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Task Force Subgroup Report: Surgery Service Line

VA New Hampshire VISION 2025 Task Force

Ronnie A. Rosenthal, MD

October 31, 2017 - v2

Membership

- Ronnie Rosenthal, MD, VISN 1 Chief Surgical Consultant, VACT HCS
- Robert Zwolak, MD, Chief of Surgery WRJ VAMC and Acting Chief of Surgery Manchester VAMC
- Kay Leissner, MD, Chief of Anesthesia, VA Boston HCS
- Frederick Burgess, MD, Chief of Anesthesia/Pain Providence VAMC
- Angelo-Pete Horatagis, MD Gastroenterologist, Manchester VAMC
- Alana Santaro, OD, Optometrist, Manchester VAMC
- John Mcnemar, CRNA, Manchester VAMC
- Lisa Ryder, RN, VISN 1 Surgical Nurse Lead, WRJ and Manchester VASQIP Nurse
- Denise Ormrod, RN, Nurse Manager OR/PACU VACT HCS
- Michelle Andrejak, Nurse Manager Surgery, Manchester VAMC
- Andrea Kushman, V1 HSS for Surgery and Medicine

Process: Data file Examples Reviewed

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

- Manchester Non-VA Outpatient Surgery
- Utilization by Geography
- Manchester Surgical 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
- VA and Non VA Manchester Surgical Procedures 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
- NSO VASQIP report FY17 3rd Quarter
- Operating Room stats FY15018
- NH Inpatient Model Data
- Facility and Operating Room costs

Process (cont.)

- **Site visits completed:** 2
- **Staff listening sessions completed:** 1
- **Other resources considered:**
  - 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
  - VHA Handbook 1102.01 National Surgery Office
  - 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)
  - National Surgery Office Operative Complexity Matrix July 27, 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
  - VA New Hampshire Vision 2025 Task Force Focus Group Report October 4, 2017

Background of VA Surgery

- **Inpatient**
  - Standard-low risk procedures
  - Intermediate-most of the rest of surgery
  - Complex-tertiary high risk cases

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- **Outpatient ASC**
  - Basic
  - Advanced

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NSO
ComplexityMatrix

Inpatient Definitions

Standard

- **Standard Surgical Complexity -** with the following infrastructure.

  - EKG, Basic Lab, Radiology: In house weekdays dayshift, on call 24/7 within 30 mins.
  - Inpatient surgeon coverage: Available 24/7 within 60 mins.
  - Staffing: One Full time FTEE General Surgeon, specialty surgeons as needed.
  - Anesthesia: In house weekdays dayshift, on call 24/7 within 60 mins(Airway plan)
  - OR Coverage: Nursing and operating room must be available 24/7 within 60 mins.
  - ICU: Level 4 or Level 3 without intensivist.
  - Blood bank: Blood products within 60 mins, weekdays, day shift
  - Medical Consultation & Cardiology and Vascular Surgery available 24/7 within 15 minutes by phone and within 60 minutes in person.

(Please see directive for entire listing of infrastructure requirements.)

Inpatient Definitions

Intermediate

- **Intermediate Surgical Complexity – with the following infrastructure**
  - EKG, Basic Laboratory, Radiology: In house 24/7.
  - Cardiac stress testing, Pulmonary Function tests: In house day tour.
  - Computerized Tomography (CT), Vascular Ultrasound: In-house weekdays, on call 24/7 within 30 mins.
  - Non-Vascular and Vascular Interventional Radiology: 24/7 in-house (fee or contract) within 60 mins.
  - Interventional Cardiology: 24/7 in-house (fee or contract} within 60 minutes.
  - Radiology Interpretation in-house weekdays, on call 24/7 within 30 minutes
  - Inpatient coverage: Surgical staff, resident/fellow 24/7 within 15 mins by phone or 60 mins in person.
  - Staffing: Two or more General surgeons, specialty surgeons as needed
  - Anesthesia Pre-Op in house weekdays, on call 24/7 within 15 mins by phone or 60 mins in person
  - OR Coverage: Nursing and operating room must be available 24/7 within 60 mins.
  - ICU: Level 2or Level 3 with intensivist.
  - Inpatient dialysis: on site within 6 hours.
  - Blood Bank: Blood products available 24/7 within 60 mins.
  - Medical Specialties Consultation & Cardiology and Vascular Surgery available 24/7 within 15 minutes by phone and within 60 minutes in person.

(Please see directive for entire listing of infrastructure requirements.)

Ambulatory Definitions

- **Ambulatory Surgery Center (ASC).** An ASC is a free standing VHA facility separate from an inpatient VHA Surgery Program. Outpatient (same day) surgery performed in a separate building on a VHA campus with an inpatient VHA Surgery Program would be considered an ASC if community paramedics are used to respond to emergencies according to current VHA policy on Out-of-Operating Room Airway Management.
  - Veterans Health Administration (VHA) facilities with an Ambulatory Surgery Center (ASC) must have a written plan or policy for the safe and timely transfer of the patient who requires treatment or therapy which the facility is unable to provide or perform. Every effort must be made to select appropriate patients who are suitable to have their procedure performed in an ASC. Patients must be discharged from the ASC according to an established protocol, or must be transferred to a facility with 24 hour observation and inpatient surgical services.

Ambulatory Definitions Cont'd

Basic Surgical Complexity

- EKG, Basic Laboratory, Basic Radiology within 30 minutes during the hours of operation.
- Staffing: One FTEE general surgeon, specialty surgeons as needed.
- Anesthesia: Anesthesiologist/CRNA, available within 30 min during hours of operation.
- OR: Nursing staffing A policy or protocol defining training and competencies (AORN)
- Blood bank: Blood products within 60 mins, during hours of operation
- Postop General Surgery Consult within 15 min by phone and 60 mins in person
- **Back-up 23 Hour Observation and In-patient Surgical Services.** Protocols to transfer patients within 60 minutes to a VHA acute care facility with an Inpatient Surgery Program or community provider must be established through Memorandums of Understanding. ***NOTE:*** *Timeliness of patient transfer in any given situation is dictated by the clinical condition of the patient.*

(Please see directive for entire listing of infrastructure requirements.)

Ambulatory Definitions Cont'd

Advanced Surgical Complexity

- EKG Basic, Laboratory, Basic Radiology: Within 30 minutes during the hours of operation.
- Radiology Interpretation: Available within 30 minutes during the hours of operation
- Staffing: At least Two FTEE General surgeons, one board certified or eligible
- Anesthesia: One or more board certified or eligible anesthesiologists
- OR: Addition of with specific competencies and supplemental staffing for emergencies
- Blood Bank: Blood products within 60 mins, during hours of operation
- Medical Consultation & Cardiology and Vascular Surgery within 15 minutes by phone and within 60 minutes in person, during the hours of operation.
- **Back-up 23 Hour Observation and In-patient Surgical Services.** Protocols to transfer patients within 60 minutes to a VHA acute care facility with an Inpatient Surgery Program or community provider must be established through Memorandums of Understanding. ***NOTE:*** *Timeliness of patient transfer in any given situation is dictated by the clinical condition of the patient.*

(Please see directive for entire listing of infrastructure requirements.

Current State Summary Manchester

Green indicates procedures currently performed at Manchester. **Orange** indicates procedures performed in the past.

	Ambulatory Basic (2861 CPT codes)	Ambulatory Advanced (416 CPT codes)
General	**Excision of skin masses** (BCCA, SCCA, **lipomas,** etc.) I&D abscess/perirectal abscess I&D/excision pilonidal cyst **Laparoscopic repair of umbilical**/spigelian/ventral/epigastric hernia Laparoscopic repair of inguinal/ incisional hernia **Inguinal hernia repair** Colonoscopy/sigmoidoscopy/ERCP/EGD Mediport placement	Axillary lymphadenectomy Laparoscopic cholecystectomy/IOC Incisional/ventral hernia repair
Orthopedics	**Knee arthroscopy/meniscectomy** Ankle arthroscopy Shoulder/elbow/wrist arthroscopy **Shoulder arthroscopy/Rotator cuff repair/acromioplasty** ORIF ankle fracture Repair Achilles tendon I&D leg abscess/hematoma Hand surgery (ganglion/trigger finger) Excision olecranon bursa	Open treatment patella fracture Hip arthroscopy
Plastics	Repair entropian Repair ectropian	Reduction mammoplasty Mastopexy Lipectomy/panniculectomy (removal excessive skin)
Ophthalmology	**Cataract /IOL**	
Urology	**Vasectomy** Excision spermatocele Orchiectomy Penile prosthesis placement **Circumcision** Male sling procedure **Cystoscopy**/ureteroscopy/placement ureteral stent Laser prostatectomy **TURBT (small tumor)** **hydrocelectomy**	TURBT (medium and large tumors) TURP Urethroplasty Insertion of bladder neck sphincter

Current State Summary Manchester

Green indicates procedures currently performed at Manchester. **Orange** indicates procedures performed in the past.

	Ambulatory Basic (2861 CPT codes)	Ambulatory Advanced (416 CPT codes)
Pain	Epidural steroid injection SI joint injection Facet and transforaminal blocks	
ENT	Thyroid lobectomy Esophageal dilation Microlaryngoscopy/biopsy Nasal endoscopy/ethmoidectomy/frontal sinus explore/etc.	Tracheal stoma revision w/flap UPPP
GYN	Leep Colposcopy	Hysteroscopy Salpingo-oophorectomy (removal tube/ovaries)
Podiatry	Ankle arthrodesis Transmetatarsal amputation Hammertoe arthroplasty bunionectomy	Open treatment of ankle fracture with internal fixation
Vascular	Vein stripping/stab phlebectomy Temporal artery biopsy AV fistula	

Current State Summary Manchester

Manchester Ambulatory Cases by CPT completed at Manchester FY2016	
FY16 Operative Complexity Stds	**(608) Manchester**
AmbAdvanced	6
AmbBasic	1007
NoAmbSetting	0
NotinASCM	0
Unknown	0
Grand Total	**1013**

CPT data for VA and Non-VA, Inpatient and Ambulatory

Inpatient Surgical Cases for Manchester Patients in FY 2016

Operative Complexity	(405) White River Junction, VT	(523) Boston Health Care System	NON VA	Grand Total	Percentage
Complex		30	14	44	11.8%
Intermediate	23	89	75	187	50.3%
Standard	14	44	69	127	34.1%
NotinSurgCM	1	1		2	0.5%
Unknown	5	7		12	3.2%
Grand Total	**43**	**171**	**158**	**372**	**100.0%**

Ambulatory Surgical Cases for Manchester Patients in FY 2016

Operative Complexity	(405) White River Junction, VT	(523) Boston Health Care System	NON VA	Grand Total	Percentage
AmbAdvanced	16	11	42	69	4.3%
AmbBasic	168	248	1,085	1,501	94.3%
NotinASCM		2		2	0.1%
Unknown	3	16		19	1.2%
Grand Total	**187**	**277**	**1,127**	**1,591**	**100.0%**

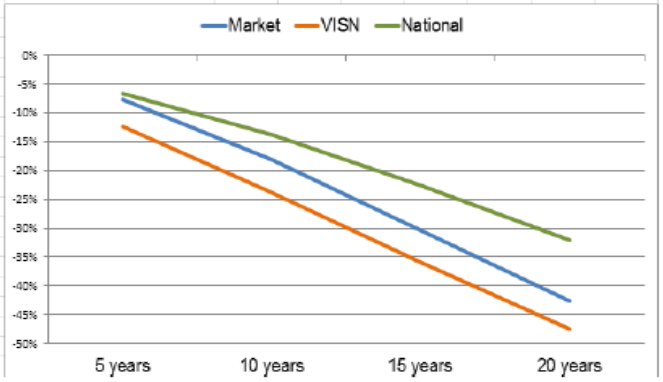
Acute Inpatient Surgery Projections

North Market Data Sets

Acute Inpatient Surgery

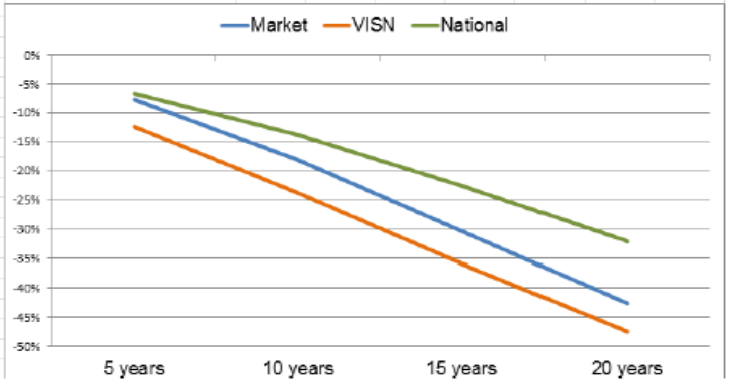
Baseline	5 Year Proj	5 Year Change	10 Year Proj	10 Year Change	15 Year Proj	15 Year Change	20 Year Proj	20 Year Change
6,358	5,871	-487	5,211	-1,147	4,428	-1,930	3,651	-2,707

Acute Inpatient Surgery (BDOC)	5 years	10 years	15 years	20 years
Market	-8%	-18%	-30%	-43%
VISN	-12%	-24%	-36%	-47%
National	-7%	-14%	-23%	-32%



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
20	19	-2	17	-4	14	-6	12	-9

Acute Inpatient Surgery (Beds)	5 years	10 years	15 years	20 years
Market	-8%	-18%	-30%	-43%
VISN	-12%	-24%	-36%	-47%
National	-7%	-14%	-23%	-32%



Facility: North Market
Data Source: VSSC , Utilization Projections by Geography by 2014 Cube
Run Date: July 20, 2015

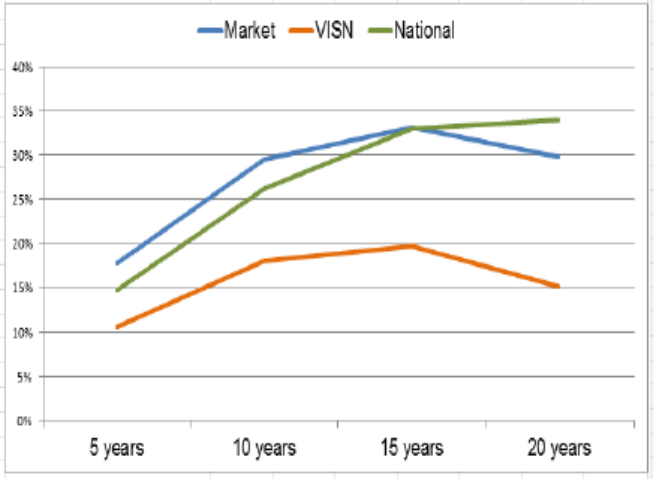
Ambulatory Medical and Surgical Projections

North Market Data Sets

Ambulatory Medical and Surgical

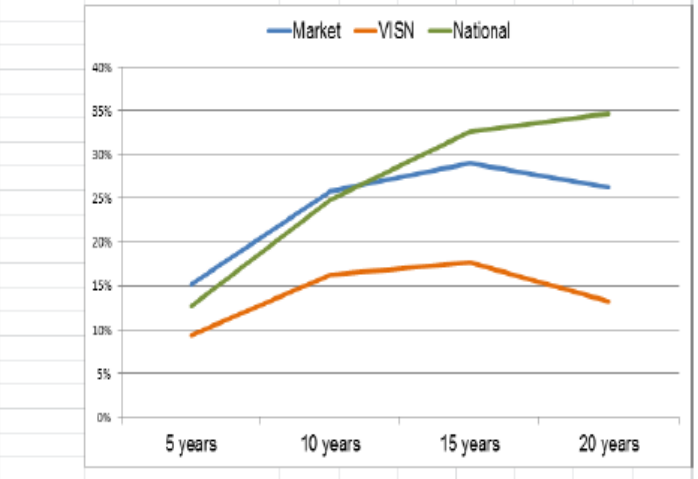
Baseline	5 Year Proj	5 Year Change	10 Year Proj	10 Year Change	15 Year Proj	15 Year Change	20 Year Proj	20 Year Change
130,214	153,478	23,264	168,784	38,570	173,461	43,247	169,048	38,834

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. **On-site Multispecialty Advanced Ambulatory Surgery Center (ASC) with higher level of care provided via either:**

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

   b) **Community Partnership (VA staff using VA Leased space)**

2. **Build a full service hospital (Intermediate Complexity) on the Manchester Campus**

Option 1a.

1a. On-site Multispecialty Advanced Ambulatory Surgery Center (ASC); higher levels of care provided via Community Partnership (VA staff in Non-VA space)

On Manchester Campus

- Advanced level Ambulatory Surgery Center (ASC)
- Integrated Multispecialty outpatient surgical services
- Full service procedure area and Endoscopy suite (EGD, Colonoscopy, Bronchoscopy, Cystoscopy, ENT procedures, etc.)
- Limited Urgent Care services

On Community Partner Campus (VA staff unless noted)

- Transfer for inpatient service when needed for emergent situations
- Elective Inpatient admissions and surgery
  - **Non-VA space with VA surgeons**
- Case management onsite by VA staff
- Consultation and ICU services provided by community partner providers (Medicine, Radiology, Anesthesia, Nursing, etc.)
- ER backup via community partner alliance after hours

Option 1a Pros and Cons

Pros

1) Would increase veteran satisfaction and would meet majority of specialty care demands.

2) The majority of the surgery needs are for high level ambulatory surgical services, which would be met by this option.

3) 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) 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 community for inpatient care will not get counted in VASQIP which makes tracking quality and safety more 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) Credentialing may be challenging

4) Community partners may not have 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.

Option 1b.

1b. On-site Multispecialty Advanced Ambulatory Surgery Center (ASC); higher levels of care provided via Community Partnership (VA staff in VA leased space)

On Manchester Campus

- Advanced Ambulatory Surgery Center (ASC)
- Integrated Multispecialty outpatient surgical services
- Full service procedure area and Endoscopy suite (EGD, Colonoscopy, Bronchoscopy, Cystoscopy, ENT procedures, etc.)
- Limited Urgent Care services

On Community Partner Campus (VA staff unless noted)

- Transfer to urgent inpatient service
- Elective Inpatient admissions and surgery
  - **Leased VA space serviced by VA surgeons and support staff**
  - Leased space complexity infrastructure must meet NSO directive for level of cases done.
- Case management onsite by VA staff
- Consultation and ICU services provided by community partner providers (Medicine, Radiology, etc.). Must meet NSO directive for level of cases done.
- ER backup via community partner alliance after hours

Option 1b Pros and Cons

Pros

1) Would increase veteran satisfaction and would meet majority of specialty care demands.

2) Would increase veteran satisfaction by having VA personnel at all levels providing the care at the community partner, identifying the surgical services as VA.

3) 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) 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 required 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 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.

Option 2.

2. Full Service Hospital (Intermediate Complexity) on the Manchester Campus.

- Facility would provide **intermediate** surgery and medical services in a small inpatient (25-30 bed) footprint.
- Critical care services must be available and in compliance with NSO directives for intermediate care.
- Strategic alliances with local hospitals and VISN 1 (Boston, WRJ) for complex surgery.
- Full service emergency services should be present in this model. Linkages with the community for complex emergency surgical procedures.

Option 2 Pros and Cons

Pros

1) 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.