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

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Project ARCH (Access Received Closer to Home) is a congressionally legislated pilot program operated out of the Veterans Health Administration (VHA) Office of Community Care Office (OCC, formerly known as the Chief Business Office, CBO) 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 inform implementation of the Choice program. This work is funded by the ORH at the request of the OCC.

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 the Choice program.

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. Tables on the next three pages summarize the findings. Table 1 presents the operational issues identified by Altarum. Table 2 presents the operational issues identified through our telephone interviews with Project ARCH care coordinators at each VHA site. Table 3 presents findings by Altarum related to Veteran participation and non-participation in Project ARCH.

Project ARCH Operational Issues and Its Relevance for Choice

The operational issues identified in by Altarum and their recommendations are summarized in Table 1.

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

Operational Stage	Challenges and Recommendations Identified in Altarum Report
Creating the networks	**Challenge:** Lack of contracted provider availability **Recommendations:** • 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 (R3[1]) • 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(AR6[2])
Improving awareness	**Challenge:** Confusion regarding Project ARCH policies and processes **Recommendation:** • Designate a single point of contact who understand VHA policies and processes and the VHA system (R1)
Access and coordination: • **Appointment** • **Medical information exchange** • **Services delivery** • **Feedback to VHA providers**	**Challenge:** Communication issues **Recommendations:** • 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) **Challenge:** Care coordination **Recommendations:** • Designate a nurse for care coordination within VHA (R1) • Have clinical staff at contracted care network review all care (AR5) **Challenge:** Lack of bundling of care **Recommendation:** • Bundle all services needed for an episode of care (AR1) **Challenge:** Incomplete medical records and progress notes • Ensure direct communication between VHA and contracted providers (R5) **Challenge:** Difficulties with prescription processes
Eligibility and payment	**Challenge:** Delays in authorizations **Recommendation:** • Ensure direct communication between VHA and contracted providers (R5) **Challenge:** High administrative burden for VHA staff and contracted providers **Recommendation:** • 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. Certain themes related to operational processes were clearly and consistently reported by multiple sites, informing the key initial impressions summarized in Table 2.

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	• 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	• Improve Veteran communication regarding eligibility: ○ 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: • **Appointment** • **Medical information exchange** • **Services delivery** • **Feedback to VHA providers**	• 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: ○ 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	• 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.

Veterans' Reasons for Participating or Not Participating in Project ARCH

A very important finding from Altarum's evaluation was that Project ARCH reached very few eligible Veterans. The primary findings related to Veteran participation and non-participation are listed in Table 3.

Table 3. Findings Related to Veteran Participation or Non-Participation in Project ARCH

Key Finding	Detailed Finding Related to Veteran Participation
10 percent of Veterans participated in Project ARCH	• 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.
Pratt KS primary care site had much higher participation than other sites	• The percent of eligible Veterans who received medical care through Project ARCH 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 learned about Project ARCH from VHA	• 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.
Participating Veterans had more disabilities	• 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.
Veterans primarily participated because of reduced travel time	• 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).
Veterans who chose not to participate primarily were satisfied with VHA care	• 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 discontinued did so due to operational issues	• 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.

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