
Outcomes and costs of coronary procedures: VA vs. non-VA hospitals



The Veterans Affairs (VA) Community Care (CC) Programme supplements VA care with community-based medical services. A new study comparing the access, cost, and quality of elective coronary revascularisation procedures between VA and CC hospitals reports these key findings: VA hospitals had lower mortality and lower costs than CC hospitals for percutaneous coronary intervention (PCI) and had similar mortality but higher costs for coronary artery bypass graft (CABG) surgery.

"As the VA considers expansion of the CC programme, ongoing assessments of value and access gains are essential to optimise veteran outcomes and VA spending," says the study published in JAMA Cardiology.

In this veteran cohort study, researchers evaluated patients younger than 65 years who had an elective coronary revascularisation (PCI or CABG) sponsored by the VA between October 2008 and September 2011. Analysis was conducted between July 2014 and July 2017.

Among 13,237 elective PCIs and 5,818 elective coronary artery bypass graft procedures in this study, use of CC reduced aggregate veteran travel distance for revascularisation. On average, use of CC was associated with reduced net travel by 53.6 miles for PCI and by 73.3 miles for CABG surgery compared with VA-only care.

Adjusted 30-day mortality after PCI was higher in CC compared with VA (1.54% for CC vs. 0.65% for VA, $P < .001$) but was similar after CABG surgery (1.33% for CC vs. 1.51% for VA, $P = .74$). There were no differences in adjusted 30-day readmission rates for PCI (7.04% for CC vs. 7.73% for VA, $P = .66$) or CABG surgery (8.13% for CC vs. 7.00% for VA, $P = .28$).

The mean adjusted PCI cost was higher in CC (\$22,025 for CC vs. \$15,683 for VA, $P < .001$). The mean adjusted CABG cost was lower in CC (\$55,526 for CC vs. \$63,144 for VA, $P < .01$). Neither procedural volume nor publicly reported mortality data identified hospitals that provided higher-value care with the exception that CABG mortality was lower in small-volume CC hospitals.

The researchers explain: "The higher mortality of CC-provided PCIs was not necessarily due to lower quality of care at CC hospitals. Other possible factors include delay in making care arrangements, incomplete coordination of care between VA and CC hospitals, or failure to refill medications prescribed by CC clinicians. These are obvious areas for future research and quality improvement efforts."

They add that one important way to improve value for veterans may be to increase capacity at high-performing VA facilities rather than seek to increase capacity by outsourcing to the community.

To ensure that veterans receive care that is timely, accessible, and of the highest quality, the researchers suggest that policymakers should consider providing information to help veterans seek care from the highest-value hospitals and healthcare professionals regardless of whether the hospitals are VA or CC.

Source: [JAMA Cardiology](#)

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