Quality care process in the VA: a synopsis and comment on “Comparison of the quality of medical care in veterans affairs and non-veterans affairs settings”

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ABSTRACT

The fourth column on Evidence-Based Behavioral Medicine presents a synopsis of the systematic review by Trivedi et al. (2011) comparing the quality of medical care in veterans affairs (VA) and non-VA settings. Thirty-six studies were included in the synthesis. Each article was given a grade of A, B, or C based on the six elements of high-quality studies. Most studies assessing adherence to recommended processes of care showed that the VA performed better than non-VA sites. Similar rates were found for both groups in studies that assessed risk-adjusted mortality. This implies that a greater adherence to evidence-based processes (e.g., preventive care, medication prescription, and referral) did not result in decreased morbidity and mortality. It is established that engaging in evidence-based practices and processes improves short-term intermediate endpoints (e.g., patient satisfaction). Future research is needed to test whether short-term benefits of evidence-based care processes connect to mortality outcomes.

KEYWORDS

Evidence-based practice, Care processes, Quality of care, Outcomes, Research-to-practice translation

The fourth column on Evidence-Based Behavioral Medicine presents a synopsis of the systematic review by Trivedi et al. [3] comparing the quality of medical care in veterans affairs (VA) and non-VA settings. A synopsis is a very brief description of an original article or review, which conveys findings in an efficient format. Synopses illustrate the secondary, synthesized infrastructure of evidence-based practice that makes pre-appraised primary research findings accessible to a broad audience of end users [1].

The Veterans Health Administration's stated mission is to “honor America's Veterans by providing exceptional health care that improves their health and well-being” [4]. The VA is the largest health care system in the USA. In the 1990s, the VA launched a clinical performance improvement program aimed at delivering high-quality processes of care and reducing mortality outcomes [2]. The VA's health care system

Implications

Researchers: Future research should examine whether evidence-based practices or care processes affect long-term morbidity and mortality outcomes for patients and populations.

Practitioners: Evidence-based care processes improve short-term patient outcomes (e.g., patient satisfaction). Impact on long-term outcomes (e.g., decreased mortality) has not been established.

Policy makers: Policy support for evidence-based processes of care improves short-term patient outcomes. Policies that reduce long-term morbidity and mortality remain needed.

espouses a commitment to evidence-based, patient-centered care that is delivered by collaborative teams. Patients can access a wide variety of medical services (e.g., primary care, preventive services, and specialty medicine) through a single system involving a coordinated electronic medical record. To determine whether the VA's quality aspirations translate to actual improvement, Trivedi et al. [3] synthesized the primary research evidence on how medical care at the VA compares to care at non-VA settings. In this review, care processes refer to the steps in treatment that precede a health outcome (e.g., intensive behavioral counseling for obese patients as a process for preventing increased morbidity and mortality).

Question—How does the quality of medical and other nonsurgical care in the VA compare to non-VA settings?

Search strategy—The MEDLINE database was searched for studies published between January 1990 and August 2009 using the following search terms: hospitals, veterans, and United States Department of Veterans Affairs. Two physicians critically appraised the literature and collected information on sources of data, years of data collection, clinical conditions, measures of quality, and geographical areas. Reviews were restricted to articles that compared quality of care for health conditions in VA and non-VA settings in the USA. Studies were excluded if they focused solely on patient satisfaction.

Care Processes and Outcomes—Studies that met inclusion criteria included studies of mortality following an acute coronary event, care processes after an acute myocardial infarction, diabetes care processes, hospital mortality, and general comparison studies. Trivedi et al. [3] examined care processes in diabetes and after a myocardial infarction (MI) and linked these to outcomes including mortality in hospital and after an acute MI. The authors allowed a variety of measurements including the use of preventive services, rates of vaccination, and risk-adjusted mortality rates.

Data analysis—A conceptual framework was developed to compare quality in VA and non-VA settings. Six elements of high-quality studies were identified, including evaluation of performance measures in VA and non-VA settings, national study populations or cohorts representative of the national population, assessments of outcomes and/or processes that show better clinical outcomes, clinical or public health significant indicators, and adequate sample size and analysis methods. Each article was given a grade of A, B, or C based on the six elements of high-quality studies.

Results—Thirty-six studies were included in the synthesis. Heterogeneity of designs and populations precluded conducting pooled meta-analyses. Of these, nine studies assessed general care processes for preventive services, medical conditions, or outcomes. The rest addressed cardiovascular diseases ($n=8$), diabetes ($n=3$), hospital and nursing home care ($n=9$), mental health care (four), and other conditions (three). All nine general care processes studies showed greater adherence to processes of care or better health outcomes in VA settings as compared to non-VA settings. Of the studies addressing cardiovascular disease, five showed no clear differences in survival, three showed greater processes of care (e.g., evidence-based drug therapy), and one found less use of clinically appropriate angiography in the VA. Studies addressing diabetes care processes showed better performance outcomes in the VA, and studies of hospital mortality found no significant difference in risk-adjusted mortality rates between VA and non-VA settings.

Conclusions—Most studies assessing adherence to recommended processes of care showed that the VA performed better than non-VA sites. Similar rates were found for both groups in studies that assessed risk-adjusted mortality. This implies that a greater adherence to evidence-based processes (e.g., preventive care, medication prescription, and referral) did not result in decreased morbidity and mortality.

Comment—These findings suggest that the VA either meets or outperforms non-VA settings in adherence to evidence-based practices. Meeting standards for processes of care was notably better in VA settings, but this did not result in significant improvement in risk-adjusted mortality in the VA as compared to non-VA settings. It is possible that an effect on mortality is merely delayed. In other words, VA's performance improvement program may have resulted only recently in improvements in care processes that have not yet had time to decrease mortality outcomes. However, even though VA policy and private sector incentives encourage evidence-based practices and processes, it should be noted that there is little evidence showing a direct linkage between evidence-based practice processes and long-term endpoints including decreased mortality. It is established that engaging in evidence-based practices and processes improves short-term intermediate endpoints (e.g., patient satisfaction). Future research is needed to test whether short-term benefits of evidence-based care processes connect to mortality outcomes.

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