Task Force Subgroup Report: Medicine Service Line

VA New Hampshire VISION 2025 Task Force

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Membership

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- Stephen F. Tacopina, HSS for Medicine, Manchester VAMC
- Irisbel Guzman Sanchez, Program Analyst, VISN 1 Informatic

Process: Data File Examples Reviewed

(Please see Service line Lead analysis folder for full list of documents)

- 1 Year & 90 day Potential Event Care Assessment Need Score Manchester
- Manchester Non-VA Outpatient Medicine
- Utilization by Geography
- Manchester Medicine Specialty Appointments FY16 and 17
- Manchester Patients Discharged from other VISN 1 Facilities FY 2016
- Manchester Inpatient Scenarios data
- Manchester Veterans with a VA CITC Discharge in FY16
- Manchester Veterans with a VA Inpatient Discharge in FY16
- Non VA Manchester by ICD and CPT
- SL Manchester Encounters FY 16 and 17
- VISN 1 Discharges with DRG Weighted Value
- 2016 VA Enrollee Health Care Projection Model- Base Year 2015
- NH Inpatient Model Data

Process (cont.)

- **Site visits completed:** 2
- **Staff listening sessions completed:** 3
- **Other resources considered:**
  - Facility Infrastructure requirements to perform Standard, Intermediate, or Complex Surgical Procedures (VHA Directive 2010-018)
  - Facility infrastructure requirements to perform Invasive Procedures in an Ambulatory Surgery Center (VHA Directive 2011-037)
  - David J. Kenney, Chairman, NH State Veterans Advisory Committee: Testimony on Manchester VA Medical Center; State Veterans Advisory Committee *New Hampshire; September 15, 2017*
  - Specialty Care Complexity Policy Work Group Final Charter 8-24-2017
  - Statement of Carolyn Clancy Deputy Under Secretary for Health and Organizational Excellence Veterans Health Administration Department of Veteran Affairs Before the HOUSE COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS U. S. HOUSE OF REPRESENTATIVES , September 18, 2017
  - Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center. William Edward Kois, MD September 18, 2017
  - 2012 ACC Foundation/Society for Cardiovascular Angiography andInterventions Expert Consensus Document on Cardiac Catheterization Laboratory Standards Update

Current State summary Manchester Medicine/Urgent Care

Total Provider FTEE

- Chief, Medical Service (vacant)
- Chief Urgent Care 1.0 ARNP
- Urgent Care 6.0 MD, 5 Fee MD providers 2.0 ARNP, 1 PA
- Cardiology 1.5 MD, 1 ARNP
- Oncology 1.0 MD, 1 ARNP
- GI 2.0 MD, 2 Fee MD, 1 ARNP
- Neurology 3.0 MD
- Rheumatology 0.5 MD
- Dermatology ,5 MD, 1.4 PA
- Pulmonary 1.0 MD
- Endocrinology 1.0 MD
- Infectious Disease (contract)

Total Support FTEE

- Nurse Manager 1.0 Medicine
- Nurse Manager 1.0 Urgent Care
- Health Systems Specialist (Detail) 1.0
- Administrative Officer (1.0)

Vacancies

- Oncologist, Urgent Care MD

Procedures

- Limited due to OR closure but includes
- Endoscopy with community partners, in-house Sleep studies, Nuclear stress testing and limited joint injections

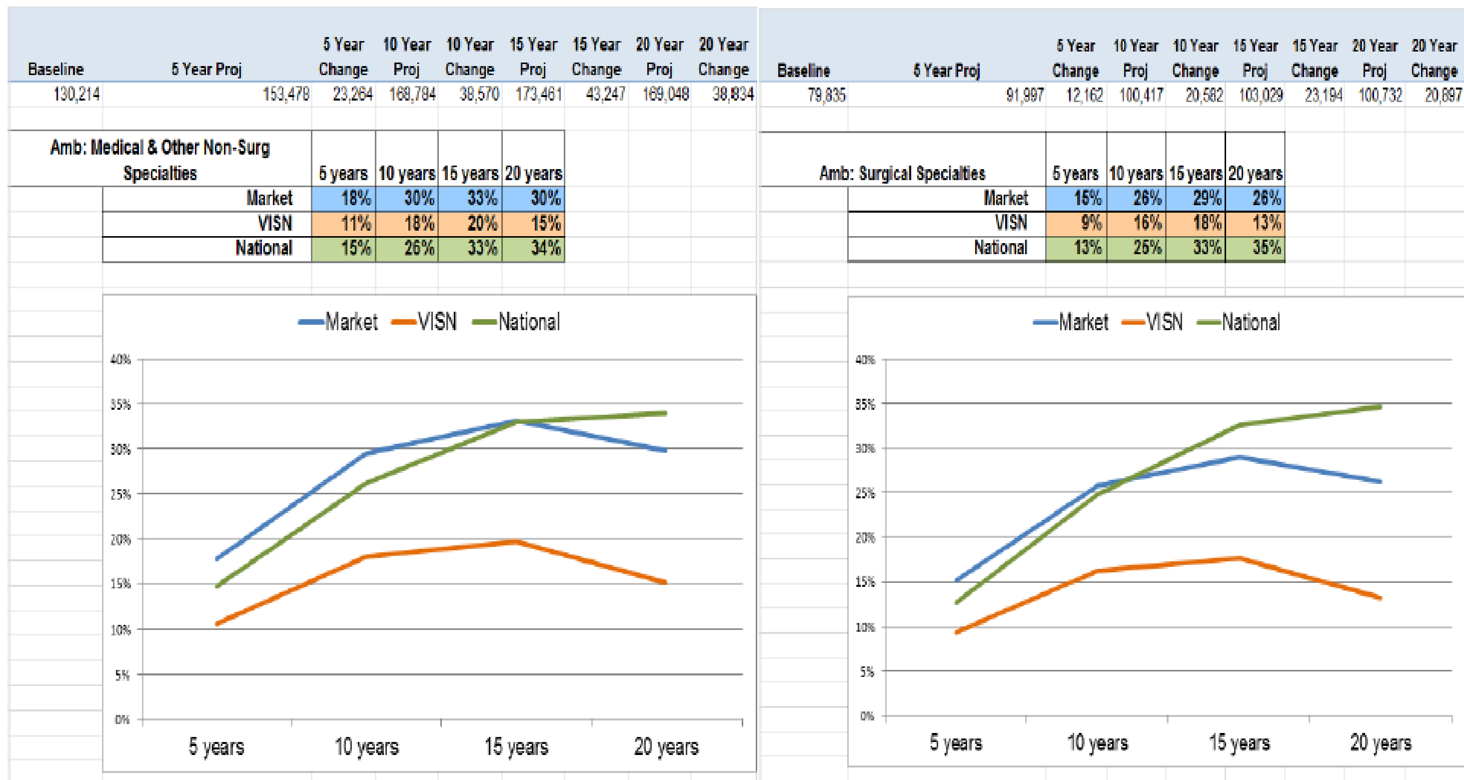
Needs

- Pulmonary mid-level, Cardiologist,
- Staffing to support clinical providers
- Resume on-sight procedures including TEE, bronchoscopy, joint injections, endoscopy, etc.

Total Provider Encounters

- FY16 - 26,885 Urgent Care 12,000
- FY17 - 27,383 Urgent Care 12,488

Ambulatory Medical and Surgical Projections



North Market Data Sets

Ambulatory Medical and Surgical

Baseline	5 Year Proj	5 Year Change	10 Year Proj	10 Year Change	15 Year Proj	15 Year Change	20 Year Proj	20 Year Change
130,214	153,478	23,264	168,784	38,570	173,461	43,247	169,048	38,834

Amb: Medical & Other Non-Surg Specialties	5 years	10 years	15 years	20 years
Market	18%	30%	33%	30%
VISN	11%	18%	20%	15%
National	15%	26%	33%	34%

Baseline	5 Year Proj	5 Year Change	10 Year Proj	10 Year Change	15 Year Proj	15 Year Change	20 Year Proj	20 Year Change
79,835	91,997	12,162	100,417	20,582	103,029	23,194	100,732	20,897

Amb: Surgical Specialties	5 years	10 years	15 years	20 years
Market	15%	26%	29%	26%
VISN	9%	16%	18%	13%
National	13%	25%	33%	35%

Initial Options Considered

1. **Build a full service Med/Surg hospital with Enhanced Endoscopy Capability on the Manchester VA Campus**

2. **On-site Multispecialty clinic with Full Endoscopy capability integrated with Ambulatory Surgery Center; more advanced services provided via either:**

    a) **Community Partnership (VA staff using non-VA space)**

    b) **Referral to Community Providers (non-VA providers in non-VA space)**

Option 1. Full Service Hospital

1. **Build a full service Med/Surg Hospital with Enhanced Endoscopy Capability. Multispecialty Clinic with Ambulatory Surgery and Medicine procedures. 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.
   - 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, WRJ & Bedford) for complex care.

Pros and Cons (Option 1)

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.

Option 2a. Multispecialty Clinic; Community Partnership version 1

2a. On-site Multispecialty clinic with Full Endoscopy capability; more advanced care delivered via Community Partnership (VA providers in non-VA setting)

- 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 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.

Pros and Cons (Option 2a)

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 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.

Option 2b. Multispecialty Clinic; Community Partnership version 2

2b. On-site Multispecialty clinic with Full Endoscopy capability; more advanced care referred to Community Partners

- 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

Pros and Cons (Option 2b)

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 seen with Option #2a.
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.