APPENDICES

APPENDIX 1. EVIDENCE TABLE OF SURGICAL STUDIES

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Austin, G.L., et al.; 2004[6]	Solid Organ Transplant-ation	Single ctr	149	1991-2000	Single med ctr	285	1991-2000	Other Surgical	mortality at 1,3,5 years	VA patients had increased mortality rates as assessed by Kaplan-Meier curves. However after adjusting for gender, donor age, recipient age, etiology of liver disease and MELD score, hospital status was not a significant predictor of mortality RR 1.15 (95% CI 0.94-1.43)	A
Bilimoria, K.Y., et al.; 2007[7]	Oncology	Nat'l	513	1985-2004	Nat'l	12,756/ 18,299	1985-2004	General surgical, Surgical Oncology	60 day and 3 year mortality	Unadjusted and adjusted mortality rates at 60days and 3 years were comparable between VA, academic and community hospital settings for resection of stage I and II pancreatic cancer.	B
Feria, M.I., et al.; 2003[8]	Cardiac	Nat'l	808	1995-1998	Mult ctrs	18,299	1996-1998	IHD, Car-diothoracic	perceptions of various dimensions of care	VA patients were more likely than non-VA patients to note a problem with patient care; when analysis limited to teaching hospital settings, VA patients remained more likely to note a problem with care in 5 dimensions.	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Fink, A.S., et al.; 2007[9]	General	Nat'l	5157	2001-2004	Mult. Ctrs	27467	2001-2004	General surgical	30 day postoperative morbidity and mortality	Risk adjusted mortality rates are comparable between PS and VA patients, although setting of care did not enter the mortality regression model. Risk adjusted morbidity was higher in the PS compared with the VA OR 0.8 (CI 0.71-0.90)	B
Gill, J.S., et al.; 2007[10]	Solid Organ Transplan-tation	Nat'l	7395	1995-2004	Nat'l	144651/ 357345	1995-2004	Other surgical	time to treatment	Both VA-insured and Medicare/Medicaid-insured patients were approximately 35% less likely to receive transplants than patients with private insurance (hazard ratio [HR] 0.65; 95% CI 0.60 to 0.70; P _ 0.0001). Most of this difference was explained by the fact that VA patients were less likely to be placed on the wait-list (HR 0.71; 95% CI 0.67 to 0.76), but even listed VA patients received transplants less frequently than those insured privately (HR 0.89; 95% CI 0.82 to 0.96).	A
Glasgow, R.E., et al.; 2007[11]	Oncology	Nat'l	377	2001-2004	Mult. Ctrs	692	2001-2004	Other surgical	postoperative outcomes (primarily morbidity and mortality)	Adjusting for case mix differences, postoperative morbidity and mortality rates for pancreatectomy were higher in the VA compared with the PS (OR 1.581, 95% CI 1.084-2.307 and 2.533 95% CI 1.020– 6.290 respectively).	A/B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Hall, B.L., et al.; 2007[12]	Endocrine	Nat'l	2814	2001-2004	Mult. Ctrs	357345	2001-2004	General surgical, head and neck	30 day morbidity and mortality; specific adverse event rates, LOS	Overall 30day morbidity and mortality do not differ significantly in the VA vs PS in risk adjusted model. Mortality event rate is too low to accurately evaluate, odds ratio for morbidity associated with VA care is 1.25 (95% CI 0.87-1.78)	B
Henderson, W.G., et al.; 2007[13]	General	Nat'l	9409818	2001-2004	Mult. Ctrs	18399	2001-2004	General surgical	30 day postoperative morbidity and mortality	After risk adjustment for patient comorbidities and severity of illness, the odds of mortality at 30days were higher in the VA compared with the PS (OR 1.23, 95% CI). There was no significant difference in morbidity at 30days among the sites.	A/B
Hutter, M.M., et al.; 2007[14]	Vascular	Nat'l	5174	2001-2004	Mult. Ctrs	30058	2001-2004	Vascular	30 day postoperative morbidity and mortality	Risk adjusted mortality was comparable among the two groups, although hospital site/type did not enter the stepwise regression model. Accounting for comorbidities and severity of illness, postoperative morbidity rates were lower in the VA population, OR 0.84 (95% CI 0.78-0.92)	A/B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Johnson, R.G., et al.; 2007[15]	Vascular	Nat'l	458	2001-2004	Mult. Ctrs	3535	2001-2004	Vascular	30 day postoperative morbidity and mortality	After risk adjustment, no significant difference in 30 day mortality rates among VA and PS female vascular patients. After adjusting for severity of illness, 30 day complication/morbidity rates were significantly lower in the VA compared with the PS (OR 0.60, 95% CI 0.44-0.81)	B
Lancaster, R.T., et al.; 2007[16]	General	Nat'l	237	2001-2004	Mult. Ctrs	783	2001-2004	General surgical	post-operative morbidity and mortality at 30 days; also evaluated LOS, need for re-operation and occurrence of 18 specific postoperative events	Risk adjusted outcomes suggest that 30day post-operative morbidity and mortality rates in the VA compared with the PS for hepatic resections do not vary significantly. (after risk adjustment, morbidity rates and mortality were comparable in VA and PS. Comparing Morbidity of VA w/ PS OR was 0.94 (95% CI 0.62-1.42) and Mortality OR was 1.623 (95% CI 0.61-4.32))	A/B

Author; Year	Category	VA Sample: Data Level	VA Sample: Sample Size	VA Sample: Years Collected	Non-VA Sample: Data Level	Non-VA Sample: Sample Size	Non-VA Sample: Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Lautz, D.B., et al.; 2007[17]	General	Nat'l	374	2001-2004	Mult. Ctrs	2064	2001-2004	Other surgical	30 day postoperative outcomes: morbidity (overall, specific adverse events, # complications), mortality, LOS	No significant difference in postop morbidity or mortality among women in the VA versus non-VA settings (16.07 vs 12.02 % p =0.21 and 0.89 vs 0.42%, p=0.47). Unadjusted and adjusted morbidity rates were higher among men treated at the VA versus non-VA (OR 2.77, 95% CI 1.78-4.31 unadjusted and OR 2.29, 95% CI 1.28-4.10 adjusted). Unadjusted mortality rates significantly higher among men treated at VAversus non-VA((1.91% vs 0.25% p=0.03).	A/B
Moore, D., et al.; 2003[18]	Solid Organ Transplant-ation	Single ctr	380	1990-2002	Single med ctr	1429	1990-2002	Other surgical	graft survival; patient survival, Karnofsky score, SF36	No significant difference in graft or patient survival in liver, heart, or kidney between veteran and nonveteran patients, and survival statistics were consistent with recently published national data	A
Neumayer, L., et al.; 2007[19]	Oncology	Nat'l	644	2001-2004	Mult. Ctrs	3179	2001-2004	General surgical	30day postoperative morbidity and mortality, LOS	After adjusting for comorbidities and preoperative factors, there was no significant difference in 30day morbidity or mortality in female patients at the VA compared with the PS (OR 1.404, 95% CI 0.894-2.204).	B

Author; Year	Category	VA Sample Data Level	VA Sample Sample Size	VA Sample Years Collected	Non-VA Sample Data Level	Non-VA Sample Sample Size	Non-VA Sample Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Rosenthal, G.E., et al.; 2003[20]	Cardiac	Nat'l	19266	1993-1996	Lrg geo area	44247/ 9696	1993-1996	Cardio-thoracic	in hospital mortality	Adjusting for patient-level predictors and volume, the odds of death was higher in VA patients, relative to private sector patients (OR, 1.34; 95% CI, 1.11-1.63; P <0.001).	A
Turrentine F.E., et al.; 2007[21]	Endocrine	Nat'l	178	2001-2004	Mult. Ctrs	371	2001-2004	Other surgical	30 day morbidity and mortality	Unadjusted morbidity and mortality rates were higher in VA compared with PS (16.3% vs 6.7%, p=0.003 and 2.8% vs. 0.4%, p=0.0074). Mortality event rate was too low for adjustment. Adjusting for comorbidities, the 30day postoperative morbidity ratio in the VA versus the PS was no longer significant (adjusted OR1.33, 95%CI 0.49-3.6 compared with unadjusted OR 2.75, 95% CI: 1.55-4.91).	B
Weiss, J.S., et al.; 2006[22]	Vascular	One VISN	140	1997-2002	Lrg geo	6949	1997-2002	Vascular	perioperative mortality, stroke and cardiac complications	After risk adjustment, having surgery at the VA was not a significant predictor of death (OR 2.98, 95% CI 0.51-17.6), stroke (OR .95, 95% CI 0.3-3.4) or cardiac complications(OR 1.07 95% CI 0.37-3.1)	B

APPENDIX 2. EVIDENCE TABLE OF MEDICAL AND NON-SURGICAL STUDIES

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Asch, S.M., et al.; 2004[23]	General, mult conditions	Mult. VISNs	596	1997-1999	Nat'l	992	1996-2000	CHF, DM, IHD, HTN, Pulmonary Disease, Preventive Care, Cancer, Osteo-arthritis, Depression, TIA/Stroke	adherence to 348 indicators targeting 26 conditions	VA scored better on adjusted overall quality 67% vs 51%; chronic disease care (72 vs 59) and preventive care (64 vs 44), but not acute care.	A
Bansal, D., et al.; 2005[24]	Cardio-vascular	Single ctr	92/117	2002	Nat'l	not described	2002	IHD	use of aspirin, betablockers, aceinhibitors, heparin, gp2a3b inhibitors among pts with MI	Use of all these agents were higher in the Little Rock VA compared to the rest of Arkansas and the entire US	B
Barnett, M.J., et al.; 2006[25]	Other	Nat'l	123633	2002-2003	Nat'l	157517	2000-2001	Other safety	use of potentially inappropriate medications among the elderly	Compared with private sector patients, VA patients were less likely to receive any inappropriate medication (21% vs. 29%, P <0.001), and in each classification: always avoid (2% vs. 5%, P <0.001), rarely appropriate (8% vs. 13%, P<0.001), and some indications (15% vs. 17%, P <0.001).	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Berlowitz, D.R., et al.; 2005[54]	Hospital and nursing home care	One VISN	3802/961	1997-1999	Lrg geo area	52986/ 142452	1997-1999	Other medical/ nonsurgical condition	Risk-adjusted rates of pressure ulcer development, functional decline, behavioral decline, and mortality.	Veterans in VA nursing homes were significantly (Po.05) less likely to develop a pressure ulcer (odds ratio (OR)50.63) but more likely to experience functional decline (OR51.6) than veterans in community nursing homes. Veterans in VA nursing homes were also less likely to die but more likely to experience behavioral decline, but these differences did not achieve statistical significance after risk adjustment.	A
Busch, S.H., et al.; 2004[26]	Mental health care	Nat'l	27713	2000-2001	Nat'l	4852	2000-2001	Depression	Receipt of 84, 140, and 181 of antidepressant therapy among patients with initial diagnosis of depression	The VA slightly outperformed the private sector in the prescription of antidepressants during the acute phase of treatment, the first 84 days (84.7 compared with 81 percent) and during the maintenance phase of treatment, the first 181 days (53.9 compared with 50.9 percent). The findings persisted after adjustment for age and sex but lost significance after adjustment for comorbid conditions.	A

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Campling, B.G., et al.; 2005[27]	Other	One VISN	862	1995-1999	Lrg geo	27936	1995-1999	Cancer	survival following diagnosis of lung cancer	The median survival was 6.3 months for VA patients compared with 7.9 months for patients in the rest of the state, and the 5-year overall survival rate was 12% for VA patients compared with 15% for patients in the rest of the state. The Cox model showed a hazard ratio for VA patients compared with non-VA patients of 1.22 (P_ 0.001) after adjusting for age, disease stage, and race.	B
Chi, R.C., et al.; 2006[28]	General, prevention	Nat'l	3265	2003	Nat'l	10677/ 40331	2003	Preventive Care	Influenza and pneumococcal vaccination	Among veterans, Influenza and vccinatin rates highers for VA users compared to non-users. For veterans, VA care was independently associated with influenza vaccination (adjusted OR 1.8; 95%CI 1-5-2.2) and pneumococcal vaccionation (adjusted OR 2.4; 95%CI 2.0-2.9).	A
Cox, R.M., et al.; 2005[59]	Other	Mult VISNs	151	2000-2003	Mult ctrs	79	2000-2003	Other medical/ nonsurgical condition	satisfaction with hearing aid fitting	Three weeks after the fitting, VA patients reported more satisfaction with their hearing aids. On some measures VA patients reported more benefit, but different measures of benefit did not give completely consistent results.	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Gordon, H.S., et al.; 2000[53]	Hospital and nursing home care	Single ctr	5016	1993	Nat'l	850000	1991	Other medical/ nonsurgical condition	hospital mortality	Adjusted death rates were similar in the VA and a private sector sample	B
Harada, N.D., et al.; 2002[45]	General, patient satisfaction	One VISN	1262/ 840 dual	2000	Lrg geo areao	550	2000	Other medical/ nonsurgical condition	patient satisfaction with outpatient care	VA users were 2-8 times more satisfied than va non-users on 5 of 10 measures of satisfaction. VA users were less satified than non-VA users on one measure – number of days waited for an appointment.	B
Jha, A.K., et al.; 2003[29]	General, mult conditions	Nat'l	48505-84503	1994-2000	Nat'l	diff. to ascertain	1997-2001	CHF, DM, IHD, Preventive care	3 preventive measures, 3 diabetes measures, 5 ami measures, 2 chf measures	The VA outperformed the Medicare fee-for-service program on all 11 similar indicators from 1997 to 1999 and of 12 of 13 indicators in 2000.	A
Jha, A.K., et al.; 2007[30]	General, prevention	Nat'l	48505-84503	1994-2000	Nat'l	diff. to ascertain	1997-2001	Preventive Care	3 preventive measures, 3 diabetes measures, 5 ami measures, 2 chf measures	The VA outperformed the Medicare fee-for-service program on all 11 similar indicators from 1997 to 1999 and of 12 of 13 indicators in 2000.	A
Kaboli, P.J., et al.; 2001[61]	Hospital and nursing home care	Single ctr	1142	1994-1995	Mult ctrs	51249	1994-1995	Other medical/ nonsurgical condition	risk adjusted mortality	Using logistic regression to adjust for severity, the odds of death was similar in VA patients, relative to private sector patients (OR 1.16, 95% CI 0.93-1.44; P = 0.18). Using proportional hazards regression and censoring patients at hospital discharge, the risk for death was lower in VA patients (hazard ratio 0.70; 95% CI 0.59-0.82; P <0.001).	B

Author; Year	Category	VA Sample: Data Level	VA Sample: Sample Size	VA Sample: Years Collected	Non-VA Sample: Data Level	Non-VA Sample: Sample Size	Non-VA Sample: Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Kerr, E.A., et al.; 2004[31]	Diabetes	Mult. VISNs	1285	2000-2001	Mult. Ctrs	6616	2001-2002	DM	Process of care measures of quality as derived from the Diabetes Quality Improvement, Project accountability and measurement set, Intermediate outcomes, Patient satisfaction with care	After adjustment, VA significantly outperformed mgd care on all process of care measures. Intermediate outcome of blood pressure control was comparable between the two cohorts, however the VA cohort had significantly greater percentage of patients tight HgbA1C and LDL control. Patients reported similar overall satisfaction in the two cohorts, though there was significantly greater satisfaction with diabetes care in the VA.	A
Keyhani, S., et al.; 2007[32]	General, prevention	Nat'l	171/ 1009/145	2000-2003	Nat'l	3552/576	2000-2003	Preventive Care	self-reported use of influenza vaccination, pneumonia vaccianation, serum cholesterol screening	Veterans receiving care through VA reported 10% greater use of influenza vaccination (P<.05), 14% greater use of pneumococcal vaccination (P<.01), And a nonsignificant 6% greater use of serum cholesterol screening (P=.1), than did veterans receiving care through Medicare HMOs. Veterans receiving care through Medicare FFS reported less use of all 4 preventive measures (P<.01) than did veterans receiving care through Medicare HMOs.	B

Author; Year	Category	VA Sample: Data Level	VA Sample: Sample Size	VA Sample: Years Collected	Non-VA Sample: Data Level	Non-VA Sample: Sample Size	Non-VA Sample: Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Krein, S.L., et al.; 2007[33]	Hospital and nursing home care	Nat'l	95 hospitals	2005	Nat'l	421 hospitals	2005	Other medical/ nonsurgical condition	regular use of specific prevention modalities (maximum sterile barrier precautions, use of chlorhexadine gluconate for insertion site and antimicrobial CV catheters, routine change of catheters, use of antimicrobial impreganated dressing); also a composite measure of max sterile barrier, chlorhexadine and avoidance of routine changes.	Adjusted findings revealed that VA hospitals were significantly more likely to use chlorhexadine gluconate (OR 4.8, 95%CI 1.6-15.0) and/or to use a composite approach (OR 2.1, 95%CI 1.0-4.2) as compared with non-VA hospitals.	B
Landrum, M.B., et al.; 2004[34]	Cardio-vascular	Nat'l	15259/ 13129	1996-1999	Nat'l	447445/ 384470	1996-1999	IHD	mortality (30 day and one year)	VA pts had significantly higher one year mortality rates across all years studied; 30day mortality rates were higher in VA in 1997 however 30day mortality rates decreased overtime and were comparable between the two sites by 1999.	B

Author; Year	Category	VA Sample: Data Level	VA Sample: Sample Size	VA Sample: Years Collected	Non-VA Sample: Data Level	Non-VA Sample: Sample Size	Non-VA Sample: Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Leslie, D.L., et al.; 2000[55]	Mental health	Nat'l	181132	1993-1997	Nat'l	12163	1993-1995	Depression, Psychosis/ schizo-phrenia, other medical/ nonsurgical condition	Readmission rates and outpatient follow-up care following hospitalization for a psychiatric or substance abuse disorder	This study found that, overall, private-sector mental health inpatients had shorter lengths of stay, more days to the next inpatient readmission, and lower readmission rates within 14, 30, or 180 days of discharge compared with VA mental health inpatients. Although VA patients had higher continuity-of-care scores, moderately higher proportions of private-sector patients had an outpatient visit within 30 and 180 days after discharge. Private-sector patients also had fewer days to the first outpatient visit and more outpatient visits in the six months after discharge.	B
Leslie, D.L., et al.; 2003[56]	Mental health	Nat'l	2636	2000	Nat'l	1318	2000	Psychosis/ schizo-phrenia	adherence to treatment guidelines for antipsychotic prescribing	Patients in the VA and private sector were equally likely to receive an antipsychotic regimen that complied with PORT guidelines.	B
Nelson, K.M., et al.; 2005[50]	Diabetes	Nat'l	254/281	2000	Nat'l	10632	2000	DM	They studied five self-reported measures of diabetes self-management and preventive care practices	Persons who received care through the VA were more likely to report taking a diabetes education class and HbA1c testing than those covered by private insurance.	B

Author; Year	Category	VA Sample Data Level	VA Sample Sample Size	VA Sample Years Collected	Non-VA Sample Data Level	Non-VA Sample Sample Size	Non-VA Sample Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Petersen, L.A., et al.; 2000[35]	Cardiovas-cular	Nat'l	2486/ 13310	1994-1995	Nat'l	29249/ 41754	1994-1995	IHD	comparison of coexisting conditions, severity of AMI and mortality at 30days & one year	Adjusted rates of mortality at 30days and one year were not significantly different among VA and Medicare patients after AMI (OR 0.94, 95% CI 0.82-1.07 and OR 0.94, 95% CI 0.84-1.05 respectively).	B
Petersen, L.A., et al.; 2001[47]	Cardiovas-cular	Nat'l	2486	1994-1995	Nat'l	29249	1994-1995	IHD	use of thrombolytics, _-blockers, ACE inhibitors, or aspirin among ideal candidates following an acute myocardial infarction	Ideal VA candidates were more likely to undergo thrombolytic therapy at arrival (OR [VA relative to Medicare] 1.40 [1.05, 1.74]) or to receive ACE inhibitors (OR 1.67 [1.12, 2.45]) or aspirin (OR 2.32 [1.81, 3.01]) at discharge and equally likely to receive _-blockers (OR 1.09 [1.03, 1.40]) at discharge.	A
Petersen, L.A., et al.; 2003[36]	Cardiovas-cular	Nat'l	1665/ 2486	1994-1995	Nat'l	19305/ 29249	1994-1995	IHD	use of angiography (appropriate use) and mortality	After accounting for patient characteristics and need for angiography, VA pts were significantly less likely to receive angiography (43.9 vs 51%, OR 0.75, 95% CI 0.57-0.96). After accounting for hospital and capability of cardiac interventions, underuse of angiography and mortality did not differ significantly between patient groups.	A
Piette, J.D.; 1999[51]	Diabetes	Mult ctrs	310	1996-1997	Mults ctrs	228	1996-1997	DM	Six dimensions of patient satisfaction	VA patients were more satisfied than were county patients overall and with 5 of 6 dimensions of their care.	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Polsky, D., et al.; 2007[37]	Hospital and nursing home care	Nat'l	369155/ 427367	1995-2001	Lrg geo	1509891/ 3861953	1995-2001	CHF, IHD, Pulmonary Disease, TIA/Stroke	30 day mortality (for white and black males after hospital admission for any of the above conditions)	After risk adjustment, racial (black vs white) differences in 30 day mortality rates after admission for 6 medical conditions were similar among VA and non-VA care settings.	B
Rehman, S.U., et al.; 2005[38]	Cardio-vascular	One VISN	12366	2001-2003	Lrg geo	7734	2001-2003	HTN	control of blood pressure below 140/90	Blood pressure control to below 140/90 mmHg was comparable among white hypertensive men at VA (55.6%) and non-VA (54.2%) settings (P=.12). In contrast, BP control was higher among African American hypertensive men at VA (49.4%) compared with non-VA (44.0%) settings (P_.01), even after controlling for age, numerous comorbid conditions, and ruralurban classification. Being in a non-VA site was negatively associated with blood control adjusted OR 0.839 (0.742-0.949)	A

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Reiber, G.E., et al.; 2004[39]	Diabetes	Nat'l	535	2000	Nat'l	1848/ 9055	2000	DM, Preventive care	a1c testings foot exam, diabetes education, bp measurement, cholesterol measurement, sigmoidoscop, fotb testing among patients with diabetes	Veterans who use VA have higher rates of foot exams, diabetes education, and sigmoidoscopy an da lower rate of a1c testing compared to veterans who did not use the VA. There were non-signifcatn difference for eye exams, bp measurements, cholestestorol testing and fobt screening.	A
Ritchie, J.L., et al.; 1998[48]	Cardiovas-cular	One VISN	8326	1993-1994	Lrg geo area	6666	1993-1994	IHD	10 and 30 day mortality, 10 and 30 day use of cardiac bypass surgery	Overall mortality and same-admission bypass surgery rates were similar for patients undergoing PTCA in the VA and Washington State hospitals.	B
Rosenheck, R.A., et al.; 2000[57]	Mental health	Mult ctrs	192/274	1994-1996	Mult ctrs	96/184	1994-1996	Psychosis/ schizophre-nia	adherence to port recom-mendations	On 5 of 26 Schizophrenic Patient Outcomes Research Team treatment recommendations, a smaller proportion of VA than non-VA patients adhered to standards. Four of these reflected reduced access among VA patients to psychosocial services such as work therapy, job training, or case management services.	B
Rosenthal, G.E., et al.; 2003[60]	Hospital and nursing home care	Single ctr	1960	1994-1995	Mult ctrs	157147	1994-1995	Other medical/ nonsurgical condition	mortality	Risk adjusted inhospital mortality was similar for VA and private sector patients OR 1.07 95%CI 0.74-1.54.	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Ross, J.S., et al.; 2008[40]	General, mult conditions	Nat'l	10007	2000-2004	Nat'l	393873	2000-2004	DM, IHD, HTN, Preventive Care	self reported use of 17 recommended health care services including cancer prevention, cardiovascular risk reduction, diabetes management and infection prevention.	VAMC care was associated with greater use of recommended services in both years of study (6/17 services more used in 2000, 12/17 more used in 2004)	B
Selim, A.J., et al.; 2006[41]	General, mortality and health status	Nat'l	420514/ 1.5m	1999-2004	Nat'l	584294/ 879202	1998-2004	Other medical/ nonsurgical condition	Risk adjusted mortality	After adjusting for case-mix, the HR for mortality in the MAP was significantly higher than that in the VA (HR, 1.404; 95% CI _ 1.383–1.426).	B
Selim, A.J., et al.; 2007[42]	General, mortality and health status	Nat'l	12177/ 16725	1998-2000	Nat'l	26225/ 62614	1998-2000	None	Risk-adjusted 2 year mortality, change in physical and mental health status	Higher risk-adjusted mortality in the VA compared to Medicare Advantage (2 year mortality 7.6% in VA vs. 9.2% in MA); There were no significant differences in the probability of being alive with the same or better PCS except for the South (VA 65.8% vs. MAP 62.5%, P = .0014).VA patients had a slightly higher probability than MAP patients of being alive with the same or better MCS (71.8% vs. 70.1%, P = .002)	B

Author; Year	Category	VA Sample			Non-VA Sample			Conditions	Outcomes	Primary Findings	Final Grade
		Data Level	Sample Size	Years Collected	Data Level	Sample Size	Years Collected				
Selim, A.J., et al.; 2009[46]	General, mortality and health status	Nat'l	2361	1999-2000	Nat'l	1912	1999-2000	Other medical/ nonsurgical condition	3 year risk adjusted mortality rate	The adjusted HR of mortality in the MA dual enrollees was significantly higher than in the VHA dual enrollees (HR, 1.260 [95% CI, 1.044–1.520]).	B
Stineman, M.G., et al.; 2001[58]	Other	Nat'l	3056	1994-1995	Nat'l	52382	1995	TIA/Stroke	functional independence	Stroke patients receiving rehabil- itation in the VA setting were discharged with slightly better functional outcomes.	B
Weeks, W.B., et al.; 2008[43]	Hospital and nursing home care	One VISN	105026	1998-2000	Lrg geo	163853	1998-2000	None	length of stay, readmission within 30 days	Across conditions, the length of stay was longer for VA patients compared with non-VA patients. In logistic regression, VA care was not a significant predictor of 30day readmission for veterans <65years old, however for veterans >=65 years of age initial VA admission was associated with a significantly higher odds of readmission within 30 days than non-VA index admission (OR2.79, 95%CI 1.4-5.6)	B
Weeks, W.B., et al.; 2008[44]	Hospital and nursing home care	One VISN	50429	1998-2000	Lrg geo	74017	1998-2000	Patient Safety Indicators	Risk adjusted rates of non-obsteric patient safety indicators	Rates similar for 9 of 15 PSIs, ulcer, sepsis, iatrogenic infection, postop resp failure, post op metabolic derangement lower in VA, mortality higher in VA for low-risk DRGs	B

Author; Year	Category	VA Sample: Data Level	VA Sample: Sample Size	VA Sample: Years Collected	Non-VA Sample: Data Level	Non-VA Sample: Sample Size	Non-VA Sample: Years Collected	Conditions	Outcomes	Primary Findings	Final Grade
Wright, S.M., et al.; 1999[49]	Cardio-vascular	Nat'l	14853	1992-1995	Nat'l	32745	1992-1995	IHD	30 day and 1 year adjusted mortality rates	After adjusting for patient characteristics, the odds of 30-day mortality were not significantly different between patients admitted to VA basic service hospitals (reference) and patients admitted to any other type of hospital within either system of care. The odds of 1-year mortality were significantly lower in patients admitted to Medi- care cardiac surgery hospitals (OR 0.88, 95% CI 0.79-0.98) compared to patients admitted to VA basic service hospitals	B

APPENDIX 3. SCREENER FORM

Article ID: _____ Reviewer:

First Author:_____
(Last Name Only)

Study Number: ___of____ Description:_____
(Enter '1of 1' if only one) (if more than one study)

1. Does the paper present a comparison of quality of clinical data in VA and US non-VA settings?

Yes.....☐

No.....☐

If No→ Stop

[NB: exclude the following: pure utilization rates, rates of disease, efficiency, recruitment techniques, and lack of direct comparisons]

2. Are the data for the comparison sufficiently contemporaneous (within 1 to 2 years)?

Yes.....☐

No.....☐

3. How are the VA data assembled (within sites)?

Random/representative sampling.....☐

Convenience sampling.....☐

Other (specify_____) .....☐

4. How are the non-VA data assembled (within sites)?

Random/representative sampling.....☐

Convenience sampling.....☐

Other (specify_____) .....☐

5. At what level do the VA data come from?

National or sufficiently multisite
to represent national data .....☐

Multiple VISNs.....☐

One VISN (or state) .....☐

Multiple medical centers or clinics.....☐

Single medical center or clinic.....☐

Unknown.....☐

6. At what level do the non-VA data come from?

National or sufficiently
representative .....☐

Large geographic area like a state.....☐

Multiple centers or clinics.....☐

Single medical center or clinic.....☐

7. What conditions are covered by the quality assessment (check all that apply)

Medical and Non-Surgical Quality Areas

CHF ☐
DM ☐
IHD ☐
HTN ☐
Pulmonary Disease ☐
Preventive Care ☐
Cancer (list type) ☐
Osteoarthritis ☐
Depression ☐
Psychosis/schizophrenia ☐
PTSD ☐
TIA/Stroke ☐
Other (specify_____) ☐

Surgical Quality Areas

General ☐
Cardiothoracic ☐
Head and Neck ☐
Orthopedic ☐
Surgical Oncology ☐
Urology ☐
Vascular ☐
Other surgical ☐
Other (specify_____) ☐

Safety Areas

Patient Safety Indicators ☐
Other (specify_____) ☐

8. What features of quality are measured?

Structure ☐
Process ☐
Outcomes ☐

Structure includes presence/absence of facilities
Process includes overuse, underuse, misuse
Outcomes includes intermediate outcomes

9. How did the specifications for the quality assessments compare in VA and non VA samples?

Identical ☐
Sufficiently similar for valid comparison ☐
Sufficiently dissimilar to present a threat to valid comparison ☐
Unclear ☐

APPENDIX 4. DATA ABSTRACTION FORM

Data Abstraction Form: Round Two

Article ID: <<Pre-filled from database>>
Reviewer: <<Pre-filled from database>>
Author/ Year: <<Pre-filled from database>>
VA sample: <<Pre-filled from database>> (random/rep, convenience AND national, multisite, etc.)
Non-VA sample: <<Pre-filled from database>> (same two sets of information)
Conditions: <<Pre-filled from database>>

Sample size used
VA:
Non-VA:
Years of data collection covered
VA:
Non-VA:
Control variables:
Primary outcomes:
Findings (adjusted if possible):
Secondary/associated findings (optional):
Assessment (grade each of the following with A/B/C scale):
___1. Time frames
___2. Samples (both VA and non-VA)
___3. Quality measurements
___4. Outcomes
___5. Importance of measures
___6. Statistical methods
Other/notes:
Overall assessment/assignment of level:
Rejected (Graded C or lower, or failed to meet prior criteria):

APPENDIX 5. DATA ABSTRACTION GRADING GUIDELINES

Assessment (grade levels detailed below):

1. Time frames
    - A. Contemporaneous time frames
    - B. All between A and C
    - C. non-contemporaneous
2. Samples (both VA and non-VA)
    - A. representative or national samples (both VA and non-VA)
    - B. All between A and C
    - C. small, limited, unequal or non-representative samples
3. Quality measurements
    - A. specified and identical measures with a similar assessment format for those measures
    - B. All between A and C
    - C. dissimilar measures and/or dissimilar assessment methods
4. Outcomes
    - A. outcomes are either well established clinical endpoints or processes strongly associated with well-established clinical endpoints
    - B. All between A and C
    - C. outcomes are structures, processes or clinical endpoints that are not well-established or are indirect measures of quality
5. Importance of measures (e.g. number of clinically relevant indicators, potential impact of indicators)
    - A. High
    - B. Medium
    - C. Low
6. Statistical methods
    - A. Sufficient sample size and/or methods appropriate to address hypothesis(ses)
    - B. All between A and C
    - C. Insufficient sample size and/or methods questionable to address hypothesis(ses)

Overall assessment/assignment of level: Measured as an average of grades assigned above

APPENDIX 6. SEARCH STRATEGY

TOPIC: Veterans Hospitals and Non-Veterans Hospitals Quality of Care – Search Methodology

NOTE: Search strategy was derived from subject terms used in 34 articles provided by the project

Database: PubMed
Years Covered: 1996- 2009 (August)
Number of results: 432

Search Strategy:
hospitals, veterans[MeSH Terms] OR hospitals, veterans[majr] OR hospitals, veterans/standards OR hospitals, veterans/statistics and numerical data OR united states department of veterans affairs OR united states department of veterans affairs/standards OR united states department of veterans affairs/statistics and numerical data OR united states department of veterans affairs/utilization

APPENDIX 7. PEER REVIEW COMMENTS TABLE

Location	Comment	Change
Executive Summary, Background	I am curious about why you do not mention the "Best Care Anywhere" book and others, and only focus upon negative?	Background updated to incorporate suggested citation.
Executive Summary, Conclusion	Might clarify that medication process of care showed VA was better, but procedural process of care not uniformly better (ie angiography).	"…and interventional procedures" added for clarification.
Hospital and Nursing Home Care, Summary	"Racial mortality differences" to "mortality rates for racial minorities"	Change incorporated
Mental Health, Summary	It wasn't clear in the summary how outpatient follow-up rates could be worse when outpatient continuity was better, so I tried to clarify: "…and [timely] outpatient visit follow-up rates [after discharge] were worse in the VA, but continuity of care [in the outpatient setting]…"	Change incorporated
Conclusions, paragraph 9	Same comments as in the mental health section above: "…equivalent racial mortality differences…" to "equivalent mortality rates across racial groups"	Change incorporated