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Findings

After an extensive review of all data and information available, input from stakeholders, and deliberations spanning over six months, the New Hampshire Vision 2025 Task Force (Task Force) developed and endorses the findings listed below. Findings are organized into three sections. First, two cross-cutting, non-clinical findings about the culture and process at Manchester that will be vital to the success of the following proposals. Then, interdisciplinary initiatives that would improve the health and quality of life for Veterans in New Hampshire and the North Market across multiple needed areas and services. Finally, the Task Force made a number of additional findings related to specific service lines which are organized as follows: Medicine and Surgery; Radiology; Primary Care; Mental Health; Rehabilitative Services; and Geriatrics and Extended Care.

Cross-cutting Findings

The Task Force recognizes the critical importance of culture and process in the genesis of events leading to the creation of the Task Force. To fulfill its original charge, the Task Force has examined the origin of challenges in Manchester in addition to envisioning the way forward. The following findings aim to ensure that such challenges will not be allowed to recur, and that the future of service to Veterans through this facility will be increasingly collaborative, Veteran-centered, and of exceptional quality.

Culture

The Task Force notes that the ongoing work of The Task Force on Improving Culture at Manchester VAMC is vital in addressing current aspects of culture in Manchester. Dr. Lehmann is currently [describe ongoing work from presentation], with administrative and clinical leadership engaged. In addition, the Task Force advocates that a proactive focus on culture be maintained going forward.

Implementation Suggestions

The Task Force understands that the absence of specific mechanisms to promote cultural health within the Manchester facility contributed to declines in employee empowerment, effective communication across teams, care delivery, and ultimately collective ability to identify and resolve challenges. On this basis, the Task Force advises the following:

- Regular senior leadership engagement in structured town hall discussions of culture, with specific focus on employee fulfillment and empowerment;
- Formal and informal rewarding of those who elevate concerns in a timely fashion and prevent any negative impact to Veterans;

- Proactive leadership engagement of clinical staff in decision-making relevant to care delivery;
- Leadership encouragement of professional development, interdisciplinary collaboration, innovation;
- Emphasis on accountability at all levels of the organization, to encourage collective elevation in quality of service delivered;
- Increased frequency of cultural health measurement and timely response to results.

Data to be Included

- All Employee Survey results

Process

While culture was a pre-eminent factor in Manchester's recent challenges, the Task Force also notes that quality indicators did not automatically trigger examination of care delivery. Providers were required to personally elevate clinical quality and facility cleanliness concerns in order for these to be addressed. Noting the existence of public and private sector quality assurance organizations and evaluation standards for facilities of similar scope to Manchester, the Task Force advises:

- A virtual reporting process for clinical quality concerns that offers an option of reporter anonymity;
    - A supplementary, internal virtual forum for leadership to post raised concerns for staff view and describe steps taken to address those concerns;
- Tracking of sentinel events and required documentation of steps taken in response;
- Review of Manchester quality metrics and comparison with established private sector metrics for a facility of similar scope, completed by a quality assurance organization external to VA.

Interdisciplinary Findings

The Task Force proposes and supports several interdisciplinary findings that will improve the health and quality of life for Veterans in New Hampshire and the North Market across multiple clinical and social services.

Creation of a Community Care Center located in the Manchester area providing clinical, social, and other community services to Veterans

The Task Force advocates the creation of a Community Care Center (CCC), similar to the Errera Community Care Center in West Haven, CT, to offer services to Veterans who are struggling with mental illness, substance abuse, and/or homelessness. The original center would be located in Manchester, NH, with the possibility of services expanding to other locations across the market overtime as new needs and demands develop. A central, urban location in the beginning would allow Veterans to access these resources via public transportation. The goal would be to serve Veterans with the continuous development and implementation of new resources and expansion of current resources via Veteran involvement and leadership, community networking and partnerships. The creation of this center embodies the VA's commitment to whole health by bringing together multiple service lines and community partners to provide an innovative approach to healthcare and wellness care. While the Task Force thinks that the current Errera Center serves as an ideal starting point, they also believe there is opportunity to uniquely shape the CCC in Manchester to serve the needs of Veterans in New Hampshire and to discover even more new and novel ideas.

Veterans would be able to access a number of clinical services at the CCC, and the Task Force supports the inclusion of Primary Care, Mental Health, Rehabilitative Services, and Geriatrics and Extended Care. The Homeless Patient Aligned Care Team (HPACT) would be ideally placed at the CCC, so homeless Veterans would have easy access to other tangential services. A variety of outpatient Mental Health services would be offered at the center, including a Community Reintegration program, Mental Health Intensive Case Management (MHICM), Compensated Work Therapy, Peer-Specialists, and Critical Time Intervention (CTI), among other Mental Health services. In addition to MHICM, a GERI-MHICM program would offer specialized services to aging Veterans with serious Mental Health concerns. A variety of rehabilitative services, including occupational therapy, physical therapy, and pain programs, could be run out of the space. In addition to providing on-site services, providers at the CCC could also serve Veterans across the market (and potentially across the VISN, if there were a need) via telehealth and clinical video telehealth (CVT).

In addition to clinical services, the CCC would serve as a hub for social and community support for Veterans, giving them a place to call their own, come together, and support each other. This would be accomplished by having large community space available, as well as a kitchen, where Veterans would be able to receive a hot meal and interact with others in their community. A wellness center, with exercise equipment and trained staff, would be able to assist not only Veterans in a rehabilitative program, but others trying to improve their health and wellness through exercise and fitness. The CCC could serve as a Community Resource and Referral Center for Veterans facing housing insecurity, where they could obtain information about emergency housing and housing support, and access more basic needs such as laundry, showers, and a place to store

belongings. Most importantly, the CCC could provide space where other community services – Legal Services, Housing Services, Employment Services, among others – could come in and meet with Veterans to help address their needs beyond what the VA can provide. The ideas included here are just the beginning of what this center could be to Veterans in New Hampshire. The Task Force envisions the CCC as an opportunity to provide for the total health and wellbeing of the Veteran.

Capital Assets Considerations

Space for the CCC would likely be procured via a leased space somewhere in the Manchester area. The Task Force estimates that the leased space for the original site would likely be under the $1 million threshold of a major lease. While this project is finalized, the Task Force encourages increased outreach to community partners in the Manchester and beyond to lay the ground work for this center.

Implementation Suggestions

Should the SMAG and the Secretary recommend a Community Care Center in the Manchester area, the Task Force suggests that the recommendation include the creation of a Project Implementation Team, made up of current leadership from the Errera Center, Veterans in New Hampshire, clinical representation from the Primary Care, Mental Health, Rehabilitation, and Geriatrics and Extended Care service lines, ans representation from community and Veteran's services organization in New Hampshire. This group should be given a firm timeline to develop an outline for the specific services to be offered at the CCC in Manchester and make recommendations as to the necessary stages to bring the project to fruition as well as a projected timeline for completion.

Data to be Included

- Mock up from the Mental Health subgroup containing the potential space?
- Data on effectiveness from the current Errera Center (not sure this exists, would need to ask)?
- Survey question on whether Veterans would use this? (Not already asked – would have to create a new survey/bring this idea up at the planned focus groups).

Expansion of Telehealth and Virtual Services

The Task Force advocates the expanded use of telehealth to serve Veterans in Manchester and across the North Market. With more than 2.18 million telehealth visits in Fiscal Year 2017 and 45% of Veterans served by telehealth living in rural areas, VA has established that telehealth is an effective and convenient method of care provision for

Veterans with otherwise limited access. VA telehealth care is also available in more than 50 specialties. At the time of this report, the five VISN 1 telehealth hubs all had additional capacity to support Manchester and the North Market. Notably, the Veteran population in this market is more than 60% rural.

Additionally, specific challenges faced by Manchester could be ameliorated or entirely solved by increasing virtual care delivery. For example, the urgent care in Manchester typically sees 1-2 Veterans between midnight and the early morning, making it difficult to justify personnel and resource expense during those hours. Other facilities and VISNs have demonstrated that integrating licensed independent providers(LIPs) and telemedicine into their call center functions drastically reduces the demand for Emergency Department and Urgent Care visits. An integrated call center either developed at the level of Manchester, the level of the Northern Market, or more broadly across the VISN, would allow Veterans to access licensed independent providers (LIPs) that would immediately be able to address Primary Care needs, but Mental Health and specialty concerns as well. The addition of telehealth capabilities into this concept will allow the LIP to more comprehensively address concerns raised by the Veteran calling in, and ensure they are directed to the most appropriate next step as seamlessly and expediently as possible. Rather than reduce services due to volume or space constraints, providing virtual care allows services to instead be expanded at low cost, with the added benefits of improved patient experience and convenience.

Capital Assets Considerations

In the context of the urgent physical space need in Manchester, the expansion of virtual care provides necessary access while minimizing physical footprint in the facility and CBOCs.

Implementation Suggestions

Given the significant rurality of the Veteran population in the North Market, the Task Force advises that VA work with public and private sector entities to establish non-VA telehealth sites of care (e.g., Veterans Service Organization locations, other Federal property, county or State locations).

Additional, service line-specific telehealth considerations are described in the sections below.

Data to Be Included

- Statistics on what percentage of spaces is needed to make each service line “whole”
- Market Assessment rurality map/statistics

- Data on use of telehealth in Manchester and the VISN
- List of Telehealth hubs in VISN 1

Combination of the Somersworth and Portsmouth Community Based Outpatient Clinics (CBOCs) into one larger "Sea Coast" CBOC with expanded services.

The Task Force finds that Veterans in New Hampshire, particularly those in the Southern portion of the state, would benefit from the combination of the Somersworth and Portsmouth CBOCs into one larger "Sea Coast" CBOC that offers expanded services. Currently, the two CBOCs are located within 20 minutes of each other, and each site serves about 2,000 Veterans. Both need more space to better serve Veterans in the area. Additionally, the Portsmouth CBOC is currently located on the grounds of the Pease Air National Guard Base, which creates access barriers for some Veterans. This idea is supported by the Veteran population in New Hampshire. In response to a survey question regarding the combination of these two sites, 59.11% of Veteran respondents answered positively.

The combination of these two clinics at a new location would allow for more state of the art facilities and an expansion of services offered. Currently Primary Care, Mental Health, and tangential services such as nutrition and some lab work are offered at these two sites. In a new, bigger location, the Task Force recommends expanding those services to include some rehabilitative, imaging, and specialty services, as need demands. Even if those services were not housed at the new CBOC, space could be made available for providers to rotate through and see patients. The Task Force also believes that the new CBOC may be an ideal place to locate dental services, which are currently scarce for Veterans in New Hampshire. The location could also potentially serve as a hub from which to offer telehealth services across the state and market, and space could also be designated for various community services to come in and connect with Veterans, especially while the Community Care Center is being created (and could eventually become a satellite site, offering similar services).

<u>Capital Assets Consideration</u>

As part of the Market Assessment conducted by the Office of Policy and Planning, the Dover area of New Hampshire was suggested as the location for the expanded CBOC based on demographic data and utilization patterns. The Task Force agrees that locations in the vicinity of Dover should be considered first when exploring the options for the new CBOC. In addition to exploring different leasing and contract options, the Task Force also believes that a community partnership with a local facility that may have available space should be strongly considered when selecting a site.

<u>Implementation Suggestions</u>

- Do we have any?

Data to Be Included

- Slide from the Market Assessment
- Responses from the Survey
- Information on uniques/clinic stops for the CBOCs currently – will only be Primary Care/Mental Health

Service Line-Specific Findings

In addition to the interdisciplinary findings described above, the Task Force supports a number of specific findings in the areas of Medicine and Surgery, Imaging, Primary Care, Mental Health, Rehabilitative Services, and Geriatrics and Extended Care. The findings are organized below by service line, and contain capital assets considerations and implementation suggestions where applicable. Common threads that run throughout all the findings include a commitment to right sizing and staffing each service to meet anticipated need and VA standards of care, updating infrastructure and maintaining new structures where built, establishing partnerships across the market to expand the services available to Veterans in the area, and bringing the care to the Veteran as much as possible through the utilization of CBOCs, home-based services, and telehealth capabilities.

Medicine and Surgery

The Task Force made four overarching findings in relation to the medicine and surgery service lines: in-patient services should be provided to New Hampshire Veterans through the utilization of community and network partnerships; access to services for Veterans in the entire North market will be increased through the continued development of a "Group Practice" model between Manchester and the VA Medical Center in White River Junction; there is a need for an Ambulatory Care Center on-site an Manchester; and the future use of Choice in the North Market must be handled thoughtfully and judiciously. As previously mentioned, the Task Force supports the inclusion of some specialty services, especially cardiology and endocrinology, at the new combined CBOC, either on a permanent or rotating basis. Additionally, specialty services can be provided into the CBOCs (as well as Veteran's homes and non-VA sites of care) through the use of telehealth capabilities.

Utilization of partnerships to provide in-patient care to New Hampshire Veterans.

The conversation about a full service hospital in New Hampshire long pre-dates the creation of this Task Force. In reviewing the available data and Veteran feedback, the Task Force believes that in-patient hospital services can and should be provided to

Veterans in New Hampshire, but that construction of an in-patient hospital is not the best way to deliver these services. The data shows the demand for in-patient services in the Northern Market decreasing over time. There is a high probability that by the time a new in-patient facility was constructed, there would no longer be enough demand to sustain its use. Additionally, the focus group and survey data collected by the Task Force shows that the number one priority for Veterans is to receive care close to home, regardless of who is providing it.

For all of these reasons, the Task Force finds that the best method for delivering in-patient surgical care for New Hampshire Veterans is through the use of partnerships and relationships. To start, a VA provider at Manchester will work closely with a Veteran to determine what the best option is for them on an individual level. There are surgical services available within the VA New England network, in Boston, White River Junction, and Maine. Additionally, there are many high-quality community hospitals across New Hampshire where, through partnership with the VA, many Veterans are already receiving their in-patient care. The Veteran would be able to decide for themselves, in consultation with their VA providers and family, which option will work best for them. VA providers would be kept in the loop and receive all updates, information, and an lab work. Finally, the Veteran would be able to receive their follow-up care at the VA. The Task Force believes this is the best path forward to provide in-patient services to Veterans in New Hampshire.

<u>Continued exploration and development of a “Group Practice” model with White River Junction</u>

As mentioned previously, New Hampshire and Vermont are known as “twin sister” states, which is why the Market Assessment considered them together as one market. There is much overlap in population and service area, and the VAMCs in both states have historically collaborated to provide the best possible care for all Veterans. For example, the Pathology and Laboratory medicine service line has been unified dating back to [x]. In the wake of the flood and the closing of the operating room at Manchester, efforts at collaboration have only intensified. Currently, many services, including cardiology, pulmonary, radiology, and sleep services, are being approached collaboratively by providers at both Manchester and White River Junction.

The Task Force endorse these efforts at collaboration, and encourages the two sites to further explore the possibility of establishing some form of “group practice” that allows providers to work in both sites and the CBOCs. This would have a number of benefits for Veterans in New Hampshire. It would open up White River Junction’s academic affiliation with the Geisel School of Medicine at Dartmouth. The lack of such an affiliation was identified by the Market Assessment as one of the challenges to providing comprehensive, high-quality care in Manchester, and this move would open up a

number of options to allow Manchester to expand the services offered on-site. For example, Dartmouth currently has funding for palliative, pulmonary, cardiology, and ophthalmology residency programs, and it is relying on the VA to provide the patients and clinical opportunities. Manchester would become part of that broader training opportunity. An academic affiliation would also help with recruitment and retention of providers. Additionally, it would supplement service lines at Manchester which are currently understaffed, some to the point of being only one-provider deep, and relieve the burden on those providers, to allow them to focus on providing care to Veterans.

Increased collaboration between providers at the two sites may naturally grow into a more formalized, structured regionalization of the North Market. The Task Force believes further integration should be allowed to happen organically, and that the creation of a robust group practice is needed at this time to best serve the Veterans in both states.

Construction of an Ambulatory Care Center in Manchester, New Hampshire.

The Task Force finds that the construction of an Ambulatory Care Center (ACC) on-site at Manchester is needed to address the needs and demands of Veterans in New Hampshire. Possible services offered include: a full range of ambulatory surgery, basic and advanced GI and pulmonary endoscopy, urology, minor orthopedic procedures, a full spectrum of radiology and imaging, and cataract surgery. This would allow Veterans to remain in-state for all but the most complex procedures, and offer a way forward for Manchester to specialize in certain procedures for Veterans across the North Market and the network. E

In conjunction with the development of a group practice model with White River Junction, the construction of an ACC in Manchester would offer a spectrum of care to Veterans across the North Market. This makes the entire market more attractive in terms of recruitment and hiring, because it would allow providers to see patients and perform some surgeries at Manchester, but then also have the chance to do more complex procedures at White River Junction. The same is true when it comes to academic affiliations; the two sites together are more attractive than either standing alone. Additionally, the CBOCs in both states could be looped in to a larger network of care, with the possibility of follow-up care being provided at those clinics through either a rotation of specialty providers or via telehealth services. Further collaboration would also benefit White River Junction, because it would ensure there was enough to demand to maintain its in-patient services, allowing access to new services not currently offered, and increasing access to services with longer wait times.

One required element to make this level of increased collaboration between the two sites workable is a robust transportation system running regularly between the two for

Veterans, family members, and providers. The distance between the two sites (slightly over an hour and a half) and the lack of available public transportation makes the development of a managed and coordinated transportation system imperative. The most likely solution appears to be some sort of busing system. The timing of pick-ups and drop-offs on each site, the amenities on the buses, and the necessary infrastructure to provide maintenance and upkeep to the buses themselves are all factors that must be considered. It may be possible to contract with an outside company to provide these services, and the Task Force believes all options should be considered.

Thoughtful and judicious use of the Choice program.

The Task Force recognizes that the future configuration of the Choice program will be a factor in how all Veterans in the North Market access both inpatient and outpatient services. While some elements of Choice are beyond the control of this Task Force, to the extent to which individual sites can exercise control over the use of the future Choice program, the Task Force wholeheartedly endorses a "VA first" approach. Strategic partnerships with community facilities for urgent or emergent cases,or situations where it is clearly in the best interest of the Veteran to receive care in a community setting will of course still be on the table and options for consideration. However, the Task Force believes that in all other circumstances, every effort should be made to provide care to Veterans at a VA site. Additionally, in all circumstances, VA providers should remain at the center of care coordination for all Veterans receiving there care through the VA, either at a VA facility or through a community partner.

On a practical level, there are different eligibility rules for Choice in Vermont and New Hampshire, and the lack of consistency currently provides an obstacle to increased collaboration and regionalization of services between the two states.

Capital Assets Considerations

The Task Force recognizes that the construction of an ACC on-site at Manchester is a long-term construction project that would likely require 1-2 new buildings. As will be noted in subsequent recommendations, it is unclear to what level the existing structure at Manchester could be updated and refurbished. The Task Force understands that there is an established process through which large scale construction projects must move. However, given the lack of services in Manchester currently, the Task Force encourages the consideration of all possible options to expedite this process, including the use of "minor" construction and non-recurring maintenance (NRM) projects.

In the short term, pending the completion of new ACC space, the Task Force supports the continued use of the "Hospital within a Hospital" model with community partners – where VA providers use non-VA space to provide care to Veterans – to allow Veterans

access to outpatient services in New Hampshire. As described previously, this is currently being successful executed at Frisbee Hospital and Catholic Medical Center.

Where Telehealth services are utilized, particularly in the CBOCs, there must be adequate internet strength and bandwidth to transmit live streamed video, and also for the secure transmittal of any necessary clinical information.

Implementation Suggestions

- Do we have any?

Data to Be Included

- Projections – Market Assessment – In-patient demand
- Focus groups – responses indicating Veterans wanting services close to home
- Data – Market Assessment – effect of no academic affiliation in Manchester
- Area for discussion – there was no conversation about urgent care and whether that would be included in the ACC
- Focus group response from VT Veterans
- Data on Veteran's preference for VA over community

Radiology (Imaging)

As previously mentioned, increased Imaging services are incorporated into 3 previous findings: in the new combined Sea Coast"] CBOC, as an opportunity for increased collaboration with White River Junction (which is happening to some extent already), and as part of a new ACC on site in Manchester. However, the Task Force has also made several radiology-specific findings. First, the need to right size and staff on-site services at Manchester regardless of a new ACC space. Second, the necessity of expanding radiology services into the CBOCs where appropriate. Third, a brief mention of the possible radiology services that could be expanded through partnerships, particularly with White River Junction.

Right sizing and staffing on-site at Manchester

If an ACC is constructed on-site at Manchester, the space reserved for Imaging services should be expanded to allow for the department to adjust to current and future needs as well as expanding hours for patient scheduling. The Task Force also supports the expansion of Imaging services offered, and adequate staffing to meet current and future demand. For example, Radiology services could be slightly expanded to include some basic image guided procedures with adequate space and equipment. The primary issue with the current space is that the age and design of the building itself is not conducive to the installation of modern imaging equipment. Additionally, while currently the

equipment provided is up-to -date and new equipment is procured in a timely manner, this is a practice that must be continued as new technological advances in this field are developed.

Expansion of Imaging services into the CBOCs where possible, either permanently or through mobile services

Radiology is among the services the Task Force believes should be considered for the combined “Sea Coast” CBOC. Additionally, the remaining CBOCs across the North Market should be evaluated to determine if basic Imaging could be added to the current space. If not, the possibility of increased space for Imaging services should be considered when reviewing the lease for each clinic and considering relocation to a new site. Additionally, the possibility of mobile rRdiology services, which could rotate through the various CBOCs, should be investigated for feasibility.

Expansion of Imaging services offered through partnerships

Current Radiology services offered at Manchester are general radiology, ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine. The Task Force supports the continuation of these services. Even with the expansion of Imaging space at Manchester, more advanced or critical services (such as Interventional Radiology) would still be performed at partner facilities, such as White River Junction and Boston. Manchester and White River Junction currently have an established process for sharing IR and PET services; however both sites will need additional staffing to support a more robust referral program. Mammography services are currently offered through several community partners, and the Task Force encourages the continuation of these arrangements.

The Radiology service line is already using telehealth capabilities to allow providers at remote locations to read images and data from tests and procedures performed on-site at Manchester. The Task Force supports the continuation and expansion of these efforts.

Capital Assets Considerations

As with the Medicine and Surgery findings, the capital assets needs for expanding Radiology services on-site at Manchester depend on whether the existing structure is able to be refurbished or new construction is needed. However, when it comes to Radiology equipment, special construction considerations must be made. Ground level is the ideal location for Imaging services due to the weight loads of the equipment. Imaging location should also give consideration to easy patient access and access to emergency medical back up should there be a contrast reaction.

Implementation Suggestions

- Do we have any?

Data Needed

- Space gap information on the current imaging space?
- Is there space at the current CBOCs for Imaging services – Garrett Stumb doesn't think so
- Possibility of mobile services

Primary Care

Primary Care is one of the service lines that the Task Force believes should be included as part of the services offered at the new Community Care Center. Additionally, Primary Care forms the basis of services provided at all VA CBOC's, and would be a major component of the proposed Sea Coast CBOC. Finally, new Primary Care space is one element that could be incorporated into a new ACC. However, the Task Force has made three additional findings related to Primary Care. First, there are certain elements that must be incorporated into future Primary Care space at Manchester. This includes sizing per the PACT model, including the extended care team, as well as incorporating employee and Veteran wellness areas. Second, the expansion of Primary Care services via telehealth and tele-Primary Care. Finally, the Task Force finds that there's a need to enhance the pain and opiate management programs offered to Veterans in New Hampshire, a suggestion that has implications for the rehabilitative and Mental Health service lines as well.

Right sizing and staffing on-site at Manchester per the PACT Model, including the extended care team, and incorporating wellness areas

Current Primary Care space at Manchester has a space gap of roughly 50% the recommended space per VA standards of care. Primary Care services within the VA are provided according to the PACT model, with each Veteran assigned a teamlet consisting of a Provider, RN, LPN/LVN/HT, and Clerk. Additional discipline-specific team members should be integrated into Primary Care and available to address Veterans' health needs, including: a clinical pharmacy specialist; an anticoagulation CPS; a registered dietician; Mental Health providers; and a social worker. Under the PACT model, the patient panel for a Provider is 1,200, and 900 for an RN. 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. These rooms can be used to

support the establishment of areas within primary care for employees to take a break, be refreshed, with the option to meditate and/or relax. Opportunities for health education, and other activities such as yoga and tai chi would be beneficial to both Veterans and employees and can be offered with relatively few major space considerations. PACT space design guidance should be followed.

Expand access to Primary Care services via telehealth and tele-Primary Care

The Task Force finds that there is a need to expand access not just to Primary Care but to tertiary services such as medical and surgical specialties, physical therapy, MOVE, and smoking cessation among others via telemedicine. The expanded use of tele-Primary Care would improve access to VA Primary Care services, allow for coverage at smaller sites, and could even potentially provide support for the wider North Market and VISN. Providers could connect with Veterans at the CBOCs, at the Veteran's home, and at non-VA sites of care.

Enhance pain and opiate management programs

Given the current opioid crisis, which has hit New Hampshire harder than many states across the nation, the Task Force finds there is a need to increase access for Veterans to an integrative pain clinic with complementary and integrative health services, including physiatry, anesthesia, neurology, an opioid tapering clinic with clinical pharmacy support, pain psychology, acupuncture, Battlefield acupuncture, yoga and tai chi, chiropractic care, massage therapy and aquatic therapy, among others. Some of these services could be in the community if available, or offered to Veterans via telehealth, but all should function fairly seamlessly with treatment plans developed by the interdisciplinary pain clinic. This concept was also supported by the Mental Health and rehabilitative services in their reports to the Task Force.

Capital Assets Considerations

The capital assets concerns for increased Primary Care space will be determined based on whether the current Manchester infrastructure can be refurbished or whether new construction is needed. It may be that as other services move into new structures, the "core" of the existing Manchester medical center can be transformed into Primary Care space adequate to meet the requirements of the PACT model. The inclusion of wellness and relaxation space is relatively resource-light – swing space can be used for this purpose with readily available equipment such as yoga mats and the ability to dim the lights.

As mentioned previously, any refurbishment or new construction must also take into account the technological requirements to adequately provide telehealth services across the state, as well as possibly the larger market and network.

Implementation Suggestions

- Do we have any?

Data Needed

- Information – PACT space design guidance – I have this, but it's a lot of information
- Current Primary Care space gap at Manchester -I have differing information on this

Mental Health

The Task Force believes that the provision of high-quality, easily accessible Mental Health services to Veterans is one of the most important aspects of the VA's mission in New Hampshire. Mental Health services will form the basis of many of the programs offered at the CCC, and will also figure prominently into the expanded Sea Coast CBOC. However, there are three additional findings the Task Force supports in regards to the future of Mental Health services in New Hampshire. First, there must be an effort to improve the services offered to Veterans at their initial point of contact with the VA. Second, inpatient Mental Health services must be readily accessible to New Hampshire Veterans through partnerships in the community and across the VISN. Finally, current and future need supports the establishment of an intensive residential and outpatient Mental Health services on-site at Manchester.

Improvement of services offered to Veterans at the initial point of contact regarding Mental Health, including increase of Tele-Mental Health and staff training and development.

Veterans seeking Mental Health services engage with the VA system through a variety of entry points. They can be referred by a VA or community primary provider, either in Primary Care or one of the specialty clinics. They can come in via the VA urgent care or local emergency room. They can reach out by calling or using the VA messaging service. The Task Force believes that it is vital that at this initial point of contact, Veterans are directed to the most appropriate level of care in the most seamless way possible, and believe there are a number of steps that could be taken to ensure that this level of service is maintained moving into the future. Providers who will encounter these Veterans, from front line staff, to urgent care staff and Primary Care and specialty providers outside of Mental Health, must be adequately and competently trained in the best approaches to providing care to Veterans seeking Mental Health services, and the appropriate response to any situation that might arise. This training must be maintained as new staff joins and leadership must encourage the development of expertise in this

area. Additionally, a crisis intervention team must be on call to support Veterans and staff during all hours when care is provided.

Tele-Mental Health also plays a role in allowing Veterans to expediently access appropriate Mental Health services. Concepts discussed in previous sections, such as the expansion of CBOC services through telehealth, telehealth services into both the Veteran's home and non-VA sites, and an integrated call center are all elements the Task Force believes are aspects of delivering exceptional tele-Mental Health services in New Hampshire.

Provision of inpatient Mental Health services where necessary through community partnerships and partnerships within the VISN

There are currently a lack of inpatient Mental Health beds in New Hampshire. However, the Task Force faced similar projected demand as with inpatient medicine and surgery beds. By the time such a facility was constructed, demand in the state (based off current projections) would not be large enough to sustain the facility. The Task Force believes that the best way to provide inpatient Mental Health services to New Hampshire Veterans is through increased partnerships with other sites across the network (White River Junction, Boston, Maine) and within the community where available. While this would potentially require some travel, often an inpatient stay is only for a number of days, and the Veteran requires the type of specialized services that are found at sites that have an established in-patient Mental Health unit. Manchester would not be able to develop the space or expertise in time to adequately meet the demand for Mental Health beds.

Establishment of an intensive residential and outpatient Mental Health services on-site at Manchester

Currently, when New Hampshire Veterans have completed an inpatient Mental Health stay, either at another site in the network or at a community provider, there is nowhere for them to go. There is a gap in the state, and in the market as a whole, when it comes to the next level of Mental Health services. For these reasons, the Task Force finds that there is a need for the establishment of a Residential Rehabilitation Treatment Program (RRTP) on-site at Manchester. The RRTP would be able to offer intensive residential Mental Health care to Veterans who have a wide range of problems, illness, or rehabilitative care needs which often include Mental Health and substance use disorders, often co-occurring with medical conditions and psychosocial needs such as homelessness and unemployment. The program would provide a 24/7 therapeutic setting utilizing both professional and peer supports. Treatment would focus on the Veteran's needs, abilities, strengths, and preferences. Services that could be offered in this setting include Electroconvulsive Therapy (ECT), Transcranial magnetic stimulation,

TMS, ketamine treatment, as well as intensive treatment for substance use disorder (SUD). It may be possible that some of the offered programs could be extended beyond the Veteran's stay at the RRTP through the use of telehealth services.

The establishment of a RRTP at Manchester has the ability to serve not just Veterans in New Hampshire, but Veterans across the North Market and possibly the New England network. This is an area that where Manchester could excel and standout as a leading provider of these services in the area and possibly, with time, in the VA as a whole.

Capital Assets Considerations

The establishment of a RRTP will require the new construction of at least one, if not two, new buildings. The Master Planning presentation reviewed by the Task Force contains information on the creation of an RRTP structure at the current Manchester site. Similar to concerns expressed with regards to a new ACC, due to the lack of these services in Manchester (as well as the community) currently, the Task Force encourages the consideration of all possible options to expedite this process, including the use of "minor" construction and non-recurring maintenance (NRM) projects.

As previously stated, any new construction should take into account the technical requirements to provide telehealth services.

Implementation Suggestions

The need for inpatient Mental Health beds is acute and urgent, so steps must be taken to increase partnerships with community Mental Health providers in the New Hampshire that may have available beds, as well as to ease the process through which a Veteran in New Hampshire can access in-patient Mental Health services at other sites across the network.

- Project implementation team for the RRTP?
- Any other suggestions?

Data Needed

- Projections – market assessment – residential Mental Health services/inpatient Mental Health services
- Steps NH is taking to increase Mental Health inpatient beds
- Mental Health follow ups from the face to face meeting
- More information – nonvoluntary transfer over state lines?
- Include information about how the demand projections may change over time due to unforeseen events – not sure this is helpful

- # of Mental Health beds across the VISN – have that info for WRJ, not Maine or Boston
- EBA - RRTP estimate – do we want to see if they can isolate just this element as to cost?

Sensory and Physical Rehabilitative Services (SPRS)

The Task Force envisions the incorporation of SPRS into both the CCC and the new expanded CBOC. The demand in SPRS is expected to almost double across the North Market over time. Therefore, the Task Force makes three additional findings that will be needed to meet this future demand. First, the right sizing and staffing of SPRS on-site at Manchester, including an increase of services offered. Second, a concentrated effort to expand access to SPRS services across the state and market through the CBOCs, telehealth, and community partnerships as appropriate. Finally, the creation of a regional amputation Center of Excellence (COE) in Manchester to build on innovations and relationships already established through the development of the LUKE arm breakthrough.

Previous findings regarding the need for pain management programs and an RRTP on-site on Manchester have SPRS implications as well and were supported by the SPRS information and reports received by the Task Force.

<u>Right sizing the space and staffing of rehabilitative services on-site at Manchester, including an increase in on-site services offered to meet demand</u>

The Task Force supports an increase in the provision of SPRS to better meet the needs of Veterans on-site at Manchester. This would include increasing and updating the current space and equipment available to the SPRS team, as well as increasing staff recruitment and administrative support. Additionally, the expansion in availability of SPRS to evenings and weekends would also increase Veterans' access to these services. Finally, new services should be added to the current SPRS offerings to supplement the options available to Veterans as the rehab needs change and evolve over time and as demand in the area increases. One related service that is needed sooner rather than later is the provision of a prosthetist on site (possibly at the COE mentioned below). Possible other new services include: adaptive sports clinic, amputee clinic, blind rehab, and interdisciplinary amyotrophic lateral sclerosis (ALS) provided by SCI/D team.

<u>Expansion of rehabilitative services across the market through the CBOCs, the use of telehealth, and community providers as appropriate</u>

The Task Force finds that there is a need to expand SPRS across New Hampshire and the North Market, and this can be accomplished through a combination of an increase in

services at the CBOCs, through telehealth, and through community partnerships, as appropriate for each individual Veteran. Examples of services that could be expanded to the CBOCs include audiology clinics, chiropractic services and acupuncture, and physical therapists. Telehealth could be used to perform hearing tests, as well as to allow providers to follow up with Veterans, and even view them performing certain exercises and stretches within their homes. Finally, community partnerships may work best when there is a waiting list for SPRS at Manchester or a CBOC, when neither Manchester nor a CBOC is convenient for the Veteran, or where the frequency with which the Veteran must access SPRS makes it difficult for the them to travel to one of the VA sites. There is a need to expand SPRS access across the state, and the Task Force believes that a highly coordinated approach that takes into account the individual needs and circumstances of each Veteran is the best approach moving forward.

Creation of a regional amputation Center of Excellence in Manchester

The Task Force strongly supports the creation of a state-of-the-art Regional Amputation COE at Manchester (either on-site or potentially co-located with the new CCC). 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 (Designed and fitted for the first time with calibrated sensors capable of decoding natural muscle signals, translating the user's thoughts into precise movements of hand, arm and wrist), and the creation of this amputation center presents the opportunity to expand upon this relationship and provide enhanced amputation services in VISN 1. 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.

Capital Assets Considerations

The expansion of SPRS onsite at Manchester would require either new construction or the refurbishment of existing structures. Similar to Primary Care, SPRS may be something that could be moved into an overhauled "core" of the current Manchester medical center. The concerns about the bandwidth and technological infrastructure to support telehealth would also be relevant.

The creation of a Regional Amputation COE would require a new structure, either built or leased in the community. Subject matter experts in this area should be consulted to determine the appropriate space considerations

Implementation Suggestions

- Project Implementation team for the COE?
- Anything else?

Data Needed

- Market Analysis – SPRS demand – have this
- Space gap – SPRS – may have this information
- Current staffing gap – SPRS
- Space for SPRS services at the current CBOCs – may have this information
- Information on VA regional amputation centers – included in the SPRS report

Geriatrics and Extended Care (GEC)

The Veteran population in New Hampshire (and across the country) is aging, and the VA has a duty to provide care for a Veteran's entire lifespan. GEC services are contemplated by the Task Force to be vital components of the CCC and the Sea Coast CBOC. The Task Force makes the additional findings about the future of GEC in New Hampshire. First, the number of Community Living Center (CLC) beds on-site at Manchester must be increased to [x]. Second, home based services for aging Veterans must be increased, including Home Based Primary Care (HBPC), Home Care, and GERI MHICM-enhanced home care. Finally, the Social Work Case Management Model (SWCMM) must be implemented for medically complex, vulnerable Veterans.

Increase the number of Community Living Center (CLC) beds on-site at Manchester

The Market Assessment conducted in the North Market projects a future gap of 156 in available CLC beds. Long term care options in the state are limited based on state law which limits community nursing home long stay beds and due to staffing concerns reducing the number of beds at the Tilton State Veterans Home. Manchester currently contracts with community nursing homes, but availability fluctuates due to quality of care in the community. CLCs continue to care for challenging Veterans, whom the community is unwilling to accept. Therefore, the Task Force finds that the number of CLC beds on-site at Manchester should be increased to [x].

Expansion of in-home services specific to aging Veterans including, Home Based Primary Care (HBPC), Home Care and GERI MHICM-enhanced home care services for Veterans with Mental Health issues

For Veterans who want to stay in their home, and for whom it is still medically appropriate and feasible, the provision of home services across the state must be increased. One element that should be expanded is the HBPC PACT, which cares for Veterans with multiple chronic illnesses, 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 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.

Additionally, the Task Force is proposing the expansion of a Mental Health Intensive Case Management 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 also in line with the Secretary's "Moon Shot- Choose Home". This addresses concerns raised during listening sessions with providers in home care regarding the increase and complexity of Mental Health issues within the population served.

<u>Implementation the Social Work Case Management Model for medically complex, vulnerable Veterans</u>

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 the Task Force finds that it makes the most sense to provide case management in the service areas where the patient is receiving care. This proposed model builds upon current staffing and adds specialty case management at end of life, Non-VA Community Care and increases PACT Social Work.

This model requires community requires Community Care Social Workers, which provide case management of psychosocial needs of geriatric Veterans receiving non-VA care in the community, assure maximum VA benefits, provide inter-agency and facility consultation and support with community providers, and make home visits to assist with long-term care planning and evaluation. Also suggested is the creation of PACT Social work, which provide the front-line rapid involvement and case management of the psychosocial needs of Veterans, most of whom are over the age of 65. This includes long-term care planning, crisis care, and engagement of non-VA community care service options.

Capital Assets Considerations

The exact CAM needs in relation to the CLC will depend on what the final number of beds is. This can be added later.

An increase in home-based services requires the creation of infrastructure, including administrative staff, technical support, and transportation, to support an increase in providers services Veterans in the home.

Implementation suggestions

- One option is that the Task Force doesn't make a decision as to the specific increase in CLC beds and instead refers that decision to a Project Implementation team
- Anything else?

Data Needed

- WRJ need – CLC beds – asked/received
- # of Veterans in community beds - asked/received
- Demand – market analysis – have this information
- This group has some really good charts in all their reports
- Include in background – description of CLC
- Information – Home care moonshot?