Veterans Health Administration: Community-Based Outpatient Clinics

-name redacted-
Specialist in Veterans Policy

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Summary

In the early 1990s, the Veterans Health Administration (VHA)—one of the three administrations of the Department of Veterans Affairs (VA)—began developing a strategy to expand its capacity to provide outpatient primary care, especially for veterans who had to travel long distances to receive care at VA facilities. To facilitate access to primary care closer to where veterans reside, VHA began implementing a system for approving and establishing Community-Based Outpatient Clinics (CBOCs).

A CBOC is a fixed health care site that is geographically distinct or separate from its parent VA medical facility. A CBOC can be either VA-owned and VA-staffed or contracted to Healthcare Management Organizations (HMO). Regardless of how it is administered, a CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for current or eligible veteran patients. VA policies require all CBOCs to be operated in a manner that provides veterans with consistent, safe, high-quality health care.

CBOCs are managed at the Veterans Integrated Service Network (VISN) level, and planning and development of a new CBOC is based on the VA's need, available resources, local market circumstances, and veteran preference.

In FY2010, VA expects to have a total of 833 operational CBOCs throughout the United States and its territories to serve over 2.8 million veteran patients. In addition to primary care, CBOCs provide mental health services, management of acute and chronic medical conditions, and pharmacy benefits, among other services. It should be noted that the type of medical services available at a CBOC can vary from clinic to clinic.

This report provides an overview of VA's rationale in establishing CBOCs, describes how they are managed and administered, discusses medical services provided at CBOCs, and summarizes what is known about the quality and cost of providing care in CBOCs compared to primary care clinics at VA Medical Centers. Lastly, it describes the process for developing a new CBOC. This report will be updated if events warrant.

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Introduction

Congress is interested in increasing access to care for veterans closer to where they reside.[1] The establishment of Community-Based Outpatient Clinics (CBOCs) is viewed by some as one method of increasing access to care.[2] This report provides an overview of the impetus for the Department of Veterans Affairs (VA) to establish CBOCs, describes how they are managed and administered, discusses medical services provided at CBOCs, and summarizes what is known about the quality and cost of providing care in CBOCs compared to primary care clinics at Department of Veterans Affairs Medical Centers (VAMCs). Lastly, it describes the process for developing a new CBOC.

The VA Health Care System

The Department of Veterans Affairs provides a range of benefits and services to veterans who meet certain eligibility rules, including hospital and medical care, disability compensation and pensions,[3] education,[4] vocational rehabilitation and employment services, assistance to homeless veterans,[5] home loan guarantees,[6] and administration of life insurance, as well as traumatic injury protection insurance for servicemembers and death benefits that cover burial expenses. VA carries out its programs nationwide through the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), National Cemetery Administration, and the Board of Veterans Appeals (BVA).

VHA is a direct service provider rather than a health insurer or payer of health care. VA health care services are generally available to all honorably discharged veterans of the U.S. Armed Forces who are enrolled in VA's health care system.[7] Based on a priority enrollment system,

[1] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Review of VA Challenges*, 111th Cong., 1st sess., March 12, 2009, p. 143.

[2] Ibid. U.S. Congress, House Committee on Appropriations, *Consolidated Appropriations Act, 2010*, conference report to accompany H.R. 3288 , 111th Cong., 1st sess., December 8, 2009, H.Rept. 111-366 (Washington: GPO, 2009), pp. 1351-1352.

[3] For detailed information on disability compensation and pension programs, see CRS Report RL33323, *Veterans Affairs: Benefits for Service-Connected Disabilities*, by (name redacted), and CRS Report RS22804, *Veterans' Benefits: Pension Benefit Programs*, by (name redacted) and (name redacted).

[4] For details on education benefits, see CRS Report R40723, *Educational Assistance Programs Administered by the U.S. Department of Veterans Affairs*, by (name redacted).

[5] For detailed information on homeless veterans programs, see CRS Report RL34024, *Veterans and Homelessness*, by (name redacted).

[6] For details on the home loan guarantee program see, CRS Report RS20533, *VA-Home Loan Guaranty Program: An Overview*, by (name redacted).

[7] For most veterans, entry into the veterans' health care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements. Veterans do not need to apply for enrollment in the VA's health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from disease and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%). For a description of priority groups see, CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by (name redacted).

veteran enrollees are placed into priority groups. Under this system, VA decides annually whether its appropriations are adequate to serve all enrolled veterans. If not, VA may stop enrolling those in the lowest-priority groups.[8]

The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). In FY2009, VHA operated an estimated 153 medical centers, 135 nursing homes, 783 ambulatory care and community-based outpatient clinics (CBOCs), 6 independent outpatient clinics, and 271 Readjustment Counseling Centers (Vet Centers).[9] VHA also operates 10 mobile outpatient clinics.

The VHA pays for care provided to veterans by private-sector providers on a fee basis under certain circumstances. Inpatient and outpatient care are also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The VHA also provides grants for construction of state-owned nursing homes and domiciliary facilities and collaborates with the Department of Defense (DOD) in sharing health care resources and services.

Apart from providing direct patient care to veterans, VHA's other statutory missions are to conduct medical research, to serve as a contingency back up to the Department of Defense (DOD) medical system during a national security emergency, to provide support to the National Disaster Medical System and the Department of Health and Human Services as necessary, and to train health care professionals in order to provide an adequate supply of health personnel for VA and the Nation. The next section provides a brief overview on the rationale for establishing CBOCs.

Transformation of VHA and Establishment of CBOCs

Since the early 1920s, the VA health care system had been primarily a hospital-based inpatient health care system.[10] Beginning with the 1960s, Congress gradually expanded eligibility for outpatient care.[11] Several research studies reported that a "large proportion of VA hospital admissions in the mid 1980s and early 1990s were non-acute and could have been treated in an outpatient setting if ambulatory care services had been available geographically."[12] Another study found that the "lack of geographic access to VA outpatient care can lead to higher risk of readmission post-discharge."[13]

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[8] For more on eligibility for VA Health Care, see CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by (name redacted).

[9] Department of Veterans Affairs, *FY2010 Budget Submission: Medical Programs and Information Technology Programs*, Volume 2, Washington, DC, May 2009, pp. 1E-4. E-mail communication from Department of Veterans Affairs, Veterans Health Administration, Office of Legislative Programs, December 2009.

[10] United States Veterans' Bureau, *Annual Report of the Director United States Veterans Bureau for FY1924*, December 1, 1924, p. 21.

[11] For a detailed description of the evolution of eligibility for VA health care, see CRS Report RL32961, *Veterans' Health Care Issues in the 109th Congress*, by (name redacted).

[12] As cited in John C. Fortney et al., "VA Community-Based Outpatient Clinics: Access and Utilization Performance Measures," *Medical Care*, vol. 40, no. 7 (July 2002), p. 562.

[13] Ibid.

In the mid-1990s VA recognized that its system might want to respond to certain changes taking place in the private health care market and began a process of restructuring its health care delivery network. VA established regional networks (Veterans Integrated Service Networks [VISNs]) and decentralized certain budgetary authorities to these networks.[14] Furthermore, advances in medical technology, such as laser and other minimally invasive surgical techniques, allowed care previously provided in hospitals to be provided on an outpatient basis. VA also began developing a strategy to expand its capacity to provide outpatient primary care, especially for veterans who had to travel long distances to receive care at VA facilities.[15] To facilitate access to primary care closer to where veterans reside, VHA began implementing a system for approving and establishing CBOCs.[16] In January 1994, the VHA hospital in Amarillo, TX—now located in Childress, TX—established what is generally recognized as the first VHA community based clinic.[17] Prior to the establishment of this clinic, to establish a CBOC, a clinic had to have a workload of 3,000 visits or more and had to be located at least 100 miles or three hours travel time away from the nearest VHA hospital. In 1995, VHA issued a directive to eliminate these restrictions and to expand its network of CBOCs.[18] New CBOC planning criteria were based on, among other things, (1) eligible veteran population, (2) services to be provided, (3) costs of available alternatives, and (4) sources of funds.[19] The current process of developing CBOCs is discussed later in this report.

Since VHA initiated its CBOC initiative in 1995, over 700 clinics have opened.[20] **Figure 1** displays the number of active CBOCs for each fiscal year from 1999 through projected 2010.

[14] Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA health care: Systematizing Quality Improvement and Quality Innovation." *Medical Care*. vol. 38, no. 6 (June 2000), Suppl 1:I7-16.

[15] U.S. General Accounting Office, *VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary*, HEHS-98-116, June 15, 1998, p. 4.

[16] Michael K. Chapko et al., "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care*, vol. 40, no. 7 (July 2002), p. 556.

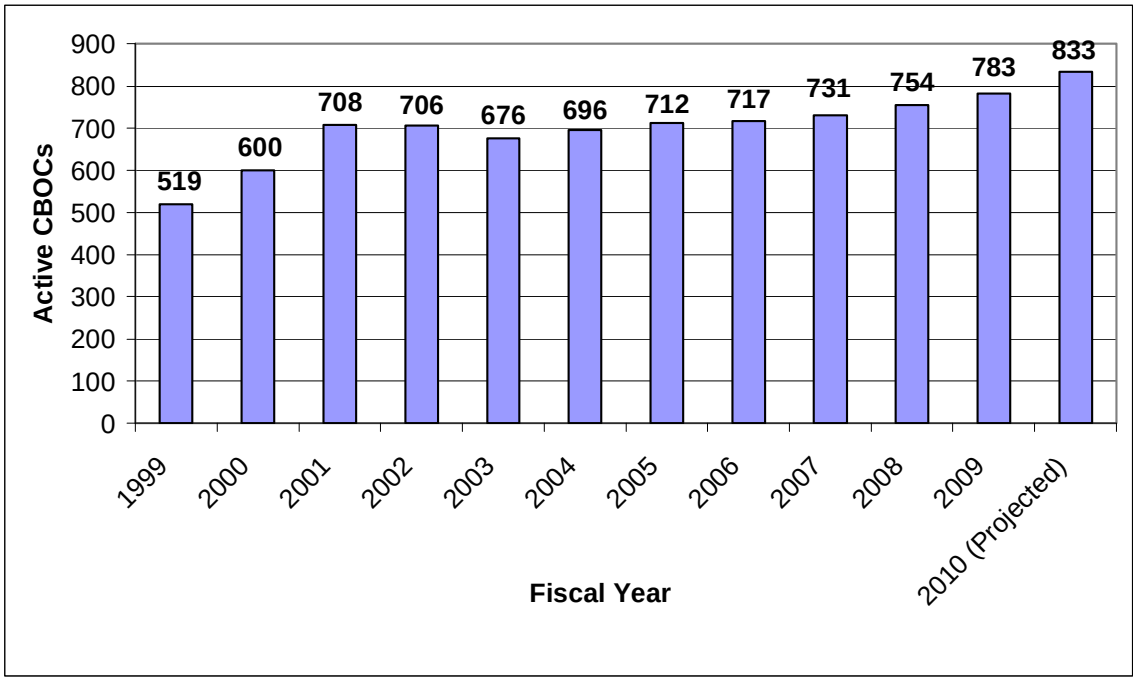
[17] Department of Veterans Affairs, Office of Inspector General, *Informational Report, Community-Based Outpatient Clinic Cyclical Reports*, Report No. 08-00623-169, Washington, DC, July 16, 2009, p.1.

[18] Department of Veterans Affairs, VHA Directive 10-95-017, *Veterans Health Administration Interim Policy for Planning and Activating Department of Veterans Affairs Access Points.* February 8, 1995.

[19] Department of Veterans Affairs, Veterans Health Administration, VHA Directive 96-049, *Veterans Health Administration Policy For Planning And Activating Community Based Outpatient Clinics*, August 7, 1996.

[20] Ibid.

Figure 1. Active Community-Based Outpatient Clinics, FY1999-FY2010



Source: Chart adapted by Congressional Research Service, from Department of Veterans Affairs, Office of Inspector General, *Informational Report, Community-Based Outpatient Clinic Cyclical Reports*, Report No. 08-00623-169, Washington, DC, July 16, 2009, p. 3.

Data for FY2009 adapted from Department of Veterans Affairs, Veterans Health Administration, Office of Legislative Programs, December 2009. Data for FY2010 are adapted from the Department of Veterans Affairs, *FY2010 Budget Submission: Medical Programs and Information Technology Programs*, Volume 2, Washington, DC, May 2009, pp. 1E-4.

Notes: In some years, services in some CBOCs are suspended and transferred to nearby CBOCs, hence the decline in active CBOCs in those years. Based on the FY2010 Budget Submission, VA expects to open 50 additional CBOCs in FY2010.

Generally a CBOC is defined as a fixed health care site that is geographically distinct or separate from its parent medical facility.[21] This site can be VA-operated, contracted, or a combination of the two; however, CBOCs are required to have the necessary professional medical staff, access to diagnostic testing and treatment capability, and referral arrangements to ensure the continuity of care for current and eligible veteran patients. A CBOC can provide primary care, specialty care, subspecialty care, mental health, and pharmacy benefits. It should be noted that services can vary from clinic to clinic.

There are currently 783 active CBOCs throughout the United States and its territories, including American Samoa, Guam, Puerto Rico, and the Virgin Islands. Over 2.8 million patients were seen at CBOCs during FY2008.[22] According to various studies conducted by the VA, CBOCs have been able to serve veterans in a more efficient and effective manner by improving access to health

[21] Department of Veterans Affairs, *Planning and Activating Community-Based Outpatient Clinics*, VHA Handbook: 1006.1, Washington, DC, May 2004.

[22] E-mail communication from Department of Veterans Affairs, Veterans Health Administration, Office of Legislative Programs, December 2009.

care services and providing high quality primary and mental health care.[23] The next section discusses how CBOCs are managed throughout the VA health care system.

Administration and Management of CBOCs

All Community-Based Outpatient Clinics operate under the supervision and guidance of a single VA hospital or medical center (VAMC). The parent VAMC maintains administrative responsibility for its CBOC(s), specifically with respect to maintaining quality of care (discussed later in this report).

CBOCs are operated by VA and/or contracted staff. In general, CBOCs fall into three major categories:[24]

- VA-Owned—a CBOC that is owned and staffed by VA personnel. The facility space is also owned by VA.
- Leased—a CBOC where the space is leased (contracted) but staffed by VA personnel.
- Contracted—a CBOC where the space and the staff are not VA personnel. This is typically a Healthcare Management Organization (HMO) type provider where there can be multiple sites associated with a single station identifier.

Table 1 displays the number and percent distribution of CBOCs by these three categories for FY2009.

Table 1. CBOCs by Category, FY2009

Type of CBOC	Number of CBOCs	Percentage
VA-Owned	84	10.7
Leased	497	63.5
Contracted	202	25.8
Total	783	100.0

Source: Department of Veterans Affairs, Veterans Health Administration, Office of Legislative Affairs, December 2009.

Notes: Data are current as of September 30, 2009. For FY2009, VA reported having an estimated total of 803 CBOCs in Department of Veterans Affairs, *FY2010 Budget Submission: Medical Programs and Information Technology Programs,* Vol.2, Washington, DC, May 2009, pp. 1E-4. CRS has been unable to reconcile this discrepancy.

[23] John C. Fortney, Matthew L. Maciejewski, and James J. Warren, et al., "Does Improving Geographic Access to VA Primary Care Services Impact Patients' Patterns of Utilization and Costs?" *Inquiry*, vol. 42 (Spring 2005), pp. 29-42. Robert Rosenheck, "Primary Care Satellite Clinics and Improved Access to General and Mental Health Clinics," *Health Services Research*, vol. 35, no. 4 (October 2000), pp. 777-790. Ashley N. Hedeen, Patrick J. Heagerty, and John C. Fortney, et al., "VA Community-Based Outpatient Clinics: Quality of Care Performance Measures," *Medical Care*, vol. 40, no. 7 (July 2002), pp. 570-577. Steven J. Borosky, David B. Nelson, and John C. Fortney, et al., "VA Community-Based Outpatient Clinics: Performance Measures Based on Patient Perceptions of Care," *Medical Care*, vol. 40, no. 7 (June 2002), pp. 578-586.

[24] Department of Veterans Affairs, Office of Inspector General, *Informational Report, Community-Based Outpatient Clinic Cyclical Reports*, Report No. 08-00623-169, Washington, DC, July 16, 2009, p. 3.

Contracts for CBOCs

The Veterans' Health Care Eligibility Reform Act (P.L. 104-262) authorized VA to obtain health care resources by entering into contracts or other agreements with any health care facility, entity, or individual. There are three statutes in current law that authorize the VA to enter into contracts for establishing CBOCs:

- Title 38 United States Code (U.S.C.) §8153—allows the VA to obtain health care resources such as health care providers, other entities or individuals. Contracts may be used to obtain professional services alone or a comprehensive practice to include the physical plant where the services are provided.
- Title 38 U.S.C. §7409—authorizes the VA to enter into contracts with schools of medicine, dentistry, podiatry, optometry and nursing. Also included in this statute are clinics and other groups or individuals capable of providing medical specialist service to VA facilities.
- Title 38 U.S.C. §8111—authorizes the VA to enter into agreements with the Department of Defense (DOD) to share health care resources. This statute may be used to establish CBOCs at DOD facilities using DOD personnel, VA personnel, or a combination of DOD and VA personnel.

For contracted CBOCs, the contractor is required to provide health care staff, medical facilities, medical equipment, supplies, and all administrative functions sufficient to achieve the contracted level of care in a manner consistent with VHA standards, and meet the requirements and guidelines set forth in the most recent edition of the Joint Commission on the Accreditation of Healthcare Organization (JCAHO, now called The Joint Commission) accreditation manuals. In general, under contracted care the contactor refers veterans to the nearest VAMC for specialty care, extensive diagnostic work, and non-emergency hospitalization. Under the contract, VA requires the contractor to utilize the VA's Computerized Patient Record System (CPRS) for documentation of all patient-related care, including clinical care provided, appointment management, completion of clinical reminders, requests for consultation, scheduling or ordering medications using the VA formulary, requests for prosthetics, and any other computer functions related to patient care. CBOCs are typically open a minimum of five days a week, for a minimum of 40 hours. These days and times could change based on the contract.

When a CBOC contract is up for renewal, it is subject to review by the VA Central Office and approval by the Secretary of Veterans Affairs. In addition to the description of the contract terms, the VISN or facility is required to submit an informational fact sheet to include justification for continued operation of the CBOC under a contract versus a VA-staffed model, and supporting demographic, utilization, and cost information. Results of this review can indicate either a renewal of the current contract, solicitation of a new contract, or conversion to a VA-staffed model CBOC.

Contract CBOCs (and their providers) operate under a capitated payment system, and the contractor is paid a monthly capitated rate for each enrolled patient.[25] For newly enrolled patients, payments commence with the month in which the patient is first seen. The next section of the

[25] Capitation payment systems are based on the number of people to be served by the provider. Here, the VA pays a monthly per capita payment to the provider institution to deliver a packet of services to enrolled veterans.

report discusses the establishment of CBOCs in collaboration with the Department of Defense (DOD) and the Department of Health and Human Services/Indian Health Services (IHS).

CBOC Collaborations with DOD and IHS

In addition to contracting for CBOC services, the VA has established memorandum of understanding (MOU) agreements with both the Department of Defense (DOD) and Department of Health and Human Services/Indian Health Services (IHS) to establish CBOCs.

VA/DOD agreements may come in many forms:[26]

- VA may use DOD space to treat VA patients only.
- DOD may use VA space to treat DOD patients only.
- VA and DOD may use common space, but each treats its own beneficiaries. Ancillary services may be contracted out or provided to both beneficiaries in the joint CBOC.
- VA and DOD may use common space to treat the combined patient populations.

VHA has also entered into sharing agreements with IHS to enhance access to health care services to American Indian and Alaska Native veterans. These agreements tend to offer IHS land or facility space for a VA-staffed CBOC, while allowing IHS providers to utilize the VA's health information technology.[27] According to VA, CBOCs operating under these joint partnerships enable sharing of resources, facilities, and personnel between VA and DOD or IHS to increase access to, and provide, primary, and mental health care.[28]

Medical Services in CBOCs

In general, all veterans receiving care through VA are provided a standard medical benefits package to include preventive care,[29] inpatient[30] and outpatient[31] diagnostic and treatment services,[32] and medication and medical supplies.[33]

[26] Department of Veterans Affairs, Veterans Health Administration, *Guidelines and Templates for Establishing Contracts for Community-Based Outpatient Clinics*, Washington, DC, September 20, 2004.

[27] Health information technology includes the VA's electronic medical record system, bar code medication administration and telemedicine. Memorandum of Understanding between the VA/Veterans Health Administration and HHS/Indian Health Service, February 25, 2003.

[28] Congressional Research Service, staff site visit to Alaska VA Health Care System, August 24, 2009.

[29] Preventive care services include immunizations, physical examinations, health care assessments, screening tests, and health education programs.

[30] Inpatient diagnostic and treatment includes emergency inpatient care in VA facilities, medical and surgical procedures, mental health and substance abuse.

[31] Medications and medical supplies include prescription medications, over-the-counter medications and medical and surgical supplies. Prescriptions must generally be from a VA provider and covered under the VA's national formulary system.

[32] Outpatient diagnostic and treatment includes emergency outpatient care in VA facilities, medical and surgical procedures, chiropractic care, mental health, bereavement counseling and substance abuse.

[33] 38 C.F.R. § 17.38.

Services delivered to veterans at CBOCs vary, however, primary care and mental health services are generally provided at all CBOCs. Primary care includes, but is not limited to, assessment, diagnosis, and medically necessary treatment(s) for physiological and pathological conditions not requiring referral to specialty care or inpatient hospital services. Care is directed toward health promotion and disease prevention, management of acute and chronic medical conditions, and pharmacological management. Many sites include at least one mental health provider, most of whom are psychologists. [34] Research has indicated that CBOCs have enhanced mental health services through VA-mandated routine screening for depression, problem drinking, traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and military sexual trauma (MST).[35] Psychiatrists, social workers, and mental health nurses are also utilized and work together with primary care staff to serve the mental health needs of veterans. CBOC patients requiring specialty care, inpatient hospital services, or extended medical services are often referred to the parent VA medical facility.

Access, Quality, and Cost of Care

There have been several research studies on access, quality of care, and cost of providing care through CBOCs. To study if CBOCs provide consistent, safe, and high-quality care, performance evaluations were initiated in 1998 at the request of the VA Undersecretary of Health. A plan was formulated by the Department's Health Services Research and Development Service to create performance measures to evaluate individual CBOCs and the program as a whole in several domains: access to care, cost, mental health, quality, satisfaction, and utilization.[36] Based on data obtained from three performance reports,[37] several studies on access and utilization, quality of care, patient perceptions of care, and cost of care were published in 2002.[38] These published studies provide some analysis of the quality and cost of care provided through CBOCs.

Access to Care

One research study has indicated that CBOCs have improved geographic access to primary care and mental health services to veterans.[39] According to this study, increases in the number of clinics have improved geographic access for veterans in underserved areas resulting in a substantial increase in the number of veterans from these underserved areas who use VA services. Furthermore, while CBOCs provide closer access points to VA health care services, it may also reduce the need or amount required for beneficiary mileage travel reimbursements.[40]

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[34] Antonette M. Zeiss and Bradley E. Karlin, "Integrating Mental Health and Primary Care Services in the Department of Veterans Affairs Health Care System," *Journal of Clinical Psychology in Medical Settings*, vol. 15, no. 1 (February 2008), p. 73-78.

[35] Ibid.

[36] Department of Veterans Affairs, *CBOC Performance Evaluation Project*, CBOC Characteristics, Washington, DC, February 17, 1999.

[37] Department of Veterans Affairs, Health Services Research and Development Service, *CBOC Performance Evaluation Project*, 2000, http://www.research.va.gov/resources/pubs/cboc.cfm.

[38] See *Medical Care*, vol. 40, no. 7 (June 2002), pp. 555-595.

[39] Robert Rosenheck, "Primary Care Satellite Clinics and Improved Access to General and Mental Health Services," *Health Services Research*, vol. 35, no. 4 (October 2000), pp. 777-790.

[40] Eligible beneficiaries are reimbursed for travel to or from VA facilities or other places for the purposes of (continued...)

Ensuring Quality of Care

VA's intent in establishing Community-Based Outpatient Clinics was to increase access to primary care and health services for veterans.[41] Though CBOCs can be located in a variety of geographic areas, ranging from rural to urban, VA policies require that veterans receive a uniform standard of care at all VHA health care facilities to ensure continuity of care and quality for the veteran. For contract CBOCs, services must be comparable to services provided to veterans seen at VA-staffed CBOCs and must adhere to the standards set forth in VA regulations and policies. Generally these standards include, but are not limited to, quality, patient safety, and performance.[42]

With regard to clinical indicators, the Office of Quality and Performance provides annual feedback on CBOC performance, including patient satisfaction surveys, preventive care, and clinical guidelines.[43] In addition to timely administrative and clinical evaluations, all CBOCs are required to be integrated into their parent VAMC quality management program and meet the standards of The Joint Commission. By delegating quality assurance and quality improvement to individual VISNs, VA is able to assess CBOC compliance to evidence-based standards of care and to investigate further if facilities fall short of requirements or expected standards. During the CBOC performance evaluation process, VISNs may decide not to open a planned clinic or to close an operating clinic based on the CBOC's ability to accommodate veterans from the service area at a different community-based site, inability to contract care in the community, and/or inability to acquire adequate staffing or site accommodations.[44]

Systematic reviews on administrative and managerial aspects of CBOCs are also conducted by the VA Office of Inspector General (OIG), as requested by Congress.[45] The results and recommendations made by OIG are intended to ensure that CBOCs are "operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures."[46] Recent CBOC inspections, which have varied between sites, address a variety of areas, including ensuring patients' auditory privacy during check-in, examining CBOC access for disabled patients, measures to secure and protect health records, ensuring clinical competencies, monitoring collaborative practice of physician assistants, ensuring quality and safety standards with dispensing outpatient medications, providing oversight and enforcement in

(...continued)

examination, treatment or care. For further details on the beneficiary travel program see CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by (name redacted).

[41] U.S. Government Accountability Office, *VA Health Care: Community-Based Clinics Improve Primary Care*, Washington, DC, March 2001.

[42] Department of Veterans Affairs, *Informational Report for the Community-Based Outpatient Clinic Cyclical Reports*, 08-00623-169, Washington, DC, January 16, 2009.

[43] Department of Veterans Affairs, Veterans Health Administration, *Planning and Activating Community-Based Outpatient Clinics*, VHA Handbook 1006.1, Washington, DC, May 9, 2004.

[44] Ibid.

[45] A request for the OIG to conduct systematic reviews of CBOCs was made in H.Rept. 110-775 to accompany H.R. 6599, the Military Construction, Veterans Affairs and Related Agencies Appropriation Bill for FY2009.

[46] Department of Veterans Affairs, Office of Inspector General, *Health Care Inspection: Community-Based Outpatient Clinic Reviews: Macon and Albany, GA, Beaver Dam, WI, Rockford, IL, Sioux City, IA, Aberdeen, SD, Waterloo, IA and Galesburg, IL*, 09-01446-37, Washington, DC, December 2, 2009.

accordance with contract terms and conditions, and improving the physician privileges (and reprivileging) process, among other things.[47]

There have also been some studies done on quality of care delivered at CBOCs. One published study has shown that overall CBOCs are providing a similar level quality of care as primary care clinics at parent VAMCs.[48] According to the authors of this study, when data from the VHAs Prevention Index (PI) and Chronic Disease Care Index (CDCI)[49] were compared for both CBOCs and parent VAMCs, "CBOCs in aggregate were not significantly different from parent VAMCs on 15 of the 16 Prevention Index and Chronic Disease Care Index indicators."[50] The PI and CDCI measure the compliance of VA providers with nationally accepted clinical guidelines for primary prevention, early disease detection of patients with chronic diseases such as diabetes and hypertension.[51] Another study comparing quality of care between contract CBOCs and VA-staffed CBOCs found that based on "two measures—flu shot rate among chronic obstructive pulmonary disease (COPD) patients and retinal exam rate among diabetes patients"—quality was similar in both VA-staffed CBOCs and contract CBOCs.[52]

Cost of Treating Veterans in CBOCs

Comparative cost studies of CBOCs and primary care clinics at VAMCs have focused on costs per patient, costs per visit, and total direct costs. Increased geographic access, costs to the patient in drive time, and increased access to VA health care have also been reviewed. In general, these studies have found that CBOC costs are lower than costs for patients receiving care at parent VAMC primary care clinics. One specific goal set by VA in transitioning from hospital-based care to outpatient care was to reduce the cost-per-user amount by 30%.[53] In a recent study on the cost comparisons of CBOCs versus parent VAMC clinics, the total direct costs were lower for VA-staffed CBOC patients because of "lower specialty and ancillary care costs."[54] While this may be

[47] Department of Veterans Affairs, Office of Inspector General, *Health Care Inspection: Community Based Outpatient Clinic Reviews*, Report No. 09-01446-233, Washington, DC, September 30, 2009. Department of Veterans Affairs, Office of Inspector General, *Health Care Inspection: Community Based Outpatient Clinic Reviews*, Report No. 09-01446-226, Washington, DC, September 23, 2009. Department of Veterans Affairs, Office of Inspector General, *Health Care Inspection: Community-Based Outpatient Clinic Reviews: Macon and Albany, GA, Beaver Dam, WI, Rockford, IL, Sioux City, IA, Aberdeen, SD, Waterloo, IA and Galesburg, IL*, 09-01446-37, Washington, DC, December 2, 2009.

[48] Ashley N. Hedeen et al., "VA Community-Based Outpatient Clinics, Quality of Care Performance Measures," *Medical Care*, vol. 40, no. 7 (July 2002), pp. 570-577.

[49] Ibid. The Prevention Index is comprised of 9 performance indicators: immunization against influenza and pneumococcal diseases; tobacco use screening and cessation counseling; alcohol use screening; breast, cervical and colon cancer screening; and counseling regarding the risks and benefits of screening for prostate cancer. The Chronic Disease Care Index is comprised of 14 performance indicators for 5 common diagnoses: hypertension, diabetes mellitus, obesity, ischemic heart disease, and chronic obstructive pulmonary disease.

[50] Ashley N. Hedeen et al., "VA Community-Based Outpatient Clinics, Quality of Care Performance Measures," *Medical Care*, vol. 40, no. 7 (July 2002), p. 574.

[51] Ibid, p. 571.

[52] Chuan-Fen Liu et al., "The Impact of Contract Primary Care on Health Care Expenditures and Quality of Care," *Medical Care Research and Review*, vol. 65, no. 3 (June 2008), p. 311.

[53] John C. Fortney, Steven J. Borowsky, and Ashley N. Hedeen, et al., "VA Community-Based Outpatient Clinics: Access and Utilization Performance Measures," *Medical Care* , vol. 40, no. 7 (July 2002), pp. 561-569.

[54] Matthew L. Maciejewski, Michael K. Chapko, and Ashley N. Hedeen, et al., "VA Community-Based Outpatient Clinics: Cost Performance Measures," *Medical Care*, vol. 40, no. 7 (June 2002), pp. 587-595. Lower specialty and ancillary care costs may be lower due to CBOC providers becoming a "veteran's locus of care to avoid specialty and (continued...)

attributable to substituting primary care at CBOCs for expensive specialty and ancillary care at VAMCs, according to the authors of this study, this alternative is able to provide care at a lower cost than the traditional delivery model in VA Medical Centers. **Table 2** illustrates the varying costs per patient for patients seen at a CBOC versus a VAMC primary care clinic.

Table 2. Costs of Patients in CBOCs and Parent VAMC Primary Care Clinics

Cost Variables	CBOC	Parent VAMC Clinics
Direct Cost per Primary Care Visit	$75.65	$77.39
Direct Primary Care Cost per Patient	$172.27	$193.54
Direct Specialty Care Cost per Patient	$209.24	$553.19
Direct Ancillary Cost per Patient	$218.67	$462.52
Direct Inpatient Cost per Patient	$49.89	$344.40
Total Direct Costs per Patient	$650.07	$1,553.65
Sample Size	6,546	101,598

Source: Chart adapted by Congressional Research Service, from Matthew L. Maciejewski, Michael K. Chapko, and Ashley N. Hedeen, et al., "VA Community-Based Outpatient Clinics: Cost Performance Measures," *Medical Care*, vol. 40, no. 7 (June 2002), p. 591.

Notes: Sample examined includes 18 VA-staffed CBOCS and 14 VA Medical Centers, in which four pair of CBOCs had a common VAMC. Contract CBOCs were not included in this study due to extreme variability in cost estimates and the inability to separate direct and indirect costs.

In 2000, a VA performance evaluation of CBOC costs and access found that VA-staffed CBOC patients had higher average direct costs per primary care visit than VAMC patients.[55] This is attributable to a variety of factors, including CBOC providers practicing more resource intensive care, providing a greater range or different set of services to their patients than VAMC providers, and the need for improved access and convenience of primary care. When ancillary costs per patient per visit are included with direct primary care costs, CBOC patients had lower total care costs than those at VAMCs. Lower total direct costs for CBOC patients can be attributable to the physical separation of CBOC primary care and VAMC specialty clinics, additional procedural requirements for specialist referrals, better unmeasured general health, and possibly CBOC patients using non-VA services for a larger portion of their total care.

According to VA, CBOCs may offer a cost-effective alternative to providing primary care at parent VAMC clinics while improving geographic access for veterans. Further study and comparative analysis of cost data would be useful to confirm these results using patient-level data on a larger sample of patients and also including contract CBOCs.[56]

(...continued)

ancillary referrals," particularly when ancillary tests tend to be a cost driver.

[55] Department of Veterans Affairs, Veterans Health Administration, *CBOC Performance Evaluation*, Performance 2: Cost and Access Measures, Washington, DC, March 2002.

[56] Department of Veterans Affairs, Veterans Health Administration, *CBOC Performance Evaluation*, Performance 2: Cost and Access Measures, Washington, DC, March 2002.

Current Process for Developing a New CBOC

This section discusses the current process for planning and establishing CBOCs. As stated previously, in 1995, VHA reorganized its health care delivery network into 22 geographically defined Veterans Integrated Service Networks (VISN).[57] At the same time, VHA gave VISN Directors the decision-making responsibility to establish CBOCs. However, the Departments of Veterans Affairs and Housing and Urban Development, Independent Agencies Appropriations Act of 1990 (P.L. 101-144), changed this, mandating that VA notify Congress of its intent to open a CBOC no later than 14 days prior to taking irrevocable action.[58]

At a recent congressional hearing, VA described the current planning process for a new CBOC:

> The CBOC process begins with a national analysis of the underserved populations as defined by limited geographic access in areas with projected increases in primary care and mental health services. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) issues a call memorandum to the [VISNs] for CBOC Business plan submissions for those areas of the country that meet the national threshold for having underserved populations. A technical review of each of these business plan proposals is then completed. Those proposals meeting the technical requirements are then reviewed by a CBOC National Review Panel (NRP).[59]

It should be noted that CBOCs are funded primarily through existing VISN resources. As a result, the CBOC planning process is closely aligned with VHA's capital planning and budget cycles.[60]

Review Process for CBOC Business Plans

The following steps briefly describe the review process of new CBOC business plans:

- VISNs submit CBOC business plans for review against national planning criteria (see below). VISNs certify that the CBOC can be implemented within existing funds once approved.
- National Review Panels (NRPs) convene to review proposals against national panning criteria. The national planning criteria include the following: if the CBOC is located in a market not meeting VA access guidelines; if there are space deficits at the parent facility; projected increases in the number of unique veteran patients and enrollees; market penetration; unique considerations—such as targeted minority veteran populations, geographic barriers, highly rural and/or low population density, medically underserved, DOD sharing opportunities, and

[57] At present there are 21 VISNs (on January 23, 2002, the VA announced the merger of VISNs 13 and 14 into new VISN 23). Although VISNs are organized geographically, some VISNs cover more than one state, and some states are covered by more than one VISN.

[58] Department of Veterans Affairs, Office of Inspector General, *Informational Report, Community-Based Outpatient Clinic Cyclical Reports*, Report No. 08-00623-169, Washington, DC, July 16, 2009, p. 2.

[59] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Assessing Capital Asset Realignment for Enhanced Services and the Future of the U.S. Department of Veterans Affairs' Health Infrastructure*, 111th Cong., 1st sess., June 9, 2009 (Washington: GPO, 2010), p. 44.

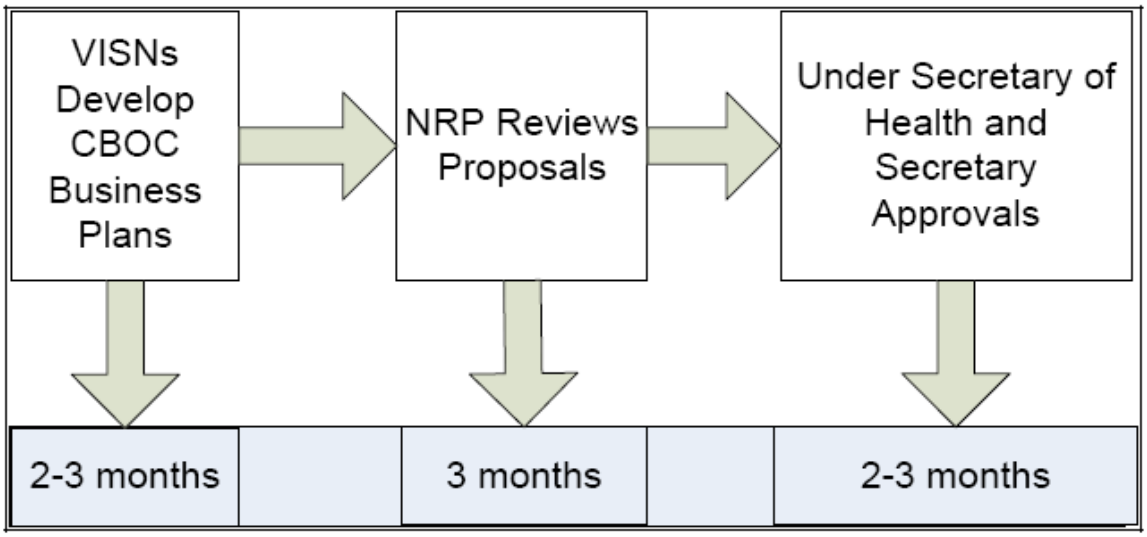
[60] Ibid.

parking and transit issues at parent facility; cost effectiveness of proposed sites; impact on specialty care, and waiting times.

- By June of each budget formulation year, the NRP results of the review and recommendations are completed and forwarded to DUSHOM.
- DUSHOM obtains approvals from Under Secretary for Health and Secretary.
- The Office of Management and Budget (OMB) reviews the CBOC plans.
- VA provides notice to Congress.

Figure 2 provides time frames involved in the CBOC planning and approval process. According to VA, it generally takes about two years from the planning process to the time when patients start receiving treatment.[61] For example, in FY2010 VHA would begin reviewing plans for CBOCs to be opened in FY2012.

Figure 2. CBOC Planning and Approval Process



Source: Congressional Research Service graphic based on VA's description of the process.

Notes: VISN = Veterans Integrated Services Network; CBOC = Community-Based Outpatient Clinic; NRP = National Review Panels.

[61] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs and Related Agencies Appropriations for 2010*, 111th Cong., 1st sess., 2009 (Washington: GPO, 2009), p. 1214, and U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Assessing Capital Asset Realignment for Enhanced Services and the Future of the U.S. Department of Veterans Affairs' Health Infrastructure*, 111th Cong., 1st sess., June 9, 2009 (Washington: GPO, 2010), p. 44.

Author Contact Information

(name redacted)
Specialist in Veterans Policy
[redacted]@crs.loc.gov, 7-....

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