**Medicine Service Line**

**Option #:** 1. Full Service Inpatient Med/Surg Facility and Multispecialty Clinic with enhanced Endoscopy Capability

| Manchester | | | | | | |
|---|---|---|---|---|---|---|
| | | | CITC* | | Non-Manchester VA Data** | |
| | Specialty | 2015 | 2025 | 2015 | $ | | |
| Inpatient (Acute) | **ADC** | | | | | | |
| | ICU - Medical | 5 | 4 | | | | |
| | Non-ICU - Medical | 20 | 14 | | | | |
| | | | | | | | |
| | Inpt: Medical | | | 2418 | 100% | | |
| | [Currently 100% in the community] | | | | | | |
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| | **Clinic Stops** | | | | | | |
| Outpatient (Ambulatory) | Amb: Medical & Other Non-Surg Specialties | 56009 | 63818 | 9362 | 14% | | |
| | Amb Medical: Cardiology | 7481 | 8198 | 1253 | 14% | | |
| | Amb Medical: Dialysis | | | 3255 | 100% | | |
| | Amb Medical: Digestive/GI/Endoscopy | 3934 | 4217 | 345 | 8% | | |
| | Amb Medical: EEG/Neurology | 2280 | 2802 | 24 | 1% | | |
| | Amb Medical: Endocrine/ Metabolic and Diabetes | 1702 | 1949 | 69 | 3% | | |
| | Amb Medical: NonSurg: All Other | 2886 | 3110 | 421 | 13% | | |
| | Amb Medical: NonSurg: Allergy & Immunology | | | 18 | 100% | | |
| | Amb Medical: NonSurg: Dermatology | 8168 | 9543 | 348 | 14% | | |
| | Amb Medical: NonSurg: Infectious Diseases | 200 | 203 | | 0% | | |
| | Amb Medical: NonSurg: Nephrology | | | | 0% | | |
| | Amb Medical: NonSurg: Rheumatology | 260 | 295 | | 0% | | |
| | Amb Medical: Oncology | 4477 | 4969 | 557 | 11% | | |
| | Amb Medical: Pulmonary/ Resp Care | 2741 | 3006 | 282 | 9% | | |
| | Oxygen | 152348 | | | | | |
| | Respiratory Equipment | 9911 | | | | | |

*CITC = Care in the Community; All CITC Combined
** Include VA Boston, Bedford VAMC and White River Junction VAMC
***Clinical Staffing Implications Only

## Option Summary

Build a full service med/surg hospital on the Manchester VA Campus. This 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. Full service emergency services could be accommodated in this model. Continued links to community providers and VA partners (Boston and WRJ) for complex surgical and medical procedures.

## Resource Impacts

| Space | Clinical Staff*** | Equipment | Other |
|---|---|---|---|
| Full Service ER with DR and CT | Additional staff needed | CT, DR | Space would need to flow with new structure |
| Full Service Radiology | Additional staff needed | CT, DR, MRI, PET, Nuc, U/S, Fluoro | |
| Hybrid OR/IR Suite | Additional staff needed | | |
| Inpatient/Outpatient Dialysis | Additional staff needed | | |
| Outpatient Endoscopy Suite | Additional staff needed | | |
| Ambulatory Surgical Suite | Additional staff needed | | |
| 4 room OR | Additional staff needed | | |
| Bronchoscopy Suite | Additional staff needed | | |
| ? Fisher House | | | |
| Parking | | | Could be integrated with the building |
| | | | |

## Pros

(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 is much better than the community, when we send patients out in the community we run the risk of losing the economies of scale which are the Department of Veterans Affairs. (6) A full service on site facility does not require considerations of local capacity/willingness to partner of local facilities.

## Cons

(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). (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.

## References

**See slide set**

**Medicine Service Line**

**Option #:** 2a. Build On-site Full service Endoscopy Suite capability; more advanced services delivered via Community Partnership (VA providers in non-VA setting)

| Manchester | | In-House Manchester | | CITC* | | Non-Manchester VA Data** | |
|---|---|---|---|---|---|---|---|
| | Specialty | 2015 | 2025 | 2015 | $ | | |
| Inpatient (Acute) | **ADC** | | | | | | |
| | ICU - Medical | 5 | 4 | | | | |
| | Non-ICU - Medical | 20 | 14 | | | | |
| | | | | | | | |
| | Inpt: Medical | | | 2418 | 100% | | |
| | [Currently 100% in the community] | | | | | | |
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| Outpatient (Ambulatory) | **Clinic Stops** | | | | | | |
| | Amb: Medical & Other Non-Surg Specialties | 56009 | 63818 | 9362 | 14% | | |
| | Amb Medical: Cardiology | 7481 | 8198 | 1253 | 14% | | |
| | Amb Medical: Dialysis | | | 3255 | 100% | | |
| | Amb Medical: Digestive/GI/Endoscopy | 3934 | 4217 | 345 | 8% | | |
| | Amb Medical: EEG/Neurology | 2280 | 2802 | 24 | 1% | | |
| | Amb Medical: Endocrine/ Metabolic and Diabetes | 1702 | 1949 | 69 | 3% | | |
| | Amb Medical: NonSurg: All Other | 2886 | 3110 | 421 | 13% | | |
| | Amb Medical: NonSurg: Allergy & Immunology | | | 18 | 100% | | |
| | Amb Medical: NonSurg: Dermatology | 8168 | 9543 | 348 | 14% | | |
| | Amb Medical: NonSurg: Infectious Diseases | 200 | 203 | | 0% | | |
| | Amb Medical: NonSurg: Nephrology | | | | 0% | | |
| | Amb Medical: NonSurg: Rheumatology | 260 | 295 | | 0% | | |
| | Amb Medical: Oncology | 4477 | 4969 | 557 | 11% | | |
| | Amb Medical: Pulmonary/ Resp Care | 2741 | 3006 | 282 | 9% | | |
| | Oxygen | 152348 | | | | | |
| | Respiratory Equipment | 9911 | | | | | |

*CITC = Care in the Community; All CITC Combined
** Include VA Boston, Bedford VAMC and White River Junction VAMC
***Clinical Staffing Implications Only

## Option Summary

Build on-site Multispecialty Clinic with Endoscopy suite with integrated Ambulatory 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. Strategic alliances with local hospitals for inpatient admissions, complex surgery, intensive care (non-VA space + VA providers). Staffed by VA physicians (e.g. hospitalists and selected subspecialties) and strategic coverage by fee inpatient consultant providers. Case management would be provided by onsite VA staff.

## Resource Impacts

| Space | Clinical Staff*** | Equipment | Other |
|---|---|---|---|
| Full Service Radiology w/ IR Suite | Additional staff needed | Per Radiology: CT, DR, MRI, PET, Nuc, U/S, Fluoro | |
| Outpatient Dialysis | Additional staff needed | | |
| Endoscopy Suite | Additional staff needed | | |
| Bronchoscopy Suite | Additional staff needed | | |
| Cardiovascular Testing Suite | Additional staff needed | | |
| Ambulatory Surgical Suite | Additional staff needed | | |
| Expanded lab/radiology for Urgent Care Center | Additional staff needed | | |
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## Pros

(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 access under-utilized advanced 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) 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.

## Cons

(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 all 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.

## References

**See slide set**

**Medicine Service Line**

**Option #:** 2b. Build On-site Full service Endoscopy Suite capability; more advanced services referred to and delivered by community providers

| Manchester | | In-House Manchester | | CITC* | | Non-Manchester VA Data** | |
|---|---|---|---|---|---|---|---|
| | Specialty | 2015 | 2025 | 2015 | $ | | |
| Inpatient (Acute) | **ADC** | | | | | | |
| | ICU - Medical | 5 | 4 | | | | |
| | Non-ICU - Medical | 20 | 14 | | | | |
| | | | | | | | |
| | Inpt: Medical | | | 2418 | 100% | | |
| | [Currently 100% in the community] | | | | | | |
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| Outpatient (Ambulatory) | **Clinic Stops** | | | | | | |
| | Amb: Medical & Other Non-Surg Specialties | 56009 | 63818 | 9362 | 14% | | |
| | Amb Medical: Cardiology | 7481 | 8198 | 1253 | 14% | | |
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| | Amb Medical: NonSurg: Allergy & Immunology | | | 18 | 100% | | |
| | Amb Medical: NonSurg: Dermatology | 8168 | 9543 | 348 | 14% | | |
| | Amb Medical: NonSurg: Infectious Diseases | 200 | 203 | | 0% | | |
| | Amb Medical: NonSurg: Nephrology | | | | 0% | | |
| | Amb Medical: NonSurg: Rheumatology | 260 | 295 | | 0% | | |
| | Amb Medical: Oncology | 4477 | 4969 | 557 | 11% | | |
| | Amb Medical: Pulmonary/ Resp Care | 2741 | 3006 | 282 | 9% | | |
| | Oxygen | 152348 | | | | | |
| | Respiratory Equipment | 9911 | | | | | |

*CITC = Care in the Community; All CITC Combined
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***Clinical Staffing Implications Only

## Option Summary

Build on-site Multispecialty Clinic with Endoscopy suite with integrated Ambulatory 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

## Resource Impacts

| Space | Clinical Staff*** | Equipment | Other |
|---|---|---|---|
| Full Service Radiology w/ IR Suite | Additional staff needed | Per Radiology: CT, DR, MRI, PET, Nuc, U/S, Fluoro | |
| Outpatient Dialysis | Additional staff needed | | |
| Endoscopy Suite | Additional staff needed | | |
| Bronchoscopy Suite | Additional staff needed | | |
| Cardiovascular Testing Suite | Additional staff needed | | |
| Ambulatory Surgical Suite | Additional staff needed | | |
| Expanded lab/radiology for UCC | Additional staff needed | | |
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## Pros

(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 access under-utilized advanced 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 with Option #2b. (6) Easier to implement enhanced ambulatory Manchester services without a full academic affiliation/residency program in place.

## Cons

(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.

## References

**See slide set**