VA versus Non-VA Quality of Care: A Living Systematic Review

Updated December 2023

U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

Recommended citation: Shekelle P, Maggard-Gibbons M, Blegen M, et al. VA versus Non-VA Quality of Care: A Living Systematic Review. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #05-226; 2023.

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PREFACE

The VA Evidence Synthesis Program (ESP) was established in 2007 to conduct timely, rigorous, and independent systematic reviews to support VA clinicians, program leadership, and policymakers improve the health of Veterans. ESP reviews have been used to develop evidence-informed clinical policies, practice guidelines, and performance measures; to guide implementation of programs and services that improve Veterans' health and wellbeing; and to set the direction of research to close important evidence gaps. Four ESP Centers are located across the US. Centers are led by recognized experts in evidence synthesis, often with roles as practicing VA clinicians. The Coordinating Center, located in Portland, Oregon, manages program operations, ensures methodological consistency and quality of products, engages with stakeholders, and addresses urgent evidence synthesis needs.

Nominations of review topics are solicited several times each year and submitted via the ESP website. Topics are selected based on the availability of relevant evidence and the likelihood that a review on the topic would be feasible and have broad utility across the VA system. If selected, topics are refined with input from Operational Partners (below), ESP staff, and additional subject matter experts. Draft ESP reviews undergo external peer review to ensure they are methodologically sound, unbiased, and include all important evidence on the topic. Peer reviewers must disclose any relevant financial or non-financial conflicts of interest. In seeking broad expertise and perspectives during review development, conflicting viewpoints are common and often result in productive scientific discourse that improves the relevance and rigor of the review. The ESP works to balance divergent views and to manage or mitigate potential conflicts of interest.

ACKNOWLEDGMENTS

The authors are grateful to the following individuals for their contributions to this project:

Operational Partners

Operational partners are system-level stakeholders who help ensure relevance of the review topic to the VA, contribute to the development of and approve final project scope and timeframe for completion, provide feedback on the draft report, and provide consultation on strategies for dissemination of the report to the field and relevant groups.

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Executive Summary

KEY FINDINGS

- This report updates an earlier review of evidence on the quality of VA care compared with non-VA care available through February 2023. Four additional studies published through October 2023 were included in this update, bringing the total number of relevant studies published since 2015 to 57 (19 of surgical care, 42 of non-surgical care, and 4 of both).
- Most available studies have found that the quality and safety of VA care is as good as, or better than, care in the community.
- Fewer studies have examined access to care, patient experience, and efficiency/cost of care. Findings from available studies are mixed but tend to favor VA care.

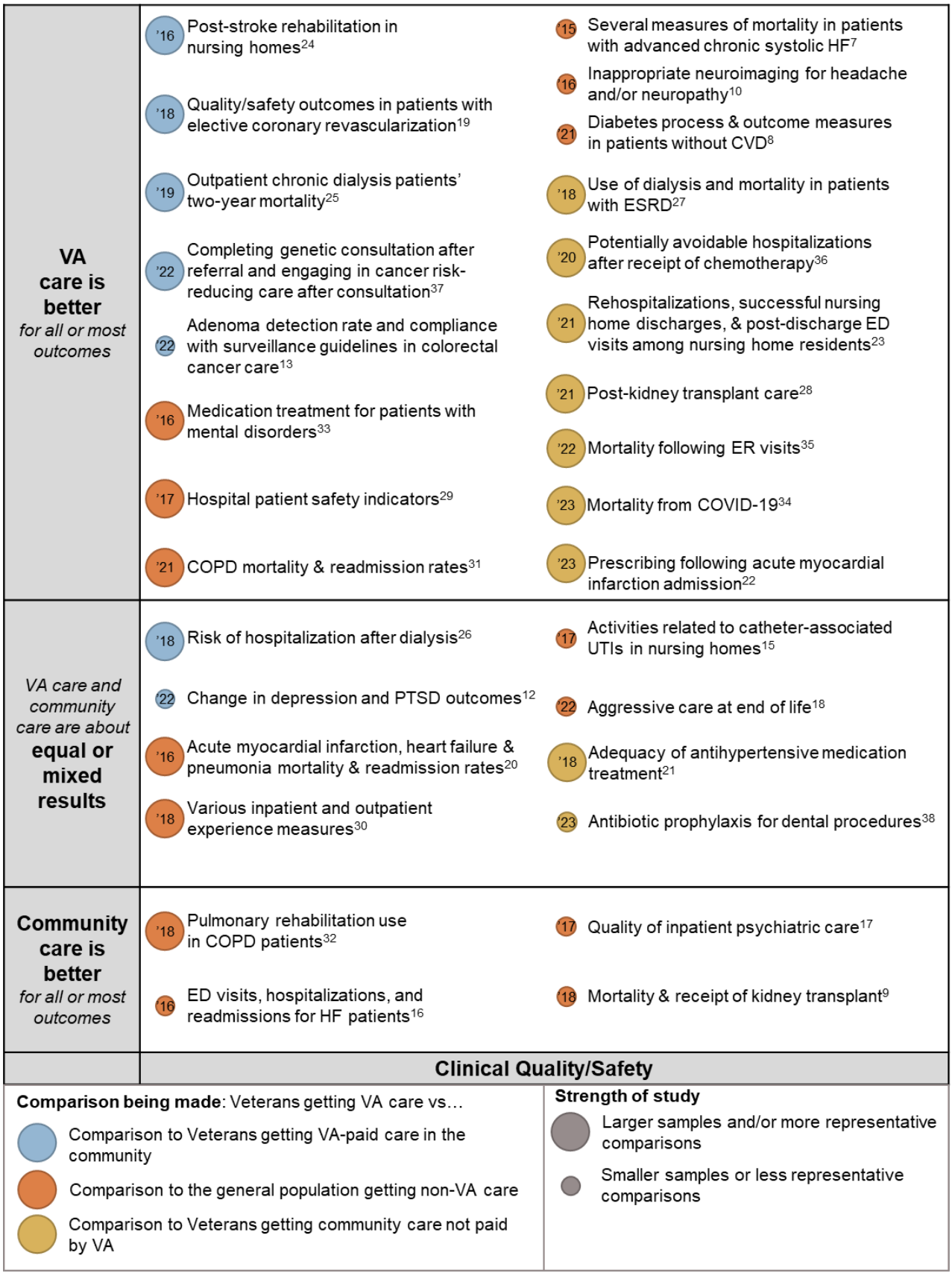
The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) is the nation's largest integrated health care system. Comparing the quality of VA-delivered health care to care delivered in non-VA settings is one way of ensuring VA maintains its commitment to providing high-quality care to Veterans. To support this aim, the VA's Evidence Synthesis Program (ESP) maintains a living systematic review of studies comparing the quality of VA and non-VA health care, which is frequently updated with the most recently available evidence.

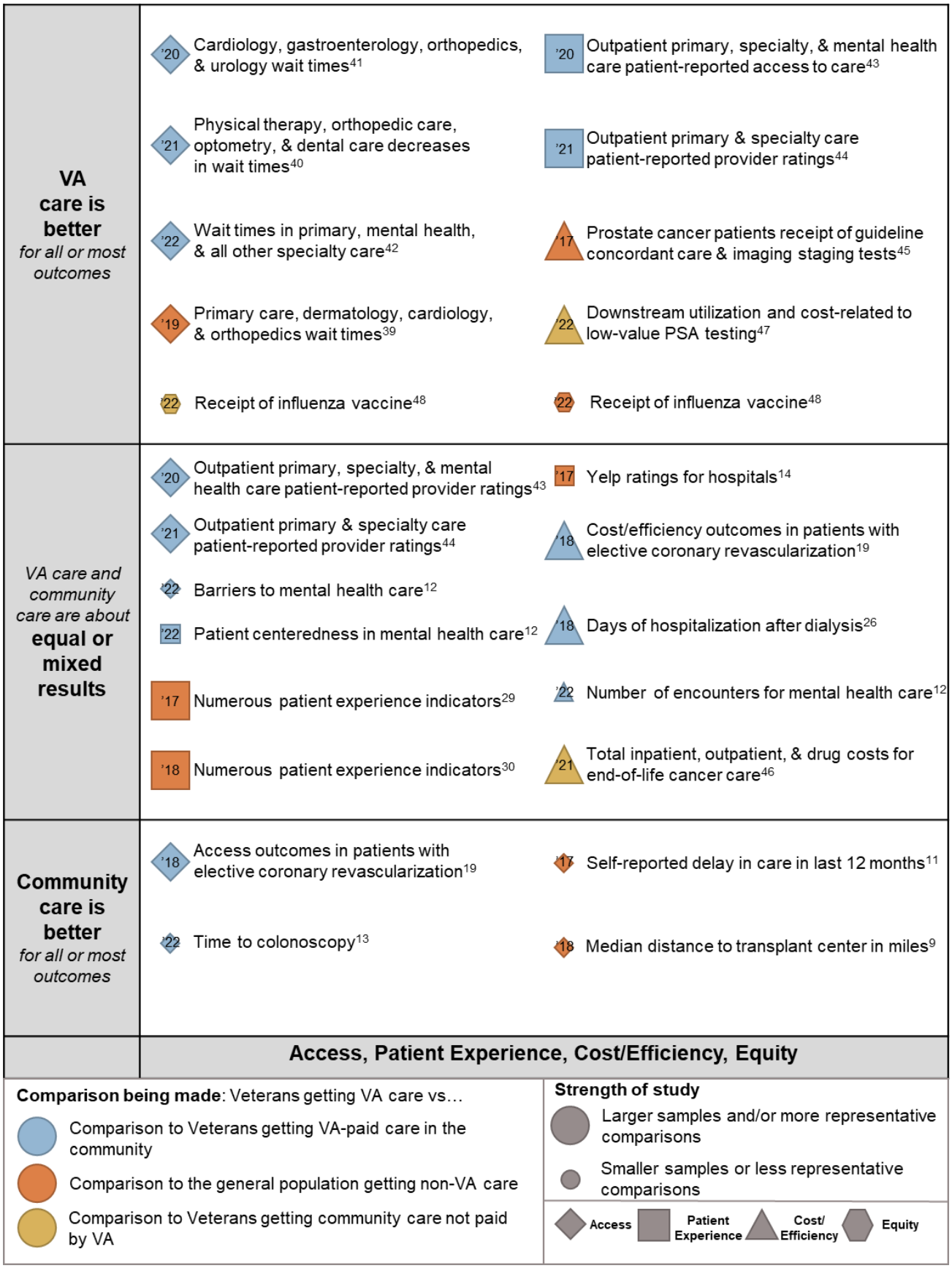
CURRENT REVIEW

To identify relevant studies, a research librarian conducted broad searches using terms relating to *Veterans health* and *community health services* or *private sector* in PubMed, APA PsycINFO, and Web of Science databases (1/1/2015–10/6/2023). Studies were included at either the abstract or the full-text level if they were original research studies of any design and made comparisons about the quality of care provided in VA Medical Centers and outpatient clinics compared with care provided in other health systems, *ie*, the general population. We included outcomes in any Institute of Medicine health care domain (clinical quality, safety, efficiency/cost, access, patient experience, or equity). Data were collected by 2 reviewers working independently, with any disagreements resolved by consensus.

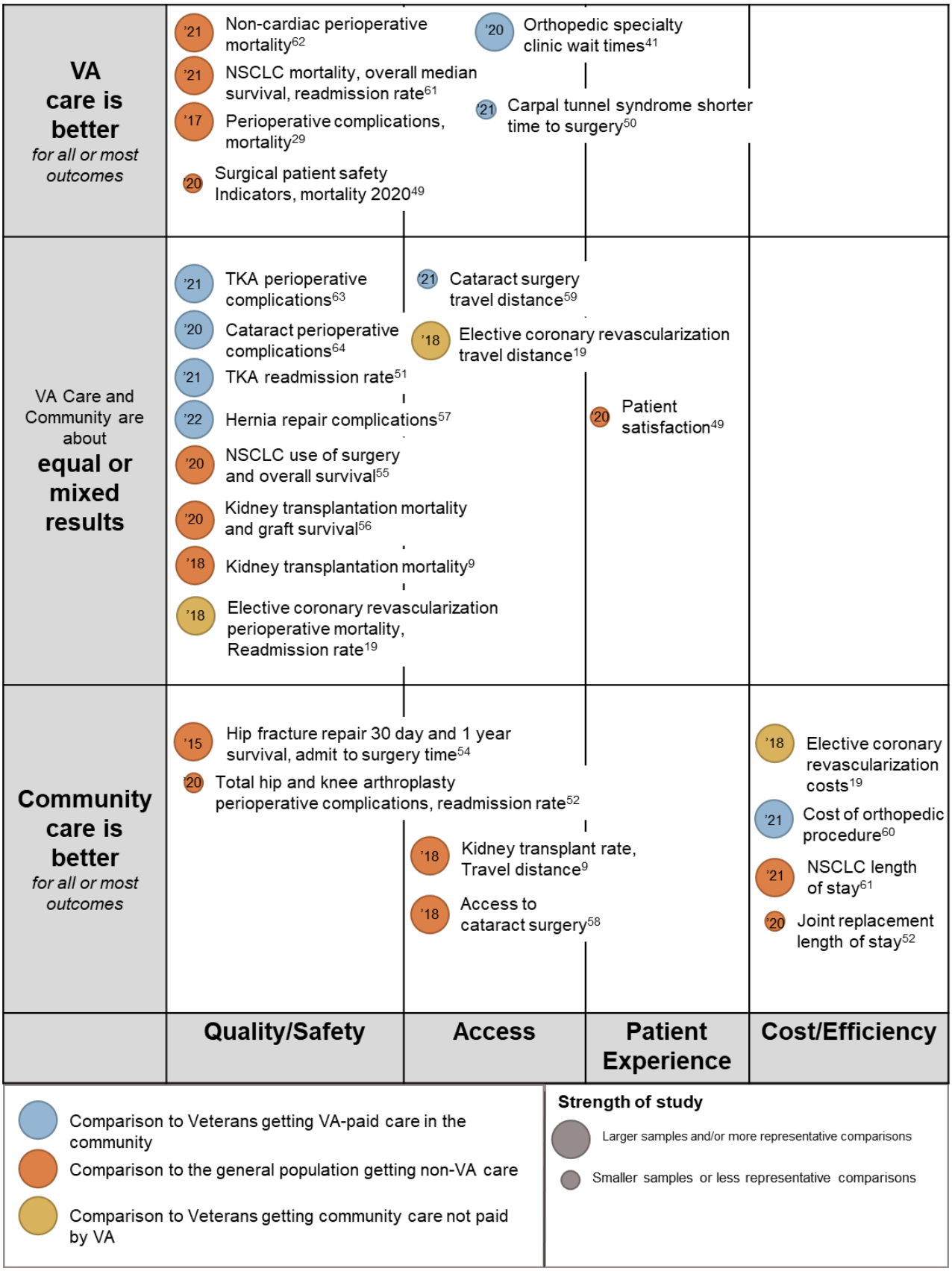
From 2,598 titles, we identified 42 studies of non-surgical care meeting inclusion criteria. From 2,591 titles, we identified 19 studies of surgical care meeting inclusion criteria. Four studies contributed data to both. Characteristics and findings of included studies are summarized in the figures below. In each plot, the domains of care are listed on the horizontal axis (quality/safety, access, patient experience, cost/efficiency, equity), the results of the study are listed on the vertical axis (VA care is better than community care, VA care and community care are about equal, or results are mixed, and community care is better than VA care), and then each study is entered as a shape, with larger shapes being studies of better quality and representativeness than studies depicted by smaller shapes. The color of the shape indicates the type of comparison: blue for studies comparing Veterans getting care from VA to Veterans getting VA-paid care in the community; orange for studies comparing Veterans getting care from VA and non-Veterans, or a general population, getting care in the community; and yellow for studies comparing Veterans getting care from VA to Veterans getting community care not paid by VA. Next to each shape is a brief thumbnail of what the study was about, and inside the shape is the year of publication (’18 = 2018, ’19 = 2019, *etc*).

ES Figure 1. Evidence Map of Studies on the Quality of Non-Surgical Care




VA care is better for all or most outcomes
'20 Cardiology, gastroenterology, orthopedics, & urology wait times[41]
'21 Physical therapy, orthopedic care, optometry, & dental care decreases in wait times[40]
'22 Wait times in primary, mental health, & all other specialty care[42]
'19 Primary care, dermatology, cardiology, & orthopedics wait times[39]
'22 Receipt of influenza vaccine[48]
'20 Outpatient primary, specialty, & mental health care patient-reported access to care[43]
'21 Outpatient primary & specialty care patient-reported provider ratings[44]
'17 Prostate cancer patients receipt of guideline concordant care & imaging staging tests[45]
'22 Downstream utilization and cost-related to low-value PSA testing[47]
'22 Receipt of influenza vaccine[48]
VA care and community care are about equal or mixed results
'20 Outpatient primary, specialty, & mental health care patient-reported provider ratings[43]
'21 Outpatient primary & specialty care patient-reported provider ratings[44]
'22 Barriers to mental health care[12]
'22 Patient centeredness in mental health care[12]
'17 Numerous patient experience indicators[29]
'18 Numerous patient experience indicators[30]
'17 Yelp ratings for hospitals[14]
'18 Cost/efficiency outcomes in patients with elective coronary revascularization[19]
'18 Days of hospitalization after dialysis[26]
'22 Number of encounters for mental health care[12]
'21 Total inpatient, outpatient, & drug costs for end-of-life cancer care[46]
Community care is better for all or most outcomes
'18 Access outcomes in patients with elective coronary revascularization[19]
'22 Time to colonoscopy[13]
'17 Self-reported delay in care in last 12 months[11]
'18 Median distance to transplant center in miles[9]
Access, Patient Experience, Cost/Efficiency, Equity
Comparison being made: Veterans getting VA care vs…
Comparison to Veterans getting VA-paid care in the community
Comparison to the general population getting non-VA care
Comparison to Veterans getting community care not paid by VA
Strength of study
Larger samples and/or more representative comparisons
Smaller samples or less representative comparisons
Access
Patient Experience
Cost/ Efficiency
Equity

ES Figure 2. Evidence Map of Studies on the Quality of Surgical Care



The large majority of studies assessed quality and safety, followed by comparisons of access to care. Few studies—only 7 and 10, respectively—assessed patient experience or cost/efficiency. We found 1 study comparing VA to non-VA care on equity. Most studies found that the quality and safety of VA care is as good as, or better than, care in the community. This was the case for both surgical care and non-surgical care, and for community care of Veterans and community care of non-Veterans. For the domains of access and of cost/efficiency, findings were more mixed and about the same number of studies found that VA care is better, VA and community care are about the same, or that community care is better. The few studies of patient experience found that VA care and community care were about the same, or VA care was better. We did not identify any study the found that patient experience was better in community care. With only 1 exception in both the surgical and the non-surgical studies, VA-delivered care was as good as or better than Veterans received from VA-paid community care. We did not identify any studies comparing care for some conditions for which the MISSION act has resulted in increased community care, such as Physical Medicine and Rehabilitation.

NEW EVIDENCE SINCE FEBRUARY 2023

This report updates an earlier review, which included evidence available through February 2023. Four additional studies published through October 2023 were included in this update. All new studies were of non-surgical care, and findings from studies that reported safety and quality outcomes continue to support the conclusion that the safety and quality of VA care is as good as, or better than, care in the community. One recent study is the first to be identified that examined a health equity outcome.

The first of the newly identified studies compared the rate of "medication safety events" (failure to prescribe certain indicated medications) following hospital discharge for acute myocardial infarction in more than 100,000 Veterans receiving care at community hospitals or at VA. The adjusted odds of omission in any drug class (a negative outcome) were 3 times higher among Veterans treated at non-VA hospitals compared with patients treated at VA hospitals.

A second study, which compared mortality among 60,000 Veterans admitted for COVID-19 between March 2020 and December 2021, found that Veterans admitted to community hospitals had higher mortality than Veterans admitted to VA hospitals. 30-day readmissions were slightly lower in community hospitals than VA hospitals.

A third study compared use of guideline-concordant antibiotic prophylaxis before dental procedures in Veterans and non-Veterans with prosthetic joints or cardiac conditions. Among 60,000 patients, guideline-concordant antibiotic prophylaxis was low, but slightly better in VA-treated patients than in non-VA treated patients.

The last recent study used data from the National Health Interview Survey to examine racial and ethnic disparities in receipt of the influenza vaccine among nearly 50,000 subjects. Self-reported vaccine receipt significantly differed between patients identifying as White, Black, and Hispanic in non-VA care settings but not in VA care settings.

CONCLUSIONS

In general, most published studies of comparisons of quality of care show that Veterans getting care from VA get the same or better quality care than Veterans getting community care or the general public getting non-VA care. The most recently available evidence, published between February and October 2023, continues to support this conclusion.