



April 2018

# VA HEALTH CARE

## Actions Needed to Improve Oversight of Community-Based Outpatient Clinics

# GAO Highlights

Highlights of [GAO-18-375](#), a report to congressional requesters

## Why GAO Did This Study

In fiscal year 2016, VHA's 733 CBOCs provided care to more than 3 million veterans at a cost of \$5.3 billion. Although most of these clinics are VHA-owned and -operated, 101 are operated through contracts with non-VHA organizations. VHA policy states that CBOCs, whether VHA-operated or contracted, must provide one standard of care that is of high quality.

GAO was asked to review VHA's use of contracts to carry out core functions. This report examines, among other issues, the extent to which VHA oversees CBOC operations.

To conduct this work, GAO reviewed VHA's policies and CBOC Report. GAO also interviewed officials from VHA's central office and from a nongeneralizable sample of eight CBOCs and their four respective VAMCs and VISNs. The CBOCs were selected for variation in factors such as contract status and geographic area.

## What GAO Recommends

GAO recommends that VHA (1) implement oversight requirements that align with existing policy; (2) establish a process to ensure the CBOC Report is accurate and complete; (3) provide guidance or training to VISNs and VAMCs on how to use the CBOC Report; and (4) require use of the CBOC Report as an oversight tool. VA concurred with all of GAO's recommendations and identified actions it is taking to implement them.

View [GAO-18-375](#). For more information, contact Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov)

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## What GAO Found

Community-based outpatient clinics (CBOC) are an important part of the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) health care delivery system. These clinics are geographically separate from VA medical centers (VAMC) and provide outpatient services, including primary care and mental health care. GAO found weaknesses in VHA's oversight of CBOCs:

- **Incomplete policy implementation.** VHA has not implemented certain CBOC oversight requirements as outlined in its policy. Specifically, VHA has not developed guidelines for monitoring the quality and comprehensiveness of care in CBOCs and officials said they have no plans to do so. Officials told GAO they believe the requirement was met as part of their regular oversight of Veterans Integrated Service Networks (VISN)—regional networks responsible for oversight of VAMCs and CBOCs. However, VHA may miss CBOC performance problems that are not identifiable in VISN-level data. Further, although policy requires VHA central office officials to review CBOC performance as part of quarterly VISN performance reviews, officials said they do not specifically do so unless the VISN identifies a problem. Officials from three of the four VISNs in GAO's review said they largely delegate CBOC oversight to VAMCs, and do not separately review clinic performance unless a VAMC identifies a problem.
- **An inaccurate and incomplete CBOC Report.** VHA's CBOC Report is prepared by VHA central office and distributed to VISNs and VAMCs quarterly and at year-end. The CBOC Report could be useful to compare clinical quality of care between VHA-operated and contracted CBOCs, but it is inaccurate and incomplete. Specifically, VHA officials have used their judgment to classify certain sites as CBOCs in the report, rather than use the official classifications in policy. GAO found that 22 percent of sites were incorrectly classified as CBOCs when they were other types of sites, including VAMCs. As a result, the report is of limited usefulness to VHA as an oversight tool.
- **Lack of guidance or training on the CBOC Report.** VHA central office officials do not provide guidance or training specific to understanding the CBOC Report to assist VISNs and VAMCs in their oversight of CBOCs. GAO found that in several places in the report, shorthand text and acronyms were used, but not defined. In addition, several VISN and VAMC officials stated that guidance or training would be helpful.
- **No requirement to use the CBOC Report.** VHA officials told GAO that VAMCs and VISNs are expected to use the CBOC Report as an oversight tool, but GAO found that VHA lacks a requirement that they do so. Officials from three of the four VISNs and three of the four VAMCs in GAO's review were not using the report.

These weaknesses potentially lead to inconsistent oversight and create a risk that VHA is not providing one standard of care that is of high quality to veterans across VHA-operated and contracted CBOCs.

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## Abbreviations

CBOC	community-based outpatient clinic
HEDIS	Healthcare Effectiveness Data and Information Set
VA	Department of Veterans Affairs
VAMC	VA medical center
VAST	VHA site tracking
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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April 12, 2018

Congressional Requesters

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health care delivery systems in the United States. In fiscal year 2016, VHA's health care system included 168 VA medical centers (VAMC) that offered inpatient, outpatient, and residential services and 733 community-based outpatient clinics (CBOC)—stand-alone clinics that are geographically separate from VAMCs and provide outpatient primary care, mental health care, and, in some cases, specialty care services. In fiscal year 2016, these clinics provided care to more than 3 million veterans at a cost of \$5.3 billion, which represented about half of the veterans treated by VHA and nearly 10 percent of total spending for their care. Although most CBOCs (632 of the 733) are owned and operated by VHA, about 14 percent (101) are operated by non-VHA health care organizations that contract with VHA to provide services.<sup>1</sup> According to VHA, as of the end of fiscal year 2016, 29 contractors held CBOC contracts, for which VHA spent nearly \$312 million.<sup>2</sup> It is VHA policy that all CBOCs provide one standard of care that is of high quality, regardless of whether they are VHA-operated or contracted.

In May 2000, VHA published the last in a series of reports in response to a 1998 request from the Under Secretary for Health to evaluate CBOC performance.<sup>3</sup> The evaluation found that VHA-operated and contracted CBOCs performed equally on most performance measures, but contracted clinics provided fewer primary care visits, had fewer patients

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<sup>1</sup>The Veterans' Health Care Eligibility Reform Act of 1996 authorizes the Department of Veterans Affairs to obtain health care resources by entering into contracts or other agreements with any health care facility, entity, or individual. Pub. L. No. 104-262, § 301, 110 Stat. 3177, 3191 (1996). Veterans Health Administration policy for acquisition of health care resources through contracting is documented in Department of Veterans Affairs, *Health Care Resources Contracting – Buying*, VHA Directive 1663. (Washington, D.C.: Aug. 10, 2006).

<sup>2</sup>A single contract can include multiple CBOCs and a single contractor can hold more than one CBOC contract.

<sup>3</sup>A. Hedeem et al., *CBOC Performance Evaluation, Performance Report 3: Quality of Care Measures Based on Medical Review*, a report prepared for the Department of Veterans Affairs, May 2000.

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with mental health diagnoses, and did not have adequate cost data available to compare their costs to those clinics operated by VHA. Since that time, outpatient care use in VHA has grown substantially. In 2015, an external assessment of VHA reported that between 2007 and 2014, VHA outpatient visits increased 41 percent while inpatient bed days declined 9 percent.<sup>4</sup> The 2015 assessment also reported that VHA's planning models predicted inpatient bed days would decline by at least another 50 percent over the next 20 years.

We and others have cited longstanding concerns about VHA's oversight of its health care system. These concerns contributed to veterans' health care being placed on GAO's High-Risk List beginning in 2015.<sup>5</sup> You asked us to conduct a management review of VHA that included, among other issues, its use of contracts to carry out core functions.<sup>6</sup> In this report, we examine the extent to which:

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<sup>4</sup>McKinsey & Company Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, (Sept. 1, 2015). The assessment was mandated by the Veterans Access, Choice, and Accountability Act of 2014. Pub. L. No. 113-146, § 201(a)(1), 128 Stat. 1754, 1769-71 (2014). It included 12 specific assessment areas and, according to VA, resulted in 188 recommendations for reforming VHA. See Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare Federally Funded Research and Development Center, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume I: Integrated Report* (Sept. 1, 2015).

<sup>5</sup>GAO maintains a high-risk list to focus attention on government agencies and programs that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Effort Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

<sup>6</sup>We have previously issued several reports that addressed specific aspects of VHA's management, including those pertaining to its policy management, human capital management, strategic planning, and organizational structure. See GAO, *Veterans Health Care: Additional Actions Could Further Improve Policy Management*, [GAO-17-748](#) (Washington, D.C.: Sept. 22, 2017); *Veterans Affairs: Improved Management Processes Are Necessary for IT Systems That Better Support Health Care*, [GAO-17-384](#) (Washington, D.C.: June 21, 2017); *VA Health Care: Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency*, [GAO-17-480](#) (Washington, D.C.: May 24, 2017); *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*, [GAO-17-30](#) (Washington D.C.: Dec. 23, 2016); *Veterans Health Care: Improvements Needed in Operationalizing Strategic Goals and Objectives*, [GAO-17-50](#) (Washington D.C.: Oct. 21, 2016); and *VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed*, [GAO-16-803](#) (Washington D.C.: Sept. 27, 2016).

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1. VHA-operated and contracted CBOCs vary in their provision of health care services; and
  2. VHA oversees CBOC operations, including ensuring the same quality of care at both VHA-operated and contracted CBOCs.

To determine the extent to which VHA-operated and contracted CBOCs vary in their provision of health care services, we analyzed fiscal years 2014 through 2016 expenditure and encounter data (the three most recent fiscal years of data available) for the 687 of 733 CBOCs that provided care as of September 30, 2016, and for which these data were available.<sup>7</sup> We compared expenditures per encounter and the types of services provided by VHA-operated clinics to those for contracted clinics.<sup>8</sup> We also spoke to officials from VHA's central office about the factors that influence per-encounter expenditure variation across CBOCs. Given that our 3-year analysis period was relatively short, we did not adjust the values for inflation. We assessed the reliability of the encounter and expenditure data by checking for missing values and obvious errors and discussing them with VHA officials who were knowledgeable about the data. We analyzed the data as reported by CBOCs in VHA's managerial cost accounting system and we did not independently verify the accuracy or completeness of the information, or the methodology used by VHA to

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<sup>7</sup>VHA requires all facilities to record and report data on expenditures and encounters in VHA's managerial cost accounting system. VHA defines an encounter as a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters can occur in both the outpatient and inpatient settings, and can include face-to-face interactions or those accomplished through telecommunications technology.

Of 733 CBOCs providing care as of September 30, 2016, we analyzed encounter and expenditure data from 687 CBOCs—589 that were VHA-operated and 98 that were contracted. Data were not available for 46 CBOCs because, according to VHA officials, encounter and expenditure data for these CBOCs were combined with data from the VAMC and could not be reliably separated. Further, 24 of the 687 CBOCs included in our analysis did not have 3 full fiscal years of data because they were new sites that began operating during the time period; we included data that were available.

<sup>8</sup>VHA pays contracted CBOCs a capitated per-member per-month rate that combines both direct and indirect expenditures—that is, a rate that covers the contractors' direct expenditures of providing care, as well as other indirect expenditures, such as overhead. These direct and indirect expenditures for contracted CBOCs cannot be separated from one another in VHA's managerial cost accounting system, unlike for VHA-operated CBOCs. Therefore, we examined total expenditures, which include both direct and indirect expenditures. For the VHA-operated CBOCs, we did not evaluate the methodology used by VHA to allocate indirect expenditures.

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calculate total costs for VHA-operated clinics.<sup>9</sup> After taking these steps, we determined the data were sufficiently reliable for the purposes of this reporting objective.

In addition, we interviewed officials from eight selected CBOCs and from the four VAMCs and the four Veterans Integrated Service Networks (VISN) that oversee them.<sup>10</sup> We also interviewed the four VHA contracting officers associated with the contracted CBOCs.<sup>11</sup> The eight selected clinics are a nongeneralizable sample of four pairs of VHA-operated and contracted CBOCs. (See table 1.) We selected these clinics from a list of CBOCs that provided services as of March 10, 2017—the most recently available data at the time of our review—using data from the VHA site tracking (VAST) system, which lists all facilities and their characteristics. We selected the clinics for variation in geographic diversity, parent VAMC complexity level, clinic type (multi-specialty vs. primary care), and clinic size.<sup>12</sup> We also interviewed officials from the American Legion, a veterans service organization, to obtain the perspective of veterans on the services provided at CBOCs. The information from our interviews is not generalizable to all CBOCs, VAMCs, VISNs, or contracting officers. We assessed the reliability of the VAST system data on clinic characteristics by reviewing relevant documentation and speaking to knowledgeable agency officials. We also performed data reliability checks, such as examining the data for missing values and obvious errors to test the

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<sup>9</sup>GAO has previously found that challenges exist in accurately determining the costs performed by federal versus contractor personnel. See GAO, *Human Capital: Opportunities Exist to Further Improve DOD's Methodology for Estimating the Costs of Its Workforces*, [GAO-13-792](#) (Washington, D.C.: Sept. 25, 2013).

<sup>10</sup>VHA organizes its system of care into regional networks called VISNs. Each VISN is responsible for coordination and oversight of all administrative and clinical activities within its specified geographic region. Specifically, the 18 VISNs oversee the day-to-day functions of VAMCs and CBOCs within their geographical regions.

<sup>11</sup>Each contracted CBOC is assigned a VHA contracting officer who works with the VISN and the VAMC to oversee the contract. We also spoke to two of the three contractors that administered the contracted CBOCs in our review; the third contractor was not available to speak with us during the time frame of our review.

<sup>12</sup>Both multi-specialty and primary care CBOCs provide primary care and mental health care services. Multi-specialty CBOCs provide two or more specialty care services on-site. We used the total number of encounters in fiscal year 2016 as a proxy for clinic size. VHA assigns each VAMC to one of five complexity groups (1a, 1b, 1c, 2, or 3) using a facility complexity model where level 1a facilities are the most complex and level 3 facilities are the least complex. VHA uses multiple variables to measure facility complexity in four categories: patient population served, clinical services offered, education and research complexity, and administrative complexity.

internal consistency and reliability of the data. After taking these steps, we determined the data were reliable for the purposes of selecting sites and determining the complete list of CBOCs.

**Table 1: Site Selection for Interviews with Community-Based Outpatient Clinics (CBOC)**

CBOC	State	Department of Veterans Affairs medical center (VAMC)	Veterans Integrated Service Network	Veterans Health Administration (VHA)-operated or contracted
Binghamton	NY	Syracuse VAMC	2	VHA-operated
Watertown	NY			Contracted
Anderson	SC	William Jennings Bryan Dorn VAMC	7	VHA-operated
Rock Hill	SC			Contracted
Gillette	WY	Sheridan VAMC	19	VHA-operated
Powell	WY			Contracted
Fergus Falls	MN	Fargo VAMC	23	VHA-operated
Williston	ND			Contracted

Source: GAO analysis of VHA data. | GAO-18-375

To evaluate the extent to which VHA oversees CBOC operations, including ensuring the same quality of care at both VHA-operated and contracted CBOCs, we reviewed VHA policies, including Directive 1229 that establishes VHA and VISN oversight responsibilities for outpatient sites of care, including CBOCs.<sup>13</sup> We also reviewed and interviewed officials about VHA’s CBOC Report that documents clinical quality of care measures for both VHA-operated and contracted clinics.<sup>14</sup> In addition, we analyzed the report from the first quarter of 2017—the most recently available report at the time of our review—and compared CBOCs in the report against sites in the VAST system as of January 3, 2017. We also interviewed officials from VHA central office and our selected clinics (including the contracting officers for our selected contracted clinics), as well as officials from the selected clinics’ VAMCs and VISNs. We

<sup>13</sup>Department of Veterans Affairs, Veterans Health Administration, *Planning and Operating Outpatient Sites of Care*, VHA Directive 1229. (Washington, D.C.: July 7, 2017).

<sup>14</sup>The CBOC Report is prepared and distributed by VHA’s Reporting, Analytics, Performance, Improvements and Development office within the office of the Deputy Under Secretary for Health for Organizational Excellence. An official from this office told us that they began producing the report in 2009 to compare quality of care between VHA-operated and contracted CBOCs.

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assessed the oversight activities performed by VHA's central office and the VISNs in the context of the federal standards for internal control.<sup>15</sup>

We conducted this performance audit from February 2017 to April 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Over the last decade, VHA has increasingly provided care on an outpatient basis, including primary care and mental health care services. VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, defines classifications for outpatient sites of care including CBOCs.<sup>16</sup> VHA's Directive 1229, *Planning and Operating Outpatient Sites of Care*, outlines the process for establishing new CBOCs.<sup>17</sup>

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## VHA's Outpatient Sites of Care

VHA provides outpatient care through CBOCs, health care centers, and other outpatient services sites, which are defined in VHA's site classification policy:<sup>18</sup>

- CBOCs are clinics that provide primary care and mental health care services, and also may provide specialty care services such as cardiology or neurology, in an outpatient setting. CBOCs can provide a wide array of services, ranging from a small, mainly telehealth clinic with one technician and a nurse, to a large clinic with several specialty

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<sup>15</sup>GAO, *Standards for Internal Control in the Federal Government*. [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

<sup>16</sup>Department of Veterans Affairs, Veterans Health Administration, *VHA Site Classifications and Definitions*, VHA Handbook 1006.02 (Washington, D.C.: Dec. 30, 2013). Classifications are tracked in VAST.

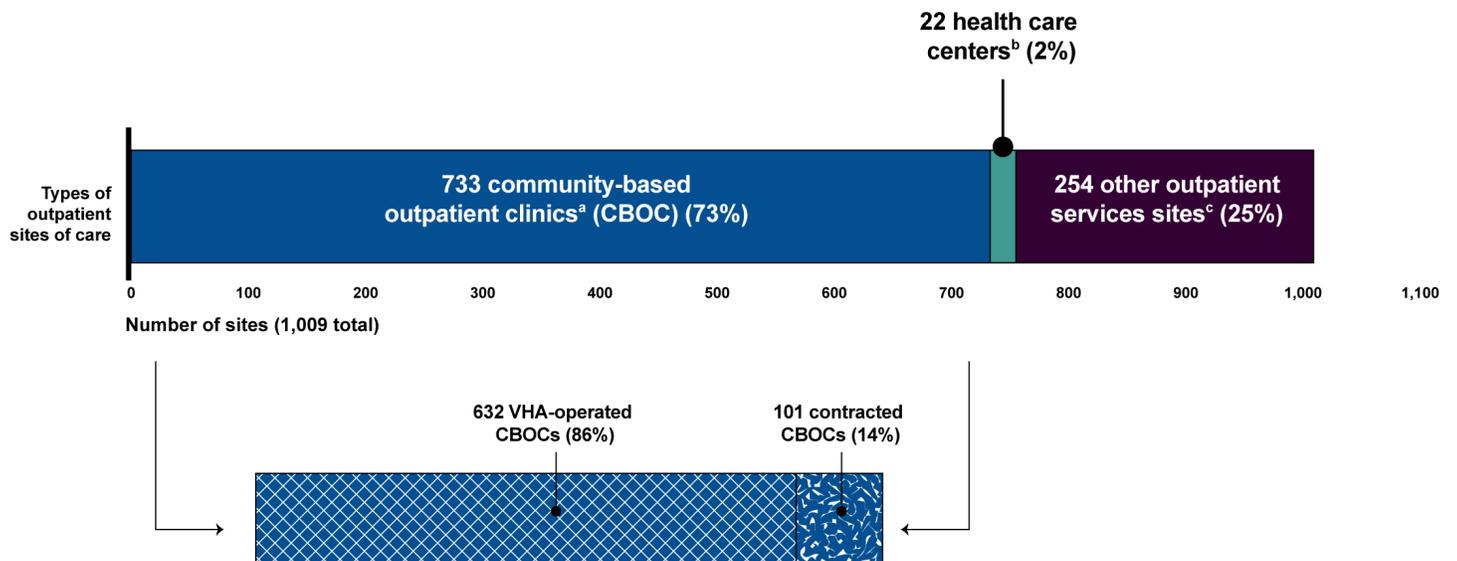
<sup>17</sup>VHA Directive 1229.

<sup>18</sup>VHA Handbook 1006.02.

care services and providers.<sup>19</sup> Each clinic is overseen by, and separate from, its VAMC; each VAMC in turn is overseen by one of 18 VISNs.

- Health care centers are large multi-specialty outpatient clinics that provide primary care, mental health care, and on-site surgical services, in addition to other health care services.
- Other outpatient services sites provide nonclinical services, such as social services, homelessness services, and support services. They may also provide services that are clinical in nature through telehealth or other arrangements. (See fig. 1.)

**Figure 1: Veterans Health Administration (VHA) Outpatient Sites of Care, as of September 30, 2016**



Source: GAO analysis of VHA data. | GAO-18-375

Note: Fiscal year 2016 was the most recent complete fiscal year of data available at the time of our review.

<sup>a</sup>CBOCs are clinics that provide primary care and mental health care services, and also may provide specialty care services such as cardiology or neurology, in an outpatient setting.

<sup>19</sup>Telehealth refers to clinical services provided remotely via telecommunications technologies. For more information on how telehealth is used in VA and other federal programs, see GAO, *Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs*, [GAO-17-365](#) (Washington, D.C.: Apr. 14, 2017).

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<sup>b</sup>Health care centers are large multi-specialty outpatient clinics that provide primary care, mental health care, and on-site surgical services, in addition to other health care services.

<sup>c</sup>Other outpatient services sites provide nonclinical services, such as social services, homelessness services, and support services. They may also provide services that are clinical in nature through remote telecommunications technologies or other arrangements.

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## VHA's Process for Establishing New CBOCs

To establish a new CBOC, VHA's policy states that the VAMC and VISN must ensure that one is needed by first exhausting existing VHA resources (such as changing clinic hours or staffing) and determining that VHA community care programs cannot meet the identified demand.<sup>20</sup> The VAMC and VISN follow several steps to assess the need for a new clinic:

- Step 1—The VAMC and VISN identify an underserved area using VHA models that project changes in the veteran population and trends in veterans' health care needs.
- Step 2—The VAMC develops a detailed proposal for the new clinic—an Access Expansion Plan—that includes information such as whether the proposed clinic will be VHA-operated or contracted, projected workload, scope of the services to be provided, and cost. It also describes, as required by VHA policy, how the VAMC has exhausted existing VHA resources before proposing a new clinic.
- Step 3—The VISN reviews the expansion plan, and if approved forwards it to an interdisciplinary panel at VHA's central office, which reviews it. A list of approved clinics is then sent to the Under Secretary for Health for endorsement.
- Step 4—Endorsed clinics are included in the VISN's Strategic Capital Investment Planning process submission for the fiscal year.<sup>21</sup> Final approval and funding for a new CBOC is dependent on Office of Management and Budget approval of VA's budget submission and VHA's final appropriations.

In fiscal year 2015, VHA suspended the establishment of new CBOCs beginning in fiscal year 2018 due to several factors, including budget

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<sup>20</sup>VHA Directive 1229. When care is not readily accessible from VA providers, VA may purchase care from non-VA providers under various community care programs. Such care is provided under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

<sup>21</sup>The Strategic Capital Investment Planning process is VHA's mechanism for planning and prioritizing capital projects. For more information on the process, see GAO, *VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs*, [GAO-17-349](#) (Washington, D.C.: Apr. 5, 2017).

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constraints and an emphasis on the use of VHA community care programs. However, VISNs can submit requests for exceptions to the Deputy Under Secretary for Health for Operations and Management for review. VHA officials told us 11 exceptions had been granted as of February 2018.

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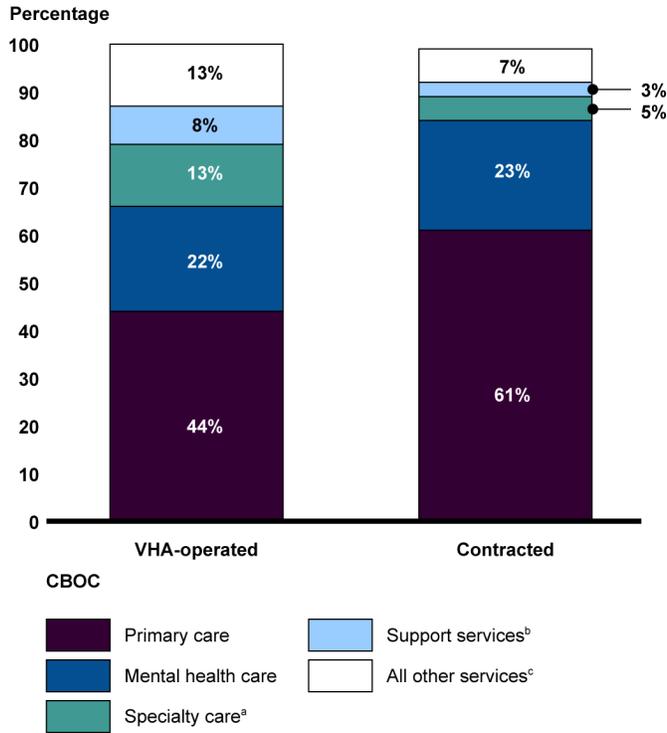
## VHA-Operated CBOCs Provided Proportionally More Specialty Care and Had Higher Expenditures than Contracted CBOCs in Fiscal Years 2014 through 2016

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### VHA-Operated CBOCs Provided Proportionally More Specialty Care and Less Primary Care and Mental Health Care than Contracted CBOCs

We found that VHA-operated CBOCs provided more specialty care and less primary care and mental health care as a proportion of their total provided services than contracted CBOCs in fiscal years 2014 through 2016. For example, in fiscal year 2016, specialty care (e.g., cardiology, gastroenterology, physical therapy) comprised 13 percent of services provided at VHA-operated clinics and 5 percent of services provided at contracted clinics. In contrast, VHA-operated clinics provided proportionally less primary care and mental health services (services offered at all CBOCs) in fiscal year 2016—these services comprised 66 percent of the services provided at VHA-operated clinics, but 84 percent of the services provided at contracted clinics. (See fig. 2.)

**Figure 2: Service Types Provided at Veterans Health Administration (VHA)-Operated and Contracted Community-Based Outpatient Clinics (CBOC), Fiscal Year 2016**



Source: GAO analysis of VHA data. | GAO-18-375

Notes: As of September 30, 2016, there were 733 CBOCs—632 VHA-operated and 101 contracted. For these analyses, data were missing for 46 CBOCs; VHA only recorded data for these clinics at the Department of Veterans Affairs medical center level. Therefore, we analyzed data for 687 CBOCs—589 VHA-operated and 98 contracted.

We measured services provided through encounters, which VHA defines as a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition. Encounters can occur in both the outpatient and inpatient settings, and can include face-to-face interactions or those accomplished through telecommunications technology.

Percentages do not add to 100 due to rounding.

<sup>a</sup>Specialty care services include cardiology, gastroenterology, and rehabilitation services (e.g., physical therapy).

<sup>b</sup>Support services include radiology and laboratory services.

<sup>c</sup>All other services include nutrition and social work services.

We found that VHA-operated CBOCs provided several specialty care services that were not offered in contracted CBOCs. For example, dental care services and gastrointestinal endoscopy were provided by multiple VHA-operated clinics, but were not provided by any of the contracted clinics in fiscal year 2016. In addition, we found that VHA-operated clinics

were generally larger and provided more complex services than contracted clinics. For example, multi-specialty CBOCs (clinics that provide two or more on-site specialty care services, and which may offer procedures requiring local anesthesia or sedation) were more often VHA-operated than contracted. Of the 733 CBOCs in fiscal year 2016, 210 were classified by VHA as multi-specialty, and nearly all of these (206) were VHA-operated.

Officials from the four VAMCs and VISNs in our review told us decisions about what types of services CBOCs provide are made on a case-by-case basis according to local needs.<sup>22</sup> For example, officials from one VAMC told us they decided to add physical therapy specialty care to one of their VHA-operated clinics based on analysis indicating that veterans' need for this care in their community would increase. Also, officials said they wanted to alleviate the travel burden for veterans who needed the care, as the next closest VHA facility that offered this care was a 2.5-hour drive away. Officials from another VAMC told us that they approached the service needs at their clinics from a regional perspective, allowing for veteran demand for services to be met across multiple clinics in the same geographic area instead of relying on one clinic to meet the need. As a result of this approach, VAMC officials were in the process of expanding services at two of its clinics.

### VHA-Operated CBOCs Had Higher Expenditures than Contracted CBOCs

From fiscal years 2014 through 2016, we found that VHA-operated CBOCs had higher per-encounter expenditures than contracted CBOCs—a difference ranging from 3 to 5 percent per encounter. (See table 2.)

**Table 2: Average Expenditures per Encounter by Veterans Health Administration (VHA)-Operated and Contracted Community-Based Outpatient Clinics (CBOC), Fiscal Years 2014 – 2016**

Fiscal year	VHA-Operated	Contracted
2014	\$219	\$209
2015	\$225	\$218
2016	\$240	\$229

Source: GAO analysis of VHA data. | GAO-18-375

<sup>22</sup>VHA policy outlines the review and approval of the expansion, reduction, or elimination of major clinical services or programs in VHA facilities including CBOCs. See Department of Veterans Affairs, Veterans Health Administration, *Restructuring of VHA Clinical Programs*, VHA Directive 1043 (Washington, D.C.: Nov. 2, 2016).

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Notes: Expenditures are not adjusted for inflation.

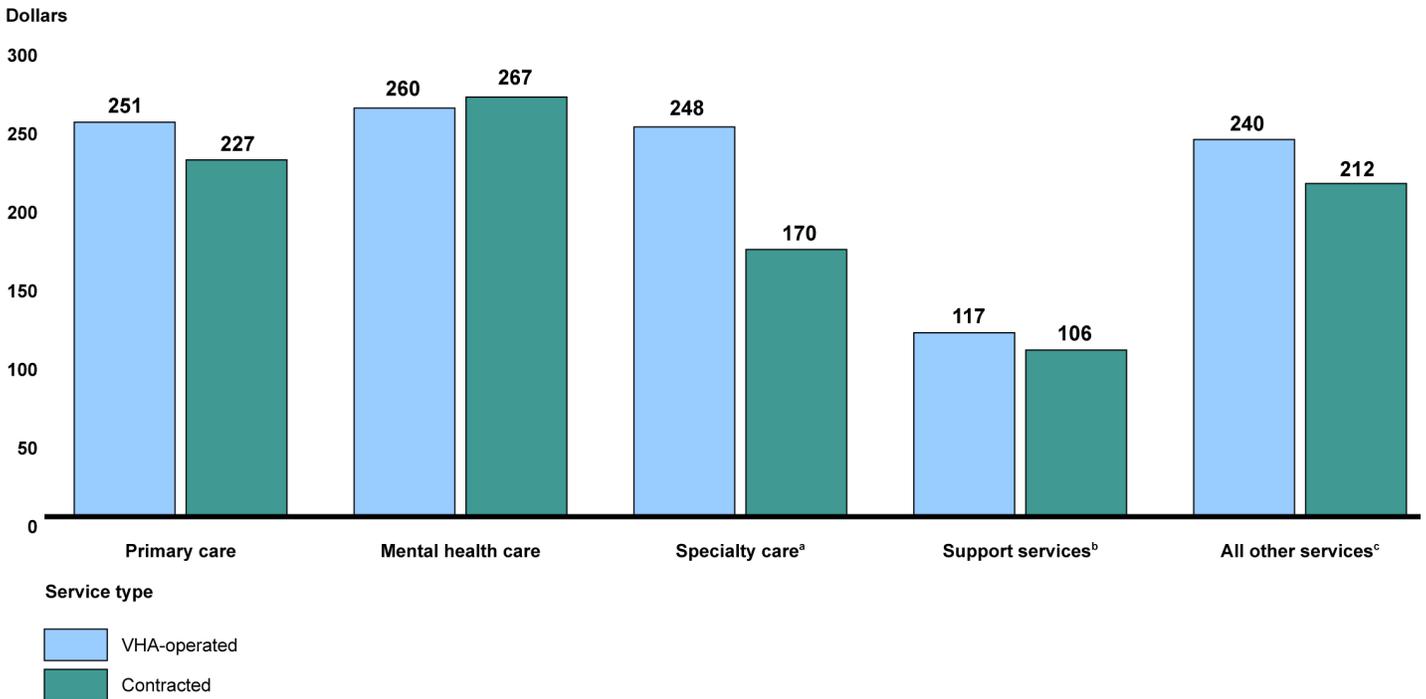
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VHA defines an encounter as a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters can occur in both the outpatient and inpatient settings, and can include face-to-face interactions or those accomplished through telecommunications technology.

VHA pays contracted CBOCs a capitated per-member per-month rate that combines both direct and indirect expenditures, which cannot be separated from one another in VHA's managerial cost accounting system, unlike for VHA-operated CBOCs. Therefore, we examined total expenditures, which include both direct and indirect expenditures. For the VHA-operated CBOCs, we did not evaluate the methodology used by VHA to allocate indirect expenditures.

We also found that per-encounter expenditures for almost all service types were higher on average for VHA-operated CBOCs than contracted CBOCs in fiscal year 2016; the exception was mental health care services, where VHA-operated clinics' per-encounter expenditures were 2 percent lower than for contracted clinics. The difference in per-encounter expenditures was greatest for specialty care services. For example, VHA-operated clinics' per-encounter expenditures for specialty care services were 46 percent higher than for contracted clinics. This is in contrast to primary care, where VHA-operated clinics had 11 percent higher per-encounter expenditures, on average, compared to contracted clinics. (See fig. 3.)

**Figure 3: Veterans Health Administration (VHA)-Operated and Contracted Community-Based Outpatient Clinics (CBOC) Average per-Encounter Expenditures by Service Type, Fiscal Year 2016**



Source: GAO analysis of VHA data. | GAO-18-375

Notes: Expenditures are not adjusted for inflation.

As of September 30, 2016, there were 733 CBOCs—632 VHA-operated and 101 contracted. For these analyses, data were missing for 46 CBOCs; VHA only recorded data for these clinics at the Department of Veterans Affairs medical center level. Therefore, we analyzed data for 687 CBOCs—589 VHA-operated and 98 contracted.

VHA defines an encounter as a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition. Encounters can occur in both the outpatient and inpatient settings, and can include face-to-face interactions or those accomplished through telecommunications technology.

VHA pays contracted CBOCs a capitated per-member per-month rate that combines both direct and indirect expenditures, which cannot be separated from one another in VHA’s managerial cost accounting system, unlike for VHA-operated CBOCs. Therefore, we examined total expenditures, which include both direct and indirect expenditures. For the VHA-operated CBOCs, we did not evaluate the methodology used by VHA to allocate indirect expenditures.

<sup>a</sup>Specialty care services include cardiology, gastroenterology, and rehabilitation services (e.g., physical therapy).

<sup>b</sup>Support services include radiology and laboratory services.

<sup>c</sup>All other services include nutrition and social work services.

Officials told us that several factors can influence per-encounter expenditures, including (1) differences in provider compensation and types of providers (physicians vs. physician assistants); (2) the number of

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patients with complex health conditions that generally require longer visits and more costly services (as opposed to patients with well-managed conditions); and (3) geographic differences in the cost of providing care. One of our selected contracted CBOCs had one of the highest per-encounter expenditures for fiscal year 2016 among all clinics. Officials from this clinic's VAMC told us this was due to the contractor being able to command a very high payment rate at the time of the contract award, due to temporarily strong local economic conditions, as well as being the only contractor in the area capable of providing the required services. Officials said the VAMC is in the process of awarding a new contract for this clinic.

Although per-encounter expenditures were generally lower for contracted CBOCs, officials from the VISNs and VAMCs in our review told us they consider several factors in determining whether a new clinic will be VHA-operated or contracted. Such factors include the ability to directly monitor performance and implement new standards of care, as well as the ability to recruit and staff the clinic. For example, officials from two VAMCs in our review told us that VHA-operated clinics can be easier to manage because the VAMC has direct control of the clinic. Officials said this makes it easier to implement changes to VHA standards of care without the need to enter into contract modification negotiations. On the other hand, officials from three of the four VISNs and three of the four VAMCs in our review told us that contractors can be more flexible than VHA in recruiting staff (such as the ability to offer higher salaries), making a contracted clinic desirable for geographic areas where VHA has challenges recruiting or retaining providers.

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## VHA Has Not Fully Implemented Policy Requirements, and Inaccurate Information Limits Its Oversight of CBOC Quality of Care

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### VHA Has Not Fully Implemented CBOC Oversight Policy Requirements

We found that VHA has implemented certain oversight requirements, but not others described in Directive 1229—its policy that outlines VHA’s oversight responsibilities for outpatient sites of care, including CBOCs.<sup>23</sup> In terms of the oversight requirements that VHA implemented, we found it has provided reports on patient satisfaction to VISNs and VAMCs on a monthly basis. Specifically, VHA distributes the results of the VHA Survey of Healthcare Experiences, a monthly survey of veterans’ satisfaction with the care they received through VHA health care facilities. In addition, VHA implemented the requirement to make measures related to evaluating the progress of outpatient sites of care, such as data on wait times, workload, and costs, available on an internal VHA website. However, VHA has not implemented other oversight requirements, which is inconsistent with federal standards for internal control related to monitoring, which state that management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.<sup>24</sup>

We found that VHA has not implemented the following requirements in Directive 1229:

- **VHA has not developed guidelines for monitoring the quality and comprehensiveness of care in CBOCs.** Officials from the three VHA offices with responsibility for collaborating to develop guidelines for monitoring the quality and comprehensiveness of care in CBOCs, as required in the policy, told us that they are not currently developing these guidelines and they have no plans to do so. First, officials from the office of the Assistant Deputy Under Secretary for Health for

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<sup>23</sup>VHA Directive 1229.

<sup>24</sup>[GAO-14-704G](#).

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Policy and Planning told us they had not developed these guidelines because they no longer believed it was their office's responsibility, despite the fact that officials from the office had helped to develop the recently issued policy. Second, officials from the office of the Deputy Under Secretary for Health for Organizational Excellence told us that their office was not responsible for addressing the broader issue of monitoring clinics. Third, officials from the office of the Deputy Under Secretary for Health for Operations and Management told us that although they do not have formal guidelines in place, they believe their office meets the Directive 1229 requirement as part of their regular VISN oversight. Officials said they collect and review VISN-level performance data, such as patient satisfaction data, which can be broken down to the level of the CBOC if there is a performance problem. However, VHA may miss clinic performance problems that are not identifiable in the VISN-level data. In addition, without developing such guidelines, VHA has not established standardized processes for how it monitors CBOCs, which can lead to inconsistent oversight. This poses the risk that veterans may be subject to different standards of care depending on the clinic visited.

- **VISNs do not conduct continuous quality monitoring of CBOCs to ensure that consistent, quality care is being delivered.** We found that three of the four VISNs in our review largely delegated oversight of the CBOCs to the VAMCs, rather than conducting continuous quality monitoring as required in the policy. Specifically, officials from these VISNs said that they largely focus their oversight on the VAMCs and do not separately review the performance of every CBOC unless the VAMC informs them of a quality problem at a particular clinic. Officials from the remaining VISN in our review said they do conduct CBOC-specific oversight activities. Specifically, this VISN had created a performance review survey tool that it sends to each clinic on an annual basis, and the results are reviewed by a workgroup made up of VISN staff. The workgroup examines trends across the CBOCs, including a comparison of VHA-operated and contracted performance. For example, one question in the tool asks how an individual CBOC's performance compares with others overseen by the VAMC. The delegation of oversight responsibility for the CBOCs to the VAMCs without consistent VISN-level oversight creates the potential for inconsistencies in oversight, which does not align with VHA policy to provide one standard of care for all clinics. Consequently, veterans may be subject to different standards of care across clinics.
- **The Deputy Under Secretary for Health for Operations and Management has not reviewed CBOC performance with VISNs as**

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**part of the quarterly VISN performance reviews.** The Deputy Under Secretary for Health for Operations and Management is responsible for conducting reviews of VISN performance with each VISN director. Specifically, the office of the Deputy Under Secretary for Health for Operations and Management is required by VHA policy to review CBOC-level performance data during quarterly VISN performance reviews. However, officials from this office and two of the VISNs we contacted told us they do not specifically do this unless the VISN identifies a performance problem. Of the remaining two VISNs, officials at one VISN reported only having mid-year and year-end meetings with VHA central office at which they did not specifically discuss the CBOCs, and officials from the other VISN said they did not have any regular quarterly performance reviews with VHA central office. This lack of consistent oversight poses the risk that VHA is not providing one, high quality standard of care to veterans across CBOCs.

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## VHA's CBOC Report Lacks Accurate and Complete Information

Directive 1229 requires VHA to provide reports to the VISNs and VAMCs on CBOC quality of care on a quarterly and year-end basis. We found that the CBOC Report, which is VHA's only report that allows for comparing clinical quality of care data across VHA-operated and contracted CBOCs, lacks accurate and complete information.<sup>25</sup> These gaps limit the CBOC Report's usefulness as a monitoring tool to determine whether VHA-operated and contracted CBOCs are providing the same standard of care. This is inconsistent with federal standards for internal control for information and communication, which state that management should use quality information to achieve the entity's objectives.<sup>26</sup>

Specifically, VHA distributes the CBOC Report to VISNs and VAMCs on a quarterly and year-end basis, which compiles CBOC quality of care performance results based on the Healthcare Effectiveness Data and

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<sup>25</sup>The CBOC Report is prepared and distributed by VHA's Reporting, Analytics, Performance, Improvements and Development office within the office of the Deputy Under Secretary for Health for Organizational Excellence.

<sup>26</sup>[GAO-14-704G](#).

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Information Set (HEDIS)—an industry standard set of quality measures.<sup>27</sup> VISNs and VAMCs have access to other types of CBOC performance data, such as patient satisfaction data and wait time data, but these data are not used to assess clinical quality of care and they cannot be used to examine performance across all CBOCs or stratified by VHA-operated versus contracted CBOCs. In contrast, the CBOC Report allows for the comparison of clinical quality of care data across all CBOCs, which can be stratified according to whether the clinic is VHA-operated or contracted.

However, we found the following issues with the CBOC Report:

- **Incorrect classification of CBOCs.** We compared CBOCs from the most recent CBOC Report at the time of our review (the first quarter of fiscal year 2017) against sites in the VAST system as of January 3, 2017, which is VHA’s listing of all VHA sites of care and their characteristics. We found that 22 percent of sites were incorrectly classified as CBOCs, based on the site classifications in VAST. Several of these sites were much more complex, such as health care centers and VAMCs.<sup>28</sup> For example, a VAMC was included in the report as a CBOC, but this VAMC has three specialized intensive care units and serves as a regional referral center for intensive inpatient surgery, including open heart surgery. In addition, we also identified sites included in the report that provided less complex services than those that are provided in CBOCs, such as other outpatient services sites.

VHA officials who produce the CBOC Report told us that, prior to the establishment of the VAST site classifications in 2014, they used their judgment to classify existing sites of care as CBOCs and they have not updated their classifications since then.<sup>29</sup> For sites established since 2014, officials told us they use the VAST site classifications, but may also use their judgment in certain situations. For example, if a

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<sup>27</sup>HEDIS is a standardized dataset designed by the National Committee for Quality Assurance—a private, nonprofit organization—to help consumers compare the performance of health plans in providing selected services. VHA has adopted HEDIS measures to assess the quality of care provided by facilities in the VHA health care system. These measures include those related to behavioral health screening, diabetes, and heart disease.

<sup>28</sup>Health care centers and VAMCs are, in general, highly complex and provide services that are much more resource-intensive than the services that are provided in CBOCs.

<sup>29</sup>VHA Handbook 1006.02.

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site's classification changed in VAST from a non-CBOC to a CBOC, they would make a decision about whether to classify it as a CBOC in the report by examining various aspects of the facility, such as the services provided and encounters. This procedure differs from what is documented in the methodology section of the CBOC Report, which states that site classifications are based on VAST. Further, VHA officials said they did not have a document available that outlined how they make these decisions. Because the site classifications in the CBOC Report are based, in part, on officials' judgment in addition to the classifications in VAST, the report does not present accurate information on CBOCs across VHA and is of limited usefulness to VHA as a tool to ensure that VHA-operated and contracted CBOCs are providing the same standard of care that is of high quality.

- **Missing CBOCs.** We found that 53 CBOCs (7 percent of all CBOCs) were missing from the CBOC Report from the first quarter of fiscal year 2017, rendering the data incomplete. VHA officials provided examples of why a CBOC might not be included in the report. For example, a newer CBOC might not be included because it did not have quality of care data available at the time the report was developed. However, we identified several other sites that were listed in the report, despite unavailable data.
- **Inaccurate summary calculations.** Due to the incorrect site classifications and missing CBOCs, the national- and VISN-level summary calculations of performance in the CBOC Report were also inaccurate. Specifically, the report includes national- and VISN-level averages for each HEDIS measure, which VHA officials can use as benchmarks for clinic performance. These averages were over-inclusive—incorporating performance results from additional sites that were not CBOCs, and under-inclusive—omitting performance results from CBOCs that were missing from the report. These inaccuracies may lead VHA officials to draw incorrect conclusions about the quality of care provided in CBOCs. For example, officials from one VAMC told us that they use the national averages as benchmarks against which they compare the performance of their CBOCs. Because this VAMC requires CBOCs with lower-than-average HEDIS performance results to develop a formal action plan to improve performance, officials may not be identifying clinics that are in need of an action plan due to the inaccuracy of the averages. In addition, VHA central office officials who develop the CBOC Report said that the results from recent reports have shown that VHA-operated and contracted clinics in general provided the same standard of care, but this conclusion may not be correct as it is based on unreliable data.

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- **No guidance or training for use of the CBOC Report.** VHA central office officials do not provide guidance or training specific to the CBOC Report to assist VISNs and VAMCs in using it to oversee CBOCs. This is inconsistent with federal standards for internal control related to the control environment, which state that management should, among other things, develop personnel to achieve the entity's objectives. Such development may include training to enable individuals to develop competencies appropriate for key roles.<sup>30</sup> In our review of the CBOC Report from the first quarter of fiscal year 2017, we found that in several places in the report, shorthand text and acronyms were used, but not defined. In addition, although there is a methodology section, it is not clear that the measures described in the report are HEDIS measures, for which VHA makes training available. Several VAMC and VISN officials stated that guidance or training that is specific to understanding the CBOC Report would be helpful. If VISNs and VAMCs are not trained on how to use the report, they may not know how to use it to oversee CBOCs and ensure they are providing one standard of care that is of high quality.
  - **No requirement for VISNs or VAMCs to use the CBOC Report.** VHA does not require that the CBOC Report be used as a tool to oversee CBOCs. As a result, we found that the report was not widely used. Specifically, an official from the office of the Deputy Under Secretary for Health for Organizational Excellence—which produces the CBOC Report—told us that the office's role is to compile the reports and distribute them, but not to monitor performance. Officials from the office of the Deputy Under Secretary for Health for Operations and Management said that VISNs and VAMCs are expected to use the report as part of their CBOC oversight; however, we found there is no requirement that they do so. We found that officials from three of the four VISNs and three of the four VAMCs in our review were not regularly using the CBOC Report. Officials from one of the four VAMCs and one of the four VISNs in our review were using it as part of CBOC oversight activities at the time of our review. Officials from another VISN said that they planned to start using the CBOC Report after we made them aware of it during our interview. If VISN and VAMC officials do not use the report as a part of their oversight, they may be missing opportunities to compare VHA-operated and contracted CBOCs and ensure they are providing one standard of care that is of high quality.

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<sup>30</sup>[GAO-14-704G](#).

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## Conclusions

CBOCs are an integral part of VHA's health care delivery system, and VHA requires that such clinics, whether VHA-operated or contracted, provide the same standard of care to veterans that is of high quality. Although VHA has implemented certain policy requirements for CBOC oversight, we found several weaknesses in its oversight that make it difficult to determine whether it is ensuring this consistent standard of care across the clinics.

Specifically, VHA has not fully implemented oversight requirements that align with its established policies, including a requirement to establish guidelines for overseeing CBOC quality of care. The CBOC Report, as VHA's only report comparing clinical quality of care across both VHA-operated and contracted clinics, could be an important part of those guidelines. However, as it currently stands, the report is inaccurate and incomplete and VISNs and VAMCs are not trained on or required to use it; thus, it is of limited use to VHA, including the VISNs and VAMCs that have responsibility for CBOC oversight. As a result, VHA lacks assurance that both VHA-operated and contracted CBOCs are providing one standard of care that is of high quality.

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## Recommendations for Executive Action

We are making the following four recommendations to the VHA Undersecretary for Health:

Implement oversight requirements that align with VHA's existing policy, including developing guidelines for monitoring quality of care in CBOCs. (Recommendation 1)

Establish a process for regularly updating the CBOC Report to ensure it contains an accurate and complete list of CBOCs that is consistent with VHA's established site classifications. (Recommendation 2)

Ensure that VISNs and VAMCs receive guidance or training on how to use the CBOC Report. (Recommendation 3)

Require the use of the CBOC Report as an oversight tool for ensuring one standard of care that is of high quality across VHA-operated and contracted CBOCs. (Recommendation 4)

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## Agency Comments

We provided VA with a draft of this report for its review and comment. VA provided written comments, which are reprinted in appendix I. In its

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written comments, VA concurred with all four of the report's recommendations, and identified actions it is taking to implement them.

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We are sending copies of this report to the appropriate congressional committees, the Acting Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Debra A. Draper  
Director, Health Care

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*List of Requesters*

The Honorable Johnny Isakson  
Chairman

The Honorable Jon Tester  
Ranking Member  
Committee on Veterans' Affairs  
United States Senate

The Honorable Phil Roe  
Chairman

The Honorable Tim Walz  
Ranking Member  
Committee on Veterans' Affairs  
House of Representatives

The Honorable Derek Kilmer  
House of Representatives

The Honorable Mark Takano  
House of Representatives

# Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

March 19, 2018

Ms. Debra Draper  
Director  
Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA HEALTH CARE: Actions Needed to Improve Oversight of Community-Based Outpatient Clinics**" (GAO-18-375).

The enclosure sets forth the actions to be taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

  
Jacquelyn Hayes-Byrd  
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***VA HEALTH CARE: Actions Needed to Improve Oversight of  
Community-Based Outpatient Clinics***  
(GAO-18-375)

**Recommendation 1: Implement oversight requirements that align with VHA's existing policy, including developing guidelines for monitoring quality of care in CBOCs.**

**VA Comment:** Concur. In collaboration with the Office of Performance Measurement in the Office of Reporting, Analytics, Performance, Improvement and Deployment, the Office of the Assistant Deputy Under Secretary for Health for Clinical Operations will issue guidance outlining requirements for Veterans Integrated Service Networks (VISN) and VA medical facilities. These requirements will be discussed with Network Directors, Medical Center Directors, and Chief Medical Officers on various Veterans Health Administration (VHA) National calls. Additionally, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will incorporate these requirements into the quarterly VISN Director Performance reviews. The status is in process with a target completion date of September 2018.

**Recommendation 2: Establish a process for regularly updating the CBOC Report to ensure it contains an accurate and complete list of CBOCs that is consistent with VHA's established site classifications.**

**VA Comment:** Concur. The Office of the Deputy Under Secretary for Health for Operations and Management will develop a process for regularly updating the VA Site Tracking application to ensure the Community-Based Outpatient Clinic (CBOC) Report accurately reflects requests received by the VHA Support Service Center from VA medical facilities. The status is in process with a target completion date of September 2018.

**Recommendation 3: Ensure that VISNs and VAMCs receive guidance or training on how to use the CBOC Report.**

**VA Comment:** Concur. The Office of the Assistant Deputy Under Secretary for Health for Clinical Operations will provide guidance concerning use of the CBOC Report to VISNs' Chief Medical and Quality Management Officers. Additionally, in collaboration with the Office of Performance Measurement in the Office of Reporting, Analytics, Performance, Improvement and Deployment, the Office of the Deputy Under Secretary for Health for Operations and Management will provide training to VA medical facilities during the annual training on the Performance Measure report. The status is in process with a target completion date of September 2018.

**Recommendation 4:** Require the use of the CBOC Report as an oversight tool for ensuring one standard of care that is of high-quality across VHA-operated and contracted CBOCs.

**VA Comment:** Concur. The Office of the Assistant Deputy Under Secretary for Health for Clinical Operations will provide guidance concerning use of the CBOC Report to VISNs Chief Medical and Quality Management Officers. Additionally, in collaboration with the Office of Performance Measurement in the Office of Reporting, Analytics, Performance, Improvement and Deployment, DUSHOM will provide training to VA medical facilities during the annual training on the Performance Measure report. The DUSHOM will also incorporate the required utilization into the quarterly VISN Director Performance reviews. The status is in process with a target completion date of September 2018.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

Debra A. Draper, (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov).

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## Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Malissa G. Winograd, Analyst-in-Charge; Jennie F. Apter; Zhi Boon; Keith Haddock; and Sarah-Lynn McGrath made key contributions to this report. Also contributing were Jacquelyn Hamilton and Vikki Porter.

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