

April 11, 2018

The Honorable Robert Wilkie  
Acting Secretary of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Acting Secretary Wilkie,

The Special Medical Advisory Group New Hampshire Vision 2025 Recommendations presented for your consideration describe full-service care delivery for New Hampshire Veterans, advancing access to expertise and innovation across the region. While this model was specifically developed for New Hampshire, SMAG advises that best practices from this work may be applicable to markets and regions across the Veterans Health Administration.

The VA New Hampshire Vision 2025 Task Force established as a Subcommittee of the SMAG, convened face-to-face meetings and additional conference calls over a six month time frame in its effort to determine the best way forward for VA care of New Hampshire Veterans. The Subcommittee analysis maintained a primary focus on Veteran and Manchester VA Medical Center employee voices, and the group additionally conducted extensive listening sessions with external stakeholders. As the Task Force was comprised of public and private stakeholders in unprecedented fashion, recommendations reflect extensive work across a broad range of expertise. All are grounded in direct Veteran input and aim for a future where this region is positioned at the leading edge of excellence in care delivery and healthcare evolution.

Enclosed is the full report for your review. The following 29 recommendations are grouped into three cohorts: **I. fundamental recommendations**, on which the success of the subsequent recommendations depends; **II. interdisciplinary recommendations** that involve multiple service lines; and **III. service line-specific recommendations**.

## **I. Fundamental Recommendations**

### **1. Sustained Investment in Organizational Culture**

Culture was a primary factor in Manchester's challenges. Completion of the *Manchester Culture Task Force* work is vital, as is proactive and ongoing leadership engagement with a focus on accountability at all levels of the organization. Employees need multiple specific options to elevate and resolve concerns before adverse events occur. The ecosystem culture – facility, regional, and National – should emphasize mission, ethics, teamwork, communication, and respect.

2. Evaluation of Process, Metrics, and Role Efficacy

Quality metrics did not automatically trigger examination of care delivery in Manchester. Providers were required to personally elevate clinical quality and facility cleanliness concerns in order for these to be addressed. This type of risk to Veteran well-being needs to be fully resolved, therefore the Task Force recommends: 1) ensuring that existing reporting mechanisms and quality standards are meaningfully implemented and; 2) review of care quality and culture metrics by an independent, external quality organization. Additionally, external assessment of interdisciplinary team roles and team productivity - with an emphasis on employees working to the top of their ability and/or licensure - will promote efficiency, enhanced access, and empowerment to raise concerns.

3. Leadership Engagement of External Stakeholders

When care delivery and structural challenges compounded in Manchester in 2017, the robust relationships with external stakeholders that could have eased the impact and accelerated solutions were not in place. Current leadership's proactive approach has been pivotal in turning Manchester in a better direction. Notably, Manchester employees, local Veterans Service Organizations, community healthcare organizations, the Governor's Office, the Congressional delegation, and the community at large are highly invested in the success and excellence of care delivery to Veterans in the State and region. This is a sound foundation on which further progress should be built.

4. Emphasis on Educations and Awareness

As today's inpatient procedures become tomorrow's ambulatory care, and as inpatient stays are reserved for cases of increasingly high acuity, New Hampshire Veterans will benefit from public-private partnerships that expand services ahead of this trend. Breaking from the traditional brick-and-mortar models of years past, the Task Force envisions comprehensive services delivered in innovative fashion, with greater accessibility and fewer barriers to care. This model, and many of the other recommendations that comprise this vision are concepts not well known among Veterans and the broader community, and a robust marketing and education campaign is necessary to communicate the Secretary's decisions for the way forward in New Hampshire and make these innovations accessible.

5. Timely, Innovative Approach to Infrastructure

A critical element of any future vision for New Hampshire is renovation of the existing infrastructure on-site in Manchester. Much of the facility infrastructure is

failing, and renovation is needed to provide a secure platform for clinical operations. Clinical services also require more space than is currently available, and “swing” space is needed to begin renovations without impact to care delivery. Furthermore, the Task Force advises a shift in capital assets philosophy – from VA as the sole construction planning and funding source to collaboration with the community on major projects. Engaging academic affiliate and community entities on joint ventures can create synergy, position VA as a leading collaborator, reduce project risk, and expedite timelines.

6. Enhanced Regional Collaboration

The Task Force encourages regional collaboration, rooted firmly in the concept that efforts must not consolidate but rather regionalize for expansion of services. Close affiliation with White River Junction VAMC is paramount for growth and introduces the possibility of a Dartmouth academic affiliation that would bring intellectual invigoration and new pipelines of talent to New Hampshire. Structured regionalization of the two facilities should be further explored with full stakeholder engagement and, if pursued, implemented with a deliberate, phased approach. It is imperative that any steps taken result in benefit to Veterans in both States. Additionally, a regional shuttle system would enhance service line collaboration opportunities and create ease of movement for providers to bring care to more Veterans in the North Market.

7. Focus on Right Care, Right Place, Right Time

The Task Force recognizes the pending reconfiguration of the Veterans Choice program as an opportunity to advocate for a transparent, efficient system that complements VA care and partnerships and minimizes bureaucratic burden on Veterans and providers. Additionally, consistency of eligibility rules across a region, aiming for the intersection of best possible access and greatest continuity of care, will facilitate partnerships across State lines.

8. Leveraging Interdisciplinary Academic Affiliations

Enhanced collaboration with the White River Junction VAMC opens the possibility of bringing the Dartmouth Geisel School of Medicine academic affiliation to Manchester. The lack of such an affiliation was identified by the Market Assessment as a key challenge to providing comprehensive, high-quality care in the facility. Additionally the Task Force advises an expansive, interdisciplinary approach to academic affiliations, building talent pipelines and enhancing recruitment and retention potential for nursing, social work, and other disciplines.

## II. Interdisciplinary Recommendations

### 9. Creation of a Whole Health Community Care Center

A Whole Health Community Care Center (CCC), similar to the Errera Community Care Center in West Haven, Connecticut, would provide wrap-around VA and community services to Veterans who are facing mental illness, substance abuse, homelessness, and other conditions at the intersection of medical and socio-behavioral care.

### 10. Expansion of Telehealth and Virtual Services

Enhancement of access through Telehealth, especially for rural Veterans and those needing Mental Health or specialty care, is feasible and necessary. Utilizing excess VISN Telehealth hub capacity and pursuing non-VA rural Telehealth sites will rapidly expand access and services.

### 11. Combination of the Somersworth and Portsmouth Community Based Outpatient Centers for Expanded Services

Veterans would benefit from the combination of the Somersworth and Portsmouth CBOCs, located just 20 minutes apart, into one larger “Seacoast” CBOC that offers expanded services. Combined patient volume could bring expanded specialty and other services on-site.

## III. Service Line- Specific Recommendations

### *Medicine and Surgery*

- 12. Establishment of an Ambulatory Surgical Center in Manchester
- 13. Inpatient services provided through community and network partnerships

### *Primary Care*

- 14. Right-sizing space and fully-staffing Patient Aligned Care Teams
- 15. Supporting Women Veterans Through an Enhanced Women’s Clinic
- 16. Enhancement of Primary Care access via Telehealth
- 17. Enhancement of pain and opiate management programs

### *Mental Health*

- 18. Seamless Connection from Initial Point of Contact into Mental Health Services
- 19. Collaboration with the community to establish full spectrum of Mental Health services
- 20. Establishment of residential and intensive outpatient Mental Health services

*Prosthetics and Rehabilitation Services*

21. Creation of a regional amputation Center of Excellence in Manchester
22. Right-sizing space and staffing Rehabilitative services on-site at Manchester
23. Expansion of access to Rehabilitative services via CBOCs, Telehealth, and community partnerships.

*Radiology*

24. Right-sizing space and staffing Imaging services on-site at Manchester
25. Expansion of Imagine services into the CBOCs where appropriate
26. Expansion of Imaging services through partnerships

*Geriatrics and Extended Care*

27. Increasing the number of Community Living Center (CLC) beds on-site at Manchester
28. Expansion of home-based services, including Home Based Primary Care
29. Implementing the Social Work Case Management Model for medically complex, vulnerable Veterans

The SMAG reserves the right to amend any recommendation based on new reports or evidence that may arise after this report is submitted. We also emphasize the need to have continued evaluation and accountability of the implementation of these recommendations by an established body of internal and external stakeholders.

On behalf of the Special Medical Advisory Group and the VA New Hampshire Vision 2025 Task Force Subcommittee, I thank you for the opportunity to bring these matters to your attention. I am optimistic that this communication will help to establish a future of Veteran care in New Hampshire that is full-service and human-centered, with a whole health approach and ground-breaking partnerships driving the leading edge of healthcare evolution. Thank you for your leadership and dedication to ensuring VA deliver the best possible care to our Nation's Veterans.

Sincerely,

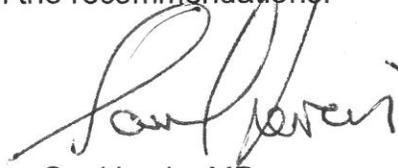


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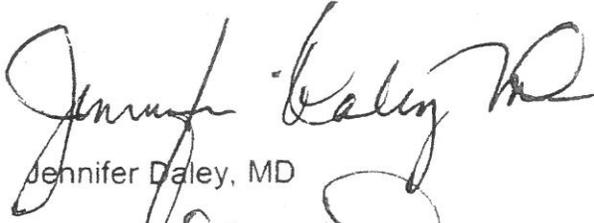
The SMAG members have reviewed and agreed on the recommendations.



Keith Cook, DPM



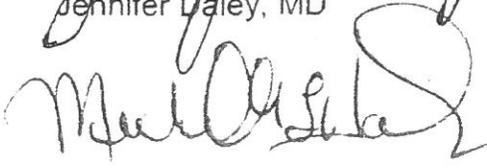
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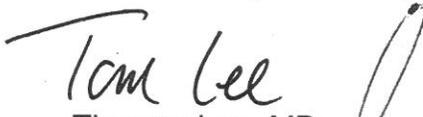
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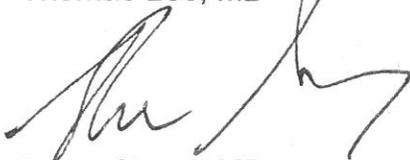
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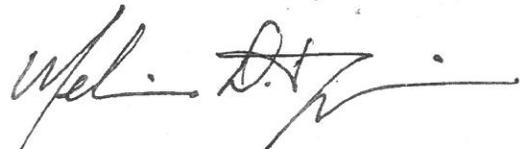
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# **Special Medical Advisory Group**

**VA New Hampshire VISION 2025 Task Force**



**Final Recommendations to the Secretary of the  
Department of Veterans Affairs**

***A New Vision for Full-Service Care***

***April 2018***

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## Executive Summary

### Vision Statement

The future of Veteran care in New Hampshire is full-service and human-centered, with a whole health approach and ground-breaking partnerships driving the leading edge of healthcare evolution.

### Background

#### **Origin of the Task Force**

On July 15, 2017, the *Boston Globe* Spotlight team released an article entitled, “Portrait of a four-star Veterans’ hospital: care gets ‘worse and worse.’”<sup>1</sup> The primary sources for the story were 11 Manchester VA Medical Center (VAMC) employee Whistleblowers who had raised concerns about patient safety and access to care at the facility. The Medical Center Director and Chief of Staff were subsequently removed, and the Director at White River Junction was made Acting Director in Manchester. Additional senior leadership from White River Junction immediately began providing support across both facilities.

Days later, a pipe failure caused severe flooding and the closure of several floors of the Manchester facility. This compounded existing clinic space needs and prompted the exploration of community partnerships. The Acting Medical Center Director pursued VA “hospital within a hospital” arrangements with local community hospitals, and this innovative model is succeeding. The initiative was advanced by an Executive Order from Governor Sununu allowing VA providers licensed outside New Hampshire to practice in community hospitals.<sup>2</sup>

On August 4, 2017, Secretary Shulkin announced the creation of the public-private VA New Hampshire Vision 2025 Task Force (“Task Force”). Established as a subcommittee of the Special Medical Advisory Group, the Task Force was charged with developing a vision for VA care delivery in the State that would best meet the needs of Veterans now and in the future.

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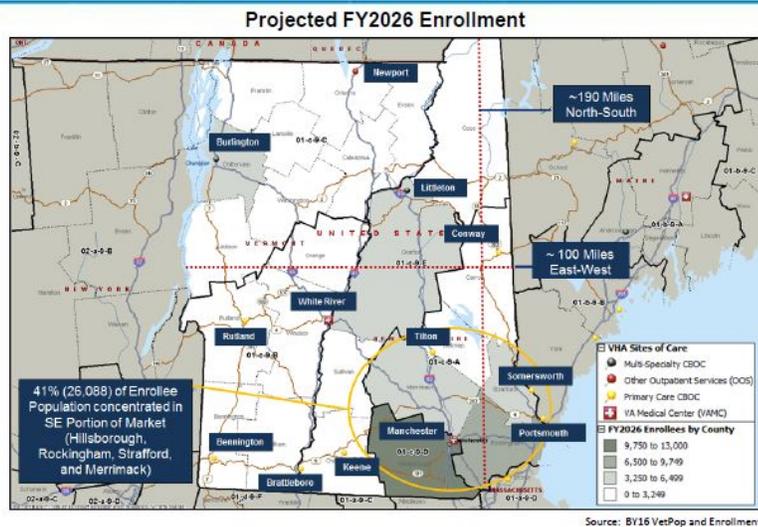
<sup>1</sup> Jonathan Saltzman and Andrea Estes, *At a four-star Veterans’ hospital: Care gets ‘worse and worse’*, BOS. GLOBE (July 15, 2017), <https://www.bostonglobe.com/metro/2017/07/15/four-star-case-failure-manchester/n9VV7BerswvK5akCgNzvK/story.html>.

<sup>2</sup> Exec. Order No. 2017-03, *An order suspending licensing requirements for United States Department of Veterans Affairs physicians due to flooding at the Manchester, NH Veterans Affairs Medical Center*, <https://www.governor.nh.gov/news-media/orders-2017/documents/2017-03.pdf>.

## VISN 1 North Market

The VISN 1 North Market is comprised of New Hampshire and Vermont and has a total VA enrollee population of ~63,000 (60<sup>th</sup> of 96 VA markets). The market is 64% rural and includes large expanses of low-density population areas; Critical Access Hospitals and Federally Qualified Health Centers provide care for some enrollees in the north. Veteran demand for care at VA sites is heavily tied to population centers, with 41% of demand originating from the Southern New Hampshire area. The enrollee population in the North Market is expected to remain stable over the next 10 years, but to decline by 13% in 20 years.<sup>3</sup>

Figure 1. Map of VISN 1 North Market with Enrollment



Source: VISN 1 North Market Assessment, Office of Policy and Planning, VHA

## Recommendations

After thorough review of all data and information available, extensive stakeholder engagement, and deliberations spanning many months, the New Hampshire Vision 2025 Task Force endorses recommendations that collectively achieve a new vision for full-service care of New Hampshire Veterans. With the direct input of Veterans and Manchester employees as a constant compass, the Task Force arrived at a vision that not only overcomes challenges, but recognizes larger trends in medicine and places New Hampshire at the leading edge of progress. The implementation of these recommendations will make New Hampshire and the North Market a model for the rest of the Nation and restore well-deserved trust and pride for Veterans in this area.

<sup>3</sup> Market Area Health Systems Optimization Workgroup, VISN 1 North Market Assessment (New Hampshire and Vermont (“North Market Assessment”)), January 5, 2018 (Revised March 20, 2018).

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Recommendations are grouped into three cohorts: 1) fundamental recommendations, on which the success of the subsequent recommendations depends; 2) interdisciplinary recommendations that involve multiple service lines; and 3) service line-specific recommendations.

## **Fundamental Recommendations**

- Sustained Investment in Organizational Culture  
Culture was a primary factor in Manchester's challenges. Completion of the *Manchester Culture Task Force* work is vital, as is proactive and ongoing leadership engagement with a focus on accountability at all levels of the organization. Employees need multiple specific options to elevate and resolve concerns before adverse events occur. The ecosystem culture – facility, regional, and National – should emphasize mission, ethics, teamwork, communication, and respect.
- Evaluation of Process, Metrics, and Role Efficacy  
Quality metrics did not automatically trigger examination of care delivery in Manchester. Providers were required to personally elevate clinical quality and facility cleanliness concerns in order for these to be addressed. This type of risk to Veteran well-being needs to be fully resolved, therefore the Task Force recommends: 1) ensuring that existing reporting mechanisms and quality standards are meaningfully implemented and; 2) review of care quality and culture metrics by an independent, external quality organization. Additionally, external assessment of interdisciplinary team roles and team productivity - with an emphasis on employees working to the top of their ability and/or licensure - will promote efficiency, enhanced access, and empowerment to raise concerns.
- Leadership Engagement of External Stakeholders  
When care delivery and structural challenges compounded in Manchester in 2017, the robust relationships with external stakeholders that could have eased the impact and accelerated solutions were not in place. Current leadership's proactive approach has been pivotal in turning Manchester in a better direction. Notably, Manchester employees, local Veterans Service Organizations, community healthcare organizations, the Governor's Office, the Congressional delegation, and the community at large are highly invested in the success and excellence of care delivery to Veterans in the State and region. This is a sound foundation on which further progress should be built.
- Emphasis on Educations and Awareness  
As today's inpatient procedures become tomorrow's ambulatory care, and as inpatient stays are reserved for cases of increasingly high acuity, New Hampshire Veterans will benefit from public-private partnerships that expand

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services ahead of this trend. Breaking from the traditional brick-and-mortar models of years past, the Task Force envisions comprehensive services delivered in innovative fashion, with greater accessibility and fewer barriers to care. This model, and many of the other recommendations that comprise this vision are concepts not well known among Veterans and the broader community, and a robust marketing and education campaign is necessary to communicate the Secretary's decisions for the way forward in New Hampshire and make these innovations accessible.

- Timely, Innovative Approach to Infrastructure

A critical element of any future vision for New Hampshire is renovation of the existing infrastructure on-site in Manchester. Much of the facility infrastructure is failing, and renovation is needed to provide a secure platform for clinical operations. Clinical services also require more space than is currently available, and “swing” space is needed to begin renovations without impact to care delivery. Furthermore, the Task Force advises a shift in capital assets philosophy – from VA as the sole construction planning and funding source to collaboration with the community on major projects. Engaging academic affiliate and community entities on joint ventures can create synergy, position VA as a leading collaborator, reduce project risk, and expedite timelines.

- Enhanced Regional Collaboration

The Task Force encourages regional collaboration, rooted firmly in the concept that efforts must not consolidate but rather regionalize for expansion of services. Close affiliation with White River Junction VAMC is paramount for growth and introduces the possibility of a Dartmouth academic affiliation that would bring intellectual invigoration and new pipelines of talent to New Hampshire. Structured regionalization of the two facilities should be further explored with full stakeholder engagement and, if pursued, implemented with a deliberate, phased approach. It is imperative that any steps taken result in benefit to Veterans in both States. Additionally, a regional shuttle system would enhance service line collaboration opportunities and create ease of movement for providers to bring care to more Veterans in the North Market.

- Focus on Right Care, Right Place, Right Time

The Task Force recognizes the pending reconfiguration of the Veterans Choice program as an opportunity to advocate for a transparent, efficient system that complements VA care and partnerships and minimizes bureaucratic burden on Veterans and providers. Additionally, consistency of eligibility rules across a region, aiming for the intersection of best possible access and greatest continuity of care, will facilitate partnerships across State lines.

- Leveraging Interdisciplinary Academic Affiliations

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Enhanced collaboration with the White River Junction VAMC opens the possibility of bringing the Dartmouth Geisel School of Medicine academic affiliation to Manchester. The lack of such an affiliation was identified by the Market Assessment as a key challenge to providing comprehensive, high-quality care in the facility. Additionally the Task Force advises an expansive, interdisciplinary approach to academic affiliations, building talent pipelines and enhancing recruitment and retention potential for nursing, social work, and other disciplines.

### **Interdisciplinary Recommendations**

- Creation of a Whole Health Community Care Center  
A Whole Health Community Care Center (CCC), similar to the Errera Community Care Center in West Haven, Connecticut, would provide wrap-around VA and community services to Veterans who are facing mental illness, substance abuse, homelessness, and other conditions at the intersection of medical and socio-behavioral care.
- Expansion of Telehealth and Virtual Services  
Enhancement of access through Telehealth, especially for rural Veterans and those needing Mental Health or specialty care, is feasible and necessary. Utilizing excess VISN Telehealth hub capacity and pursuing non-VA rural Telehealth sites will rapidly expand access and services.
- Combination of the Somersworth and Portsmouth Community Based Outpatient Centers for Expanded Services  
Veterans would benefit from the combination of the Somersworth and Portsmouth CBOCs, located just 20 minutes apart, into one larger “Seacoast” CBOC that offers expanded services. Combined patient volume could bring expanded specialty and other services on-site.

### **Service Line- Specific Recommendations**

- Medicine and Surgery
  - Establishment of an Ambulatory Surgical Center in Manchester
  - Inpatient services provided through community and network partnerships
- Primary Care
  - Right-sizing space and fully-staffing PACT
  - Supporting Women Veterans Through an Enhanced Women’s Clinic
  - Enhancement of Primary Care access via Telehealth
  - Enhancement of pain and opiate management programs
- Mental Health

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- Seamless Connection from Initial Point of Contact into Mental Health Services
  - Collaboration with the community to establish full spectrum of Mental Health services
  - Establishment of residential and intensive outpatient Mental Health services
  - Prosthetics and Rehabilitation Services
    - Creation of a regional amputation Center of Excellence in Manchester
    - Right-sizing space and staffing Rehabilitative services on-site at Manchester
    - Expansion of access to Rehabilitative services via CBOCs, Telehealth, and community partnerships.
  - Radiology
    - Right-sizing space and staffing Imaging services on-site at Manchester
    - Expansion of Imagine services into the CBOCs where appropriate
    - Expansion of Imaging services through partnerships
  - Geriatrics and Extended Care
    - Increasing the number of Community Living Center (CLC) beds on-site at Manchester
    - Expansion of home-based services, including Home Based Primary Care
    - Implementing the Social Work Case Management Model for medically complex, vulnerable Veterans.

## **Way Forward**

The public-private composition and specific mission of the New Hampshire Vision 2025 Task Force was novel within VA. Thus, the Task Force identified lessons learned for reference in future visioning work, best practices for use across the enterprise, and next steps to enable implementation of the Secretary's decisions on these recommendations. Recommended next steps include establishment of an Advisory Council for implementation accountability; secondary master planning and economic analyses; and a robust education and awareness campaign to communicate the envisioned future for Veteran care in New Hampshire.

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## General Overview

### Creation of the Task Force

On July 15, 2017, the *Boston Globe* Spotlight team released an article online (which ran on the front page of the Sunday edition of the *Boston Globe* on July 17) entitled, “Portrait of a four-star Veterans’ hospital: care gets ‘worse and worse.’”<sup>4</sup> The article articulated concerns raised by 11 whistleblowers to the VA Office of Accountability and Whistleblower Protection (OAWP) regarding patient safety and access to care at the Manchester VA Medical Center (VAMC). Following publication of the article, the Medical Center Director and Chief of Staff of the Manchester VAMC were removed from the facility; the Associate Director of Patient and Nursing Services also subsequently left the VA. Al Montoya, Director at White River Junction, was detailed to the Manchester VAMC as the Acting Director and was joined by the White River Junction Chief of Staff and other leadership to provide support at Manchester, many splitting their time between the two campuses. The New Hampshire Congressional delegation sent a letter to the Secretary of the VA requesting background information, and an investigation into the problems at the Manchester VAMC.

On July 19, 2017, the Manchester VAMC experienced substantial flooding causing the closure of several floors on-site. The Acting Medical Center Director began conversations with Catholic Medical Center (CMC), a local community hospital, about the possibility of VA patients accessing care at CMC. Patients were seen by VA providers at CMC starting on August 20, 2017, and similar agreements with other community providers were pursued and secured to allow Veterans to access care. This effort was buoyed by an Executive Order from the Governor of New Hampshire allowing Manchester VA providers licensed outside New Hampshire to practice in community hospitals.<sup>5</sup>

Representatives from across the VISN and VA National Network visited the Manchester campus to provide evaluation and support, including the Department of Nursing Services, the Office of Community Care, and the National Center for Patient Safety, among others. Reports prepared by the Office of the Medical Inspector (OMI) and OAWP are still pending at the time of the writing of this report. The VA Acting Under Secretary for Health visited the Manchester VA on July 24, 2017 to view the areas of the facility affected by the flood and to speak to employees and leadership.

Secretary Shulkin visited the Manchester VAMC on August 4, 2017 and announced the creation of the VA New Hampshire Vision 2025 Task Force (“Task Force”). The Task

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<sup>4</sup> Saltzman and Estes, At a four-star Veterans’ hospital: Care gets ‘worse and worse’.

<sup>5</sup> Exec. Order No. 2017-03.

Force was charged with developing a vision for VA care delivery in the State that would best meet the needs of Veterans presently and in the future. This comprehensive visioning charge was to involve robust input from Veterans and other key stakeholders, and to ultimately result in recommendations delivered to the Special Medical Advisory Group. Notably, the Task Force was created as a Subcommittee of the Special Medical Advisory Group (SMAG) and was subject to the Federal Advisory Committee Act.<sup>6</sup> Upon receipt of the Task Force recommendations, the SMAG will decide how and whether these recommendations go forward to the Secretary for decision. A multidisciplinary group of public and private sector subject matter experts from the Manchester VAMC, the local community, the VISN, and VA Central Office were brought together to form the Task Force.

### **VISN 1 North Market**

New Hampshire, the “Granite State”, is a small state rich in history and beauty. The first state to break away from Great Britain in 1776, its license plates still depict the state motto, “Live Free Or Die”. Coastline, mountains, and numerous rivers and forests grace its interior. The capital of New Hampshire is Concord, and the most populous city is Manchester.<sup>7</sup> Notably, New Hampshire’s population of just over 1.35 million is significantly rural. Manchester is the only city in the state with more than 100,000 residents, and Nashua is the only other city in the state with a population of over 50,000. The northern third of the state has just 5% of the state’s total population.

Figure 2 Geographic Map of Vermont



Source: World Atlas

Figure 3 Geographic Map of New Hampshire



Source: World Atlas

<sup>6</sup> Federal Advisory Committee Act, Pub. L. 92-463, 86 Stat. 770 (1972).

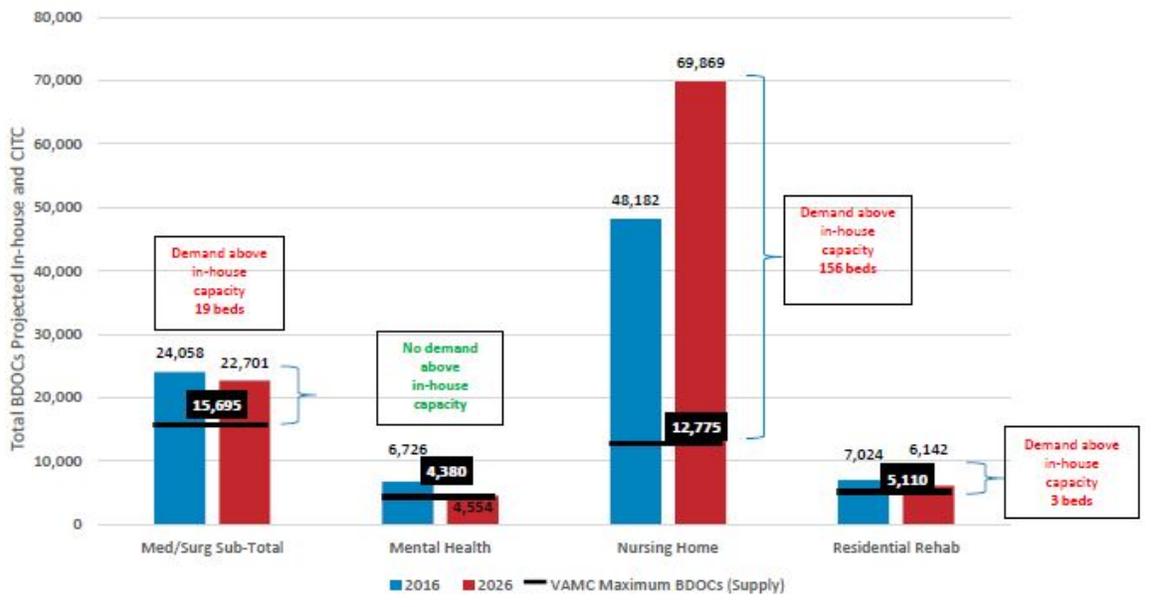
<sup>7</sup>New Hampshire Cities By Population, Demographics by Cubit, [https://www.newhampshire-demographics.com/cities\\_by\\_population](https://www.newhampshire-demographics.com/cities_by_population) (last accessed March 18, 2018).



the market where Critical Access Hospitals (CAH) and Federally Qualified Health Centers (FQHCs) are located. The Centers for Medicare and Medicaid Services designates CAHs as rural hospitals with 25 acute care beds or fewer and located more than 35 miles from another hospital. The Veterans Integrated Service Network (VISN) is currently using FQHCs to serve a portion of enrollees in the North Market. Additionally, these enrollees are generally older and are denoted by a lower VA Priority Category than the national average.

Veteran demand for care at VA sites is heavily tied to population centers. As such, demand growth is expected to follow future Veteran enrollee population around the south eastern portion of the market near the Manchester VAMC. Across the North Market, the Veteran enrollee population is expected to remain stable over the next 10 years. However, Veteran enrollment is projected to decline by 13% in 20 years.<sup>8</sup> The chart below show the North Market demand projections for inpatient care. General trend projections for individual service lines are discussed in greater detail in the following sections of this report.

**Figure 4 Veteran Enrollee Inpatient Projected Demand and VA Supply**



Source: VISN 1 North Market Assessment

<sup>8</sup> All information in this section came from the North Market Assessment

## Manchester VA Medical Center

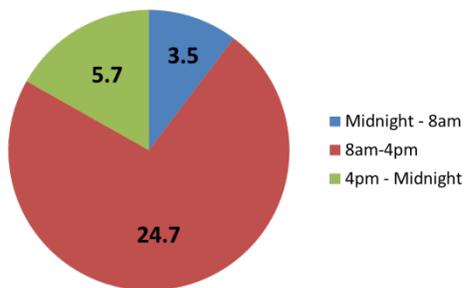
Figure 5 Manchester Area Outpatient Encounters

Facility	FY 16	FY 17	% Change
Manchester VAMC	349,588	340,845	-3%
Portsmouth CBOC	6,787	5,875	-13%
Somersworth CBOC	8,717	9,430	8%
Conway CBOC	4,109	3,811	-7%
Tilton CBOC	7,595	7,936	4%
<b>Total</b>	<b>376,796</b>	<b>367,897</b>	<b>-11%</b>

Source: VISN 1 North Market Assessment

Manchester VAMC is a Joint Commission accredited, complexity level three facility serving Veterans in southern and eastern New Hampshire. The Medical Center is located in Manchester, New Hampshire, and has four affiliated Community Based Outpatient Clinics (CBOCs) in Conway, Portsmouth, Somersworth and Tilton, New Hampshire. Manchester VAMC provides General Medicine and Surgical Acute Inpatient Care through a contract with Concord Hospital in the state Capitol, which is approximately a 20 minute drive north of the VA campus. The Manchester VAMC has a 41 bed Community Living Center (“CLC”) that includes a 35-bed CLC and a 6 bed Palliative Care Unit. The VAMC provides an array of outpatient services in Primary Care, Specialty Care, Mental Health, and Extended Care. Currently, the Manchester VAMC has a 24-hour Urgent Care on-site. However, the average Veteran patient demand between the hours of midnight and eight AM is only 3.5 Veterans, total.

Figure 6 Average Number of Urgent Care Patients Seen



Source: Urgent Care WHEN Hours

Prior to 1999, Manchester VAMC delivered inpatient acute and critical care services; however these units were closed after the medical center’s long standing affiliation with Boston Deaconess Hospital was ended by the affiliate, This change eliminated a trainee infrastructure to support 24/7 operation. Subsequently, concern about care, quality, and

safety due to reduced service volume led to the closure of the inpatient units. These two events began a long, often fraught discussion about New Hampshire Veteran’s access to a full spectrum of VA care. Many of these issues have remained unresolved in New Hampshire for the past 20 years and played a large role in the deliberations and recommendations of the Task Force.

The Manchester VAMC received its triennial review by the Joint Commission in 2015. The Manchester VAMC CLC is a participant in the unannounced survey process with the Long Term Care Institute (LTCI). During a recent survey by the LTCI, Manchester received zero Health and Safety Recommendations, including 25 different medication passes with 0 recommendations as well as 25 different control issues. This achievement is especially exemplary given the LTCI’s recent change to add an additional category to their survey.

Staffing for the services currently offered at the Manchester VAMC has proven to be an obstacle to care, in particular in regards to specialty providers. Many specialties at the Manchester VAMC are only 1-provider deep. Recruitment and retention of providers are severely impacted by the lack of an academic affiliation.

The infrastructure on-site at the Manchester VAMC is aging and in need of updating and replacement. The medical center is approximately 200,000 square feet short of ideal space. The boiler plant, electrical system, and the steam & chilled water loop are among the elements that must be updated to provide for a secure platform for clinical operations at the VAMC. Dedicated swing space is needed as there is a severe shortage of available square footage. However, a number of projects are in development to begin to address this disparity. Recently, a new Women’s Clinic was opened on the 6<sup>th</sup> floor of the Manchester VAMC. Additionally, two construction projects – a clinical services building and a specialty services building, both expected to add 13,000 square feet of space – are just wrapping up the design process. However, the campus at the Manchester VAMC is very small and can only accommodate limited construction at any given time due to the impact on clinical operations as well as parking. The chart below shows the existing square footage for services at the Manchester VAMC and affiliated CBOC.

**Table 1 Manchester VAMC Square Footage**

<b>Service</b>	<b>Existing SF (CAI) 6/2014</b>
Nursing	653
Diagnostic & Treatment	91,321
Behavioral Health	13,273
Long Term Care	18,200
Support	47,462
Education	2,371

Administration	30,267
Research	846
Infrastructure	2,174

The current state of seven service lines – Medicine and Surgery, Radiology, Primary Care, Mental Health, Rehabilitative Services, and Geriatrics and Extended Care – will be included in later sections.

### CBOCs

The chart below shows the services offered at each of the four CBOCs currently affiliated with the Manchester VAMC, as well as any notes about their location and the patients served.

**Table 2 Manchester VAMC Affiliated CBOCs**

<b>CBOC</b>	<b>Location</b>	<b>Services Offered</b>	<b>Unique Veterans Served (FY16)</b>
Conway CBOC	Shares a building with the New Hampshire Department of Health and Human Services	Primary Care Preventive Health Laboratory Mental Health Women’s Health New Patient Orientation Referrals to Other VA Services	~1000
Portsmouth CBOC	On-site of the Pease Air National Guard Base (Added Security Requirements to Enter)	Primary Care Preventive Health Chronic Health Management Mental Health Nutrition Women’s Health Physical Examinations Laboratory (Monday, Tuesday, Wednesday and Thursday mornings) Referrals to Other VA Services	~2200
Somersworth CBOC	N/A	Primary Care Preventive Health Chronic Health	~3000

		Management Mental Health Nutrition Physical Examinations Laboratory – Monday, Wednesday and Friday mornings Referrals to other VA Services	
Tilton CBOC	N/A	Primary Care Preventive Health Chronic Health Management Physical Examinations Nutrition Laboratory (Tuesday and Thursday mornings) Referrals to Other VA Services	~2112

Figure 7 FY16 CBOC Workload

Station Number	CBOC Size	Station Name	Unique SSNs	# of Encounters	Avg. Cost per Encounter
608GA	3 - Medium	<a href="#">PORTSMOUTH VA CLINIC</a>	1,912	<a href="#">3,832</a>	\$318
608GC	3 - Medium	<a href="#">SOMERSWORTH VA CLINIC</a>	2,367	<a href="#">4,603</a>	\$326
608GD	2 - Small	<a href="#">CONWAY VA CLINIC</a>	1,081	<a href="#">2,166</a>	\$330
608HA	2 - Small	<a href="#">TILTON VA CLINIC</a>	1,777	<a href="#">3,748</a>	\$351
			<b>7,137</b>	<b>14,349</b>	

Source: Voi North Market Somersworth and Portsmouth CBOC Location Analysis

## White River Junction VA

Figure 8 White River Junction VAMC and Affiliated CBOCs



Source: Teresa Stearns, Quality Manger; Katherine Tang, Public Affairs Officer, White River Junction

Figure 9 White River Junction Area Outpatient Encounters

White River Junction Area Outpatient Encounters			
Facility	FY 16	FY 17	% Change
White River Junction VAMC	360,414	354,114	-2%
Bennington VA Clinic	14,330	14,206	-1%
Brattleboro VA Clinic	8,009	8,493	6%
Burlington VA Clinic	36,080	38,164	6%
Littleton VA Clinic *	14,209	13,934	-2%
Keene VA Clinic	5,198	4,877	-6%
Rutland VA Clinic	10,871	10,729	-1%
Newport VA Clinic		1,783	N/A
<b>Total</b>	<b>449,111</b>	<b>446,300</b>	<b>1%</b>

Sources: 1. VSSC Outpatient Encounters Cube 2. Connected Care Report 3. Percent of Population  
 \* Per WRJ leadership on 03/19/18, Littleton FY17 encounters updated to adjust for inappropriate workload mapping.

Source: VISN 1 North Market Assessment

White River Junction VAMC (“WRJ VAMC”) is a Joint Commission accredited 60-bed surgical complexity level 2 facility with a 14-bed Residential Recovery Center and 74 total beds. The facility provides care for 26,342 unique Veterans across its two-state hospital service areas, including Vermont and the four contiguous counties of New Hampshire. WRJ VAMC is located in White River Junction, Vermont, and operates

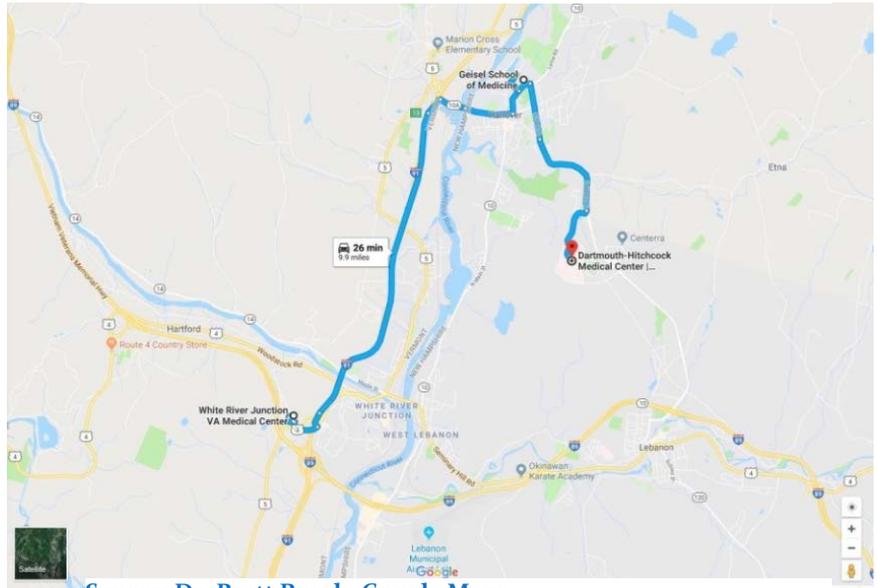
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CBOCs in five Vermont locations: Bennington, Brattleboro, Burlington, Newport, and Rutland; and two New Hampshire communities, Keene and Littleton. WRJ VAMC hosts five national VA Centers: Executive Division of the National Center for Post-Traumatic Stress Disorders (PTSD); Hub Site for the National Quality Scholars Program; Field office for National Center for Patient Safety (NCPS); the Field Office to the Rural Health Resource Center – Eastern region; and the New England Healthcare Engineering Partnership.

The WRJ VAMC is closely affiliated with the Geisel School of Medicine at Dartmouth, the University of Vermont College

**Figure 10 Distance Between WRJ VAMC and the Geisel School**

of Medicine, and over 40 nursing and allied health teaching affiliations. The facility actively supports research and residency training programs. The close relationship with Dartmouth is at least partially due to proximity; even though Dartmouth is located in New Hampshire, it is only about 15 minutes away from the WRJ VAMC campus. Acute inpatient services at the WRJ VAMC are essential to the success



**Source: Dr. Brett Rusch, Google Maps**

of the Dartmouth affiliation and the future of the medical center. For example, the Geisel School has created a number of residency programs, including Palliative care, Pulmonary, Cardiology and ophthalmology, on the assumption that the VA system will provide the patients to sustain these programs. Additional programs offered at the WRJ VAMC are a 24 hour emergency room and a residential lodge.

The WRJ and Manchester VAMCs are roughly 1 hour and 15 minutes apart via car. There is currently no easily accessible public transportation available between the two.

### **Task Force Decision Making Process**

The VA New Hampshire Vision 2025 Task Force convened monthly face-to-face meetings and additional conference calls in its effort to determine the best way forward for VA healthcare of New Hampshire Veterans. Initial meetings and calls achieved the aim of gathering relevant information for future decisions. The table below shows the date of the meeting and the inputs received by the Task Force during each meeting.

Table 3: Data Inputs Received by the Task Force

Date of Meeting	Input Received
September 13, 2017 Conference Call	<ul style="list-style-type: none"> <li>➤ Review of the Charter</li> <li>➤ Ethics Training</li> <li>➤ Overview of Subcommittee Process</li> <li>➤ Review of Meeting Schedule</li> </ul>
September 25, 2017 Conference Call	<ul style="list-style-type: none"> <li>➤ Market Assessment Overview</li> <li>➤ Data Set Overview</li> </ul>
October 3-4, 2017 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ Data Set Review</li> <li>➤ Communication Plan Review</li> <li>➤ Listening Session – State Veterans Advisory Committee/Veteran Service Organizations</li> <li>➤ Listening Session – Congressional Staffers</li> <li>➤ All Employee Forum</li> <li>➤ Tour of the Manchester VAMC</li> <li>➤ Listening Session – Manchester Whistleblowers</li> </ul>
October 16, 2017 Conference call	<ul style="list-style-type: none"> <li>➤ Market Assessment Update</li> <li>➤ Manchester VAMC Master Planning Analysis</li> </ul>
October 31-November 1, 2017 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ Mental Health Service Line Draft Report</li> <li>➤ Focus Group Report</li> <li>➤ Surgery Service Line Draft Report</li> <li>➤ Manchester Way Forward</li> <li>➤ Manchester Culture Update</li> <li>➤ Medicine Service Line Draft Report</li> <li>➤ Radiology Service Line Draft Report</li> <li>➤ Rehabilitation Service Line Draft Report</li> <li>➤ Primary Care Service Line Draft Report</li> <li>➤ Geriatrics and Extended Care Service Line Draft Report</li> </ul>
November 13, 2017 Conference call	<ul style="list-style-type: none"> <li>➤ VA Delivered Foundational Services &amp; Locally Determined Services</li> <li>➤ Data Set Updates</li> </ul>
November 29-30, 2017 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ Mental Health Service Line Update</li> <li>➤ Rehabilitation Service Line Update</li> <li>➤ Surgery Service Line Update</li> <li>➤ Medicine Service Line Update</li> <li>➤ Radiology Service Line Update</li> <li>➤ Primary Care Service Line Update</li> </ul>

	<ul style="list-style-type: none"> <li>➤ GEC Service Line Update</li> <li>➤ Cate in the Community/Veterans Choice</li> <li>➤ Manchester Culture of Improvement Update</li> </ul>
December 18, 2017 Conference call	<ul style="list-style-type: none"> <li>➤ Focus Group Update</li> </ul>
January 9-10, 2018 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ VISN 1 North Market Assessment</li> <li>➤ Manchester VAMC Facility Working Tasks</li> <li>➤ Focus Group/Survey Update</li> </ul>
January 22, 2018 Conference call	<ul style="list-style-type: none"> <li>➤ Telehealth information</li> <li>➤ Service Lines – Criteria and Guidance Review</li> </ul>
February 14-15, 2018 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ Focus Group/Survey Update</li> <li>➤ Errera Community Care Center</li> <li>➤ Manchester Culture Task Force Update</li> <li>➤ Final Option Evaluations and Reports from all Seven Service Lines</li> <li>➤ Coordination of Services between WRJ and Manchester – Current State</li> </ul>
March 14-15, 2018 Face-to-face meeting at the Manchester VAMC	<ul style="list-style-type: none"> <li>➤ Final Survey and Focus Group Report</li> <li>➤ Updated Way Forward presentation</li> <li>➤ Status update from the Manchester Culture Task Force</li> </ul>

While outreach on specific topics was ongoing, the Task Force moved to the decisional phase of its charge at its January face-to-face meeting. Considering the inputs above, Task Force members worked through a series of facilitated exercises and discussion, ultimately identifying seven criteria that served as the lens through which potential options were evaluated. By numerical vote, the Task Force also weighted the importance of each criterion; this ranking was revisited and refined at the next face-to-face meeting in February. The ranking was not intended to be a “hard and fast” cut off, rather a decisional tool to ensure the Task Force was considering its core values when evaluating potential recommendations. A brief description of each criterion is included below.

- **Veteran Centered Care:** The Veteran is at the center of any and all care provided by the VA, whether care occurs physically or virtually by VA providers or

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in the community. Any option put forward must reflect Veteran focus group and online feedback and must be mindful that the needs of the Veteran population in New Hampshire will change over time. Needs of Veterans must be considered first and foremost, without inherent constraints due to bureaucratic process or policy, historical resource limitations, or traditional models of care delivery.

- **Potential to Foster Relationships and Partnerships:** The future of VA care for New Hampshire Veterans is most promising with strong regional partnerships. The Manchester VAMC's ability to foster relationships with national and VISN 1 sites and entities (e.g., White River Junction VAMC and telehealth hubs), Federal partners (e.g., Department of Defense sites and Federally Qualified Health Centers), academic affiliates, and community providers is essential to achieving the best possible care. Partnerships must be of primary benefit to New Hampshire Veterans.
- **Employee Empowerment:** The ongoing input, specific needs, and professional fulfillment of employees at the Manchester VAMC are of critical importance. The best options will create a sense of pride and excitement for working within and contributing to the facility's future, enhance potential for recruitment and retention, and empower employees to innovate, teach, and develop professionally in ways that elevate morale and improve Veteran care.
- **Preserving and Fulfilling the Mission of the VA:** Veterans must be able to distinguish the care they receive within or through VA as being of exceptional quality and experience. Options should preserve the unique mission of VA and elevate the VA "brand", promoting trust in care and services. The best options will be innovative, placing VA at the leading edge of modern care delivery.
- **Timely Access to Appropriate, Evidence-Based Care:** VA must deliver high quality care to New Hampshire Veterans where they need it, when they need it, and how they need it. Options should incorporate current models and technology with the aim of improving timeliness, convenience, and experience.
- **High Value Use of Resources:** For agility in the setting of changing Veteran needs and system resources over time, options should place an emphasis on VA foundational services and take advantage of established community services to supplement care. VA must be able to sustain a high level of care.
- **Feasibility:** Options must be supported by trend and projection data regarding Veteran's future use of VA care, taking into consideration necessary time, resources, and personnel.

In addition to the criteria above, the Task Force developed a list of concepts of particular interest for service lines to consider as they revisited their proposed options. These included: 1) Virtual Care; 2) Opportunities for increased partnership with White River Junction; 3) The Errera Community Care Center (community-based rehabilitation

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center at VA Connecticut) whole health model; and 4) other innovative opportunities for partnerships in the community.

With guidance on these concepts, the service lines reviewed and refreshed their previously submitted options in light of the criteria and concepts of interest. The Task Force reviewed these revised options at its February face-to-face meetings, and at that meeting developed a set of draft recommendations. Recommendations fell into three categories: core, thematic recommendations; interdisciplinary recommendations across multiple services; and service line-specific recommendations. The Task Force members discussed the broad themes behind these draft recommendations at a number of listening sessions with New Hampshire VSOs, Vermont VSOs, and Congressional representatives from the North Market. The Task Force finalized these recommendations in this report, including development of Lessons Learned, Best Practices, and Way Forward sections at its last face-to-face meeting in March 2018.

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## Recommendations

After thorough review of all data and information available, extensive engagement with stakeholders, and deliberations spanning many months, the Task Force developed and endorses the recommendations described below. Each recommendation is centered on the direct feedback of Veterans, VA employees, and stakeholders, and the Task Force believes each is a vital piece of the envisioned future of VA care in New Hampshire. Recommendations were developed with deep consideration of new methods for expanding access to care and enhancing experience, drawing on the innovation and strength of the community and region to accomplish these aims. The following recommendations are grouped into three cohorts: 1) foundational, non-clinical recommendations on which the success of the subsequent recommendations depends; 2) interdisciplinary initiatives that involve multiple service lines; 3) service line-specific recommendations for Medicine and Surgery; Radiology; Primary Care; Mental Health; Rehabilitative Services; and Geriatrics and Extended Care. Background information regarding the current state of each service line will be included at the beginning of the section.

## Fundamental Recommendations

The following recommendations aim to ensure that challenges experienced at the Manchester VAMC leading up to the creation of the Task Force will be prevented

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moving forward, and that the future of service to Veterans through this facility and its partners will be increasingly collaborative, Veteran-centered, and of exceptional quality.

### **Sustained Investment in Organizational Culture**

The Task Force notes that the ongoing work of the *Manchester Culture Task Force* is vital for the future of care delivery and employee experience in Manchester. The *Manchester Culture Task Force* is an effort to engage leadership and employees and build collective understanding of the shared behaviors, values, and mindsets that now exist. From that foundation, the team is beginning to describe a new experience that emphasizes ethics, teamwork, communication, trust, and respect. The Task Force further notes that the absence of specific leadership-driven mechanisms to promote cultural health previously contributed to declines in employee empowerment, effective communication across teams, care delivery, and a collective ability to identify and resolve challenges. The Task Force advocates that a proactive focus on culture be maintained going forward and advises the following:

- Regular facility and regional leadership engagement in structured discussions of organizational culture, with specific focus on employee fulfillment and empowerment;
- Formal and informal rewarding of those who elevate concerns in a timely fashion and prevent negative impact to Veterans, and deliberate efforts to create a safe and supportive environment for employees when they raise concerns;
- Multiple specific, well-communicated process options and contacts for elevating and resolving concerns, including outside chain of command;
- Proactive leadership engagement of clinical staff in decision-making relevant to care delivery;
- Leadership support for professional development, interdisciplinary collaboration, innovation;
- Emphasis on accountability at all levels of the organization, specifically including all levels of leadership, to encourage collective elevation in quality of service delivered;
- Complementary investment in healthy culture at the regional and national levels as this ecosystem directly influences culture within facilities;
- Processes to empower leadership and employees to suggest and implement innovative ideas to improve care;
- Increased frequency of cultural health measurement and timely response to results.
- Utilization of available tools, including the 360 Assessment process through the National Center for Organization Development (NCOD), incorporated into the

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personal development plan (PDP) of all levels of leadership, including service line chiefs and other supervisors. Another example is use of the Quarterly Employee Satisfaction Surveys, which are currently in the process of being implemented for the first time, with results expected mid-April 2018.

### **Evaluation of Process, Metrics, and Role Efficacy**

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 national public and private sector quality assurance organizations and evaluation standards for facilities of similar scope to Manchester, the Task Force advises:

- Deliberate steps to ensure that the existing virtual reporting process for clinical quality concerns, with the option of reporter anonymity and including leadership feedback, is in meaningful effect;
- Alignment with evidence-based quality standards (e.g., The Joint Commission), including tracking of sentinel events and 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;
- Commitment to tracking of team efficiency metrics and a deliberate effort to identify and disseminate best practices, including interdisciplinary staffing models proven to increase workflow efficiency and thereby enhance team capacity and Veteran access;
- Commitment to adequately staffing each unit to allow for sufficient support for providers and optimal Veteran access to care
- Encouragement of workflow efficiencies and productivity levels to best serve Veterans
- Engagement of an external organization to benchmark interdisciplinary role definitions, team efficiency metrics, and safety concern reporting processes with industry leaders; focus on team members working to the top of their ability and licensure.

### **Leadership Engagement of External Stakeholders**

Across months of extensive listening sessions with external stakeholders, the Task Force identified a common theme: these entities had desired greater openness and communication with leadership long prior to the creation of the Task Force. When care delivery and structural challenges compounded in Manchester in 2017, the robust

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leadership relationships with external stakeholders that could have eased the impact and accelerated solutions were not in place. Since that time, positive impact has grown in response to Manchester leadership's new and proactive approach. The Task Force notes that New Hampshire stakeholders - VSOs, local hospitals and organizations, the Congressional delegation, and the community at large - are highly invested in the success and excellence of care delivery to Veterans in the State and region; this is a sound foundation on which further progress can be built.

The Task Force advises:

- Frequent facility and regional leadership engagement with external stakeholders, including those listed above and expanding as strategic priorities demand;
- Commitment to an approach that prioritizes transparency, proactive communication, and trust-building.

### **Emphasis on Education and Awareness**

The delivery of medical care is evolving, and the Task Force recognizes that a vision for 2025 needs to look forward, anticipating trends and crafting care delivery that puts VA at the leading edge of progress. The future of full-service Veteran care in New Hampshire is human-centered, integrated, innovative, and collaborative. As today's inpatient procedures become tomorrow's ambulatory care, and as inpatient stays are reserved for cases of increasingly high acuity, New Hampshire Veterans will benefit from public-private partnerships that expand services ahead of this trend. Breaking from the traditional brick-and-mortar model of years past, the Task Force envisions comprehensive services delivered in innovative fashion, with greater accessibility and fewer barriers to care.

Many of the recommendations that comprise this vision – a Community Care Center, an Ambulatory Surgical Center, and integrated Mental Health services – are not concepts that are commonly known among the Veteran population or the larger community in New Hampshire. The Task Force recognizes these innovative ideas can only be effective and successful in improving care if Veterans and employees understand what they are and how to utilize them. Many of these ideas will distinguish New Hampshire VA care from any other site in the country, and Veterans deserve to understand and be proud of these accomplishments. Additionally, transparency and a deliberate, ongoing effort to engage the community throughout implementation will help assuage the uncertainty and concern that can accompany change. The Task Force advises development of a robust marketing and education campaign to communicate the Secretary's decisions for the Way Forward in New Hampshire and the region. Specifically, the Task Force recommends that this campaign include information on how

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the adopted recommendations will improve overall VA care in New Hampshire and the North Market, and on how to access new services as they become available.

### **Timely, Innovative Approach to Infrastructure**

A critical element of any future vision for VA healthcare in New Hampshire is necessary renovation of the existing infrastructure on-site in Manchester. The Task Force received data on the current state of the Manchester VAMC, and much of the infrastructure at the current facility is failing. The boiler plant, electrical system, and the steam & chilled water loop are among the elements that must be updated to provide for a secure platform for clinical operations at the VAMC. Additionally, a number of service line-specific recommendations include expansions that would require more space than is currently available; not only is space needed for these services, but swing space is needed to begin renovations without impact to care delivery. Further assessment is needed to understand the extent to which a retrofit of the current site would satisfy anticipated needs, or whether new construction beyond the specifics of this report will be needed. However, it is clear that for the current infrastructure to continue to be useful, a number of improvements must be made.

The current VA budgeting and construction process is an obstacle to refurbishment of the existing VA infrastructure as well as the construction of new space, as is the leasing process for accessing space in the community. Time is of the essence for all of the recommendations put forward in this report; most are desperately needed services for which there are currently limited avenues of access for Veterans in New Hampshire.

The Task Force advises a shift in philosophy for internal capital assets management - from VA as the sole construction planning and funding source to collaboration with the community on major projects. Engaging academic affiliates and community entities in joint ventures can create synergy, position VA as a leading collaborator, reduce project risk, and expedite timelines. The strengths of VA programming can also be highlighted in joint spaces (e.g., joint venture to lease/build Mental Health space that is badly needed in the private sector as well, highlighting VA PTSD care). The Task Force advises leveraging public-private partnerships to increase space wherever possible, either as a bridge to new construction or for the construction itself. Where construction is undertaken by the VA, the Task Force advocates the use of alternative options, such as minor construction and non-recurring maintenance (“NRM”) projects to expedite the process.

Ernest Bland & Associates previously completed an analysis of structural options for the Manchester VAMC.<sup>9</sup> The Task Force advises that an updated analysis be completed,

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<sup>9</sup> See Ernest Bland & Associates, Facility Planning Meeting 1 Day Session, November 30, 2017.

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fitting the recommendations in this report and taking into context potential engagement of community partners as previously described. The Task Force also advises that decision-makers consider specific elements and options for rapid advancement of service delivery and “quick wins” building a roadmap to completion of a longer range plan.

### **Enhanced Regional Collaboration**

In a few short months, new Manchester leadership has forged highly effective partnerships that allow the facility to better serve New Hampshire Veterans. New relationships with multiple community hospitals have provided access and timeliness that would not have been possible within the VAMC while it was under flood repair. Service line collaboration and discussions of academic affiliation have been strengthened with the WRJ VAMC. New partnerships with world-class New Hampshire bionics and prosthetics companies have been established. Notably, the latter recently resulted in a Veteran receiving bilateral bionic arms - a preeminent achievement in the Nation and world. The Task Force believes that partnerships with familiar and emerging partners across the North Market, within the VA system and beyond, are a critical piece of the way forward in providing the best quality care to Veterans in New Hampshire. The Task Force encourages the strengthening and maintenance of existing relationships and the continued exploration and development of new avenues to enhance care delivery.

The Task Force wishes to underscore the importance of ongoing collaboration between the Manchester and White River Junction VAMCs. Multiple service lines currently collaborate for care delivery across the two facilities, and there is much overlap in population and service area. The Pathology and Laboratory service line has been unified dating back to 2000-2001, and in the wake of the July 2017 challenges and flood, collaboration efforts have organically grown. Increased collaboration between Cardiology, Pulmonary, Radiology, and Sleep Medicine services, among others, has demonstrated expansion of access and added value across facilities. The Task Force encourages this growing collaboration, rooted firmly in the concept that efforts must not consolidate or diminish services in either state, but rather expand services across the North Market. Notably, collaboration creates potential to solve current service gaps in New Hampshire, including in ophthalmology, optometry, and dental care. Close affiliation also introduces the possibility of a Dartmouth academic affiliation and interdisciplinary training opportunities, which would bring intellectual invigoration and new pipelines of talent to New Hampshire. The importance of academic affiliation cannot be overstated, and this will be further explored in a subsequent recommendation.

As the White River Junction leadership team began to demonstrate successful recovery of services and progress while in Acting roles in Manchester (the Chief of Staff and others devoting time to both facilities), the prospect of structured regionalization came to be promoted by multiple stakeholders. The Task Force recommends exploring further collaboration opportunities as they arise, underscoring that regionalization would need to unequivocally benefit Veterans in each State. Exploration and any steps taken should be done with full transparency and broad stakeholder engagement, including Veterans, employees, VSOs, State partners, and Congressional delegations. Additionally, any regionalization pursued should be done with a thoughtful, deliberate, phased approach, achieving success of each phase before the next is pursued.

An additional element needed to facilitate increased service line collaboration across the region is a robust, interfacility shuttle system for providers, Veterans, family members, and caregivers. While the aim of collaboration should be to bring provider services to Veterans rather than burden the Veterans with any additional travel, this shuttle system could support those Veterans that choose to or need to travel for specific services. The 78 mile distance between Manchester and White River Junction and the lack of available public transportation make the development of a coordinated transportation system an enormous accelerator for access and experience. Additionally, shuttle services to Boston or other facilities in the region should be considered. The Task Force specifically recommends exploring shuttle options that would allow providers to work in transit and have appropriate amenities for Veterans.

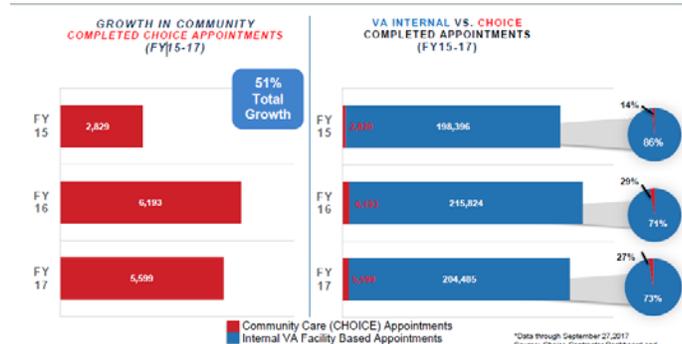
**Focus on Right Care, Right Place, Right Time**

The Task Force recognizes that the Veterans Choice program is part of VA’s duty to provide the most accessible and timely care possible for every Veteran we serve. The pending reconfiguration of this program

will be a factor in future North Market access to both inpatient and outpatient services and the Task Force advises advocating for a transparent, efficient system that complements VA care and partnerships while minimizing bureaucratic burden on Veterans and providers. Additionally, consistency of

eligibility rules across the Market will facilitate partnerships across State lines that complement VA care and partnerships. This “Veteran-first” approach prioritizes strategic community and regional partnerships that aim for the intersection of best-

**Figure 11 New Hampshire's Growth in the Community**



**Source: Choice Presentation - November 29, 2017**

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possible access and greatest continuity of care. Conceptually, the Task Force advises that VA providers remain at the center of care coordination for all Veterans who choose VA as their primary system. The Task Force strongly encourages strategic thinking around ways to lighten the burden that the administrative processes and paperwork associated with use of the Choice program places on both Veterans and VA and community providers. Finally, the Task Force believes that in order for the VA to be a strong partner within the community, bills must be paid to the community in a timely and efficient manner, and there must be accountability when these processes breakdown.

### **Leverage Interdisciplinary Academic Affiliations**

Enhanced collaboration with the WRJ VAMC would open the possibility of bringing the Dartmouth Geisel School of Medicine academic affiliation to Manchester. 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. This initiative would open up a number of options to allow Manchester to expand care services on-site and beyond. For example, Dartmouth currently has funding for Palliative, Pulmonary, Cardiology and Ophthalmology residency programs. These programs were created with a reliance on the VA to provide patients and clinical opportunities. Academic affiliation will invigorate training and professional development opportunities for clinicians at all levels. This also builds a talent pipeline and enhances recruitment and retention potential, thereby enhancing access for Veterans.

An immediate benefit of strong affiliations would be resident augmentation of understaffed service lines at Manchester, some of which consist of only one provider with no backup. Residents and fellows will provide both intellectual invigoration and a relief from the burden of solo coverage, allowing employed providers to offer an even more attentive level of care to Veterans.

As the Dartmouth Geisel School of Medicine is located within New Hampshire's borders, it is intuitive that Veterans and trainees in the State benefit in complement.

The importance of affiliations in all disciplines, including nursing and social work, cannot be overstated. Several of the initiatives pursued by VA and listed in this report, including staffing of Patient Aligned Care Teams and investment in Home Based Primary Care, are heavily dependent on nursing and other services. Academic affiliations in this and other areas strengthen pipelines of talent and also prepare more future providers to be able to competently care for Veterans.

Bringing a broad lens to geography, the Task Force recommends engaging potential affiliates within New Hampshire, the Boston area, and even beyond – including innovative partners like the Uniformed Services University of the Health Sciences

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(USUHS). These may offer world class opportunities for bilateral education; trainees can provide important care for Veterans and in turn benefit from New Hampshire's unique strengths, learning about ground-breaking technologies like the LUKE arm prosthesis and special amputee needs not offered within their school curriculum.

The Task Force believes exceptional benefit will be gained by an expansive affiliation approach, whereby Veterans receive a high level of care with improved access and interdisciplinary student's experience the personal satisfaction of applying their skills in service to our nation's Veterans.

## **Interdisciplinary Recommendations**

The Task Force acknowledges the necessity of collaboration across teams for the effective delivery of health care and supports several interdisciplinary recommendations. The following recommendations aim to improve care delivery across multiple clinical and social services, ultimately elevating quality of life for Veterans in New Hampshire and the North Market.

### **Creation of a Whole Health Community Care Center**

The Task Force advocates the creation of a Community Care Center (CCC), similar to the Errera Community Care Center in West Haven, Connecticut, to offer integrated services to Veterans who are facing mental illness, substance abuse, homelessness, and other issues at the intersection of medical and socio-behavioral care. As demonstrated effectively by the Errera Center, the Task Force supports the inclusion of Primary Care, Mental Health, Rehabilitative Services, and Geriatrics and Extended Care in this space. A Homeless Patient Aligned Care Team (HPACT) would be ideally placed at the CCC, allowing homeless Veterans easy access to other tangential services. The HPACT at the Errera Center is currently the top performing HPACT nationally for care management, connecting Veterans to housing and to substance abuse treatment. A variety of outpatient Mental Health services are envisioned at the center as well, including a Community Reintegration program, addiction recovery programs, Mental Health Intensive Case Management (MHICM), Transitional Supported Employment Services (TSES), Peer Support Specialists, and Critical Time Intervention (CTI) programming.

The original Errera Center was instrumental in proving the efficacy of programs such as MHICM and TSES, and served as a "mentor site" to allow these programs to spread across the VA nationally.<sup>10</sup> The Errera Center has received innovation grants from the

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<sup>10</sup> See RA Rosenheck, M Neale, P Leaf, R Milstein, and L Frisman. Multisite Experimental Cost Study of Intensive Psychiatric Community Care, SCHIZOPHRENIA BULL (1995), 21:129-140; RA Rosenheck and MS

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VA related to use of electroconvulsive therapy (ECT) to address Veteran suicide, their “Vet-to-Vet” group diabetes program, and the development of Buprenorphine home induction applicators. In the vision for such a center in Manchester, a Geri-MHICM program would complement MHICM, offering specialized services to aging Veterans with serious Mental Health concerns. A variety of rehabilitative services, including Occupational Therapy, Physical Therapy, and chronic pain management programs, could also meaningfully coexist in such a space. With the efficiency of co-located, interdisciplinary teams, the Task Force anticipates that providers serving on-site in this model could also bring expertise across the market or region via Telehealth.

Of note, the current Errera Center model continues to be highly desirable to the academic affiliates of the VA Connecticut Healthcare System. Currently, students from several other regional medical, social work, nursing, and psychology schools rotate through the Errera Center. Among the affiliated programs are Yale Medical School, University of Connecticut Medical School, Fairfield Nursing School, and Yale Nursing School. Yale Medical School students, in their first week of training, spend time at a homeless shelter that frequently serves Veterans, then walk side-by-side with Veterans down the side of the highway to the Errera Center, hearing their stories and beginning to learn the special considerations involved in providing healthcare to the Veteran population.

A new CCC in Manchester would need to be located centrally and on a public transportation line for best access. As typified by the Errera Center, the development and expansion of resources in this model would be co-designed by a Veteran consumer council, community partners, and VA. This Community Care Center would embody the VA’s commitment to whole health, bringing together multiple service lines and community entities to provide innovative health delivery and wellness care. While the Task Force recognizes that the Errera Center model serves as an excellent reference point, there is opportunity to uniquely shape a Community Care Center (CCC) in Manchester to the unique needs of Veterans in New Hampshire and foster continued innovation.

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 while building a mutually-supportive community. This would be accomplished by establishing a large community space and kitchen, where Veterans would be able to make and share a hot meal and interact with others. Social space would be available that is comfortable and

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Neal. Cost-Effectiveness of Intensive Psychiatric Community Care for High Users of Inpatient Services. ARCHIVES GEN PSYCHIATRY (1998), 55(5):459-466; RA Rosenheck and AS Mares. Implementation of Supported Employment for Homeless Veterans with Psychiatric or Addiction Disorders: Two-Year Outcomes. PSYCHIATRIC SERVICES (2007), 58: 315-324.

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accommodating to Veterans, as well as their families and children. A wellness center, with exercise equipment and trained staff, would assist Veterans in pain rehabilitative programs and also promote health and wellness in the larger Veteran community. The CCC would also serve as a Community Resource and Referral Center (“CRRC”) for Veterans facing housing insecurity, where they can access housing support and basic needs such as laundry, showers, and a place to temporarily store belongings. A number of job training and other employment services would also be co-located at the CCC. Per the National Call Center for Homeless Veterans, the Errera Center and VA Connecticut receive the most calls in the VISN to support Veterans who are homeless or at risk for homelessness; averaging 34 calls a month.<sup>11</sup> Most importantly, the CCC would provide space where other community services – such as legal and employment services– could meet with Veterans and contribute important supports to address various factors that impact Veteran wellness. For example, the Task Force envisions local Veterans’ Service Organizations (VSOs) holding office hours to assist Veterans in accessing their benefits. The current Errera Center has a robust medical-legal partnership (MLP) that spans both campuses, and was part of a four year research study with Bristol Meyers studying the positive effects of MLPs.<sup>12</sup> A study published in December 2017 in *Health Affairs* showed that Veterans who receive legal help with housing, benefits, and consumer or personal matters have increased income, fewer problems recommendation housing, and even experience some Mental Health benefits.<sup>13</sup>

There are many committed organizations in New Hampshire – such as Easter Seals, Veterans Count, Home Base, Harbor Homes, and Liberty House – that the Task Force believes would make good use of this space to connect directly with Veterans. The ideas described here are just an initial concept of how this center could serve New Hampshire’s Veterans. The Task Force envisions the CCC as an important opportunity to provide for the total health and wellbeing of the Veteran.

## **Capital Assets Considerations and Implementation**

Space for the CCC would likely be procured via a leased space in the Manchester area.

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<sup>11</sup> National Call Center for Homeless Veterans (FY17).

<sup>12</sup> Peggy McCarthy, Study: Integrating Legal Aid With Medical Care Improves Veterans’ Lives, Hartford Courant (December 5, 2017, 9:25 AM), <http://www.courant.com/news/connecticut/hc-news-Veterans-health-20171205-story.html>; Bill Hathaway, Vets who receive medical-legal aid show improvements in Mental Health, Yale News (December 4, 2017), <https://news.yale.edu/2017/12/04/vets-who-receive-medical-legal-aid-show-improvements-mental-health>; National Center for Medical Legal Partnership. The Invisible Battlefield: Veterans Facing Health-Harming Legal Needs in Civilian Life (June 2016).

<sup>13</sup> Jack Tsai, Margaret Middleton, Jennifer Villegas, Cindy Johnson, Randye Retkin, Alison Seidman, Scott Sherman, and Robert Rosenheck. Medical-Legal Partnerships At VeteransAffairs Medical Centers Improved Housing and Psychosocial Outcomes for Vets. 36 HEALTH AFF. 12 (December 2017), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0759>

The Task Force estimates that the leased space for the original site would likely be under the \$1 million in serviceable rent threshold of a major lease. While this project is developed, the Task Force encourages increased outreach to community partners in Manchester and beyond to lay the ground work for the center. Included in the Addendum is a location in Manchester currently available for lease that the Mental Health Subgroup of the Task Force recommended as an ideal location for the future CCC.

Should the Secretary ultimately recommend a Community Care Center in the Manchester area, the Task Force suggests that engagement of a number of stakeholders as the project is operationalized, including representatives from the Errera Center, Veteran consumers from across the Market, clinical representation from the Primary Care, Mental Health, Rehabilitation, and Geriatrics and Extended Care service lines, and representation from community and Veterans Service Organization in New Hampshire.

**Expansion of Telehealth and Virtual Services**

The Task Force advocates 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 is also available in more than 50 specialties. At the time of this report, the five VISN 1 Telehealth hubs all have additional capacity to support Manchester and the North Market. Notably, the Veteran population in this market is more than 60% rural. The “top five” volume clinical video Telehealth (CVT) clinics in FY17 for Manchester Veterans were Clinical Pharmacy, Mental Health Clinic – Individual Sessions; Nutrition and Diabetes – Individual Sessions; Amputation Clinic; and Physical Therapy.

**Table 4 VISN 1 Telehealth Hubs and Location**

<b>TeleHealth Hubs – VISN 1</b>
VISN 1 TeleMental Health – VA Connecticut
National TeleMental Health Center – VA Connecticut
TeleDermatology – Providence VAMC; VA Boston
TeleSpinal Cord Injury – VA Boston
TeleRetinal Imaging – VA Boston

**Figure 12 Manchester Connected Care Utilization FY18**

FY 18	Measure	Performance Numerator	Performance Denominator	% of Population
(1V01) (608) Manchester, NH HCS	Telehealth Use (Tele1)	785	25,549	3.07 %
	Home Telehealth (Tele2)	434	25,549	1.70 %
	Clinical Video Telehealth (Tele3)	273	25,549	1.07 %
	Store and Forward Telehealth (Tele4)	105	25,549	0.41 %
	<a href="#">eConsult (SC10)</a>	305	25,549	1.19 %
	Video Telehealth to Off Site Patients (Tele9)	6	25,549	0.02 %

Measure

\* Home Telehealth Vendor Extract 2017-12-23 \* Clinical Video and Store & Forward updated 2018-01-13

\* eConsult and SCAN ECHO updated 2018-01-13 \* Report Run Date 2018-01-15

**Source: VISN 1 Telehealth Dashboard Through 01/15/18**

Specific challenges faced by Manchester could be ameliorated by expanding virtual care delivery. For example, the Urgent Care in Manchester typically sees few Veterans between midnight and the early morning, making it difficult to justify personnel and resource expense during those hours. Other facilities and regions have demonstrated that creating an interdisciplinary contact center environment, complete with licensed independent providers and Telemedicine, can drastically reduce unnecessary Emergency Department and Urgent Care visits. This trend is also increasingly seen in the private sector. Providing this type of virtual care can prevent a reduction in services due to volume or space constraints, and can instead create enhancement in access, experience, timeliness, and convenience.

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

On this basis, the Task Force specifically advises:

- Immediate engagement of VISN 1 Telehealth hubs to bring additional Telehealth services to New Hampshire Veterans, addressing regulatory hurdles that impact their function
- Exploration of collaboration with Telehealth programs at other facilities in the region to rapidly accelerate expansion;
- A concerted effort to identify space, personnel, and resources necessary for Telehealth expansion within each service line in Manchester and in the affiliated CBOCs;

- 
- Commitment to adequate physical space reserved in each site for Telehealth services, so that Veterans and providers have easy access to Telehealth without disrupting other care offered on-site;
  - Leadership team engagement of the VA Office of Rural Health and other stakeholders, locally and nationally, inside and outside the VA;
  - Public-private collaboration to establish non-VA Telehealth sites of care, focusing first in rural areas with the greatest access barriers. Potential options may include Veterans Service Organization locations, other Federal property, and State, county, or city locations, among others;
  - Exploration of bandwidth and technological capacity in the State followed by consideration of VA strategic partnerships with telecommunications providers to expand Broadband access and other services for the benefit of Veterans.

### **Combination of the Somersworth and Portsmouth Community Based Outpatient Clinics for 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 “Seacoast” 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. The CBOCs offer Primary Care, Mental Health, and tangential services such as nutrition and some laboratory services. Each clinic currently has insufficient space to effectively expand to meet volume and specific service demands. Additionally, the Portsmouth CBOC is currently located on the grounds of the Pease Air National Guard Base, which creates access barriers for some Veterans. Included in the chart below is the Veteran utilization of the Somersworth and Portsmouth CBOCs for FY17.

Figure 13 Veteran Utilization at Somersworth and Portsmouth CBOC (FY17 Encounters)

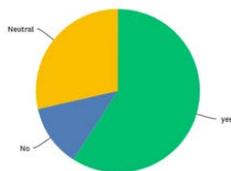
Facility	Mental Health	Primary Care	Specialty Care
<b>(1V01) (608GA) Portsmouth, NH</b>	<b>913</b>	<b>3,690</b>	<b>139</b>
<i>(23031) York, ME</i>	<i>185</i>	<i>703</i>	<i>25</i>
(33001) Belknap, NH	10	13	1
(33003) Carroll, NH	33	45	3
(33013) Merrimack, NH	1	7	
(33015) Rockingham, NH	377	2,023	67
(33017) Strafford, NH	287	739	39
Counties outside of sector	20	160	4
<b>(1V01) (608GC) Somersworth, NH</b>	<b>2,636</b>	<b>4,870</b>	<b>409</b>
<i>(23031) York, ME</i>	<i>534</i>	<i>814</i>	<i>53</i>
(33001) Belknap, NH	44	116	3
(33003) Carroll, NH	218	452	22
(33013) Merrimack, NH	5	12	
(33015) Rockingham, NH	270	284	20
(33017) Strafford, NH	1,474	3,135	311
Counties outside of sector	91	57	0
<b>Grand Total</b>	<b>3,549</b>	<b>8,560</b>	<b>548</b>

Source: Voi North Market Somersworth and Portsmouth CBOC Location Analysis

Figure 14 Survey Response - Combined CBOC

Currently there are two CBOCs a short distance from each other - Somersworth and Portsmouth. Both serving a similar, small volume of patients with limited onsite services. There is an opportunity to expand services available if the two CBOCs are combined into one larger CBOC. Would you be supportive of combining the two smaller CBOCs into a larger CBOC?

Answered: 812 Skipped: 1



ANSWER CHOICES	RESPONSES
Yes	59.1% 480
No	12.32% 100
Neutral	28.57% 232
<b>TOTAL</b>	<b>812</b>

Source: Veteran Survey Responses updated March 2018

The combination of these two clinics at a new location would allow for expanded state-of-the-art facilities. The

Task Force envisions expanded services to include Cardiology, endocrinology, rehabilitative, imaging, and specialty services, as needed. Even if those services were not housed every day at the new CBOC, space could be made available for providers to rotate through and see Veterans on an intermittent basis, preventing some travel to the Manchester campus and increasing convenience for residents of the Seacoast region. The Task Force also believes that the new CBOC may be an ideal place to locate dental services, which are currently

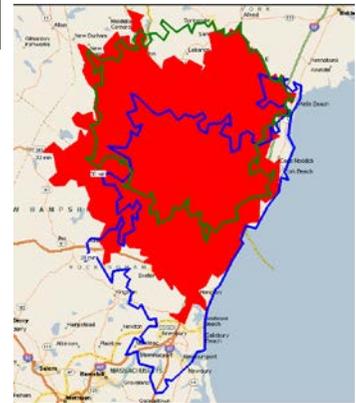
scarce for Veterans in New Hampshire. The location could also potentially serve as a hub from which to offer telehealth services across the state and North Market, and space could also be designated for various community services to connect with

Veterans, especially while the Community Care Center is being created (and eventually the CBOC could evolve into a CCC satellite site, offering similar services).

The idea of combining the two small CBOCs into a larger centralized space with a wider range of services is widely supported by the Veteran population in New Hampshire. In response to a survey question regarding the concept, 59% of Veteran respondents offered their support.



Figure 15 Estimated 30 Minute Drive Times for New Location



Source: V01 North Market Somersworth and Portsmouth CBOC Location Analysis

### Capital Assets Consideration

As part of the Market Assessment conducted by the Office of Policy and Planning, the Dover area of New Hampshire was identified as the optimal 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 options for a new CBOC. In addition to exploring different leasing and contract options, the Task Force also believes that a community partnership with a local medical facility that has available space should be strongly considered when selecting a site.

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### Service Line Specific Recommendations

In addition to the interdisciplinary recommendations described above, the Task Force supports a number of specific recommendations in the areas of Medicine and Surgery, Imaging, Primary Care, Mental Health, Rehabilitative Services, and Geriatrics and Extended Care. Common themes include: 1) a commitment to right sizing space and staffing each service to meet anticipated need and VA standards of care; 2) updating infrastructure and maintaining new structures where built; 3) establishing partnerships across the Market to expand the services available to Veterans in the area; and 4) bringing the care to the Veteran rather than requiring the Veteran to travel for care - through expanded CBOC services, home-based services, and Telehealth.

Background information on the current state of each Service Line is included at the beginning of the individual sections.

The Task Force acknowledges that all of the service lines will experience a future space gap per the future usage projections for the North Market. The Task Force aimed to

provide several options to address this future space concerns, through the use of both  
[Figure 16 VHA Space Gap Analysis \(Includes CBOCs\)](#)

Calculator Category	Space Calculator Projections	Existing SF (CAI) 6/2014	Future Gap
Nursing	455	653	198
Diagnostic & Treatment	176,934	91,321	-85,613
Behaviorial Health	19,200	13,273	-5,927
Long Term Care	95,760	18,200	77,560
Mental Health Residential Rehab			
Support	86,750	47,462	-39,288
Education	4,386	2,371	-2,015
Administration	49,117	30,267	-18,850
Research		846	846
Infrastructure	18,887	2,174	-16,713
<b>TOTAL</b>	<b>451,489</b>	<b>206,567</b>	<b>-244,922</b>

Source: EBA Presentation, Progress Meeting 1 Day Work Session, October 18, 2017

new construction and retrofitting and updating current space. Below are the projected future space gap calculations for all service lines. The total estimated future space gap across all VA sites in New Hampshire is 244,922 square feet.

## Medicine and Surgery

### Background Information

Overall, there has been an 8% growth in Medical specialty patients and workload over the past 5 years. This growth has continued, even though the total number of Veterans in the geographic area has declined. The total square footage of the Medicine Specialty at the Manchester VAMC is below the square footage recommended under current VHA guidance for the current Medicine workload. At the Manchester VA, the Department of Medicine services are split between 2 non-contiguous floors. Staffing for medical specialty providers is currently at 68%, though there are 5 potential candidates currently in the interview process.

The surgical services provided on-site at Manchester have been eroded over the past 5 years. The Manchester OR was closed for renovations from approximately July 2012 to July 2014. They were still ramping up services when the flood occurred on July 19, 2017. One OR had been closed since October 2016 due to a cluster fly issue. Steps to mitigate this issue have been taken and the space is actively monitored (there have been no flies in the OR space for the last four months). The Manchester Surgical Service is currently classified as a Basic Ambulatory Surgical Center. As such, it meets the infrastructure requirements to do a wide variety of lower risk procedures in General Surgery (including Breast, Soft tissue, and anorectal), Podiatry (foot), ENT, Eye,

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Facial/Plastics, Gynecology, Orthopedics, Thoracic, Urology and Vascular surgery. Staffing is not adequate to meet current need, and providers needed include a General Surgeon, ENT Surgeon, Ophthalmologist, Anesthesiologist and a GYN. Many of the surgical programs, especially ENT, require a complete overhaul of equipment and instruments in order for the VAMC to run a meaningful program.

At present, there are no operating room procedures performed in ENT, Eye, Plastics, Podiatric Surgery, Thoracic or Vascular Surgery, and relatively limited services in Urology. In fiscal year 2016, there were 1025 cases done in the OR's at the Manchester medical center, only 423 of which were actual ambulatory basic surgical cases; the remainder (602) were GI endoscopies were performed in the OR suite. In the same year, a total of 1501 ambulatory basic surgical cases, which could have been done at the medical center, were sent to other VA's in the VISN such as WRJ VAMC and VA Boston Healthcare System or out to Community Care (Choice not included), because appropriate providers and equipment were not available at Manchester.

### **Recommendations**

The Task Force has arrived at five overarching recommendations that form the future vision for the medicine and surgery service lines. Of utmost importance is the concept that the combination of these recommendations must achieve full-service care delivery to New Hampshire Veterans.

The recommendations that together form the basis of a new vision for surgical and inpatient full service care are:

- Establishment of a comprehensive Ambulatory Surgical Center in Manchester;
- Inpatient services provided through community and network partnerships. Such partnerships should be pursued with the energy and commitment that would in past times have been devoted to brick and mortar construction;
- Service line regional collaboration, as described above;
- Expansion of key specialty services into CBOCs, where demand supports; the feasibility of mobile teams could also be considered for some specialties.
- Increased use of Telehealth to bring services into CBOCs and across the market.

The concepts of ASC establishment and partnerships for inpatient care are further described below.

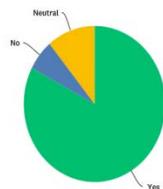
### **Construction of an Ambulatory Surgical Center in Manchester, New Hampshire**

The Task Force finds that the construction of an Ambulatory Surgical Center (ASC) in Manchester is needed to meet and exceed the needs of Veterans in New Hampshire and expand the Manchester VAMC to a state-of-the-art facility. As the practice of medicine trends away from inpatient care and toward comprehensive ambulatory services, this facility positions New Hampshire as a national leader in healthcare. The facility is envisioned to provide comprehensive procedural care delivery, including a full range of ambulatory surgery,

**Figure 18 Survey Response - Outpatient Surgery at Manchester**

Do you support the recommendation that Manchester VA provided a full spectrum of outpatient surgery, with more extensive inpatient surgery being done at the local community partner hospitals?

Answered: 766 Skipped: 3



**Source: Veterans Survey Responses updated March 2018**

Another element of the new ASC would be a reconfigured Urgent Care space. As previously mentioned, current utilization of the Urgent Care during the nighttime hours is extremely low, and the requirement to provide adequate staffing during those hours places a strain on the facility. The Task Force supports the creation of a full service Urgent Care Center as part of the new ASC, with development of virtual support and a community alliance for after-hours service. Urgent Care would also support all the specialties working within the ASC. Notably, a change in Urgent Care location or function would require an extensive educational and outreach campaign. If a community alliance for nighttime hours were established, Veterans would need to know the parameters for accessing community Emergency Departments without fear of suffering financial consequences.

**Figure 17 Trend in Surgical Care**

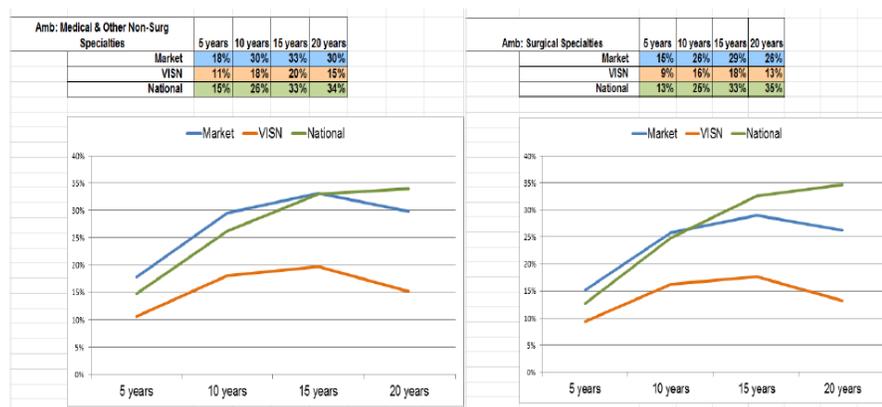


**Source: OPP ADUSH Presentation, February 2018**

basic and advanced GI and Pulmonary endoscopy, urology, minor orthopedic procedures, a broad spectrum of Radiology and imaging, and cataract surgery. Additionally, the Task Force advises that further refinement of this idea include discussion of psychiatric procedures and specific services not currently offered in Manchester or White River Junction. This would allow Veterans to remain in-state for a wide array of procedures, and would offer a way forward for Manchester to specialize in certain procedures for Veterans across the North Market, the region, and even nationally. Many (if not all) of the procedures and services that Veteran’s in New Hampshire want and require access to (cataract procedure, minor to mid-level orthotic surgeries, and all but the most complex cardiac procedures) are envisioned to be offered at the future ASC.

Complementary to the concept of regional collaboration, establishment of an ASC 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 retention as it allows providers to see patients and perform a variety of surgeries at both the Manchester and White River Junction facilities. 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 into a larger network of care, with the possibility of follow-up care being provided at those clinics through either a rotation of specialty providers at the clinic sites or via telehealth services. Further collaboration would also benefit White River Junction, because it would ensure there was enough to demand to maintain its inpatient services, allow access to new services not currently offered, and increase access to existing service offerings.

**Figure 19 Projected Trend in Ambulatory Care**



**Source: Manchester Task Force Data Set**

## Capital Assets Considerations

The Task Force recognizes that the construction of an ASC on-site at Manchester is a long-term project. The Task Force understands that there is an established process through which large scale construction projects must move. However, the Task Force strongly recommends the strategy outlined under *Timely, Innovative Approach to Infrastructure*, engaging community partners where possible to accelerate progress. The Task Force also encourages consideration of all possible options to expedite establishment of an ASC, including leasing options as a bridge to construction, as well as splitting construction up into several smaller projects.

In the short term, pending the completion of new ASC 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. This is currently being successfully

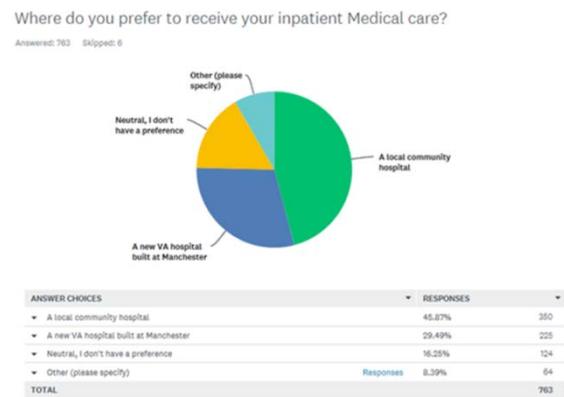
executed at Elliot Hospital and Catholic Medical Center.

Also of note, Telehealth used from the ASC to CBOCs or other locations will require adequate internet strength and bandwidth to transmit live streamed video, and also for the secure transmittal of any necessary clinical information. Designated Telehealth space is also a requirement such that provision of Telehealth services does not disrupt the delivery of on-site care to Veterans.

### Inpatient Services Provided through Community and Network Partnerships

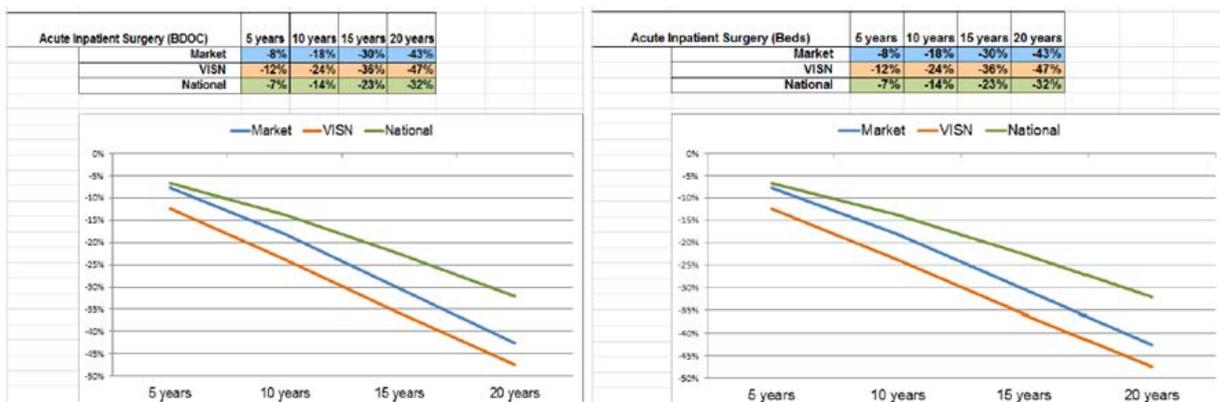
A full spectrum of options for delivery of inpatient services to Manchester Veterans were considered and remained on the table throughout the Task Force process. However, the data received, including direct Veteran and provider feedback, guided the work in the direction of providing full-service through partnerships. The outcome showed that Veterans' number one priority is to receive inpatient care close to home, regardless of who is delivering it or where it is provided.<sup>14</sup> This recommendation is centered on the input the Task Force heard from the Veterans in New Hampshire and employees in Manchester; strong trends in healthcare toward ambulatory services, with inpatient care reserved for increasingly high acuity cases; and a vision of an innovative

Figure 20 Survey Response - Inpatient Care



Source: Veteran Survey Responses updated March 2018

Figure 21 Projected Trend in Inpatient Care



Source: Manchester Task Force Data Set

future with New Hampshire as a model for the rest of the country. Projected utilization

<sup>14</sup> See Veteran Survey Responses updated March 2018

data shows the demand for inpatient services in the North Market decreasing over time, a trend not unique to the North Market or even to the VA.<sup>15</sup> The urgency of providing full-service care to New Hampshire Veterans now was highly considered, as was the future benefit of investment in partnerships vs. a brick and mortar endeavor. There is a high probability that by the time a new inpatient facility was constructed, there would no longer be enough demand to sustain its use. The Task Force wishes to emphasize that access to local inpatient services – as close to home as possible – is an absolute necessity for New Hampshire Veterans. Robust partnerships should be pursued with the same amount of energy that would have been devoted in past years to major construction. Partnerships for inpatient service need to be secure and robust to the point that Veterans in New Hampshire are fully able to rely on these services, regardless of geography.

## Primary Care

### Background Information

Primary Care is a VA Foundational Service. The number of unique patients and encounters for Primary Care at the Manchester VAMC and affiliated CBOCS are shown in the tables below. Overall there has been an upward trend in the number of Veterans seeking Primary Care services at Manchester and the affiliated CBOCs. This growth has continued, even though the total number of Veterans in the geographic area has declined. The number of Women Veterans utilizing the VAMC and CBOCs for Primary Care has grown at an even faster rate.

**Table 5: Five Year Growth - Manchester Primary Care Outpatient Uniques**

Site	FY12	FY13	FY14	FY15	FY16	FY17	Sparkline
Manchester VAMC	13,790	14,117	13,830	14,028	14,389	14,077	
Women's Population**	—	724	693	720	819	879	
Portsmouth CBOC	1,643	1,694	1,718	1,790	1,912	1,939	
Somersworth CBOC	2,279	2,276	2,368	2,325	2,368	2,395	
Conway CBOC	842	874	905	919	1081	918	
Tilton CBOC	1,542	1,425	1,526	1,651	1,778	1,803	

\*\*Manchester VAMC only; Phone clinic uniques not included in this number

Source: Manchester Task Force Data Set, Run: 9/15/2017

<sup>15</sup> Alex Kacik. To build or not to build? Micro-hospitals gaining favor with health systems amid shift to ambulatory care. MOD. HEALTHCARE (February 17, 2018), [http://www.modernhealthcare.com/article/20180217/NEWS/180219951?utm\\_source=modernhealthcare&utm\\_medium=email&utm\\_content=20180217-NEWS-180219951&utm\\_campaign=dose](http://www.modernhealthcare.com/article/20180217/NEWS/180219951?utm_source=modernhealthcare&utm_medium=email&utm_content=20180217-NEWS-180219951&utm_campaign=dose)

**Table 6: Five Year Growth - Manchester Primary Care Outpatient Encounters**

Site	FY12	FY13	FY14	FY15	FY16	FY17	Sparkline
Manchester VAMC	38,502	34,508	31,844	34,964	36,986	34,508	
Women's Population**	—	1,418	1,367	1,389	1,665	1,782	
Portsmouth CBOC	3,835	3,682	3,703	3,540	3,839	3793	
Somersworth CBOC	5,156	4,930	4,707	4,681	4,624	4978	
Conway CBOC	2,207	2,210	2,004	1,971	2,177	1993	
Tilton CBOC	3,481	3,368	3,514	3,589	3,787	3581	
**Manchester VAMC only; Phone clinic uniques not included in this number							

Source: Manchester Task Force Data Set, Run: 9/15/2017

The total square footage of Primary Care space at the VAMC and related CBOCs is 22,003.50 square feet. At the VAMC, Primary Care is currently split into two adjacent yet separate locations on the first floor of the facility. There is a Women’s clinic located on the 6<sup>th</sup> floor of the VAMC. However, this space currently contains only two dedicated exams room, a very small waiting area, and no private entrance. In addition, there is a provider team which provides Primary Care services to homeless Veterans, both by going out into the community and seeing Veterans at the VAMC. This team falls under Mental Health services at Manchester.

The current combined space gap for Primary Care space at the Manchester VAMC (based on recommendations under

current VHA guidance) is 24,500 SF. Ideally, Primary Care services in the VA are provided according to the Patient Aligned Care Team (“PACT”) model, with each Veteran assigned a teamlet consisting of a Provider, RN, LPN/LVN/HT, and Clerk. Additional discipline-specific team members must 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 1200, and 900 for a Nurse Practitioner. Currently, the Primary Care staff at the Manchester VAMC and

**Table 7: Manchester Primary Care Space (SF)**

Site	SF
Manchester VAMC	13,300.92
Women's Clinic	1,107.63
Portsmouth CBOC	1,124.61
Somersworth CBOC	2,196.34
Conway CBOC	2,032.65
Tilton CBOC	2,241.35
<b>Total</b>	<b>22,003.50</b>

Source: VISN 1 Capital Asset Inventory

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related CBOCs includes 22 Provider Full Time Employee Equivalent (“FTEE”) with 1.7 Provider float FTEE; 22 RN FTEE, with 1.0 Provider float FTEE; 22.8 LPN/HT FTEE with 2 LPN/HT float FTEE; and 11.3 MSA FTEE.. Staffing levels for the expanded care team are: 1.5 Clinical Pharmacist FTEE; 1.0 anticoagulation CPS; 3.0 social work FTEE; and 3.5 PCMH FTEE. The current Primary Care management team consists of a full-time health systems specialist, administrative officer (also the PCMM Coordinator), and secretary. There is a full-time Nurse Manager for the VAMC and for the CBOCs, and a half-time assistant Nurse Manager for both the VAMC and the CBOCs.

### **Recommendations**

Primary Care has been incorporated in multiple prior recommendations. It is one of the service lines that the Task Force believes should be included as part of the services offered at a new Community Care Center. Additionally, Primary Care forms the basis of services provided at all VA CBOC’s, and thus it would be a major component of the proposed Seacoast CBOC. Finally, Primary Care space is one element that could be incorporated into a new ASC. Beyond these prior recommendations, the Task Force has made three additional recommendations related to Primary Care:

- Incorporation of sizing per the PACT model, including the extended care team, and wellness areas into redesigned Primary Care Space;
- Support of Women Veterans by enhancing the Women’s Clinic and moving the location;
- Expansion of Primary Care services via Telehealth and Tele-Primary Care;
- Enhancement of 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 space and fully staffing PACT**

Current Primary Care space at Manchester has a space gap of roughly 50% the recommended space per VA standards of care. This gap is expected to persist through 2020 if no action is taken. Given the status of Primary Care as a VA Foundational Service, the Task Force endorses exploring capital asset options to right-size this space and integrate discipline-specific team members into PACT, e.g., clinical pharmacists, anticoagulation specialists, registered dietitians, Mental Health providers, and social workers. Space should provide the opportunity for co-location of 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

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cessation, physical activity, shared medical appointments and other uses. PACT space design guidance should be followed.

### **Supporting Women Veterans Through an Enhanced Women's Clinic**

The Task Force also believes that the needs of Women Veterans must be carefully considered. Women Veterans are a growing demographic within the Veteran population, and the VA must continually evolve to meet the unique needs of this group. The Task Force suggests co-locating a Women's clinic adjacent to the redesigned Primary Care space. A separate entrance and waiting area for the Women's clinic are necessary components to promote a sense of safety, privacy, and security. Adjacency allows the two services to share back office functions, while concurrently allowing women Veterans to easily access supplemental wrap-around services such as Integrated Primary Care – Mental Health, clinical pharmacists, and social work.

### **Enhancement of Primary Care access via Telehealth**

The Task Force finds a need to expand access not just to Primary Care but to various tertiary services such as 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, facilitate coverage at smaller sites, and could even potentially provide support for the wider North Market and VISN. Expansion would also support rural Veterans and those with barriers to traveling for care. Providers could connect with Veterans at the CBOCs, at the Veteran's home, and at non-VA sites of care.

Currently, 3% of the Veterans users at the Manchester VAMC have access to a Telehealth encounter as part of their overall care plan. The internal goal is to increase this to 20% over the next 2-3 years. The Task Force supports and encourages this plan.

### **Enhancement of pain and opiate management programs**

The opioid crisis has had a greater impact in New Hampshire than in many states across the Nation, and the Task Force finds that there is a need to increase access to integrative approaches to pain management. Such programs are envisioned to include complementary and integrative health services, e.g., physiatry, anesthesia, neurology, opioid tapering clinics with clinical pharmacy support, pain psychology, acupuncture, Battlefield acupuncture, yoga and tai chi, chiropractic care, and massage therapy. 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.

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## 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 would require relatively minor alterations; swing space can be used for this purpose with readily available equipment such as yoga mats and the ability to dim the lights. Future sites of Primary Care and Mental Health clinical space should be co-located as closely as possible, given their status as Foundational Services and the high level of overlap in patient population and programming.

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. Additionally, there must be adequate physical space at the VAMC and/or CBOCs to accommodate the provision of Telehealth services without disrupting the care offered to the Veterans who see their provider on-site.

## Mental Health

### Background Information

Mental Health is a VA Foundational Service. The number of unique patients and encounters for Mental Health at the Manchester VAMC and affiliated CBOCS are shown in the tables below

**Table 8: Five Year Trend - Mental Health Outpatient Uniques**

Site	FY12	FY13	FY14	FY15	FY16	FY17	Sparkline
Manchester VAMC	4062	4140	4288	4371	4712	4648	
Portsmouth CBOC	130	260	355	356	332	296	
Somersworth CBOC	286	293	417	385	463	532	
Conway CBOC	200	219	181	152	121	81	
Tilton CBOC	232	248	207	192	145	309	

Source: VSSC Encounter Form Pyramid

**Table 9: Five Year Trend - Manchester Mental Health Outpatient Encounters**

Site	FY12	FY13	FY14	FY15	FY16	FY17	Sparkline
Manchester VAMC	25630	29471	30930	30268	34824	34285	
Portsmouth CBOC	505	995	1252	1324	1166	937	
Somersworth CBOC	982	909	2364	2078	2563	2674	
Conway CBOC	799	806	742	781	529	341	
Tilton CBOC	743	827	666	711	1382	1706	

**Table 1 Source: VSSC Encounter Form Pyramid**

Veterans who receive Mental Health care at Manchester have varying levels of Mental Health needs, with some needing immediate, acute care. Nine Involuntary Emergency Admissions (IEAs) took place for NH Veterans from March 1, 2017 to Feb. 28, 2018. Not seemingly a high number, but these are of course the most emergent and challenging psychiatric situations, and often pose great difficulty when attempting to place the Veteran in an available bed at one of the receiving centers

The table below shows the Mental Health services currently available at VA facilities across New England. There are 332 inpatient psychiatry beds across VISN 1, located in Connecticut, Central Western Massachusetts, Providence, Boston, Bedford, White River Junction, and Maine.

**Figure 22 VISN 1 Mental Health Service Offerings**

Mental Health Services	Togus	WRJ	Bedford	Boston	Manchester	Northampton	Providence	Connecticut
Inpatient Care								
Residential Rehabilitation (RRTP)								
Low Threshold Housing (SAFE Haven)								
PCMH								
General Mental Health Ambulatory Care/BHIP								
PTSD Care								
SUD/Dual Diagnosis								
Intensive Outpatient Services								
MH Intensive Case Management								
Recovery/SMI								

**Source: Mental Health Uniform Services Package**

The services currently offered at the Manchester VAMC include General Mental Health, PTSD care, PCMHI (Primary Care Mental Health Integration), SUD/Dual Diagnosis (Substance Use Disorder), and Recovery/SMI. The current square footage for Mental Health Space at the Manchester VAMC is 12270 square feet, which is 50% less than the needed space per current VHA standards of care.

On January 9, 2018, a new Presidential Executive Order (EO) was issued, “Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life.”<sup>16</sup> The EO expands Mental Health programs and other resources to new Veterans to the year following their departure from uniformed services provided the Veteran served on active duty and received an honorable discharge. The EO includes the elimination of prior time limits, expansion of peer community outreach, and expansion of community groups. Veterans do not have to show a verified service connection to access these services during the first year. The EO also expanded the VA Whole Health initiative. Other VA Mental Health initiatives include the expansion of VA’s telehealth technology, and the expansion of access to “urgent Mental Health care” to former services members with other-than-honorable discharges starting July 5, 2018.<sup>17</sup>

Total psychiatrist FTEE at the Manchester VAMC is only 0.86 FTEE per 1000 Mental Health outpatient unique, which is less than the OMHO recommendation for 1.22 FTEE per 1000 unique. This impacts the ability to deliver specialty services to the Veterans.

### **Recommendations**

The Task Force believes that the provision of full-spectrum, integrated, easily accessible Mental Health services for Veterans is among the most critical aspects of VA’s mission in New Hampshire.

Demand for a range of Mental Health services – Mental Health triage, treatment for substance use disorders, intensive outpatient therapy, residential programming, and inpatient services – exceeds capacity in Manchester and across the State. The Manchester VAMC is not easily able to source these types of care from the community as community resources are also scarce. The Task Forces also recognizes that

**Figure 23 Projected Percentage Change in Mental Health Visits**

Outpatient Mental Health Manchester	Projected Pct. Change in Visits 2015 – 2025
Amb Mental Hlth: Homeless	21.4
Amb Mental Hlth: Mental Health Clinic	24.1
Amb Mental Hlth: Mental Health Clinic Psychotherapy	15.1
Amb Mental Hlth: Substance Abuse Clinic	2.7
Amb Mental Hlth: Work Therapy	-10.7

Source: VISN 1 North Market Assessment

<sup>16</sup> Exec. Order No. 13,822, 83 Fed. Reg. 9, 1513 (Jan. 12, 2018).

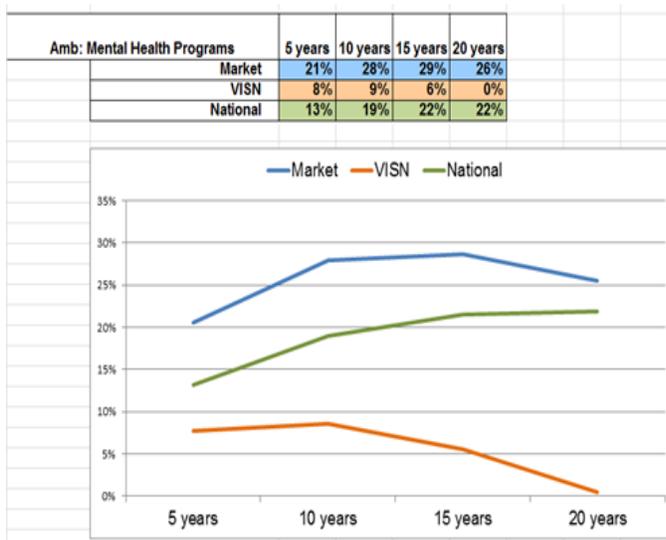
<sup>17</sup> Linda M. Richmond. New Vets Eligible to Receive One Year of Mental Health Care. PSYCHIATRIC NEWS (January 29, 2018), <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.2a25>.

demand will likely increase as the above EO is implemented. Mental Health services will form the basis of many of the programs offered at the Community Care Center and will also figure prominently into the expanded Seacoast CBOC. The Task Force also believes that Mental Health is an area where the Manchester VA can be a leader in the community, and share resources and knowledge that will improve Mental Health access across New Hampshire

The Task Force recommends the following steps to achieve a full integrated Mental Health System across the North Market, benefiting not only New Hampshire, but WRJ and the community as well.

### Seamless Connection from Initial Point of Contact into Mental Health Services

Figure 24 Projected Trend in Ambulatory Mental Health Programs



Source: Manchester Task Force Data Set

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, come in via VA Urgent Care or local emergency room, reach out by calling or using the VA messaging service, contact the call center, or use several other avenues. The Task Force advises that it is vital to have appropriately trained staff ready to meet Veterans at these initial points of contact and able to direct them to care in the most seamless way possible.

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 in the appropriate response to acute Mental Health situations. This is especially important given that recent initiatives undertaken by the VA - including the EO and other steps taken to expand access to Mental Health care – will likely increase the number of Veterans seeking Mental Health services from the VA. This training must be maintained as new staff joins and leadership must encourage the development of expertise in this area. Additionally, the Task Force endorses that a crisis intervention team be on-call to support Veterans and staff during all hours when care is provided. Education and training around Mental Health are contributions that the VA can make to the New Hampshire community at large, particularly in regards to Veteran specific conditions, such as PTSD, Traumatic Brain Injury (TBI), and Suicide Prevention. One example of

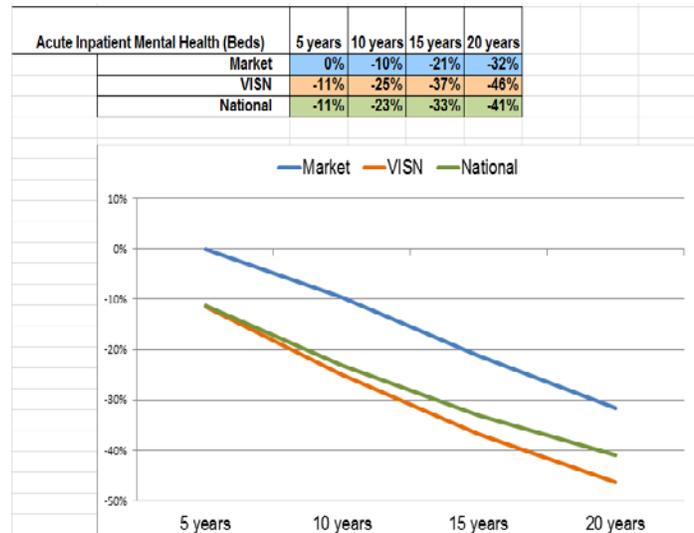
work already being done in this space across the VA New England network are first responder trainings, aimed at helping police, EMTs, and other first responders appropriately engage with Veterans they encounter who may be in crisis.

Additionally, Tele-Mental Health 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 interdisciplinary call center are all elements the Task Force believes are aspects of delivering exceptional Tele-Mental Health services in New Hampshire. However, in order for the potential of this service to be fully realized, certain regulatory and other obstacles must be overcome. For example, under current state law, a Mental Health provider must have an in-person appointment with a Veteran in order to suboxone, which is a service impediment to the availability of Telehealth for SUD treatment.

### Collaboration with the community to establish full spectrum Mental Health services

There is currently a lack of full spectrum Mental Health capacity in New Hampshire and across the North Market, including Mental Health triage, intensive outpatient, residential, substance use disorder programming, and inpatient beds. The Task Force sees this as an area where the VA can partner with the community in innovative ways to increase access for all. There is an opportunity for the co-design and co-investment in a full spectrum of programming, supported by the common needs of VA and community partners. This would allow Veterans in New Hampshire to access desperately needed services closer to home, and increased joint

Figure 25 Projected Trend in Inpatient Mental Health Beds



Source: Manchester Task Force Data Set

programming would also boost the recruitment and retention of Mental Health providers in this area; hiring is a current obstacle for both VA and the community. Additionally, in joint venture space, medical sharing agreements can be utilized to ensure the benefit of both parties.

There is known, urgent need for inpatient Mental Health beds and a full spectrum of programming that aims to prevent crises rather than solely react and hospitalize patients; this include a need for dedicated Mental Health triage. Enrollee projections

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indicate the Veteran volume demand for inpatient Mental Health will decrease over time, but the present need remains acute; partnering with the community may create the combined volume that would support a joint effort to urgently expand space and offer this full spectrum of programming. Where appropriate for the Veteran and where space allows, inpatient care can also be provided at other VA Medical Centers, most ideally WRJ, but also at the VA sites in Boston and Maine.

### **Establishment of residential and intensive outpatient Mental Health Services**

An important consideration in the planning for inpatient Mental Health services is that hospitalization serves an important but typically very brief (several day) role in the overall Mental Health recovery spectrum. Treatment can be initiated or adjusted during this brief timeframe, but the vast majority of care must be transitioned to a next level of care. The immediate period following hospitalization is also an extremely high risk period for Veteran suicide.

A service offering unique to the VA and no longer readily available in the community is residential Mental Health treatment, which is often the next step after inpatient care. Currently, Manchester is the only VA in New England that does not offer either a residential or intensive outpatient program to facilitate the transitional care of Veterans post-discharge. For these reasons, the Task Force finds a need to establish a Residential Rehabilitation Treatment Program (RRTP) on-site at Manchester, regardless of any other Mental Health inpatient capacity that is created. The RRTP would be able to offer intensive residential Mental Health care to Veterans who have 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. It may be possible that some of the offered programs could be extended beyond the Veteran's stay at the RRTP either at the CCC or through Tele-Mental Health services.

The establishment of a RRTP at Manchester has the potential to serve Veterans across the entire North Market and possibly the New England network. Elsewhere in the Market, White River Junction offers a very successful Substance Abuse RRTP that regularly serves Manchester VA Veterans. Establishing a new RRTP in Manchester offers an opportunity to develop complementary programming, such as a PTSD-focused treatment track. This would position Manchester to develop a niche of expertise to support the wider region. Considered as part of an effort to build capacity with the community, beds could also be made available to non-Veterans when appropriate.

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## Capital Assets Considerations

The establishment of an RRTP alone will require the new construction of at least one new building. The Master Planning estimates reviewed by the Task Force contained information on the creation of an RRTP structure on the Manchester campus.<sup>18</sup> Similar to prior recommendations, the Task Force encourages the use of the construction timeline outlined in the *Timely, Innovative Approach to Infrastructure* recommendation to expedite this process. This emergent need is also one of the reasons all avenues for a public private partnership in the Mental Health space should be explored, both to build triage and inpatient capacity, as well as the RRTP itself. Any new space should be able to accommodate the technological and physical space needs for Telehealth. As indicated in the previous recommendation, general Mental Health services and Primary Care space should be located as close together as space allows.

## Sensory and Physical Rehabilitative Services (SPRS)

### Background Information

The Sensory and Physical Rehabilitation (SPRS) service line encompasses a wide and diverse range of services, including: traditional Physical, Occupational and Speech/Language therapies; high demand services such as Audiology; VA foundational services to support Traumatic Brain Injury (“TBI”), Spinal Cord Injury/Disorder (SCI/D), Blind Rehabilitation and amputation care; and increasingly complementary & integrative services such as Chronic Pain Rehabilitation, Acupuncture, Chiropractic care, Sports Rehabilitation and Recreational Therapy. Of these programs, Blind Rehab and Physiatry are currently operating at one provider deep. The recommended additional staffing to meet the current population needs include 1.0 MSA for Spinal Cord Injury, 1.0 Physicatrlist, 1.0 Blind Rehab Specialist, 0.5 Speech Pathologist, and 1.0 Outpatient Recreational Therapist.

The SPRS department has been a leader at the Manchester VAMC in telehealth implementation. Since the programming and equipment was introduced years ago, the Amputation Clinic has operated using this technology with great success; the Boston VA Prosthetist is able to view the patient and the amputation team here in Manchester, providing collaborative evaluations for these highly complex patients. Rehab previously offered pre-operative education classes with Boston Orthopedics for some time using Telehealth; this eliminated the need for NH Veterans to travel to Boston for that appointment. The SPRS department has been providing durable medical equipment (DME) to Veterans at the NH CBOCs for several years now with great success and

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<sup>18</sup> See Ernest Bland & Associates Manchester VA Master Planning.

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reports of patient satisfaction. This technology is readily available and staff is familiar with the possibilities that exist with Telehealth. Plans to expand services into the CBOCs will help Veterans receive the full service experience (without the drive time). In alignment with the VHA's Strategic Objectives, Manchester continues to utilize this technology to its full potential.

Manchester VAMC SPRS has not been without access issues in the last few years. Particular access issues have been experienced in the Spinal Cord Injury/Disorder (SCI/D) clinic, Speech/Language Pathology (SLP), and Blind Rehab. There is strong interest and concern regarding lack of Outpatient Recreational Therapy Services. The Audiology department has experienced very high demand with wait time over 30 days in recent years; patients continue to choose to wait for this service rather than explore community care, due to the fragmented care provided in the community.

The current square footage for Audiology at the Manchester VAMC is 9012 (with a 7824 square footage space gap and the current space for rehab medicine is 10,800 square feet (with a 5097 square footage space gap).

### **Recommendations**

As previously described, the Task Force envisions the incorporation of SPRS into both the CCC and the new expanded Seacoast CBOC. Previous recommendations regarding the need for pain management programs and an RRTP at Manchester also incorporate SPRS services.

In addition, market projections anticipate a near doubling in demand for most SPRS services over the next 10-20 years. Therefore, the Task Force identified three additional recommendations to meet this future demand:

- Creation of a regional amputation Center of Excellence (COE) in Manchester to build on public-private partnerships that are generating ground-breaking innovations, such as the LUKE arm, which promises to revolutionize prosthetic care across VA and American healthcare;
- Right-sizing space and staffing of SPRS on-site at Manchester, including an increase of services offered;
- Concerted effort to expand access to SPRS services across the state and market through the CBOCs, telehealth, and community partnerships.

**Figure 26 Projected Trend in SPRS Visits**

Ambulatory Group	2016-2021	2021 – 2026	2026 – 2036	Overall Change 2016 - 2036
Chiropractic	55.3%	18.4%	11.9%	105.7%
Pain Medicine	44.6%	18.4%	14.2%	95.6%
Physical Med and Rehab	47.3%	19.8%	16.0%	104.6%
Audiology	25.9%	12.4%	2.8%	45.5%
Blind Rehab	57.0%	24.5%	46.8%	187.0%
Occupational Therapy	52.3%	19.6%	17.1%	113.4%
Physical Therapy	54.2%	20.6%	16.6%	117.0%
Recreational Therapy	6.8%	-2.8%	-7.2%	-3.7%
Speech Lang Pathology	58.5%	23.9%	13.6%	123.0%

Source: VISN 1 North Market Assessment

### Creation of a regional Amputation Center of Excellence (COE) 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 led by a Manchester Staff Prosthetist and utilize significant Telehealth to support care of Veterans from other VA facilities. A prosthetics lab on-site would be included for limb fabrication



**Demonstration of the LUKE Arm**  
Source: MedGadget

and fittings. Manchester VAMC is already working closely with the creators of the LUKE Arm, and the creation of this amputation center presents the opportunity to expand upon this relationship and provide enhanced amputation services in VISN 1 and beyond. In clinical testing at four VA sites, 90% of participants were able to perform activities with the LUKE arm that they were not able to perform with their current prosthesis, including using keys, preparing food, eating, using zippers, and hair care.<sup>19</sup> The development of this center will create a greater potential for the VA to apply

<sup>19</sup> Justin Barad. Dean Kamen’s “Luke Arm,” World’s Most Advanced Prosthesis, Receives FDA Approval. MEDGADGET (May 12, 2014), <https://www.medgadget.com/2014/05/dean-kamens-luke-arm-worlds-most-advanced-prosthesis-receives-fda-approval.html>.

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for research grants, as well as promote enhanced collaboration with academic affiliates. The established partnerships available in the Manchester community (e.g., DEKA, Mobius Bionics, Next Step Prosthetics) make this location ideal for continued innovation. The center would welcome all VISN 1 Veterans, and the COE would work with partners in the community to provide accommodations if necessary for their fittings/trainings.

**Right sizing space and staffing of rehabilitative services on-site at Manchester, including an increase in on-site services offered to meet demand**

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. The Task Force further endorses exploration of an Adaptive Sports Clinic, Amputee Clinic, Blind Rehabilitation programming, and interdisciplinary Amyotrophic Lateral Sclerosis (ALS) programming.

**Expansion of rehabilitative services across the market through the CBOCs, the use of Telehealth, and community providers as appropriate**

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 Therapy. Telehealth could be used to perform hearing tests, as well as allowing 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 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 strategy moving forward.

**Capital Assets Considerations**

The expansion of SPRS on-site at Manchester would require either new construction or

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the refurbishment of existing structures. Similar to Primary Care, SPRS may fit well into a refurbished “core” of the current Manchester campus. The concerns about the bandwidth and technological infrastructure to support Telehealth would also be important factors to consider.

The creation of a Regional Amputation COE would likely require a new structure, likely leased in the community, ideally co-located with the CCC. Subject matter experts in this area should be consulted to determine the appropriate space considerations.

## **Radiology (Imaging)**

### **Background Information**

The Radiology department current occupies approximately 11,985 square feet at the Manchester VAMC. It is estimated that current needed square footage is approximately 24,700 square feet, leaving a space gap of 12,000 square feet. There are 26.1 total FTEE in the Radiology service line, with 4.2 FTEE vacant. There is a pending contract to provide additional radiologist support. The Manchester VAMC currently receives Tele-Radiology support from WRJ as needed and where available. Currently, the Manchester VAMC is trying to build a pool of intermittent technical and medical staff to support planned and unplanned leave periods. The current Radiology services offered on-site are General Radiology, Ultrasound, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Nuclear Medicine. The services not offered are PET/CT, Interventional Radiology, and on-site Mammography. However, Mammography is readily available in the community.

### **Recommendations**

Increased Imaging services are incorporated into 3 previous recommendations: in the new combined Seacoast CBOC; as an opportunity for increased collaboration with White River Junction (which is happening to some extent already); and as part of a new ASC on-site in Manchester. However, the Task Force has also identified several Radiology-specific recommendations:

- Right sizing Radiology space and staff on-site services at Manchester;
- Expansion of Radiology services into the CBOCs where appropriate;
- Potential expansion of Radiology service offerings through partnerships, particularly with White River Junction.

### **Right sizing Radiology space and staffing on-site at Manchester**

The current square footage allotted to the Imaging department is insufficient to meet demand, according to VA design standards. The Task Force supports the expansion of Imaging services and 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. While current equipment is up-to-date and new equipment is procured in a timely manner, this practice must be continued as new technological advances in this field are developed

**Table 10. Imaging Current Square Footage**

Site	SF	Needed Space	Space Gap
Manchester VAMC	~11,900sqft	~24,700 sqft	~12,000 sqft
Portsmouth CBOC	0	No Imaging	
Somersworth CBOC	0	No Imaging	
Conway CBOC	0	No Imaging	
Tilton CBOC	0	No Imaging	

Source: Manchester Task Force Data Set

Based upon trends from the Market Assessment and anecdotal information from the Manchester Radiology staff, workload is projected to remain stable with a slight growth (3-5%) given status quo. As new programs are added or current programs are expanded Radiology growth will increase. Services such as Orthopedics have a larger impact on Radiology workload, whereas services such as Mental Health have a lesser impact. Therefore future space and staffing needs will be dependent on the final scope and provision of care mix.

Additionally, if an ASC is constructed on-site at Manchester, the space reserved for Imaging services must be further expanded to allow the department to adjust to future needs and expanded hours for patient scheduling.

**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 “Seacoast” 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. Finally, the possibility of mobile Radiology services, which could rotate through the various CBOCs, should be investigated for feasibility.

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## **Expansion of Imaging services through partnerships**

The Task Force supports the continuation of Radiology services currently offered on-site at Manchester. Even with the expansion of Imaging space at Manchester, more advanced or critical services such as Interventional Radiology (IR) would still be performed at partner facilities, whether community partners or other VA sites. Manchester and White River Junction currently have an established process for sharing IR and Positron Emission Tomography (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 prior recommendations, the capital assets needs for expanding Radiology services on-site at Manchester depend on whether the existing structure is able to be refurbished or if new construction is needed. In particular, special construction considerations must be made in regards to Radiology equipment. For example, 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 if needed.

## **Geriatrics and Extended Care (GEC)**

### **Background Information**

The tables below show the average length of stay, the number of unique patients, and the average daily censuses over the past three years at the Manchester VAMC.

Tables 11, 12, 13: Current GEC Usage

<b>Table 11. CLC – Average Length of Stay</b>				
Treating Specialties	FY13	FY14	FY15	FY16
(44) NH LONG STAY MAINTENANCE CARE	162.4	144.9	144.9	169
(47) NH RESPITE CARE (NHCU)	12.5	12.1	15.1	16
(64) NH SHORT STAY REHABILITATION	27.3	32.1	24.6	27.3
(66) NH SHORT STAY RESTORATION				
(67) NH SHORT STAY MAINTENANCE			3.5	7.5
(95) NH SHORT STAY SKILLED CARE	39.4	48.6	25.1	29.1
(96) HOSPICE	24.9	27.1	43.5	54.7

<b>Table 12. GEC – Unique Patients</b>				
Treating Specialties	FY13	FY14	FY15	FY16
(44) NH LONG STAY MAINTENANCE CARE	43	52	53	48
(47) NH RESPITE CARE (NHCU)	36	27	14	4
(64) NH SHORT STAY REHABILITATION	134	92	94	83
(66) NH SHORT STAY RESTORATION				
(67) NH SHORT STAY MAINTENANCE	2		2	8
(95) NH SHORT STAY SKILLED CARE	27	7	32	25
(96) HOSPICE	75	76	62	46
<b>Total Unique Pts</b>	<b>317</b>	<b>254</b>	<b>257</b>	<b>214</b>

<b>Table 13. CLC – Average Daily Census</b>				
Treating Specialties	FY13	FY14	FY15	FY16
(44) NH LONG STAY MAINTENANCE CARE	15.4	18.8	19.1	24.2
(47) NH RESPITE CARE (NHCU)	1.5	1.1	0.6	0.2
(64) NH SHORT STAY REHABILITATION	9.9	8	7.2	6.3
(66) NH SHORT STAY RESTORATION	0	0	0	0
(67) NH SHORT STAY MAINTENANCE	0.1	0	0	0.5
(95) NH SHORT STAY SKILLED CARE	2.5	0.8	2.3	1.7
(96) HOSPICE	5.1	7.4	6.3	5.8
<b>Total ADC</b>	<b>35</b>	<b>36</b>	<b>36</b>	<b>39</b>

Source: Treating Specialty Cube and MCA Treating Specialty Cube, Server: VHAAUSBI5

Currently, the Manchester VAMC Community Living Center (“CLC”) is located on the second floor of the building with no direct access to the gated outside common area. The CLC has 41 physical beds and 39 Bed Days of Care. The current space does not have dedicated social and recreational space in the CLC for Veterans and their families. The current space has 15 one bed rooms, 10 two bed rooms, and 3 four bed rooms. VHA standards recommend a maximum of 2 Veterans per room with one Veteran per room preferred. There are currently 629 CLC beds in VISN 1, located at Manchester, Maine, Bedford, Boston, Central Western Massachusetts, and Connecticut.

In the New Hampshire community, one State Veterans Home is located in Tilton, NH, with 250 operational beds (195 beds in use), and there are 7 contracted Community Nursing Homes under the Manchester VAMC with 56 Veterans enrolled. Currently, the occupancy rate for community nursing homes in the state is 90.2% and New Hampshire law prevents any increase in the number of beds. The Manchester VAMC is exempt from this cap.

Manchester CLC staffing is currently at 87% with an expectation of increased vacancies in April from 13% to 28%. The majority of vacancies are RN and LPN, who provide direct care to the Veteran. This supports the need for increased training affiliation to support these areas, as well as more active outreach.

Current Non Institutional Care (NIC) services offered to Veterans who want and are able to stay in their home include: Homemaker/Home Health Aide, Home Respite, Veteran Directed Care, Home Hospice, Purchased Skilled Home Care, Inpatient Respite, and Contract Adult Day Care, and Home Based Primary Care (HBPC).

**Recommendations**

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. The Task Force incorporated GEC services as vital components of the CCC and the Seacoast CBOC. The Task Force also makes the following additional recommendations about the future of GEC in New Hampshire.

- Increase the number of Community Living Center (CLC) beds on-site at Manchester to ameliorate the Market demand gap and accommodate projected growth;

**Figure 27 FY17 HBPC Usage**

HBPC PATIENT LIST FY 17	
Patient Info UPDATED: 9/25/17	
HBPC PROGRAM =	251
Total # of pts MANCHESTER =	93
Somersworth/Portsmouth total # of pts =	86
Tilton total # of pts =	48
Conway total # of pts =	24

Source: GEC Service Line Options Grid

- Invest in home-based services to support aging Veterans maintaining independence, including Home Care, Home Based Primary Care (HBPC), and GERI MHICM-enhanced home care;
- Implement the Social Work Case Management Model (SWCMM) 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. Staffing concerns at the Tilton State Veterans Home negatively affects the number of available beds. 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 cannot care for. Therefore, the Task Force finds that the number of CLC beds on-site at Manchester should be increased to address this projected gap.

Figure 28 Modeled Future CLC Demand

Other Subacute Beds by Fiscal Year (Fiscal Year) on columns; and Facility (Parent Facility) and Planning Categories (Planning Categories) on rows		FY2016 Modeled		FY2026 Modeled	
		In-House (see notes on data limitations)	Community (see notes on data limitations)	In-House (see notes on data limitations)	Community (see notes on data limitations)
(1V01) (608) M	LTSS - Community Living Center (Long) (Days)	25		29	
	LTSS - Community Living Center (Short) (Days)	14		17	
	LTSS - Community Nursing Home (Long) (Days)		40		61
	LTSS - Community Nursing Home (Short) (Days)		7		10
	Subtotal	39	47	46	71
	FY Total	86		117	

Source: Millman Long Term Care Projection Model

The Task Force did not feel they had the clinical expertise or experience to determine the exact number of CLC beds to build on-site at Manchester, and recommends the consultation of subject matter experts during the implementation of this recommendation to determine the exact number and mix of CLC beds added at the Manchester VAMC.

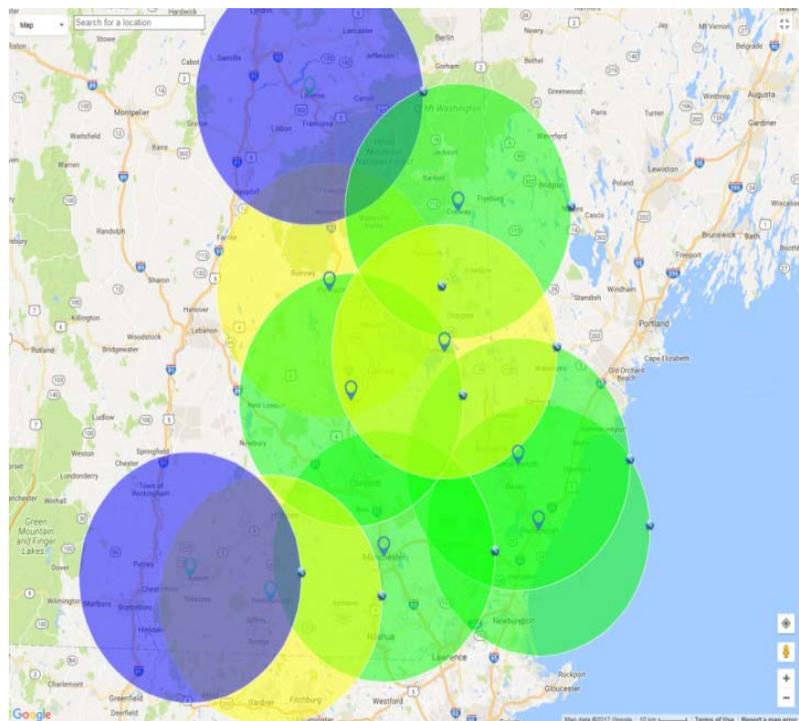
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## Expansion of in-home services specific to aging Veterans including, Home Based Primary Care (HBPC), Home Care and GERI MHICM-enhanced home care services for Veterans with Mental Health issues

For Veterans who want to stay in their home, and for whom it is still medically appropriate and feasible, it is important to enhance the provision of home services across the state. One element that should be expanded is the HBPC PACT, which provides interdisciplinary Primary Care services in the home for Veterans with multiple chronic illnesses who are at risk for high service utilization and poor outcomes. Home Based Primary Care reduces hospitalization frequency, length of stay and Emergency Room visits. HBPC aligns with the Secretary’s “Moon Shot- Choose Home” and may incorporate Telehealth to increase access. The New Hampshire region is served by HBPC teams from both White River Junction and Manchester. One factor that must be kept in mind is that the expansion of HBPC may also lead to an increased demand for respite services for Veteran caregivers

Additionally, the Task Force is proposing the expansion of the MHICM program or a specialized Geriatric MHICM Program (in collaboration with Mental Health) for Veterans with complex geriatric and Mental Health diagnoses to receive wrap-around case management care in the home environment. This recommendation is also in line with the Secretary’s “Moon Shot- Choose Home,” and addresses concerns raised during listening sessions with home care providers regarding the increasing frequency and complexity of Mental Health issues within the population they serve.

Figure 29 Heat Map of Proposed HBPC Expansion



**Green- current HBPC catchment area**

**Purple -White River Junction catchment area**

**Yellow- proposed**

Source: GEC Service Line Options Grid

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## **Implementation of a Social Work Case Management Model for medically complex, vulnerable Veterans**

Given the VA's current structure the Task Force finds providing comprehensive case management to targeted vulnerable Veterans would both enhance Veteran independence and reduce preventable service utilization, morbidity and mortality. This proposed model includes enhanced long-term care planning, crisis care, and engagement of non-VA community care service options. As Veterans age and develop increasingly complex medical and emotional comorbidities, their reliance on various healthcare services also increase. Older Veterans are at risk for cognitive or other psychosocial limitations that challenge their ability to manage their healthcare interfaces independently. Even with the help of dedicated caregivers, the management and coordination of care throughout the spectrum becomes increasingly complex, increasing the risk of missed care opportunities or follow-up, which subsequently increases morbidity and mortality risk. The case management needs of complex geriatric patients must be addressed throughout the healthcare continuum and make sufficient bridges to important community and social supports.

### **Capital Assets Considerations**

An increase in CLC beds will have major impact on the Manchester campus. Any increase greater than six beds will necessitate new construction per VA standards. Any new CLC construction should follow the "Green House model," an innovative alternative for long-term care within the VA. Green House homes are self-contained, eliminate the traditional nurses station, and accommodate 12 or fewer residents.

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.

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### **Lessons Learned**

Given that the public-private composition and specific mission of the New Hampshire Vision 2025 Task Force are novel within VA, the Task Force has identified lessons learned for reference in future endeavors. Outlined below are key enablers, opportunities, and themes that the Task Force believes to be relevant to future market, regional, and visioning work. Pending a viable public-private vehicle for additional work, the Task Force offers that this work could be done proactively in markets and regions, not solely in response to crisis.

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## **Key Enablers**

- **Transparency**

The Task Force was the first public-private endeavor of its kind, and the first such visioning group whose process was entirely transparent to stakeholders and the public. This transparency prompted discussion, questions, and at times, angst regarding the degree to which organizational information could be shared outside of typical clearance processes. However, the benefits of this transparency far outweighed any challenge. The open nature of the process allowed for innovative thinking, collaboration, and insight from a broad range of stakeholders. This proved to be essential to the achievement of the original charge.

*Opportunity: Future efforts would benefit from clear and repeated explanation – internally and to stakeholders – of the boundaries of allowed transparency. This clarity from the outset would remove negotiation of these issues from the work of the group and enable the effort to be effectively messaged to those with equities.*

- **Stakeholder engagement**

The Task Force engaged in a series of initiatives to ensure that all decisions were based on direct Veteran, employee, and stakeholder input. To accomplish this, the Task Force held focus groups, released an optional questionnaire, and conducted multiple listening sessions with Veterans Service Organizations, Whistleblowers, staff, and Congressional delegations.

*Opportunity: Future efforts would benefit from engaging a broad range of stakeholders early and often, and ensuring that these stakeholders know they are meaningfully heard.*

- **Public-private stakeholder representation**

The inclusion of both public and private stakeholders in the composition of the Task Force made possible a great deal of thought and discussion beyond historical and traditional boundaries. This proved vital to an expansive view of the potential directions forward.

*Opportunity: Even more robust community stakeholder representation, both clinical and administrative, would provide additional breadth and depth to future work.*

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- **Broad range of relevant expertise**

The breadth of expertise held by executives on the Task Force contributed tangibly to the quality of discussions and recommendations. Specifically, representation from the following stakeholder groups was essential: Whistleblowers; local facility clinicians and frontline staff; external Medical Center Directors; regional clinical leadership; private sector healthcare systems and representative organizations; Department of Defense; labor unions; VA Central Office, including Office of Policy and Planning; and the State Veterans Advisory Committee. Seven Service Line subgroups also contributed key insights to the work.

*Opportunity: Future work could be enhanced by the additional inclusion of representation from Veterans Service Organizations (local and/or national), Federally Qualified Health Centers, regional academic affiliates, local VA engineering or facilities management; VA and/or community Primary Care and Mental Health clinicians in addition to specialty clinicians; additional frontline staff; and personnel with healthcare economics expertise.*

- **Combination of local, regional, and national experience**

Task Force members contributed experience from local, regional, and national-level work. This gave strength to the process and created a positive intersection of local and external spheres of ideas.

*Opportunity: While potentially more resource-intensive than a locally-derived group, future groups would do well to maintain such variety of geography and local/regional/national experience.*

- **Chartered mission**

As the Task Force worked to envision the way forward for New Hampshire VA health care, the scope of the effort became a frequent conversation. The group returned repeatedly to review the originally chartered mission and determine boundaries of the effort.

*Opportunity: The Task Force found its scope to be easily conflated with other endeavors, including management decisions and investigative reports. Clear, repeated messaging that differentiates between such efforts would serve future work well.*

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- **Skilled facilitation, administrative support**

The progress of the Task Force was furthered substantially by skilled facilitation of the group's in-person and virtual meetings. Given the broad scope of the charge, the wide range of stakeholder equities, and the amount of data received, conversations and decisions were weighty and complex. Skilled facilitation promoted collaboration and productivity. Additionally, regional administrative support was critical in allowing Task Force members to focus on substantive while procedural issues were capably addressed.

*Opportunity: While skilled facilitation and administrative support may require additional time and resources, future efforts would do well to include these as they ultimately enable higher productivity and better depth of discussion.*

- **Time commitment and duration of effort**

The Task Force benefited from the full-time, dedicated support of a Presidential Management Fellow with excellent written and communication skills. This eased somewhat the significant time commitment required to complete a comprehensive review of available data and fully engage stakeholders. Additionally, accountability to a parent committee and a clear timeline accelerated the transition from the planning to decision-making phase of the work.

*Opportunity: Future efforts would do well to acknowledge in advance that dedicated hours outside of meetings will be required for stakeholder engagement, document review, planning, and discussion. A dedicated, skilled support staff member is critical to making meaningful executive participation feasible. Groups would also benefit from accountability to a parent organization that sets a clear timeline for deliverables.*

- **Robust communication**

The Task Force benefited from a skilled team of communicators locally, regionally, and nationally. Both internal and external messaging of the ongoing work proved to be vital to maintaining trust and positive stakeholder perception of the work.

*Opportunity: Robust communications engagements, both internal and external, should be a key aspect of future efforts. Consistency of message will promote the trust needed for collaboration.*

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- **Impact of internal progress**

The progress made internally in Manchester during the work of the Task Force furthered the quality of the vision ultimately delivered. Palpable positive change in culture, the physical progress of renovated infrastructure, and ever-expanding community partnerships were tangible steps forward that emboldened innovative thinking. The inclusive, transparent, human-centered approach of new leadership and the energy and commitment of employees also complemented the goals of the Task Force and demonstrated the type of rapid progress achievable in a space previously riddled with challenges.

*Opportunity: New Medical Center and Regional leaders may benefit from a leadership “Play Book” that emphasizes the core tenets of healthy organizational culture, VA-specific values, and specific recommended actions in times of controversy or challenge. The knowledge the current leadership team in Manchester has developed through the successful “turn-around” efforts these last months is specifically valuable for other facilities facing challenges and should be documented.*

- **Legislative advancement**

Governor Sununu signed Executive Order 2017-03 on August 14, 2017 enabling VA providers with licenses outside New Hampshire to provide care to Veterans through community healthcare facilities. This immediately restored and expanded access that had been at risk due to challenges and flooding at the Manchester VAMC.

*Opportunity: Exploring opportunities for this type of legislation on a national level could facilitate expanded access and partnerships across the country. This may be especially beneficial for facilities of similar size and scope to Manchester.*

## **Key Themes**

- **Veteran and employee centeredness**

The Task Force centered its direction and decisions squarely on the wants and needs of New Hampshire Veterans, placing VA at the center of the envisioned care. Through that lens, it was possible to arrive at the best vision for this space without the cognitive constraints of historical practice, current challenges, policy

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barriers, or cost. Rather, the Task Force first envisioned the best future for VA care of Veterans in New Hampshire and then worked with an innovative mindset to address feasibility.

- **Employee empowerment and fulfillment**

For exceptional care delivery to be sustained across the inevitable flux in a large system – resources, personnel, even natural disasters and structural issues – employee empowerment and fulfillment must be of utmost priority to leadership at all levels. The implementation success of even the best ideas rests on the motivation of and energy of employees to adopt change. With an empowered, vibrant workforce, aspirational visions become possible.

### Best Practices

The Task Force believes the work of this group may serve as a model for many other spaces within and beyond VA. Recognizing that other markets, States, or regions may benefit from the framework developed through this effort, the Task Force has listed those “Best Practice” concepts believed to have national applicability.

- Continuous, robust investment in a healthy culture
  - Establishment of a dedicated Culture Task Force when serious challenges arise
  - Ensure regional and national culture have positive impact on local cultures
- Establishment of multiple avenues for employees to elevate concerns before adverse events occur
  - Rewarding proactive behavior and creating a safe environment to come forward
- External validation of metrics and interdisciplinary team roles
- Leadership engagement of stakeholders
- Focus on Right Care, Right Place, Right Time with VA as the epicenter of care
- Advocacy for a transparent, efficient, Veterans Choice program that complements VA care and partnerships
  - Advocacy for consistency of Veterans Choice parameters across a region
- Full-service care delivery through partnerships
- Full spectrum Mental Health services through partnerships
- Excellent stewardship of partnerships
  - Timely payment of bills
  - Robust engagement and relationship building
- Consideration of joint VA/academic affiliate/community ventures for new major capital assets and service investments

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- Co-design and co-investment of plans and programming
  - Phased approach to major long-term initiatives (e.g., lease space as a bridge to building an ASC)
  - Whole Health Community Care Center model
    - Include service elements that capitalize on local strengths
    - Innovative co-location and integration of services
  - Expansion of telehealth and virtual services
  - Combination of close-proximity CBOC volume to justify additional on-site resources
  - Ensuring all new collaborations result in expansion, not consolidation or elimination, of services
  - Ensuring administrative processes are completed to facilitate information exchange between VA and collaborating providers (e.g., bidirectional release of information)
  - Pursuit of multi-disciplinary academic affiliations
  - Competitive compensation and regionalization to promote recruitment and retention
  - Right-sizing clinic space and fully staffing teams
  - Elevation of local innovation
  - Expansion of Mental Health intensive outpatient and preventive programming
  - VA as the epicenter of Veteran care, including Choice
  - Robust communication of programs and resources, especially new efforts
  - Focus on in-home and community geriatric services, case management

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## Way Forward

While the Task Force took a comprehensive, highly inclusive approach to envisioning the future of VA care in New Hampshire, this work represents a first milestone in the progress that needs to occur. Limitations of the work and recommended next steps are described below.

### Limitations

- Limited data and evidence base for innovative concepts (e.g., VA/academic affiliate/community joint ventures)
- Scope of work in the given time required focus on critical service lines; several services were not studied in depth (e.g., dental, pharmacy, lab, human

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resources, information technology, transportation, etc).

- Unknown impact of pending legislation (reconfiguration of Veterans Choice program)

### **Next Steps**

- **Creation of an Advisory Council for Accountability**

The Task Force recommends an advisory council, similar to the design of the Task Force, be established to ensure accountability for implementation of the Secretary's decisions on these recommendations. This group should include representation from VAMC leadership, VAMC employees (frontline staff including a White River Junction representative), members of this Task Force, Veterans, academic affiliates, community healthcare partners, Veteran Service Organizations, and VACO representation. This group should also be provided with staff support as needed. As there are no avenues beyond the Federal Advisory Committee structure for this type of public-private endeavor, this council may need to operate within that structure.

- **Secondary Analyses**

The Task Force recommends specific analyses to assist VA in implementing the Secretary's decisions and the advisory council in ensuring accountability for that implementation:

- Completion of a new Master Planning analysis in light of the recommendations adopted from this report;
- Completion of a full economic analysis on all recommendations adopted from this report, with a special emphasis on the role of Community Care and the Veterans Choice program.
- Analysis of other critically needed services that were not included with the previous Service Line Subgroups (i.e. dental).

- **Education and Awareness Campaign**

The Task Force recommends that a proactive communication campaign regarding the envisioned future for Manchester and the region be initiated. This will need to occur locally and nationally and begin at the time of announcement of the Secretary's decisions.

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## Addendum – List of Sources

### I. Executive Summary

#### A. Vision Statement

#### B. Background

##### 1. Origin of the Task Force

- Boston Globe Spotlight Article ([\*At a four-star Veterans' hospital: Care gets 'worse and worse'\*](#))
- New Hampshire Executive Order 2017-3: An order suspending licensing requirements for United States Department of Veterans Affairs physicians due to flooding at the Manchester, NH Veterans Affairs Medical Center
- VA New Hampshire VISION 2025 Charter dated 9.12.17
  - Second Amendment to the VA New Hampshire Vision 2025 Task Force

##### 2. VISN 1 North Market

- VISN 1 Market Assessment

#### C. Recommendations

##### 1. Core recommendations

##### 2. Interdisciplinary Recommendations

##### 3. Service line Specific Recommendations

#### D. Way Forward

### II. General Overview

#### A. Creation of the Task Force

- Boston Globe Spotlight Article (already cited above at I.B.1)
- New Hampshire Executive Order 2017-3 (I.B.1)
- VA New Hampshire Vision 2025 Charter dated 9.12.17 (I.B.1)

#### B. VISN 1 North Market

- VISN 1 Market Assessment (I.B.2)

#### C. Veteran Population – VISN 1 North Market

- [New Hampshire Demographic Information](#)
- VISN 1 Market Assessment (I.B.2)

#### D. Manchester VA Medical Center

- VISN 1 Urgent Care WHEN Hours
- Medicine Service Line Recommendations dated 11.22
- Surgery Service Line Recommendations dated 11.22
- Radiology (Imaging) Service Line Recommendations dated 11.22
- Primary Care Service Line Recommendations dated 11.22

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- Patient Aligned Care Teams Spacing Model
  - Mental Health Service Line Recommendations dated 11.22
  - Presidential Executive Order on Supporting Our Veterans During Their Transit
  - New Vets Eligible to Receive One Year of Mental Health Care
  - VISN 1 total bed count for all types of beds
  - Sensory and Physical Rehabilitative Services (SPRS) Service Line Recommendations dated 11.22
  - Geriatrics and Extended Care Service Line Recommendations dated 11.22
  - Nursing Home Bed Count
  - CLC Bed Count
  - Dean Kamen's Luke Arm
- E. CBOCs**
- VISN 1 Market Assessment (I.B.2)
  - Somersworth and Portsmouth CBOC Heat Maps
- F. White River Junction VA**
- Manchester-WRJ Presentation by Dr. Brett Rusch
- G. Task Force Decision Making Process**
- [VA New Hampshire Vision 2025](#) website for meeting agendas and minutes

### **III. Recommendations**

#### **A. Fundamental Recommendations**

- 1. Sustained Investment in Organizational Culture**
  - Charge Letter – Manchester Culture Task Force
  - Charter – Manchester Culture Task Force
  - PowerPoint – Manchester Culture Task Force
  - A Leader's Pledge
- 2. Evaluation of Process, Metrics, and Role Efficacy**
- 3. Leadership Engagement of External Stakeholders**
- 4. Emphasis on Education and Awareness**
- 5. Timely, Innovative Approach to Infrastructure**
  - Ernest Bland & Associates Manchester VA Master Planning
  - Follow-up questions regarding Manchester VA campus
  - Manchester VAMC Facilities Presentation
  - EBA Manchester VA Space Gap
- 6. Enhanced Regional Collaboration**
  - Manchester-WRJ Presentation by Dr. Brett Rusch (II.F)
- 7. Focus on Right Care, Right Place, Right Time**
  - VA Community Care PowerPoint

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8. **Leverage Interdisciplinary Academic Affiliations**
    - VISN 1 Market Assessment (I.B.2)
- B. Interdisciplinary Recommendations**
1. **Creation of a Whole Health Community Care Center**
    - Errera Community Care Center ('ECCC') Programs
    - ECCC Presentation
    - Errera Center Concept
    - E-mail with more information on ECCC
    - ECCC TSAI projects and programs
    - Medical-Legal Partnerships At Veterans Affairs Medical Centers Improved Housing And Psychosocial Outcomes For Vets
    - The Invisible Battlefield
    - HPACT Successes
    - West Haven HPACT Performance 2017
    - ECCC Training and Innovations
  2. **Capital Assets Considerations and Implementation**
    - Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
    - Errera Center Concept (III.B.1)
  3. **Expansion of Telehealth and Virtual Services**
    - VA Telehealth Services
    - Telehealth and Virtual Modalities for VISN 1
    - VISN 1 Telehealth Dashboard
    - Connected Care Program White River Junction VAMC
  4. **Combination of the Somersworth and Portsmouth Community Based Outpatient Clinics for expanded services**
    - Survey
      - Veteran Survey Responses
      - Survey Comments
      - Veteran Survey Responses updated March 2018
    - Focus Group Reports
      - Focus Group Report 10-31-17
      - Focus Group Report 10-4-17
      - Focus Group Women and Northern Vets
    - Somersworth and Portsmouth CBOC Heat Maps (II.E)
- C. Medicine and Surgery Recommendations**
1. **Background Information**
    - Medicine Service Line Recommendations dated 11.22 (II.D)
    - Surgery Service Line Recommendations dated 11.22 (II.D)
    - Medicine Service Line Options Grid dated 2.9
    - Surgery Service Line Options Grid dated 2.9

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## 2. Recommendations

- Surveys (III.B.4)
- Focus Group Reports (III.B.4)
- VISN 1 Market Assessment (I.B.2)
- To Build or Not to Build: A [Modern Healthcare Article](#)
- Manchester-WRJ Presentation by Dr. Brett Rusch (II.F)
- SecVA Morning Report Slides
- Surgery Subgroup Draft Recommendations 12.20
- Urgent Care Volume WHEN hours (II.D)
- VA Community Care PowerPoint (III.A.7)
- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
- Follow-up questions regarding Manchester VA campus (III.A.5)
- Manchester VAMC Facilities Presentation (III.A.5)
- EBA Manchester VA Space Gap (III.A.5)

## D. Primary Care

### 1. Background Information

- Primary Care Service Line Recommendations dated 11.22 (II.D)
- Primary Care Service Line Options Grid 2.9

### 2. Recommendations

- Somersworth and Portsmouth CBOC Heat Maps (II.E)
- VISN 1 Market Assessment (I.B.2)
- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
- Follow-up questions regarding Manchester VA campus (III.A.5)
- Manchester VAMC Facilities Presentation (III.A.5)
- EBA Manchester VA Space Gap (III.A.5)
- Patient Aligned Care Teams Spacing Model (II.D)
- PACT Presentation

## E. Mental Health

### 1. Background Information

- Mental Health Service Line Recommendations dated 11.22 (II.D)
- Mental Health Service Line Options Grid 2.9

### 2. Recommendations

- VISN 1 Market Assessment (I.B.2)
- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
- Follow-up questions regarding Manchester VA campus (III.A.5)
- Manchester VAMC Facilities Presentation (III.A.5)
- Behavioral Health Services – Community reintegration program

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- Higher Risk Periods for Suicide Among VA Patients Receiving Depression Treatment
  - EBA Manchester VA Space Gap (III.A.5)
  - Cost Effectiveness of Intensive Psychiatric Community Care for High Users of Inpatient Services

**F. Sensory and Physical Rehabilitative Services (SPRS)**

**1. Background Information**

- SPRS Options Grid 2.9
- SPRS Line Recommendations dated 11.22 (II.D)

**2. Recommendations**

- Dean Kamen’s Luke Arm (II.D)
- Regional Amputation Centers – Rehabilitation and Prosthetic Services
- EBA Manchester VA Space Gap (III.A.5)
- VISN 1 Market Assessment (I.B.2)
- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
- Follow-up questions regarding Manchester VA campus (III.A.5)
- Manchester VAMC Facilities Presentation (III.A.5)

**G. Radiology (Imaging)**

**1. Background Information**

- Radiology (Imaging) Service Line Recommendations dated 11.22 (II.D)
- Imaging Service Line Options Grid 2.9

**2. Recommendations**

- Primary Care Service Line Recommendations dated 11.22 (II.D)
- EBA Manchester VA Space Gap (III.A.5)
- VISN 1 Market Assessment (I.B.2)
- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
- Follow-up questions regarding Manchester VA campus (III.A.5)
- Manchester VAMC Facilities Presentation (III.A.5)

**H. Geriatrics and Extended Care (GEC)**

**1. Background Information**

- GEC Service Line Recommendations dated 11.22 (II.D)
- GEC Service Line Options Grid 2.9

**2. Recommendations**

- Nursing Home Bed Count (II.D)
- GEC Data
- EBA Manchester VA Space Gap (III.A.5)
- VISN 1 Market Assessment (I.B.2)

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- Ernest Bland & Associates Manchester VA Master Planning (III.A.5)
  - Follow-up questions regarding Manchester VA campus (III.A.5)
  - Manchester VAMC Facilities Presentation (III.A.5)
  - Valley News – Despite Offerings, Nursing Home Beds and Funds Still Lacking
  - CLC Bed Count (II.D)

#### IV. Lessons Learned

- A. Key Enablers
- B. Key Themes
- C. Best Practices

#### V. Way Forward

- A. Limitations
- B. Next Steps

### Glossary

- *Major construction*
  - Improvements to medical centers to provide state-of-the-art healthcare; seismic corrections to deficient buildings; and new sites of care.
  - Lower limit \$10,000,000 with no upper limit in total project cost.
  - Does not require any new building space, can be 100% renovation
  - Submitted and prioritized through the Strategic Capital Investment Planning (SCIP) process.
  - Project specific Congressional authorization and appropriation actions for approval prior to construction execution.
  - Medical Center develops project and oversees approved scope; VHA oversees approved scope after Budget approval; Office of Facilities Management and Construction (OCFM) executes the construction and associated contract after budget approval
- *Minor construction*
  - Projects primarily expanding existing facility square footage to provide additional capacity for healthcare services; seismic corrections; parking garages; enhanced-use lease transactions; new sites of care.
  - Upper limit \$10,000,000. For projects with design year 2013 and prior lower limit is \$500,000. The lower limit for projects in design year 2014 and later is based on costs for adding 1000 BGSF in new building space.
  - Projects in design year 2013 and earlier requires greater than \$500,000 of project cost for New Building space with exception of seismic which can be 100% renovation.

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- Projects in design year 2014 and later require greater than 1000 BGSF New Building space with exception of seismic which does not require any new building space.
  - Seismic projects must have at least 50% of project costs correcting seismic deficiencies and total project cost must be greater than \$1,000,000 if less than 1000 BGSF New Building space.
  - Projects submitted through SCIP process to central office for prioritization, approval, and funding.
  - Medical center develops projects and executes upon budget approval by SCIP.
  - *Non-Recurring Maintenance (NRM) Projects*
    - Renovation, repair, maintenance and modernization of the existing infrastructure within the existing square feet; focuses on correcting the Facility Condition Assessment, ensuring the medical center meets applicable codes, and modernizes within the existing constraints of the facility to comply with current standards of care.
    - Stand alone demolition.
    - Surface parking and roads.
    - New pure utility buildings and structures.
    - Projects in design year 2013 and prior up to \$500,000 project costs in New Building space.
    - Projects in design year 2014 and later up to 1000 BGSF New Building space.
    - Lower limit \$25,000.
    - No upper limit for pure utility/building system projects and building demolition.
    - \$10,000,000 upper limit for renovations.
    - Projects over \$1,000,000 require business case applications submitted to central office for prioritization and approval through the annual SCIP process.
    - VISNs control approval and funding for projects less than \$1,000,000.
    - Medical center develops projects and executes upon budget approval by VISN or SCIP.
  - *Major leases*
    - Larger leases greater than \$1,000,000 first year unserviced annual rent.
    - Congressional authorization and appropriation required for each specific major lease.
    - Annual rent and lease build-out costs funded with VISN or medical center medical facilities dollars.
    - Leases submitted through SCIP to central office for approval.

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- Medical center develops lease application; OCFM Real Property Service performs contracting for major leases.
  - *Minor leases*
    - Smaller leases less than \$1,000,000 annual rent for any type of space not owned by the government.
    - Leases with unserviced annual rent between \$300,000 and \$1,000,000 or greater than 10,000 NUSF require VA Secretary approval.
    - Starting in 2015 SCIP cycle all new presence or replacement leases are required to be submitted through the SCIP process. For 2014 and earlier SCIP cycles leases that are totally new presence leases or replacement lease that expand by more than 25% in space were submitted through the lease process.
    - Annual rent and lease build-out costs funded with VISN or medical center medical facilities dollars.
    - Local contracting has contracting authority for leases that meet the following criteria:
      - Less than 10,000 NUSF
      - Less than \$300,000 first year annual rent
      - Up to 10 year term
      - Up to 100 parking spaces
      - All other leases OCFM Real Property Service controls contracting authority. Local contracting can request delegation of contracting authority from OCFM Real Property Service for these other leases.
  - *Strategic Capital Investment Planning (SCIP) process*
    - The annual SCIP process includes all capital projects (major construction, minor construction, non-recurring maintenance (NRM), and leases) with the exception of information technology non-construction projects
    - Entails development of a strategic capital investment plan using a corporate portfolio approach determining where gaps exist or are projected to be and developing appropriate solutions to meet them over a 10 year timeframe. The four main components are
      - A gap analysis will be conducted for gaps identified at the Department level, such as access, workload/utilization, space, facility condition, security, and energy.
      - Based on the gap analyses, the Strategic Capital Assessment (SCA) explains how gaps will be reduced, why certain investments are chosen, and how capital investments have been tiered at each level of the organization
      - A 10 year action plan is developed for each VA facility and provides more detail than the SCA

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- Approved capital investments that are individually identified in the 10-year action plan for the budget year only (including new and design projects from prior years) and meet established thresholds will need to have a business case completed to be considered for funding. Business cases are a series of questions about the project, and are evaluated and prioritized for the development of the budget process, based on how well the project contributes to the decision criteria.
  - *VA Priority Category*
    - The VA administers its comprehensive medical benefits package through an annual patient enrollment system based on priority groups
      - Priority Group 1
        - Veterans with VA-rated service-connect disabilities 50% or more disabling
        - Veterans determined by VA to be unemployable due to service-connected conditions
      - Priority Group 2
        - Veterans with VA-rated service-connected disabilities 30% or 40% disabling
      - Priority Group 3
        - Veterans who are Former Prisoners of War (POWs)
        - Veterans awarded a Purple Heart medal
        - Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
        - Veterans with VA-rated service-connected disabilities 10% or 20% disabling
        - Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"
        - Veterans awarded the Medal Of Honor (MOH)
      - Priority Group 4
        - Veterans who are receiving aid and attendance or housebound benefits from VA
        - Veterans who have been determined by VA to be catastrophically disabled
      - Priority Group 5
        - Nonservice-connected Veterans and noncompensable service-connected Veterans rated 0% disabled by VA with annual income below the VA's and geographically (based on your resident zip code) adjusted income limits

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- Veterans receiving VA pension benefits
  - Veterans eligible for Medicaid programs
  - Priority Group 6
    - Compensable 0% service-connected Veterans
    - Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
    - Project 112/SHAD participants
    - Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975
    - Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998
    - Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987
    - Currently enrolled Veterans and new enrollees who served in a theater of combat operations after November 11, 1998 and those who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge.
  - Priority Group 7
    - Veterans with gross household income below the geographically-adjusted income limits (GMT) for their resident location and who agree to pay copays
  - Priority Group 8
    - Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays
  - *Complexity Level 2 Facility*
    - These VAMCs are considered medium complexity, with a medium patient volume and risk, some teaching and research, and level 2 and 3 ICUs.
  - *Complexity Level 3 Facility*
    - Facilities at this level are low complexity hospitals with the lowest volume and levels of patient complexity. There is generally little or no teaching/research at these sites and they have the lowest number of physicians per patient. ICUs in this category are level 4.
  - *Rural-Urban Commuting Areas (RUCA)*
    - VHA relies on a system called RUCA to define urban, rural and highly rural land areas of the United States. In this system each census tract defined by the Bureau of the Census is given a score
      - •Urban (U) - census tracts with RUCA scores of 1.0 or 1.1. These are tracts determined by the Bureau of the Census as being in located in an urban core and having the majority of their workers

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- commute within that same core (1.0). If 30%-49% commute to an even larger urban core then the code is 1.1. (The distinction between 1.0 and 1.1 is not significant to VHA.)
- Rural (R) - all tracts not receiving scores in the urban or highly rural tiers.
  - Highly rural (H) - tracts with a RUCA score of 10.0. These are the remotest occupied land areas. Less than 10 percent of workers travel to Census Bureau defined urbanized areas or urban clusters.
- *Residential Recovery Treatment Program (RRTP)*
    - RRTPs are a distinct level of Mental Health residential care designed for Veterans with mental illnesses or addictive disorders who require additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment. RRTPs are designed to provide comprehensive treatment and rehabilitative services meant to improve the quality of life and diminish reliance upon more resource-intensive forms of treatment.
    - There are several designations for RRTPs including Substance Abuse RRTPs, Mental Health RRTPs, PTSD RRTPs, and Homeless Domiciliaries. Participants are provided residence, room, board and interdisciplinary programming in a therapeutic milieu setting, located either on a VA campus or in the community. Program duration ranges from weeks to months.
  - *Community Resource and Referral Center (CRRC)*
    - CRRCs provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multiagency services to promote permanent housing, health and Mental Health care, career development and access to VA and non-VA benefits.
  - *Ambulatory Surgery Center (ASC)*
    - An ASC is a free standing VHA facility, separate from an inpatient VHA Surgery Program, in which outpatient (same day) surgery performed. VA facilities with an 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. 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.
    - ASCs are designated as either Basic or Advanced based on the complexity of procedures they are authorized to perform. Each level has specific infrastructure requirements outlined in VHA Directive 2011-037.
  - *Patient Aligned Care Team (PACT)*

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- Primary Care services in the VA are provided according to the Patient Aligned Care Team (“PACT”) model, with each Veteran assigned a teamlet consisting of a Provider, RN, LPN/LVN/HT, and Clerk. Additional discipline-specific team members must be integrated into Primary Care as available for Veterans’ health needs, including: a clinical pharmacy specialist; an anticoagulation CPS; a registered dietician; Mental Health providers; and a social worker.
  - *Homeless Patient Aligned Care Team (H-PACT)*
    - Homeless Patient Aligned Care Team (H-PACT) is an innovative treatment model being implemented at multiple VA medical centers across the country. It plays a key role in the fight to end Veteran homelessness. Located on the campuses of VA medical centers, community-based outpatient clinics, and Community Resource and Referral Centers, H-PACT clinics co-locate medical staff, social workers, Mental Health and substance use counselors, nurses, and homeless program staff. These professionals form a team that provides Veterans with comprehensive, individualized care, including services that lead to permanent housing. H-PACT teams are attuned to how housing insecurity and other social factors like poverty harm Veterans’ health overall, worsen sickness, delay care, and exacerbate both temporary and long-term homelessness.
  - *Community Reintegration*
    - An approach to supporting people living with severe mental illnesses in which the primary aim is to advance social and vocational capability outside of a treatment-defined setting. Enhancing an individual’s strengths and empowerment combats stigma by moving the individual’s focus away from a defined illness role. Interventions are commonly delivered in the community by reintegration specialists such as peer support providers.
  - *Mental Health Intensive Case Management (MHICM)*
    - MHICM is an interdisciplinary community-based intensive case management program based upon Assertive Community Treatment (ACT), which has been modified for use in the VA. When targeting persons living with severe mental illness, ACT is superior to office-based treatment-as-usual in reducing hospitalization frequency and length of stay, improving housing stability and reducing symptom severity. According to VHA Handbook 1160.01, MHICM programs must be available to patients in all VA Medical Centers with more than 1,500 patients on the VA’s psychosis registry (Manchester does not meet this threshold). At least four “on the street” Full-time Equivalent (FTE) employees are needed for each MHICM team.

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- *Critical Time Intervention (CTI)*
    - Critical Time Intervention (CTI) is a program that is designed to assist Veterans who are homeless and have serious mental illness (SMI) secure stable housing and reintegrate into the community. CTI offers intensive case management services in the areas of psychiatric rehabilitation, medication management, money management, substance abuse treatment, social support groups, vocational resources, permanent housing, and family interventions. CTI is a time limited intervention, lasting a minimum of nine months and up to one year.
  - *Geriatric Mental Health Intensive Case Management (GERI-MHICM)*
    - GERI-MHICM is a home- and community-based intensive case management program for Veterans of advanced age who live with a complex array of medical and severe mental illness comorbidities. Services offered by the GERI-MHICM team combine approaches from MHICM with Home Based Primary Care (HBPC).
  - *Home Based Primary Care (HBPC)*
    - HBPC is a unique model of home health care that is different in target population, process, and outcomes from home care that is available under Federal and state programs such as Medicare and Medicaid. The HBPC model targets persons with complex chronic diseases that worsen over time and provides interdisciplinary care that is longitudinal and comprehensive rather than episodic and single-problem focused. HBPC provides cost effective Primary Care services in the home and includes Palliative care, rehabilitation, disease management, caregiver assistance and support, and coordination of care.
  - *Green House model*
    - The Green House Model is an innovative alternative for long-term care within the Veterans Administration. Green House homes are self-contained, eliminate the traditional nurses station and accommodate 12 or fewer residents.
  - *VISN = Veterans Integrated Service Network*
  - *CAHs = Critical Access Hospitals*
    - “Critical Access Hospital” is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services.
  - *FQHC = Federally Qualified Health Center*

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- A Federally Qualified Health Center (FQHC) is a reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services. FQHC is a community-based organization that provides comprehensive Primary Care and preventive care, including health, oral, and Mental Health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status. FQHCs are automatically designated as health professional shortage facilities.
  - *Primary Care Mental Health Integration (PCMHI)*
    - The term VA uses to describe a set of mental and behavioral health care services that are provided to Veterans in collaboration with Primary Care providers. These services are fully integrated into the Primary Care setting (PACT), and support PACT-based treatment of both Mental Health conditions and behavioral aspects of chronic medical conditions. PCMHI programs seamlessly combine evidence-based care management and co-located collaborative care services.
  - *SMI = Severe Mental Illness*
    - Severe mental illness is often defined by its length of duration and the disability it produces. These illnesses include disorders that produce psychotic symptoms, such as schizophrenia and schizoaffective disorder, and severe forms of other disorders, such as major depression and bipolar disorder,
  - *SUD = Substance Use Disorder*
  - *IEA = Involuntary Emergency Admission*
    - The statutory process used by the State of New Hampshire for an involuntary admission for the purpose of safety and stabilization related to mental illness. The process surrounding an IEA is described on this [NH Dept of Health and Human Services website](#)
  - *CLC = Community Living Center*
    - CLC is the VA's term to describe facility-based residential geriatric and extended care provided to Veterans. While commonly equated with "nursing home", the CLC more accurately encompasses a broad range of services, including short-term rehab, respite care, hospice and Palliative care, along with long-term care.