Surgery Service Line

Option #: On-site Multispecialty Advanced Ambulatory Surgery (ASC); higher levels of care via Community Partnership (VA Surgeons in Non-VA space)

Manchester		Existing workload and projections					
		In-House Manchester		CITC*		Non-Manchester VA Data**	
	Specialty	2015	2025	2015	$		
	Bed Days of Care						
Inpatient (Acute)	ICU - Surgical						
	Non-ICU - Surgical						
	Observation Beds (48 hour)						
	Inpt: Maternity Deliveries			52	100%		
	Inpt: Maternity Non-Deliveries			9	100%		
	Inpt: Surgical	2	516	923	100%		
	Clinic Stops						
Outpatient (Ambulatory)	Amb Surg: ENT	951	1086	85	8%		
	Amb Surg: General and All Other Surgery	3576	3924	638	15%		
	Amb Surg: Neurological Surgery						
	Amb Surg: Obstetrics & Gynecology	174	246	5	3%		
	Amb Surg: Plastic Surgery						
	Amb Surg: Cardiovascular and Thoracic Surgery			95	100%		
	Amb Surg: Colon Rectal Surgery						
	Amb Surg: Eye Clinic	10656	11618	1051	8%		
	Amb Surg: Orthopedics	1323	1472	272	17%		
	Amb Surg: Podiatry	7538	8355	460	6%		
	Amb Surg: Urology	3365	3742	197	5%		
	Cardiothoracic Surgical Implants	17					
	Surgical Implants	116					

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

Option Summary

Build a Multispecialty Clinic with Advanced Ambulatory Surgery on the Manchester site with integrated outpatient surgical services. Full service procedure area (EGD, Colonoscopy, Bronchoscopy, Cystocopy, ENT procedures, etc.). Endoscopy suite. Advanced ASC with transfer for inpatient service for emergent situations provided by community partner. Strategic alliance with local hospitals for elective inpatient admissions and surgery (Non-VA space with VA surgeons). Consultation and ICU services provided by community partner (Medicine, Radiology, Anesthesia, Nursing, etc.). Limited VA Urgent Care services and ER backup via community partner. Case management onsite at community partner would be provided by onsite VA staff.

Resource Impacts

Space	Clinical Staff***	Equipment	Other
3-5 ORs, hybrid capability	Additional staffing needed	C-arm, full service laproscopic towers, duplicate trays for all	Completely coordinated transportation system for
Clinic space for all specialites and support services	Additional staffing needed	Specialty specific equipment (ex. Ophthalmology lanes and testing	
Full procedure suite with 4-6 rooms	Additional staffing needed	Scopes for specialities, other equipment	
Full service SPS	Additional staffing needed	equipment	
Radiology	Additional staffing needed	equipment	
Pathology	Additional staffing needed	equipment	
Lab	Additional staffing needed	equipment	

Pros

1) This option would increase veteran satisfaction by providing a new state of the art VA Advance designation Ambulatory surgery and procedure unit where the majority of specialty care demands could be met.
2) According to the data on current and projected surgery demand, the majority of the surgery needs are for high level ambulatory surgical services, which would be met by this option.
3) This option allows all the outpatient cases to be kept within the VA where they will be captured by the VASQIP quality and safety process.
4) Providing a community partnership for the inpatient surgical cases would allow patients to receive surgical care closer to home with easier access for visitation for families
5) This option allows VA surgeon to provide more complex outpatient surgery at the VA and inpatient surgery at the community partner which would help them maintain their skills and career satisfaction, which would greatly help recruitment and retention

Cons

1) Cases that go to the community for inpatient care will not get counted in VASQIP which makes tracking quality and safety mroe difficult.
2) There would be increased logistical issues getting data on patient care episode into the VA record (how to get affiliate records into CPRS.) Might require dual documentation to get medical records at both VA and community hospital.
3) Credentialling may be challenging.
4) Community partners may not have the capacity to meet all the VA needs or may not want to enter into an agreement.
5) Contracting issues are always challenging.
6) Advanced ambulatory designation would require a flawless transportation system for urgent/emergency/intra/post-op issues.

References

VHA Handbook 1102.01 National Surgery Office, VHA Directive 2010-018 Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures, VHA Directive 2010-037 Facility Infrastructure Requirements to Perform Invasive Procedures in an Ambulatory Surgery Center, NSO Operative Complexity Matrix 7-27-17

Surgery Service Line

Option #: On-site Multispecialty Advanced Ambulatory Surgery Center (ASC); higher levels of care provided via Community Partnership (VA Staff in VA leased space).

Manchester		Existing workload and projections					
		In-House Manchester		CITC*		Non-Manchester VA Data**	
	Specialty	2015	2025	2015	$		
Inpatient (Acute)	**Bed Days of Care**						
	ICU - Surgical						
	Non-ICU - Surgical						
	Observation Beds (48 hour)						
	Inpt: Maternity Deliveries			52	100%		
	Inpt: Maternity Non-Deliveries			9	100%		
	Inpt: Surgical	2	516	923	100%		
Outpatient (Ambulatory)	**Clinic Stops**						
	Amb Surg: ENT	951	1086	85	8%		
	Amb Surg: General and All Other Surgery	3576	3924	638	15%		
	Amb Surg: Neurological Surgery						
	Amb Surg: Obstetrics & Gynecology	174	246	5	3%		
	Amb Surg: Plastic Surgery						
	Amb Surg: Cardiovascular and Thoracic Surgery			95	100%		
	Amb Surg: Colon Rectal Surgery						
	Amb Surg: Eye Clinic	10656	11618	1051	8%		
	Amb Surg: Orthopedics	1323	1472	272	17%		
	Amb Surg: Podiatry	7538	8355	460	6%		
	Amb Surg: Urology	3365	3742	197	5%		
	Cardiothoracic Surgical Implants	17					
	Surgical Implants	116					

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

Option Summary

On site Multispecialty clinic withAdvanced Ambulatory Surgery Center (ASC) on the Manchester site with integrated outpatient surgical services. Full service procedure area (EDG, Colonoscopy, Bronchoscopy, cystoscopy, ENT procedures, etc). Endoscopy suite. Advanced level ASC with transfer to urgent inpatient services provided by comunity provider. Strategic alliances with local hospitals for elective inpatient admissions and surgery. (Leased space identified as VA space, staffed by VA staff). Leased space complexity infrastructure must meet National Surgery Office (NSO) directive for level of cases done. Consultation and ICU services provided by community partner (Medicine, Radiology, etc.). Must meet NSO directive for level of cases done. Urgent care during working hours and ER backup via community partner alliance after hours. Case management would be provided by onsite VA staff at community partner.

Resource Impacts

Space	Clinical Staff***	Equipment	Other
3-5 ORs, hybrid capability	Additional staffing needed	C-arm, full service laproscopic towers, duplicate trays for all	Completely coordinated transportation system for
Clinic space for all specialites and support services	Additional staffing needed	Specialty specific equipment (ex. Ophthalmology lanes and testing	
Full procedure suite with 4-6 rooms	Additional staffing needed	Scopes for specialities, other equipment	
Full service SPS	Additional staffing needed	equipment	
Radiology	Additional staffing needed	equipment	
Pathology	Additional staffing needed	equipment	
Lab	Additional staffing needed	equipment	

Pros

1) This option would increase veteran satisfaction by providing a new state of the art VA Advance designation Ambulatory surgery and procedure unit where the majority of specialty care demands could be met.
2) This option would also increase veteran satisfaction by having VA personnel at all levels providing the care at the community partner, thus identifying the surgical services as VA.
3) This option allows all the surgical cases to be captured within the VA by the VASQIP quality and safety process.
4) Providing for VA inpatient surgical services at a community partnership would allow patients to receive surgical care closer to home with easier access for visitation for families
5) This option allows VA surgeon to provide more complex outpatient surgery at the VA and inpatient surgery at the community partner which would help them maintain their skills and career satisfaction, which would greatly help recruitment and retention.

Cons

1) There could be a significant cost to ensure the infrastructure for intermediate level per NSO directives at the community partner, although some services such as ICU care could be provided by contract off the VA designated ward.
2) Logistical challenge of providing the full spectrum of services across the all of the partner support services, such as radiology and medical consultation.
3) Community partners may not have capacity to meet all the VA needs or may not want to enter an agreement.
4) Contracting issues are always challenging.
5) Advanced ambulatory designation would require a flawless transportation system for urgent/emergency/intra/post-op issues.

References

VHA Handbook 1102.01 National Surgery Office, VHA Directive 2010-018 Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures, VHA Directive 2010-037 Facility Infrastructure Requirements to Perform Invasive Procedures in an Ambulatory Surgery Center, NSO Operative Complexity Matrix 7-27-17

Surgery Service Line

Option #: Full Service Hospital (Intermediate Complexity) on the Manchester Campus.

Manchester		Existing workload and projections					
		In-House Manchester		CITC*		Non-Manchester VA Data**	
	Specialty	2015	2025	2015	$		
	Bed Days of Care						
Inpatient (Acute)	ICU - Surgical						
	Non-ICU - Surgical						
	Observation Beds (48 hour)						
	Inpt: Maternity Deliveries			52	100%		
	Inpt: Maternity Non-Deliveries			9	100%		
	Inpt: Surgical	2	516	923	100%		
	Clinic Stops						
Outpatient (Ambulatory)	Amb Surg: ENT	951	1086	85	8%		
	Amb Surg: General and All Other Surgery	3576	3924	638	15%		
	Amb Surg: Neurological Surgery						
	Amb Surg: Obstetrics & Gynecology	174	246	5	3%		
	Amb Surg: Plastic Surgery						
	Amb Surg: Cardiovascular and Thoracic Surgery			95	100%		
	Amb Surg: Colon Rectal Surgery						
	Amb Surg: Eye Clinic	10656	11618	1051	8%		
	Amb Surg: Orthopedics	1323	1472	272	17%		
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	Amb Surg: Urology	3365	3742	197	5%		
	Cardiothoracic Surgical Implants	17					
	Surgical Implants	116					

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

Option Summary

Build a service hospital on the Manchester VA campus. Facility would provide intermediate surgery and medicine services in a small inpatient (25-30 beds) footprint. Critical care services must be available and incompliance with NSO directives for intermediate care. Full service emergency services should be present in this model. Linkages with the community for complex emergency surgical and medical procedures. Strategic alliances with local hospitals and VISN 1 (Boston, WRJ and Bedford) for complex surgery.

Resource Impacts

Space	Clinical Staff***	Equipment	Other
ICU-need at least 5 beds (5-7), could be shared med/surg	1:2 ratio (RN/pt)		
ORs-need at least 3 (3-5), with one as a hybrid suite adjacent		C-arm, full service laproscopic towers, duplicate trays for all	
Full procedure suite with 4-6 rooms		Scopes for specialities, other equipment	
Full Service Emergency Room	Staffing per EM directive	Per EM directive	Staffing training (ACLS, etc)
Inpatient/Outpatient Dialysis	Staffing per Dialysis handbook	equipment	
Full service SPS	Additional staffing needed	equipment	
Radiology	Additional staffing needed	equipment	
Pathology	Additional staffing needed	equipment	
Lab	Additional staffing needed	equipment	
Fisher House?			

Pros

1) Patients and the public want a full service hospital so NH would no longer be the only state without a full service VA hospital
2) The majority of the surgical services would be provided within the VA, keeping quality and safety issues within the VASQIP system.
3) Patients would receive care locally at the VA by all VA providers, simplifying contracting and other logistics for services other than surgery such as radiology and medical consultations.
4) Less interruption in patient care and more continuity across services, such as medicine and psychiatry.

Cons

1) By the time this inpatient facility is completed, the currently projected workload would not be sufficient to justify an inpatient facility
2) 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
3) Care for complex surgery will still need to be provided in the community or other VA hospitals
4) Recruitment in this area for specialty surgeons has been difficult and is unclear that the financial and human resources are available to meet the staffing needs.
5) The required resources from other services (Medicine, Radiology, Pathology, etc) are enormous and also subject to recruitment issues.
6) There is a lack of academic affiliations and residencies needed to support this infrastructure.

References

VHA Handbook 1102.01 National Surgery Office, VHA Directive 2010-018 Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures, VHA Directive 2010-037 Facility Infrastructure Requirements to Perform Invasive Procedures in an Ambulatory Surgery Center, NSO Operative Complexity Matrix 7-27-17