

Project ARCH: Initial Summary of Findings Relevant to the Choice Program

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Key Findings

Purpose of this report

Project ARCH (Access Received Closer to Home) is a congressionally legislated pilot program operated out of the Veterans Health Administration (VHA) Chief Business Office (CBO, now the Office of Community Care, OCC) and funded by the Office of Rural Health (ORH). Project ARCH care is available to Veterans who meet certain health care criteria, drive time criteria, and live in one of five pilot sites across the country. VHA partnered with two contracted care networks to provide participating Veterans with health care services closer to where they live. Project ARCH pilot program was originally launched for three years (August 2011 – August 2014), and then was extended for two more years. The program is set to expire in August 2016. Going forward, the goals of the Project ARCH pilot program will be realized nationally through the VHA Choice program.

Altarum Institute was tasked with assessing Project ARCH over the first three years of the pilot. The RUPRI Center for Rural Health Policy Analysis at the University of Iowa has been tasked with completing reports regarding experience of Project ARCH during its final two years, and identifying the lessons learned from ARCH using Altarum's evaluation, with additional qualitative research, that could help

Altarum's evaluation identified four key findings:

- 1) **Low participation among eligible Veterans**
- 2) **High satisfaction among participating Veterans**
- 3) **Comparable quality between non-VHA care and VHA care**
- 4) **Significant operational issues in implementation**

inform implementation of the Choice program.

Altarum's evaluation of Project ARCH was generally favorable in domains of access, satisfaction, quality, and cost, but pointed to important programmatic issues including low participation (90 percent of eligible Veterans did not utilize services available through Project ARCH) and significant operational process challenges that prevented or delayed timely care. VHA Office of Rural Health is particularly interested in: 1) why eligible Veterans did not utilize services available through Project ARCH; and 2) what operational processes affected Project ARCH that could provide lessons learned for Choice.

Results of evaluation based on data collection and analysis as of November 15, 2015

To help answer these questions, the RUPRI team reviewed the Altarum evaluation report, analyzed Project ARCH utilization data, conducted initial telephone interviews with Project ARCH care coordinators at each VHA site and one of the two contracted care networks, and reviewed relevant legislation. Through the initial telephone interviews, we gained a better understanding of the operational processes, challenges, and work-arounds used during the pilot project.

Initial analyses of the interviews indicated that certain themes related to operational process stages were clearly and consistently reported by multiple sites. These stages and preliminary recommendations include

- **Creating the networks:** suggestions included establishing direct contracts between VHA and providers –eliminate the third-party administrator (TPA); adding specialties that are needed by many Veterans, or permit use of any specialty located at a contracted hospital; contracting with more than one hospital in rural areas, if available; and ensuring credentialing is up to date.

- **Improving awareness:** suggestions to raise awareness about the ARCH program included improving Veteran communication regarding eligibility; and improving provider understanding of the program and authorization process
- **Access and coordination:** suggestions included providing non-VA providers electronic access to VA records and provide VA access to non-VA provider records, or develop a secure mechanism to transfer electronic documents; having a clinical care manager at the TPA as the single point of primary contact; standardizing communication between TPA, provider, and VA; and permitting local purchase of durable medical equipment
- **Eligibility and payment:** suggestions included establishing mechanisms and timelines to track dates of all steps in bill processing; having a single point of primary contact at the TPA for eligibility and payment; clarification for non-VA providers regarding which program bills should be submitted to which program; and paying at commercial rates rather than Medicare rates for younger Veterans.

The next stage of evaluation will include further data collection through qualitative interviews and site visits.

Objectives for this Report

The Project ARCH pilot program was congressionally legislated in 2008 (Section 403 of Public Law 110-387) and amended in 2010 (Section 308 of Public Law 111-163). Operated out of the Veterans Health Administration (VHA) Chief Business Office (CBO, now the Office of Community Care, OCC) and funded by the Office of Rural Health (ORH), Project ARCH began in August 2011 and is set to expire in August 2016. Going forward, the goals of the Project ARCH pilot program will be realized nationally through the VHA Choice program.

According to the VHA, “the goal of Project ARCH is to cost-effectively increase access to non-VA medical care that meets VHA’s standards for quality and safety for eligible Veterans who must drive long distances to access VHA-provided health care”. Project ARCH care is available to Veterans who meet certain health care criteria, drive time criteria, and live in one of five pilot sites across the country (Billings, MT; Caribou, ME; Farmville, VA; Flagstaff, AZ; Pratt, KS). Farmville VA and Pratt KS provide primary care through Project ARCH and Billings MT, Caribou ME, and Flagstaff AZ provide specialty care through Project ARCH. VHA has partnered with two contracted care networks to provide participating Veterans with health care services closer to where they live. At the Caribou pilot site, the contracted care network is a local hospital that provides all inpatient care and contracts some of the outpatient care to local physician groups. The four other pilot sites are managed by a contracted care network (Humana) that creates and maintains provider networks at each location.

Altarum Institute was tasked with assessing Project ARCH’s success in meeting its stated goals over the first three years of the pilot. The RUPRI Center for Rural Health Policy Analysis at the University of Iowa will complete reports regarding experience of Project ARCH during its final two years, and identify lessons learned from Altarum’s evaluation and supplemental interviews conducted by RUPRI that will help inform implementation of the Choice program. The RUPRI team approached the first stage of its evaluation with the following activities:

- **Summarize key findings related to Altarum’s evaluation of Project ARCH**

Altarum’s evaluation of Project ARCH, as summarized in their draft final report, focused on four outcomes domains: access, satisfaction, quality, and cost. The primary conclusions from Altarum’s evaluation were generally favorable in each one of these domains. Altarum’s evaluation of Project ARCH also provided information on the degree to which eligible Veterans did or did not utilize services available through Project ARCH, and operational processes that affected Project ARCH over the three year pilot project period. As the evaluation process continues, VHA Office of Rural Health is particularly interested in: 1) why eligible Veterans did not utilize services available through Project ARCH; and 2) what operational processes affected Project ARCH that could provide lessons learned for Choice.

- **Collect/process additional data**

To help answer the first question, the RUPRI team reviewed existing quantitative data provided by VHA to examine patterns in Veterans utilization of Project ARCH services. To help answer the second question, the RUPRI team conducted initial telephone interviews with VHA Project ARCH care coordinators at each site and one of the two contracted care networks to gain a better understanding of the operational processes, challenges, and work-arounds used during the pilot project.

- **Generalize Project ARCH findings to inform the Choice program**

A primary objective of our effort is to identify lessons learned from the Project ARCH pilot that can help inform Choice and facilitate its successful implementation. Given VHA Office of Rural Health’s priorities, attention will be focused on two issues identified as challenges in Project ARCH: awareness/utilization and operational processes.

- **Identify next steps in evaluation**

Following the review of findings from the Altarum evaluation, the identification of organizational process challenges, and initial findings from interviews with care coordinators at the five Project ARCH pilot sites, the next stage of evaluation will include further data collection through interviews and site visits.

Methods

Review Altarum's evaluation of Project ARCH

The VHA provided the University of Iowa RUPRI team access to materials from Altarum's evaluation of Project ARCH through a Sharepoint site. Included were progress reports and slide decks, a few data worksheets, and some working documents. The most conclusive summary of Altarum's evaluation was contained in their draft final report, dated November 14, 2014 (please note that no final report or report dated after that was available). This draft final report, totaling 129 pages, was reviewed to identify the key findings from Altarum's evaluation.

Assemble and prepare available quantitative data for analysis

The Altarum evaluation utilized a large number of detailed data sources including the local "Veterans Health Information Systems and Technology Architecture" (Vista), VHA Corporate Data Warehouse (CDW), VHA's Health Eligibility Center (HEC), Veterans Affairs Site Tracking (VAST) database, monthly Clinical Reports, and others. Efforts were made to obtain access to the same data sources for the University of Iowa RUPRI evaluation, but the evaluation's relatively short time frame and a number of administrative barriers made that impossible. The VHA was able to provide access to a large number of files that were used as part of the Altarum evaluation process and findings, but very few of those were of value for a quantitative analysis of the Project ARCH pilot project.

The RUPRI team was able to assemble a minimal dataset of Project ARCH encounters from a variety of the data files provided by the VA. Encounter records from the participating Humana sites from August 2011 to August 2014 were extracted from an Excel spreadsheet assembled (presumably) by Altarum. Additional monthly care summary data from the Humana sites from October 2014 through June 2015 were provided in PDF files. Monthly care summary data from the Caribou site were provided in an assortment of Excel spreadsheets.

All of these data sources were processed to extract rudimentary encounter information and assembled into a single dataset for further analysis. However, the dataset is not complete: some of the files appear to contain incomplete information (i.e., there was only one encounter from Pratt, KS in March 2012); and, data files from a number of months were missing (Billings MT: September 2014, Caribou ME: November 2012, December 2012, January 2015, May 2015, Farmville VA: October 2012, September 2014, Flagstaff AZ: September 2014, and Pratt KS: March 2012, April 2012, October 2012, November 2012, December 2012, September 2014). Although the dataset is incomplete, comparisons with data published in Altarum documents indicate that the resulting dataset provides reasonable estimates of the numbers of Veterans served during Project ARCH to date.

Conduct telephone interviews with VHA Project ARCH coordinators and contracted care networks

An interview guide and protocol was developed and approved by VHA Office of Rural Health. During September 2015, the RUPRI team conducted telephone interviews with VHA Project ARCH care coordinators at each of the five sites. During October 2015, a telephone interview was conducted with the contracted care network at Caribou, ME; interviews with the Humana contracted care network are awaiting a signed non-disclosure agreement.

Review legislation and other documents to identify similarities and differences between Project ARCH and Choice

The University of Iowa RUPRI team reviewed all legislation specific to Project ARCH and to Choice in order to identify similarities and differences, especially in terms of eligibility for the programs.

Analyze and synthesize findings to develop generalizable Project ARCH findings that can be used to inform Choice

Available quantitative data were reviewed and analyzed, where possible, to examine Veteran utilization of Project ARCH services. Documents available from Altarum's evaluation were catalogued and reviewed. Altarum's Draft Final Report was studied to identify primary findings and also to examine the issues described. Key initial impressions from the September 2015 RUPRI interviews were identified. Transcripts of the interviews were reviewed and compared to identify operational processes that matched those described in Altarum's Draft Final Report.

Identify remaining issues and challenges that will be the targets for the next stage of evaluation

The September 2015 RUPRI interviews with VHA Project ARCH care coordinators contained descriptions of numerous operational processes that presented considerable challenges. Care coordinators employed multiple work-arounds to meet the needs of Veterans using services outside the VHA. In addition, review of Altarum's Draft Final Report identified issues related to Veteran enrollment in Project ARCH and continued use of services outside the VHA. The remaining issues and challenges were identified for further evaluation by the RUPRI team.

Summary of Altarum's Evaluation

Altarum Institute was tasked with assessing Project ARCH's success in meeting its stated goals over the first three years of the pilot. Altarum's evaluation of Project ARCH, as summarized in their draft final report, focused on access, satisfaction, quality, and cost. Their primary findings in each of these areas were:

Access

- Across all sites there were 27,705 outpatient encounters and 1,073 inpatient discharges. A total of 5,945 unique Veterans received clinical care through Project ARCH, with significantly more Veterans receiving Project ARCH care at pilot sites offering specialty care services (1,949 Veterans in Billings, 1,167 Veterans in Caribou; and 2,051 Veterans in Flagstaff) compared to sites offering primary care (344 Veterans in Farmville and 434 Veterans in Pratt).
- Drive time for Veterans receiving care through Project ARCH was less than a third (56 minutes) of the estimated one-way drive time to receive analogous care at a VHA facility (191 minutes).
- The percent of primary care appointments that occurred within 14 days of the appointment request (93 percent) exceeded the VHA-specified benchmark of 90 percent. The percent of specialty care appointments that occurred within 14 days of the request (61 percent) did not meet the VHA benchmark of 90 percent.

Satisfaction

- Based on the patient satisfaction survey administered to Veterans receiving care through Project ARCH, 77 percent of those responding were "completely satisfied" with Project ARCH overall, 81 percent with travel time, 65 percent with time to appointment, and 82 percent with quality of care. The percent satisfied increased over the three-year pilot project period.
- In addition, Altarum frequently heard from VHA Project ARCH staff and VHA providers that they perceived the quality of Project ARCH care to be as good as or better than analogous care provided through VHA directly.

Quality

- The contracted care network (Humana) that served both primary care pilot sites reported on 26 clinical metrics for primary care. The percent of metrics that met the VHA benchmarks rose from 65 percent in the first year to 85 percent in the third year.

Costs

- At pilot sites offering primary care, there was greater health care utilization by Veterans participating in Project ARCH, compared to non-participating Veterans. When controlling for the difference in utilization, the average cost of care per year for a participating Veteran was not different from the average cost of care for a non-participating Veteran.
- For specialty care, the cost of inpatient care provided through Project ARCH compared to VHA direct care varied by pilot site. On average, inpatient care provided through Project ARCH was less expensive than VHA direct care at the Caribou pilot site, similar to VHA direct care at the Billings pilot site, and more expensive than VHA direct care at the Flagstaff pilot site.

- In addition to the cost of care provided to the Veterans through Project ARCH, there were costs at each VHA facility associated with supporting Project ARCH, and these increased in proportion to the number of Veterans using Project ARCH services.

Thus, the primary conclusions from Altarum's evaluation of access, satisfaction, quality, and cost in the Project ARCH pilot sites were generally favorable in each one of these domains, indicating that such a program can increase rural Veterans' access and satisfaction while providing high quality care for those choosing to use contracted services outside the VHA and at reasonably comparable cost per unit of utilization.

, Altarum's evaluation of Project ARCH also provided information on why eligible Veterans did not utilize services available through Project ARCH and highlighted operational processes that affected Project ARCH over the three year pilot period.

Veterans' Reasons for Participating and for Not Participating

An important finding from Altarum's evaluation was that Project ARCH reached very few eligible Veterans. The report stated that:

- The Veterans Health Information Systems and Technology Architecture (VistA) systems indicated that 58,501 Veterans had a Project ARCH eligibility flag during the three-year pilot project, but only 5,945 eligible Veterans (10 percent) received medical care through Project ARCH. This percent was similar across all three specialty care sites and one of the primary care sites; in contrast, nearly half (48 percent) of eligible Veterans at the primary care site in Pratt KS participated in Project ARCH.
- Participating Veterans indicated that they first learned about Project ARCH from a VHA provider (72 percent) and/or the VHA Project ARCH nurse care coordinator (8 percent). Of Veterans who were eligible but not participating in Project ARCH, 68 percent indicated that they had not heard of Project ARCH prior to receiving a survey from Altarum.
- Veterans participating in Project ARCH were similar in sex and age distribution to Veterans who were eligible but not participating, but had more disabilities and mental health concerns.
- The leading reasons reported by Veterans for participating in Project ARCH were reduced travel time to the Project ARCH provider (71 percent), a recommendation from their VHA provider to participate in the program (43 percent), and the reputation of their Project ARCH provider (10 percent).
- Of the 32 percent of non-participating Veterans who were previously aware of Project ARCH but did not participate, the leading reasons for nonparticipation were satisfaction with their VHA provider (54 percent), satisfaction with VHA care (52 percent), and not wanting to change providers (50 percent).
- Veterans who participated but then discontinued provided reasons for doing so, including: better care provided by VHA, difficulty obtaining results of labs or other tests, delays receiving prescription medications, miscommunication between contracted providers and VHA Project ARCH staff or VHA providers, being billed for care received through Project ARCH, not enough time with contracted providers, and less caring contracted providers compared to VHA providers.

Operational Processes

Numerous challenges related to Project ARCH's processes and operations were identified, including the following:

- **Confusion about Project ARCH policies and processes contributed to delays in care and participating Veteran dissatisfaction throughout the three-year evaluation.** Contracted providers needed time to learn VHA processes, which led to incorrect requests for authorizations, incomplete prescriptions, inappropriate billing, and miscommunication. Veterans were confused about eligibility requirements,

covered services, authorization processes, and prescription processes. Veterans were frustrated to have to travel to the VAMC or other locations for services not covered at their specific project site. Contracted providers and Project ARCH staff spent time answering questions from Veterans who did not understand Project ARCH processes.

- **VHA Project ARCH staff and contracted providers experienced a high administrative burden associated with Project ARCH care coordination and other project processes.** Project ARCH staff spent considerable time obtaining approvals for authorization requests, ensuring discharge needs were met, disseminating progress notes, and clearing up miscommunication among all parties. Contracted providers spent time on additional paperwork, managing scheduling errors from the contracted care network, managing a heavy flow of incoming medical records and progress notes, and processing authorizations, prescriptions, and specialty referrals.
- **In four of the five sites, in order to coordinate care for Veterans, Project ARCH staff were required to communicate through the contracted care network rather than communicating directly with non-VA providers.** This three-way communication requirement led to miscommunication, delays in setting appointments, delays in the continuity of care, and considerable frustration for all involved.
- **Piecing together health care and ancillary services caused delays for some Veterans receiving health care.** Some contracted providers reported frustration that Project ARCH did not allow them to bundle care to address all of the Veterans' needs. Veterans were often required to return to the VAMC for diagnostic lab work, procedures, and follow up care. This occasionally resulted in delayed or fragmented care.
- **Lack of provider availability, particularly for some types of specialty care, remained difficult in highly rural areas.**
- **Communication issues with the contracted network provider contributed to delays in care and difficulty resolving problems.** Communication with staff at one of the contracted care networks was inconsistent and their staff were not always responsive to issues. Concerns included that the contracted care network staff did not communicate scheduled appointments accurately which led to delays for some Veterans. Other problems included delays in processing authorization, scheduling, prescription requests, and addressing issues of individual Veterans.
- **VHA was required to authorize non-VA care prior to Veterans receiving services through Project ARCH.** Delays in authorizations, often as a result of miscommunication or slow communication, led to delays in patient care and Veterans being billed for denied services. Delays in receipt of authorizations led to the rescheduling of appointments, procedures, and surgeries. Not receiving these authorizations for services that already had taken place led to denial of services and contracted providers billing Veterans for services.
- **Incomplete patient medical records and progress notes contributed to denial of claims and an inability of contracted providers to identify and meet Veterans' health care needs.** At four of the five pilot sites, there was difficulty receiving patient medical records and progress notes from VHA or the contracted care network. Progress notes missing from claims led to denial of claims and denial of follow up appointments and services. Delays in receiving results for tests conducted at the VAMC led to an inability to diagnose conditions and plan treatments by contracted providers.
- **Prescription processes led to delays in Veterans receiving prescriptions and to Veterans receiving older medications for some conditions.** There were delays in Veterans receiving needed prescriptions due to VHA mail order processes and contracted providers needing to find alternate medications listed on the VHA formulary. Some contracted providers submitted incomplete prescriptions that were not approved for processing. Contracted providers complained that the VHA formulary needs updating.

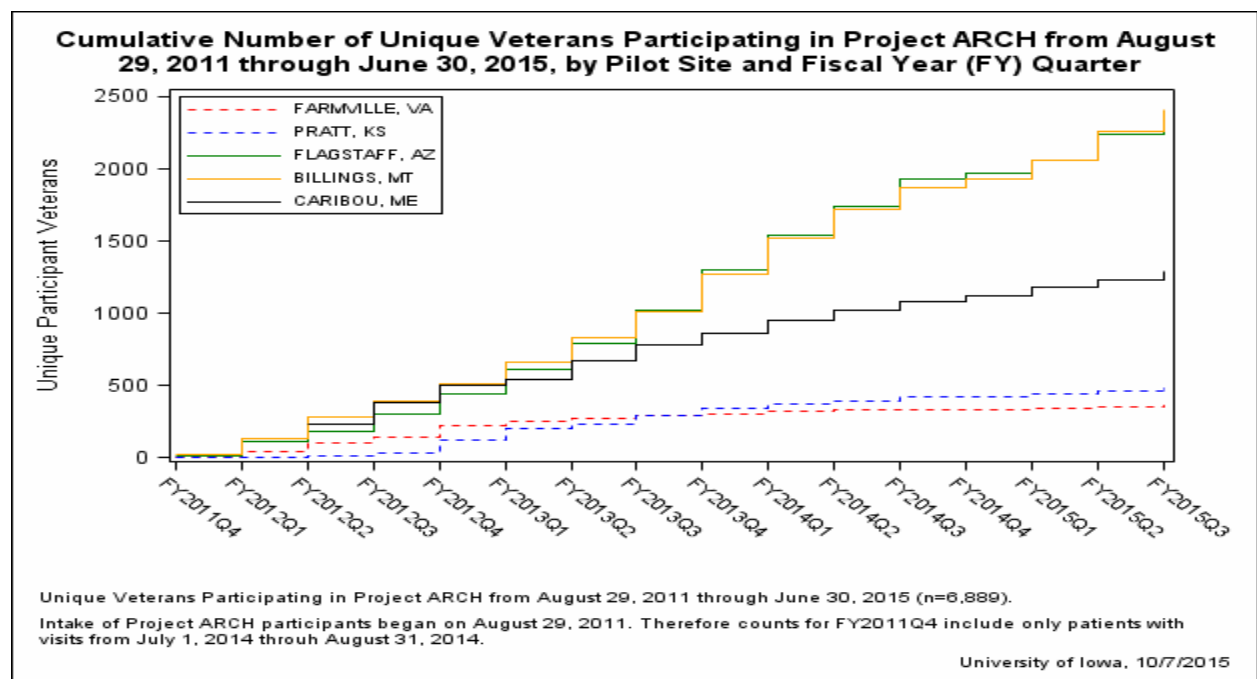
In summary, Altarum concluded that Project ARCH has been meeting the access, satisfaction, quality, and cost goals in its first three years of operation. However, remarkably, only 10 percent of eligible Veterans received care through Project ARCH, largely because many eligible Veterans were unaware of the program. The Altarum evaluation highlighted substantial operational process challenges that make the program burdensome for Veterans, VHA staff, contracting providers, and contracted care networks.

Key Findings from Quantitative Data

The first Project ARCH participants were seen on August 29, 2011. Veteran uptake in the program started relatively strong with 373 unique Veterans participating in the first full quarter of operation (FY12Q1, October-December 2011) and climbing to 629 unique participating Veterans in the next quarter. Participation peaked in FY14Q1 with 1,802 unique Veterans participating during that quarter (Altarum data). There was a slight decrease in ARCH participation after FY14Q1 which was attributed to “uncertainty about the future of the Project ARCH pilot prior to its renewal in August 2014.” (Altarum Final Report Draft 20141114, p. 25).

The data show that there was a modest recovery in the number of unique participating Veterans following renewal of the pilot project; although, the rate of growth appears to be relatively level. The three pilot sites providing specialty care (Billings, MT, Caribou, ME, and Flagstaff, AZ) generally saw steady growth in the number of unique participating Veterans each quarter from the start of the program until the peak in FY14Q1 where the counts appear to have plateaued. In the pilot sites providing primary care (Farmville, VA and Pratt, KS) the numbers of unique participating Veterans climbed more slowly and appear to have plateaued much earlier (around FY13Q1).

As shown in the figure below, the pilot sites added new participants at different rates based primarily on the types of services offered. Following the start of the pilot, the specialty care sites (Billings, MT, Caribou, ME, and Flagstaff, AZ) accumulated previously unseen Veterans at roughly the same rate (141.3 new Veterans each quarter between FY2012Q3 and FY2013Q3) for the first year. Over the last two years of the pilot project the rate of increase in the number of new participating Veterans at the Caribou, ME site slowed (averaging 62.6 new Veterans each quarter between FY2013Q4 and FY2015Q3) while the rate of increase at the other two specialty care sites grew slightly (averaging 170.8 new Veterans each quarter between FY2013Q4 and FY2015Q3). The pilot sites providing primary care (Farmville, VA, and Pratt, KS) accrued new participating Veterans at a slower pace than the specialty care sites, averaging 47.1 new Veterans each quarter for the first year of the pilot (FY2012Q3 – FY2013Q3). The accrual of “new” Veterans at the primary care pilot sites has been relatively small for the last two years of the pilot project, averaging 16.9 new Veterans per quarter between FY2013Q4 and FY2015Q3.



Project ARCH Operational Issues and Its Relevance for Choice

Altarum’s Draft Final Report described operational issues during the Project ARCH pilot and offered recommendations for addressing them. To meet identify lessons learned from Project ARCH that could be relevant to Choice, the University of Iowa RUPRI team reviewed Altarum’s Draft Final Report and categorized the operational issues into four process stages: 1) creating the network; 2) improving awareness; 3) access and coordination; and 4) eligibility and payment. The operational issues identified in the Altarum Draft Final Report and their recommendations are summarized in the table below.

Table 1. Operational Issues Identified in the Altarum Draft Final Report

Operational Stage	Challenges and Recommendations Identified in Altarum Report
Creating the networks	<p>Challenge: Lack of contracted provider availability</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Preserve Veteran choice: allow Veterans the opportunity to decline enrollment in the program, and provide opportunities for Veterans to choose their contracted provider or recommend providers who should be added to the network (R3¹) • Develop provider networks specifically in areas a long distance from a VHA facility (R4) • Conduct a national evaluation of the health care of VHA-enrolled Veterans in rural areas and/or living a long distance from a VHA facility to assess where quality and access to care is low(AR6²)
Improving awareness	<p>Challenge: Confusion regarding Project ARCH policies and processes</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • Designate a single point of contact who understand VHA policies and processes and the VHA system (R1)
Access and coordination: <ul style="list-style-type: none"> • Appointment • Medical information exchange • Services delivery • Feedback to VHA providers 	<p>Challenge: Communication issues</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Ensure direct communication between VHA and contracted providers (R5) • Explore the option of having a third-party entity negotiate and build a health care network for VHA, but have contracted providers directly contract and communicate with VHA (AR2) • Identify points of contact at contracted care networks, hospitals, and provider clinics where sizable numbers of patients receive care (AR3) <p>Challenge: Care coordination</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Designate a nurse for care coordination within VHA (R1) • Have clinical staff at contracted care network review all care (AR5) <p>Challenge: Lack of bundling of care</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • Bundle all services needed for an episode of care (AR1) <p>Challenge: Incomplete medical records and progress notes</p> <ul style="list-style-type: none"> • Ensure direct communication between VHA and contracted providers (R5) <p>Challenge: Difficulties with prescription processes</p>
Eligibility and payment	<p>Challenge: Delays in authorizations</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • Ensure direct communication between VHA and contracted providers (R5) <p>Challenge: High administrative burden for VHA staff and contracted providers</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • Standardize protocols for processes between VHA and the contracted care networks/providers, with input from contracted providers (AR4)

¹ R# refers to recommendations made by Altarum in their final report draft (page 4).

² AR# refers to additional recommendations made by Altarum in their final report draft (pages 6-7).

Key Initial Impressions from Interviews

The initial RUPRI telephone interviews with VHA Project ARCH care coordinators at each site were conducted during September 2015 and analyses is underway. However, certain themes related to operational processes were clearly and consistently reported by multiple sites, informing the key initial impressions summarized in Table 2, organized in the four process stages.

Table 2. Suggestions for ARCH and/or Choice Based on RUPRI Interviews with VHA Care Coordinators

Operational Stage	Suggestions Identified in RUPRI Interviews
Creating the networks	<ul style="list-style-type: none"> ● Establish direct contracts between VHA and providers –eliminate the third-party administrator (TPA). ● Add specialties that are needed by many Veterans, e.g. podiatry, ophthalmology, ENT, pain clinic. Or permit use of any specialty located at a contracted hospital. ● Contract with more than one hospital in rural areas, if available. ● Make sure credentialing is up to date.
Improving awareness	<ul style="list-style-type: none"> ● Improve Veteran communication regarding eligibility: <ul style="list-style-type: none"> ○ Actively promote the program. Improve educational materials including pamphlets, brochures, or electronic communication. ○ Improve provider understanding of the program and authorization process.
Access and coordination: <ul style="list-style-type: none"> ● Appointment ● Medical information exchange ● Services delivery ● Feedback to VHA providers 	<ul style="list-style-type: none"> ● Provide non-VA providers electronic access to VA records, or develop secure mechanisms to transfer electronic documents. ● Provide VA access to non-VA provider records, or develop secure mechanisms to transfer electronic documents. ● Have a clinical care manager at the TPA as the single point of primary contact. ● Regionalize states for Choice to improve care coordination and reduce burden on care managers. ● Standardize communication between TPA, provider, and VA: <ul style="list-style-type: none"> ○ Establish regular notification of unsuccessful contact efforts; ○ Establish mechanisms and timelines to track dates of authorization, appointments, visit documentation, ancillary test orders, and ancillary test results; ○ Establish timelines and processes for communication between provider or TPA and Veteran for results from visits and for scheduling visits or consults; ○ Establish a mechanism for Veteran to request VA care coordinator support when making appointments in Choice; ○ Establish algorithms for appropriate number of visits, therapy sessions, labs, and medication renewals, or permit care coordinator to use clinical judgment in establishing them; ○ Standardize policies for ASAP or stat services. ● Permit local purchase of durable medical equipment (DME).
Eligibility and payment	<ul style="list-style-type: none"> ● Establish mechanism and timelines to track dates of bill submission, rejection/request for more documentation, notification of provider, resubmission, and payment. ● Have a single point of primary contact at the TPA. ● Clarification for non-VA providers regarding which program bills should be submitted to, e.g. ARCH, PC3, etc. ● Pay at commercial rates rather than Medicare rates for younger Veterans.

Distinctions between Project ARCH and Choice

VHA Office of Rural Health is particularly interested in how the lessons learned from the Project ARCH program can help inform the evolving Choice program. To help address this objective, we the two programs in terms of eligibility, covered health services, provider requirements, program implementation, and program timeframe. Distinctions between the two programs are summarized in the table below.

Table 3. Comparison of Project ARCH and the Choice Program

	Choice Program	Project ARCH
Eligibility	<p>The Veteran is enrolled in the patient enrollment system of the Department of Veterans Affairs</p> <p>OR</p> <p>The Veteran is eligible for hospital care and medical services under title 38 of the U.S. Code</p> <p>AND the Veteran:</p> <p>Attempts to schedule an appointment but is unable to within 30 days from the date of request <i>or with respect to such care or services that are clinically necessary, the period determined necessary for such care or services if such period is shorter than such wait-time goals.</i>³</p> <p>OR</p> <p>Resides more than 40 miles <i>(as calculated based on the distance traveled)</i> from the VA medical facility closest to the Veteran’s residence; <i>or, with respect to a Veteran who is seeking primary care, a medical facility of the Department, including a community based outpatient clinic, that is able to provide such primary care by a full-time primary care physician;</i> resides in a state without a VA facility that provides hospital care, emergency services and surgical care with a surgical complexity standard and more than 20 miles from such a facility. Or, resides in an area less than 40 miles from a VA facility but is required to travel by air, boat or ferry to reach the facility; or faces an unusual or excessive burden in accessing a VA medical facility that provides the care described above in this paragraph.</p>	<p>A highly rural Veteran who is:</p> <p>Enrolled in the system of patient enrollment as of the date of commencement of the pilot program</p> <p>OR</p> <p>Eligible for hospital services under title 38 of the U.S. Code</p> <p>A highly rural Veteran is any Veteran who:</p> <p>Resides in a location that is:</p> <p>More than 60 miles driving distance from the nearest VA facility providing primary care services if the Veteran is seeking such services;</p> <p>More than 120 miles driving distance from the nearest VA facility providing acute hospital care if the Veteran is seeking such care</p> <p>OR</p> <p>More than 240 miles driving distance from the nearest VA facility providing tertiary care if the Veteran is seeking such care</p> <p>OR</p> <p>In the case of a Veteran who resides in a location less than the distances mentioned above, experiences such hardship or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of the Veteran as determined by the Secretary.</p>

³ Amendments to Choice under the VA Budget and Choice Improvement Act of 2015 are in green.

Covered Health Service	Hospital care and medical services under chapter 17 of title 38, United States Code, shall be furnished to an eligible Veteran.	Any hospital care, medical service, rehabilitative service, or preventative health service that is authorized to be provided by the Secretary to the Veteran under chapter 17 of title 38, United States Code, or any other provision of law.
Provider Requirements	<p>To be eligible to furnish care or services under this section, a health care provider must--</p> <p>maintain at least the same or similar credentials and licenses as those credentials and licenses that are required of health care providers of the VA, as determined by the Secretary for purposes of this section;</p> <p>AND</p> <p>submit, not less frequently than once each year during the period in which the Secretary is authorized to carry out this section pursuant to subsection (p), verification of such licenses and credentials maintained by such health care provider.</p>	For purposes of the pilot program under this section, an entity or individual is a qualifying non-Department health care provider of a covered health service if the Secretary determines that the entity or individual is qualified to furnish such service to Veterans under the pilot program.
Program Implementation	<p>The Secretary shall enter into agreements for furnishing care and services to eligible Veterans under this section with the following entities:</p> <p>(i) Any health care provider that is participating in the Medicare program under title XVIII of the Social Security Act, including any physician furnishing services under such program.</p> <p>(ii) Any Federally-qualified health center (as defined in the Social Security Act)</p> <p>(iii) The Department of Defense.</p> <p>(iv) The Indian Health Service.</p>	<p>The Secretary of Veterans Affairs shall conduct a pilot program under which the Secretary provides covered health services to covered Veterans through qualifying non-Department of Veterans Affairs health care providers.</p> <p>The pilot program shall be carried out within areas selected by the Secretary for the purposes of the pilot program in at least five Veterans Integrated Service Networks (VISNs).</p>
Program Timeframe	Originally implemented for three years or until exhaustion of funds.	Three year period, with two year extension through August 2016

Plan for the Next Stage of Evaluation

Following the review of findings from the Altarum evaluation, identification of organizational process challenges, and initial findings from interviews with care coordinators at the five VHA Project ARCH pilot sites, the next stage of evaluation will include further data collection through qualitative interviews and site visits. In particular, the RUPRI team plans to schedule a site visit to the Pratt KS facility in the next two months. Ideally, the site visit will include interviews with VHA Project ARCH staff, VHA providers engaged in the program, non-VA care staff, and contracted care network staff. The interviews will include topics to collect further information on the operational challenges and possible approaches for overcoming those challenges. Altarum's evaluation of VistA data indicated that the percent of eligible Veterans who received care through Project ARCH was low (10%) at four of the five pilot sites, but substantially higher (48%) at one site (Pratt KS). Thus, the RUPRI team will focus a portion of data collection on identifying specific strategies and procedures that the Pratt KS site used that could serve as a "best practice" for VHA facilities to increase utilization rates in the Choice program.

Appendix A. Interview Questions for VHA Project ARCH Care Coordinators and Contracted Care Networks

Ask each party whether or not they can give us a copy of the contract between the VHA and the TPA. Also ask the TPA if we can have a de-identified copy of their contract with the providers.

Provider Selection – For TPA

1. Please help us understand how the individual providers or provider groups are selected.
 - a. Are these providers or provider groups with whom the TPA has an existing contractual relationship?
 - i. Employees?
 - ii. Established contractors?
 - b. How are estimates of volume established and communicated with the providers?
 - c. What are the eligibility criteria?
 - d. Can the provider select which patients to see?
2. How did you decide whether new providers needed to be recruited?
 - a. How are they identified and recruited?
 - b. How are patient transfers managed when a provider leaves the program?
3. What are the on-boarding processes?
 - a. For the TPA?
 - b. Required by VHA?

Communication and referrals between VHA and TPA and **specialist** providers – For VHA and TPA

4. What are the procedures for making referrals from the VHA to one of the providers?
 - a. Do referrals go through a central contact person or office at the TPA?
 - i. Is there a primary contact person?
 - ii. How are providers made aware of the Veteran's eligibility?
 - iii. How are Veterans made aware of the referral?
 - iv. Do Veterans have a choice among providers?
 - How is this communicated to them?
 - How can they change providers?
 - v. Are there established response times for accepting the referrals?
 - vi. Are there established timelines for actually seeing the Veteran?
 - vii. How are these enforced?
 - viii. What are the challenges in meeting these timelines?
 - b. How are appropriate medical records transferred to the providers?
 - i. Are there established timelines for sharing these records?
 - ii. How are they shared?
 - The Veteran brings them?
 - They are sent electronically through an encrypted email system?
 - Other ways?
 - iii. Do the records go to a central contact person or directly to the provider or group?
 - Has this changed over the course of the program?
 - c. What are the procedures for obtaining diagnostic tests the provider determined are necessary?
 - i. Are there established response times for conducting these tests?
 - ii. Are there established timelines for providing the results to providers?

- iii. How are these enforced?
 - iv. What are the challenges in meeting these timelines?
 - d. What are the procedures for providers to send their reports to the VHA after services are provided?
 - i. Are they sent through a central TPA office? Or are they sent directly by the provider?
 - ii. Are there established time frames for sending them?
 - iii. How are these enforced?
- 5. Are there specific primary contact persons at the TPA and at the VHA?
 - a. Are they responsive to requests for assistance?
 - b. Are there regularly scheduled meetings between TPA staff and VHA staff?
 - c. Are there regular meetings regarding PPA patients between TPA staff and providers?
 - d. Are there regular meetings between VHA staff and providers?

6. What “work arounds” have you established to address coordination challenges?

Communication between VHA and TPA and **primary care** providers – For TPA and VHA

7. How are Veterans made aware of their eligibility?

8. Do Veterans have a choice among providers?
i. How can they change providers?

9. How are appropriate medical records shared with the providers?
a. Are there established timelines for sharing these records?
b. How are they shared?
- Does the Veteran bring them?
- Are they sent electronically through an encrypted email system?
- Other ways?
c. Do the records go to a central TPA contact person/office or directly to the provider or group?
- Has this changed over the course of the program?

10. What are the procedures for providers to send their reports to the VHA after services are provided?
a. Are they sent through a TPA central office or directly to the VHA?
b. Are there established time frames for sending them?
c. How are these enforced?

11. If the provider determines specialty care is needed, how is the referral made?
a. Is the request made through the TPA central office or directly by the provider?
b. Must the Veteran return to the VHA?
c. Can the provider or TPA select a specialist? Does the selection have to be approved by the VHA?

12. How are specialist services received reported back to the primary care provider?

13. Are there specific primary contact persons at the TPA and at the VHA?
a. Are they responsive to requests for assistance?
b. Are there regularly scheduled meetings between TPA staff and VHA staff?
c. Are there regular meetings regarding PPA patients between TPA staff and providers?
d. Are there regular meetings between VHA staff and providers?

14. What “work arounds” have you established to address coordination challenges?

Communication between VHA and TPA regarding coordination among all providers – For TPA and VHA

15. What is the procedure for providers to submit bills and receive payment?
 - a. Are bills submitted through a TPA central office? Or, do providers submit them directly to the VHA?
 - b. Is payment submitted to a TPA central office? Or, does the VHA send it directly to providers?
 - c. Are there established time frames for submitting bills?
 - d. Are there established time frames for payment?
 - e. How are these enforced?
 - f. How are disputes over what services the Veteran needs resolved?
 - i. Does the dispute resolution occur through the TPA central office?
 - ii. What role does the provider have?
 - iii. Are there established time frames for resolving disagreements?
 - iv. If the service has already been provided, how is that resolved?
16. How are problems with transferring records addressed?
 - a. Do providers have to communicate through a central TPA contact?
 - b. Does the VHA have to communicate through a central TPA contact?
 - c. Has this procedure changed over the course of the program? How?
17. When Veterans express concerns, how are they communicated with providers?
 - a. Do these go through a central TPA office? Or does the VHA contact the provider directly?
 - b. Is there an established dispute resolution process? - Explain it
 - c. Is there a time frame for addressing concerns?
 - d. How is it enforced?
18. What changes in the SOPs or the contracts would make it easier to coordinate with the TPA/VHA?
19. What changes in the SOPs or the contracts would make it easier to coordinate with the providers?

VHA Site Challenges

20. What changes in your duties have occurred as a result of this program?
21. What changes in SOPs would make it easier for you to support this program?

TPA and Provider Challenges

22. In general, how do Veterans compare to your providers' other patients in terms of:
 - a. Severity of illness?
 - b. Coming to appointments?
 - c. Participating in their care decisions?
 - d. Complying with care recommendations?
23. How do these differences impact their:
 - a. Schedules?
 - b. Work satisfaction?

24. What are the primary challenges your providers have in terms of VHA expectations for:
- a. Documentation
 - b. Timelines of submitting documentation
 - c. Timeliness of appointment
 - d. Quality of care