource Impacts						
Space	Clinical Staff***	Equipment	Other				
None	None	None					

Pros
Zero cost impact to budget
Cons
Staffing not adaquete for full coverage. WHEN hours coverage will be by on-call and NVCC. Any changes in patient/exam volume will resultin in
decreased access and poor performance scores. Space and infrastructure

<sup>\*</sup>CITC = Care in the Community; All CITC Combined

<sup>\*\*</sup> Include VA Boston, Bedford VAMC and White River Junction VAMC

<sup>\*\*\*</sup>Clinical Staffing Implications Only

# 2- Right Size Space and Staffing

	Manchester		orkload and ctions				
			Manchester	CI	TC*	Non-Manches	ster VA Data**
	Specialty	2015	2025	2015	\$		
			Clinic Stops		1	1	ı
	Amb: Nuclear Medicine	428	493	227	45%		
	Amb: Radiation Therapy			131	100%		
	Amb: Radiology	17569	19521	3412	16%		
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	TC = Care in the Community, All CITC Combined			•	•		

Summary

References

Add space to close existing space gaps and expand for future workload projections. Offer the current range of services with on-call coverage for after-hours. Explore contract services for PET/CT utilizing existing mobile pad. Increase staffing to provide for better coverage and flexibility handling slight increases in workload.

Resource Impacts						
Space	Clinical Staff***	Equipment	Other			
Investment in infrastructure	Add 1 FTE Radiologist. Up to 7 FTE Technologists. 1.5 FTE MSA	Mobile PET/CT contract with Technologist	Mobile PET/CT contract = \$30,000/month			
Space improvements for safety and patient flow			~\$325,000/ rad fte			
			~\$80,000/tech fte			
			~\$35,000/MSA fte			

Pros
ncreased coverage for stable capacity and increase access. More adaptable program for increased workload.
Cons
ncreased cost and inefficiency

*CITC -	Care in	tha	Community:	ΛII	CITC	Combined

<sup>\*\*</sup> Include VA Boston, Bedford VAMC and White River Junction VAMC
\*\*\*Clinical Staffing Implications Only

# 3- Inpatient Med/Surg

	Manchester  Specialty	In-House N							
	Specialty	III HOUSE I	/lanchester	Cl	гс*	Non-Manches	ter VA Data**		
	Specialty	2015	2025	2015	\$				
-	Clinic Stops								
А	mb: Nuclear Medicine	428	493	227	45%				
А	mb: Radiation Therapy			131	100%				
А	mb: Radiology	17569	19521	3412	16%				
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\*\* Include VA Boston, Bedford VAMC and White River Junction VAMC

### **Option Summary**

If a full-service hospital is built: Offer current services with shift coverage (possible on-call third shift). Contract services for PET/CT utilizing existing mobile pad. Increase staffing to provide for better coverage and flexability handling slight increases in workload and redundent coverage for off shifts

. Depending on surgical accuity may need to add Interventional Radiology services and 24/7 on-site coverage.

Space	Clinical Staff***	Equipment	Other
Interventional Radiology (IR) ervices require 1355 sq ft (full IR	Add 1 FTE Radiologist (contract and/or staff interventional coverage 1.5 fte).	Mobile PET/CT contract with Technologist	290 IR procedures required to qualify for new service (500 prefered)
services)	Up to 21 FTE Technologists. 1.5 FTE MSA	Interventional (IR) room plus supplies	
	Will need nursing coverage for IR		~\$325,000/ rad fte
			~\$80,000/tech fte
			~\$35,000/MSA fte
			IR equipment = \$3,000,000
			Mobile PET/CT contract = \$30,000/month

### Pros

increased coverage for stable capacity and increased access. More adaptable program for increased workload. Shift coverage for critical inpatient needs. Staffed WHEN hours. Able to provide diagnostic and treatment services (IR)

#### Cons

Increased cost and inefficiency during lulls in workload demand. Large space and supply requirements for interventional services. Lack of academic affiliation (residency/fellowship) would make staffing a 24/7 service difficult to execute and maintain.

References

<sup>\*\*\*</sup>Clinical Staffing Implications Only

# 4- Multispecialty Ambulatory Care Center (ACC)

	Manchester	proje	orkload and ctions				
			Manchester		TC*	Non-Manches	ster VA Data**
	Specialty	2015	2025	2015	\$		
			Clinic Stops	l	Ι .	1	
	Amb: Nuclear Medicine	428	493	227	45%		
	Amb: Radiation Therapy			131	100%		
	Amb: Radiology	17569	19521	3412	16%		
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### **Option Summary**

If an Ambulatory Care/Surgery Center is built: Offer current services with shift coverage (possible on-call third shift). Contract services for PET/CT utilizing existing mobile pad. Increase staffing to provide for better coverage and flexibility handling slight increases in workload and redundant coverage for after-hour shifts. May not need IR if limited to outpatient surgery. If Urgent care service/ER is located near Imaging then additional equipment (Rad, CT, US) may not be needed. Additional portable radiography and fluoroscopy may be needed to support surgical and pain management services

Space	Clinical Staff***	Equipment	Other
IR Services require 740 sq ft	Add 1 FTE Radiologist (contract and/or staff interventional coverage 1.5 fte).	Mobile PET/CT contract with Technologist	~\$325,000/ rad fte
CT = 640 sqft	Up to 12 FTE Technologists. 1.5 FTE MSA	Interventional (IR) room plus supplies (limited services)	~\$80,000/tech fte
Radiologist viewing/consult room = 100 saft	Will need nursing coverage for IR		~\$35,000/MSA fte
Radiology space = 300 sqft			Diagnostic US equipment = \$180,000
Ultrasound space =180 sqft			DR rad room = \$250,000
Changing areas x2 = 70 sqft			CT equipment = \$900,000
Subwaiting x2 = 45sqft			IR equipment (ltd) = \$2,000,000
Staff work area = 60 sqft			

#### Pros

Increased coverage for stable capacity and increased access. More adaptable program for increased workload. Shift coverage for emergent needs (may be able to use extended call coverage based on needs and usage patterns) Staffed/On-call WHEN hours

#### Cons

Increased cost and inefficiency during Iulls in workload demand. Large space and supply requirements for interventional services

References

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<sup>\*\*\*</sup>Clinical Staffing Implications Only

# 5- CBOC Imaging Services

	Manchester	proje	orkload and ctions						
			Manchester		TC*	Non-Manches	ster VA Data**		
	Specialty	2015	2025	2015	\$				
	Clinic Stops								
	Amb: Nuclear Medicine	428	493	227	45%				
	Amb: Radiation Therapy			131	100%				
	Amb: Radiology	17569	19521	3412	16%				
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#### **Option Summary**

Could be in additiona to any of the previous Options. Offer VA provided imaging services at key CBOCs in NH. Space would be needed to install basic radiology services and at least part-time Ultrasound. Mobile or modular service could be provided if space is limited. Additional services such as MRI and CT could be offered via mobile services contracts. Due to regulatory and follow up concerns mammography services should not be offered at the CBOCs. At issue are the Keene and Littleton CBOCs under WRI control but within NH borders.

Space	Clinical Staff***	Equipment	Other	
Radiology space = 300 sqft	Additional 1.5-2.0 FTE per radiology suite and .5-1.5 fte per ultrasound	"U" arm DR radiology room	Contract for mobile MR/CT ser to include tech staffing	
Ultrasound space =180 sqft	] [	Diagnostic US machine	~\$325,000/ rad fte	
Changing areas x2 = 70 sqft		Mobile pad site	~\$80,000/tech fte	
Subwaiting x2 = 45sqft			~\$35,000/MSA fte	
Staff work area = 60 sqft			Mobile pad construction \$15	
			Diagnostic US equipment = \$180,000	
			DR rad room = \$250,000	

### Pros

Provide most general radiology studies at key CBOCs. Better patient compliance and meets most stakeholder requests. Could provide expanded service offerings (improved access) for patients seen at Manchester and/or other facilities (WRJ, Togus, Bedford, Boston) Point of care testing could potentially shorten time to diagnose

#### Cons

Space could be a concern. Staffing could be difficult for remote sites. Difficult to monitor and maintain consistency at remote sites. Would need medical back-up for contrast related emergencies.

References

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<sup>\*\*\*</sup>Clinical Staffing Implications Only