

FACT SHEET

COMPARISON OF VA TO COMMUNITY HEALTHCARE SUMMARY OF RESEARCH 2000 - 2016

**Compiled by the Association of VA Psychologist Leaders
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SUMMARY

The President, Congress and Commission on Care are dedicated to assuring that Veterans receive quality healthcare in a timely fashion. In consideration of this goal, the Association of VA Psychologist Leaders reviewed research published since 2000 that contrasted the Veterans Health Administration (VA) to community healthcare (including private care, managed care, HMOs and Medicare). These ~60 studies documented that the VA, as a system, provides healthcare that is comparable and often superior to that provided in the community. Specifically, the VA outperforms community care on adherence to recommended preventative care guidelines, outpatient processes and outpatient outcomes. VA inpatient treatment is equivalent to community care. With respect to mental health, the VA far outperforms community care in adhering to recommended treatment guidelines. Given this evidence of prevailing quality within the VA, efforts to reform the VA can best serve Veterans by expanding access to services the VA currently provides. Where geographic challenges exist and/or VA does not offer specific services – and where complimentary collaborations benefit both Veterans and the general public – the VA should join with community partners to provide services.

Individual studies (including systematic literature reviews) comparing VA to community healthcare are listed in chronological order in each section below.

PHYSICAL HEALTH

Overall Quality

- VA outperformed Medicare on 12 of 13 preventative care, diabetes, myocardial infarct, and congestive heart failure measures (Jha, 2003)
- VA outperformed non-VA in adherence to recommended care guidelines across 26 conditions (Asch, 2004)
- Based on 55 studies published from 1990-2009, VA outperformed non-VA on accepted process of care measures and intermediate outcomes measures (e.g., control of blood pressure or HbA1c). VA generally performed comparably to non-VA on measures of risk-adjusted outcomes (Asch, 2010)
- VA outperformed Medicare on 12 of 12 quality measures spanning diabetes care, heart disease, and cancer screening (Trivedi, 2011a)
- Based on 36 studies published from 1990-2009, studies that examined recommended processes of care almost always favored VA. Studies that examined risk-adjusted mortality generally found comparable rates for VA and non-VA care (Trivedi, 2011b)
- For outpatient effectiveness, VA outperformed commercial HMOs on 16 of 16 measures, outperformed Medicare on 14 of 16 measures (was as effective on 2 of 16), and outperformed Medicaid on 15 of 15 measures (RAND Health, 2015)
- For inpatient effectiveness, VA outperformed non-VA care on 1 of 14 measures, performed as well on 11 of 14 measures, and underperformed on 2 of 14 measures (RAND Health, 2015)

Preventative Care

- VA outperformed Medicare on preventative mammography, influenza vaccination and pneumococcal vaccination (Jha, 2003)
- VA was more likely to adhere to recommended care guidelines for preventative care than non-VA (Asch, 2004)
- Veterans using VA had higher influenza and pneumococcal vaccination than Veterans not using VA or non-veterans (Chi, 2006)
- VA patients were more likely than non-VA patients to report having had a checkup within the past 2 years (West, 2006)
- Based on a broad literature review, VA outperformed private insurance, Medicare and Medicaid across a range of preventative care measures including percentage of patients receiving mammography, cervical cancer screening, colorectal cancer screening, influenza vaccination and pneumococcal vaccination (Oliver, 2007)
- Veterans using the VA had higher influenza vaccination, higher pneumococcal vaccination, higher prostate cancer screening and equivalent cholesterol screening than Veterans using Medicare, fee for service or HMO (Keyhani, 2007)
- VA patients were significantly more likely to use 12 of 17 preventative care services (e.g., cancer prevention, diabetes management, cardiovascular risk reduction, vaccination) than insured non-VA patients, and as likely to use the other 5 services (Ross, 2008)
- VA had higher rates of breast and colorectal cancer screening compared with Medicare (Trivedi, 2011a)

Diabetes

- VA outperformed Medicare on HbA1c measurement and semiannual lipid measurement. Medicare outperformed VA on annual eye examination (Jha, 2003)
- VA outperformed commercial managed care on 7 of 7 diabetes process variables (especially for annual hemoglobin and annual eye examinations) and 2 of 3 outcome variables (low-density lipoprotein cholesterol and hemoglobin A1c). VA was also more likely to use quality improvement strategies (i.e. diabetes registry, patient reminders, diabetes management programs) (Kerr, 2004)
- Veterans with VA care were more likely than Veterans who did not utilize VA to get foot exams, diabetes education, eye examination, and sigmoidoscopies (Reiber, 2004)
- VA was much more likely to adhere to recommended care guidelines for diabetes than non-VA (Asch, 2004)
- Patients with diabetes seen at the VA were much more likely to have taken a diabetes education class than those with private insurance, Medicare, Medicaid, or no insurance and more likely to have had an HbA1c test in the past year than those with private insurance, Medicaid, or no insurance (Nelson, 2005)
- Based on a broad literature review, VA outperformed private insurance, Medicare, and Medicaid across a range of diabetes care measures including percentage of patients receiving: HbA1c measurement, HbA1c control, lipid screening, cholesterol < 100, cholesterol < 130, annual eye examination and annual renal examination (Oliver, 2007)
- VA outperformed Medicare on 6 of 6 process and outcome measures (i.e., testing HbA1c, controlling HbA1c, BP control) (Trivedi, 2011a)

Heart Disease

- VA outperformed Medicare on congestive heart failure care variables (i.e., ejection fraction checked and ACE inhibitor if ejection fraction is low) (Jha, 2003)
- VA was more likely to use recommended care for hyperlipidemia and hypertension than non-VA. VA and non-VA had comparable rates of adhering to recommended care for coronary artery disease (Asch, 2004)

- Blood pressure control was better for African-American men at VA than non-VA settings, and comparable for White hypertensive men (Rehman, 2005)
- Based on a broad literature review, VA outperformed private insurance, Medicare, and Medicaid in percentage of patients maintaining healthy blood pressure (Oliver, 2007)
- Based on 8 studies published from 1990-2009, VA patients were more likely to receive appropriate cardiovascular discharge care (e.g., beta-blockers, angiotensin-converting enzyme inhibitors, or aspirin) than Medicare patients (Trivedi, 2011b)
- VA outperformed Medicare on 3 of 3 coronary artery disease variables (testing LDL, controlling LDL and using Beta Blockers), and had better control of blood pressure than Medicare (Trivedi, 2011a)
- Comparing men receiving VA care or Medicare, risk-standardized mortality rates were lower in VA hospitals following heart failure, and readmission rates were higher (Nutri, 2016)

Acute Myocardial Infarct (AMI)

- VA patients had comparable mortality rates to Medicare patients after MI despite having more comorbid conditions (Petersen, 2000)
- VA patients, relative to Medicare recipients, were more likely to undergo standard of care thrombolytic therapy at arrival, more likely to receive ACE inhibitors at discharge, more likely to receive aspirin at discharge, and equally likely to receive β -blockers at discharge (Peterson, 2001)
- VA outperformed Medicare on 5 of 5 variables (e.g., aspirin at discharge, beta-blocker at discharge) (Jha, 2003)
- VA and Medicare had comparable 30-day mortality rates following AMI, though VA had higher 1 year mortality rates. VA patients were less likely to undergo coronary angiography or revascularization in the 30 days following their AMI (Landrum, 2004)
- Based on a broad literature review, VA outperformed private insurance, Medicare, and Medicaid in the percentage of patients receiving a beta-blocker at discharge (Oliver, 2007)
- Mortality rates following AMI were comparable between VA and Medicare (Fihn, 2009)
- From 2003 to 2007 the mortality rate following AMI in the VA declined twice as fast as a national inpatient sample (Borzecki, 2010)
- VA and non-VA were comparable in appropriate referral for myocardial perfusion imaging tests (Nelson, 2011)
- For men ≥ 65 following AMI, mortality rates were slightly lower in VA hospitals than Medicare, though readmission rates were slightly higher (Nutri, 2016)

Cancer

- Compared with Medicare, VA patients received diagnoses of colon and rectal cancer at earlier stages and had higher adjusted rates of curative surgery for colon cancer, standard chemotherapy for non-Hodgkin lymphoma, and bisphosphonate therapy for multiple myeloma. VA had lower adjusted rates of 3-dimensional conformal or intensity-modulated radiation therapy for prostate cancer treated with external-beam radiation therapy. Adjusted rates were similar for 9 other measures (Keating, 2011)
- VA patients had higher survival rates for colon and non-small cell lung cancer, and comparable survival rates for rectal cancer, small cell lung cancer, lymphoma, and multiple myeloma (Landrum, 2012)
- Veterans with colon cancer who used VA had comparable 3 year survival rates as Veterans using Medicare. Patients utilizing both VA and Medicare care had lower survival rates (Tarlov, 2012)
- In California patients with cancer, VA patients were more likely to receive recommended care than non-VA. Specifically, VA patients were more than twice as likely to receive radiotherapy following mastectomy than Medicare or Medi-Cal patients, more likely to have colon cancer diagnosed early compared with Medi-Cal or uninsured patients, more likely to receive recommended adjuvant chemotherapy than Medicare patients, and much more likely to have lung cancer diagnosed at stage 1 than Medi-Cal or uninsured patients (Parikh-Patel, 2015)

Kidney Disease

- Among patients with end stage renal disease, VA was more likely follow guidelines for erythropoietin administration than non-VA (Hynes, 2006)
- VA was more likely to complete hemodialysis through arteriovenous fistulas than non-VA, potentially mediated through better end stage renal disease care pre-dialysis (Parikh, 2011)
- Among patients with end stage renal disease, VA patients had more co-morbidities at baseline, outpatient visits, emergency visits, inpatient admissions and days in the hospital than patients in the private sector (Hynes, 2012)
- Patients completing dialysis within the VA had more and longer hospitalizations than patients completing non-VA dialysis (Wang, 2013)

Surgery

- Compared with patients at a university hospital, VA patients who received a liver, heart, or kidney transplant showed similar graft survival and similar overall quality of life five years post-transplant (Moore, 2003)
- Patients undergoing carotid endarterectomy in VA and non-VA hospitals had similar rates of perioperative mortality, as well as stroke and cardiac complications (Weiss, 2006)
- VA patients had similar mortality rates following resection of stage I and II pancreatic cancer as compared with patients at community and university hospitals (Billmoria, 2007)
- VA patients had higher 30, 90, and 365 day mortality rates than Medicare patients following coronary artery bypass graft, and 365 day mortality rates following percutaneous coronary intervention (PCI), but comparable 30, and 90 day mortality rates following PCI (Vaughan-Sarrazin, 2007)
- VA patients and Medicare/Medicaid patients with end stage renal disease were each less likely to receive a kidney transplant than patients with private insurance (Gill, 2007)
- In a large study comparing VA to non-VA surgical results:
 - Female VA patients had lower rates of post-operative complications following surgery than in private sector. Post-operative mortality rates were comparable (Fink, 2007)
 - Following hepatic resection, rates of morbidity and mortality rates were comparable between VA and university hospitals (Lancaster, 2007)
 - VA bariatric surgery for women had comparable rates of morbidity and mortality to non-VA. Men initially had higher morbidity and mortality rates, but a change in VA's surgery program structure led to comparable morbidity and mortality rates (Lautz, 2007)
 - Male VA patients had higher mortality following general surgery than those in university hospitals, while morbidity rates trended lower (Henderson, 2007)
 - Male VA patients had lower morbidity following vascular surgery than those in university hospitals, and mortality rates were comparable (Hutter, 2007)
 - Female VA patients had lower morbidity following vascular surgery than those in university hospitals, and mortality rates were comparable (Johnson, 2007)
 - Among patients having their pancreas removed due to pancreatic cancer, VA patients had higher rates of morbidity and mortality than non-VA patients (Glasgow, 2007)
 - Among breast cancer surgery patients, VA and private sector morbidity or mortality were comparable (Neumayer, 2007)
 - Among patients undergoing adrenalectomy, morbidity between VA and non-VA were comparable (Turrentine, 2007)
 - Among patients undergoing thyroidectomy, morbidity or mortality were comparable between VA and non-VA (Hall, 2007)
- Following cataract surgery, 6 month mortality rates were the same for VA patients and Medicare patients, 1 year mortality rates were lower in the VA (French, 2012a)

- Following cataract surgery VA patients were more likely to have secondary operations than non-VA patients (French, 2012b)

Geriatric Care

- Veterans in VA nursing homes had comparable mortality and rates of behavioral decline to Veterans in community nursing homes. VA nursing home Veterans were much less likely to develop a pressure ulcer, but more likely to experience a functional decline (Berlowitz, 2005)
- Older patients in the VA were less likely to be prescribed medications classified as “always avoid” and “rarely appropriate” than when using Medicare HMOs (Barnett, 2006)

Safety Practices

- VA performed better on 4 of 16 patient safety indicators, worse on 7, and comparably on 5, compared to non-VA hospitals. When compared with Medicare covered patients, the VA performed better on 8 of 13 reported patient safety indicators, worse on 2, and comparably on 3 (Rosen, 2005)
- Higher percentage of VA compared to non-VA hospitals reported using maximal sterile barrier precautions, chlorhexidine gluconate for insertion site antisepsis, and a composite approach for preventing central venous catheter-related bloodstream infections (Krein, 2007)
- Rates of decubitus ulcer, sepsis, iatrogenic infection, postoperative, respiratory failure, and postoperative metabolic derangement were lower in the VA than non-VA hospitals. Rates of patient safety indicators were similar for other 9 of 15 indicators, and mortality rates from low-risk diagnoses were higher in the VA than non-VA (Weeks, 2008)
- VA hospitals were associated with better patient safety indicators (PSIs) than non-VA hospitals on 1 of 12, worse on 4 of 12, and the same on 7 of 12 (Rivard, 2010)

Other

- VA was more likely to adhere to recommended care guidelines for chronic care than non-VA (Asch, 2004)
- Obese VA patients were twice as likely as non-VA patients to be advised to lose weight (Wang, 2005)
- Overall antibiotic prescribing practices for acute respiratory infection were comparable across VA and non-VA settings (Gonzales, 2006)
- Patients getting care in the VA had lower 2 year mortality rates than patients in private managed care Medicare plans (Selim, 2010)

MENTAL HEALTH

Suicide

- Between 2000-2010, suicide rates for Veterans utilizing VA care decreased while rates for Veterans not utilizing VA care increased. By 2010, Veterans utilizing VA care had much lower rates of suicide than those not utilizing VA care (Hoffmire, 2015)

Depression

- VA was more likely to follow recommended care guidelines for depression than non-VA (Asch, 2004)
- VA outperformed the private sector in adhering to quality guidelines for prescription of antidepressants during the initial, early and maintenance phases of treatment (Busch, 2004)

- Compared to providers who worked in the community, providers who worked in VA and military settings were much more likely to have the expertise to deliver high quality care to Veterans or service members with major depression and/or PTSD (Tanielian, 2014)
- Compared with individuals in private plans, VA patients with major depressive disorder were more than twice as likely to receive appropriate initial medication treatment and appropriate long-term treatment (Watkins, 2015)

Serious Mental Illness

- Patients with schizophrenia in the VA were more likely to receive an antipsychotic medication than those in the private sector and were equally likely to be medicated according to nationally recommended PORT guidelines (Leslie, 2003)
- VA outperformed Medicare and Medicaid, though was worse than private insurance in percentage of patients receiving a 30 day follow-up after a mental health hospitalization (Oliver, 2007)
- Veterans with serious mental illness conditions who get VA health care (not just mental health care) live longer than persons with SMI in the general US population (Kilbourne, 2009)
- Compared with individuals in private plans, VA patients with schizophrenia were more than twice as likely to receive appropriate initial medication treatment (Watkins, 2015)

Substance Use

- Compared with non-VA facilities, VA's women's substance use programs offered a significantly greater number of testing and assessment services, addiction pharmacotherapies, and a greater number of SAHMSA-recommended key ancillary services including assistance obtaining social services, housing, and transportation (Heslin, 2015)

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