

# Mental Health and Substance Use Disorder Spending in the Department of Veterans Affairs, Fiscal Years 2000–2007

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**Objective:** This study analyzed spending for treatment of mental health and substance use disorders in the Department of Veterans Affairs (VA) in fiscal years (FYs) 2000 through 2007. **Methods:** VA spending as reported in the VA Decision Support System was linked to patient utilization data as reported in the Patient Treatment Files, the National Patient Care Database, and the VA Fee Basis files. All care and costs from FY 2000 to FY 2007 were analyzed. **Results:** Over the study period the number of veterans treated at the VA increased from 3.7 million to over 5.1 million (an average increase of 4.9% per year), and costs increased .7% per person per year. For mental health and substance use disorder treatment, the volume of inpatient care decreased markedly, residential care increased, and spending decreased on average 2% per year (from \$668 in FY 2000 to \$578 per person in FY 2007). FY 2007 saw large increases in mental health spending, bucking the trend from FY 2000 through FY 2006. **Conclusions:** VA's continued emphasis on outpatient and residential care was evident through 2007. This trend in spending might be unimpressive if VA were enrolling healthier Veterans, but the opposite seems to be true: over this time period the prevalence of most chronic conditions, including depression and posttraumatic stress disorder, increased. VA spending on mental health care grew rapidly in 2007, and given current military activities, this trend is likely to increase. (*Psychiatric Services* 62:389–395, 2011)

Per capita mental health spending in the United States was relatively stable between 1996 and 2000 (1). However, between 2000 and 2006, per capita spending increased from \$104.25 to \$148.56, which Frank and colleagues (1) attributed to the increased use of prescription drugs. They also found that spending on mental health varied considerably by payer. In Medicaid, mental health spending grew more slowly than spending for overall

health care, whereas in private insurance the opposite was true: growth in mental health spending outpaced overall spending.

Frank and colleagues (1) did not include the Department of Veterans Affairs (VA) in their analyses, and there are a number of features that make VA an interesting case study. First, VA is one of the nation's largest integrated health care providers, with 153 medical centers, 232 vet centers, more than 800 community-based out-

patient clinics, and 135 nursing homes (2), and veterans can access a wide range of services for mental health and substance use disorders. Second, the benefits are generous, and approximately two-thirds of veterans who use the VA each year receive free services because they have a service-connected disability or have passed an income-based means test. Thus the majority of veterans do not face financial barriers to care, and the VA has become an essential part of the safety net (3). Third, the VA does not use carve-outs, which are frequently used by insurers to manage mental health spending (1). Instead, all providers are employees of the VA, and they provide care in VA facilities. Finally, the VA has to provide these services within a capitated global annual budget set by the U.S. Congress.

Several studies have analyzed VA spending on treatment for mental health and substance use disorders since the mid-1990s, when the VA was reorganized into Veterans Integrated Service Networks (VISNs) that focused on access and primary care. In just four years, the VA was transformed from a system of hospitals providing inpatient care to an expanded system of hospitals and clinics emphasizing outpatient services, with no adverse effect on mortality (4). In mental health, the use of inpatient care declined dramatically, from 3.5 million bed-days in 1995 to 1.5 million bed-days in 2001. In turn, outpatient care increased, as did mental health pharmacy spending (5). The effects were similar, if not larger, for

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substance use disorder treatment. Inpatient spending for substance use disorder treatment declined from \$442 million in 1993 to \$86 million in 1999 (1999 dollars) (6). Spending for outpatient treatment of substance use disorders increased but at a slower pace than the cuts to inpatient spending, such that the net effect was a decline in the average per capita amount spent on substance use disorder treatment from \$221 to \$103 over this seven-year period. Some inpatient wards were converted to outpatient clinics or to psychosocial residential care programs. These residential programs grew rapidly after 1995 (5), and they enabled the VA to provide mental health and substance use disorder care to more veterans without increasing total costs (7).

Since 2001, little information has been reported on VA mental health and substance use disorder spending, a period for which Frank and colleagues (1) reported the largest growth in mental health spending per capita in the non-VA population. There has also been considerable discussion about the mental health of soldiers deployed to Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (OEF-OIF) (8,9). Early evidence suggests that a quarter of returning soldiers have a mental disorder diagnosis and that approximately half of those with any diagnosis have more than one (10). Common diagnoses include posttraumatic stress disorder (PTSD), anxiety, depression, and substance use disorders (10,11).

In this article, we describe VA spending on mental health and substance use disorder treatment for fiscal years (FYs) 2000 through 2007—a period during which the VA had a large increase in users.

## Methods

The VA collects cost and service utilization data in several large systemwide databases. Previously the VA used the VA Cost Distribution Report (CDR) for financial accounting (5,6). In the late 1990s, the VA replaced the CDR with a new activity-based accounting system, the Decision Support System (DSS), and then stopped producing the CDR. In this study, we summarized the DSS inpatient and

outpatient utilization data along with the outpatient pharmacy data to estimate spending per fiscal year. We identified mental health and substance use disorder care by using the outpatient clinic stop and the inpatient “treating specialty,” which are described in more detail elsewhere (12–14). A table of the specific clinic codes is available upon request. It should be noted that mental health treatment that is provided outside specialty mental health clinics—for example, in primary care—is not captured in these analyses.

We tabulated total costs, service utilization, and cost per VA user for FYs 2000–2007. The data give a complete picture of care provided by the VA. Because some care is provided in the community under contract and paid for by the VA, we tabulated these contract costs from the VA Fee Basis files, according to the year that the funding was disbursed. We did not include service utilization from the Fee Basis files because it was less clear when the care was provided. This means that total costs are accurate but that the reports of the volume of care are underestimated. We report expenditures in 2007 dollars and inflate expenditures for prior years using the general consumer price index report (15). We also report total outpatient pharmacy costs, and in a subanalysis using Smith and Chen’s (16) methods, we identified costs related to common classes of psychiatric drugs: antipsychotics, antidepressants, anxiolytics and sedatives-hypnotics, and lithium (a list of the VA drug classes is available upon request).

Comparing spending across years implicitly assumes that patient case mix is stable. To test this assumption, we tabulated the prevalence of 56 chronic illnesses for each year of data using the Agency for Healthcare Research and Quality’s Clinical Classification Software that was modified for the VA (17–19). We standardized the prevalence per 100,000 VA users. All research activities were approved by the Stanford University Institutional Review Board.

## Results

### *Total health care spending*

The VA spent \$22.4 billion on health care services in FY 2000 and \$33.1

billion in FY 2007, an average increase over that time of 5.7% per year (all in 2007 dollars) (Table 1). Annual increases exceeded 6% between FY 2000 and FY 2004, slowed for 2005 and 2006, and then increased again in 2007. These totals include all health services provided by the VA and care provided by contractors.

Expenditures for specialized mental health care increased from \$2.1 billion in FY 2000 to \$2.6 billion in FY 2007 (a 3.4% increase per year). As noted above, this total does not include mental health care provided in general medicine clinics. Outpatient specialty services grew from \$910.8 million in FY 2000 to \$1,385.5 million in FY 2007. Although smaller in magnitude, there were also notable increases in spending for residential care. Inpatient mental health spending was largely unchanged between FY 2000 and FY 2006, and then increased in FY 2007 (Table 1).

Spending on residential treatment of veterans with substance use disorders increased over the eight years, from \$49.8 million in FY 2000 to \$71.2 million in FY 2007—a 5.2% per year increase. However, spending on inpatient treatment for substance use disorders declined 5.1% per year, and spending on outpatient treatment declined an average of .6% per year. By FY 2007, VA spent approximately equal amounts on inpatient and residential care for veterans with substance use disorders.

Overall, outpatient pharmacy spending increased 60.2% from FY 2000 to FY 2007, totaling \$4.7 billion in FY 2007. Spending on medications for mental health care increased from an estimated \$359.0 million in FY 2000 to \$535.4 million in FY 2007, a 5.9% per year increase. Finally, Table 1 presents data on overall spending for homeless veterans in the domiciliaries, which increased 6.7% per year—from \$260.4 million in FY 2000 to \$409.7 million in FY 2007.

### *Spending per veteran user*

The increase in VA health care spending mirrored an increase in the number of veterans served by the VA. Overall, the VA provided care to 4.9% more veterans each year, and by FY

**Table 1**

Spending by the Department of Veterans Affairs on all health care and on treatment for mental and substance use disorders, fiscal year (FY) 2000–2007 (in millions of dollars)<sup>a</sup>

Type of treatment	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Per-year change (%)
All health care <sup>b</sup>	22,416.6	23,927.3	25,579.1	27,573.0	29,885.1	30,800.1	31,235.7	33,095.6	5.7
Mental health	2,052.1	2,127.3	2,183.5	2,253.7	2,330.2	2,372.9	2,380.9	2,595.3	3.4
Inpatient	1,085.3	1,069.6	1,062.1	1,074.0	1,095.0	1,100.8	1,077.4	1,131.8	.6
Residential	56.0	51.4	63.5	65.6	70.0	68.7	70.9	78.0	4.8
Outpatient	910.8	1,006.3	1,057.9	1,114.1	1,165.2	1,203.4	1,232.7	1,385.5	6.2
Substance use disorder	388.1	392.5	367.6	358.2	359.8	340.3	338.6	367.6	−.8
Inpatient	105.8	102.1	92.8	78.4	78.7	65.2	63.3	73.4	−5.1
Residential	49.8	43.4	53.6	57.1	57.1	57.2	61.8	71.2	5.2
Outpatient	232.5	247.0	221.2	222.7	223.9	217.9	213.5	223.0	−.6
Outpatient pharmacy									
All medications	2,954.7	3,484.7	3,920.9	4,152.1	4,687.1	4,813.0	4,732.0	4,733.0	7.0
Mental health medications	359.0 <sup>c</sup>	391.4 <sup>c</sup>	406.7	464.6	504.5	533.1	534.4	535.4	5.9
Domiciliary	260.4	326.8	404.9	412.1	417.9	425.7	403.4	409.7	6.7

<sup>a</sup> Authors' tabulations from Department of Veterans Affairs (VA) Decision Support System data. Estimates for contract care are based on disbursed amounts from the VA Fee Basis files. All dollars were inflated to 2007 dollars using the general consumer price index. Mental and substance use disorder spending as a percentage of total spending (includes mental health medications and domiciliary care but excludes contract care for mental health and substance use disorders): FY 2000, 13.6%; FY 2001, 13.5%; FY 2002, 13.1%; FY 2003, 12.7%; FY 2004, 12.1%; FY 2005, 11.9%; FY 2006, 11.7%; FY 2007, 11.8%

<sup>b</sup> Includes spending on contract care and on treatment for mental health and substance use disorders

<sup>c</sup> Authors' projections using overall pharmacy spending for FY 2000–2007 and spending on mental health medications FY 2002–2006

2007, it served 40.2% more veterans than it did in FY 2000 (5.1 million compared with 3.7 million) (Table 2). Consequently, average spending for all health care increased a very modest .7% per year per veteran. Pharmacy spending for general medical con-

ditions increased 7.1% per year per veteran.

Spending on mental health and substance use disorder treatment per veteran declined from FY 2000 to FY 2006 and then increased notably in FY 2007 (Table 2). Despite the large increase in

FY 2007, average per capita mental health spending declined an average of 1.5% per veteran per year and substance use disorder spending declined 5.5% per veteran per year, whereas mental health pharmacy spending increased on average 5.9% per year.

**Table 2**

Number of veterans served and average per capita spending by the Department of Veterans Affairs on all health care and on treatment for mental and substance use disorders, fiscal year (FY) 2000–2007<sup>a</sup>

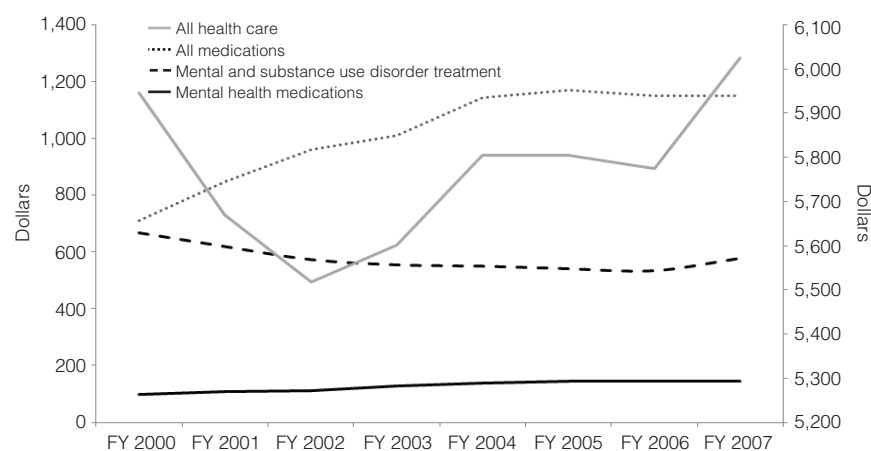
Variable	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Per-year change (%)
Number of veterans served	3,654,384	4,067,563	4,448,760	4,706,861	4,888,795	5,011,805	5,089,075	5,124,218	4.9
Per capita spending for all health care	6,134	5,882	5,750	5,858	6,113	6,146	6,138	6,459	.7
Per capita spending, excluding mental and substance use disorders	5,466	5,263	5,176	5,303	5,563	5,604	5,603	5,880	1.0
Per capita spending on prescriptions, excluding those for mental and substance use disorders	710	847	962	1,009	1,145	1,171	1,149	1,149	7.1
Per capita spending on mental and substance use disorders <sup>b</sup>	668	619	573	555	550	541	534	578	−2.0
Per capita spending on mental disorders	562	523	491	479	477	473	468	506	−1.5
Per capita spending on substance use disorders	106	96	83	76	74	68	67	72	−5.5
Per capita spending on mental health medications	98	107	111	127	138	146	146	147	5.9

<sup>a</sup> Authors' tabulations from Department of Veterans Affairs (VA) Patient Treatment Files and VA National Patient Care Database. Includes contract care. All dollars were inflated to 2007 dollars using the general consumer price index.

<sup>b</sup> Includes spending for prescription drugs

**Figure 1**

Average spending per veteran by the Department of Veterans Affairs on all health care and on treatment for mental and substance use disorders, fiscal year (FY) 2000–2007<sup>a</sup>



<sup>a</sup> All health care spending is represented by the amounts on the right axis. All other spending is represented by the amounts on the left axis. All dollars were inflated to 2007 dollars using the general consumer price index.

Figure 1 shows how average mental health and substance use disorder spending per veteran changed between FY 2000 and FY 2007. Mental health and substance use disorder spending decreased over time, except for FY 2007. In comparison, spending on medications increased rapidly between FY 2000 and FY 2004, and then the growth in spending leveled off. This was true for all medications and for mental health medications.

### Volume of care

As shown in Table 3, the mix of mental health and substance use disorder care changed between FY 2000 and FY 2007, with a notable decline in in-

patient care. Specialized mental health inpatient bed-days decreased from 1.68 million in FY 2000 to 1.23 million in FY 2007. Similarly, inpatient substance use disorder bed-days declined from 203,000 in FY 2000 to 138,000 in FY 2007 (a decline of 5.4% per year). While inpatient care declined, VA provided slightly more bed-days in residential care. For specialized mental health care, the number of residential bed-days increased on average 1.9% per year, while bed-days for residential care for substance use disorders increased .6% per year. Growth of services was also seen in outpatient mental health care, which increased from 6.7 million visits in FY

2000 to 8.3 million visits in FY 2007. However, outpatient care for substance use disorders declined during this period, from 2.6 million visits in FY 2000 to 1.9 million visits in FY 2007, an average 4.3% decline per year.

### Veterans' health conditions

Of the chronic conditions we tracked to monitor changes in case mix, hypertension was the most prevalent each year. In FY 2007 it was present for 52,847 veterans per 100,000. Table 4 shows the top five chronic conditions, along with prevalence data on diagnoses of mental and substance use disorders. All five of the most diagnosed conditions increased in prevalence from FY 2000 to FY 2007. Depression was the sixth most prevalent chronic condition, and its prevalence also increased at an average of 3.8% per year. The prevalence of PTSD increased quite quickly, at 6.4% per year, while the prevalence of schizophrenia declined at 7.2% per year.

### Discussion

The number of veterans who used VA health care grew 40.2%, from 3.65 million in FY 2000 to 5.12 million in FY 2007 (4.9% per year), and overall spending increased 5.7% per year, but average total health care spending per veteran increased only .7% per year. These findings are considerably lower than national per capita annual growth estimates from Catlin and colleagues (20), which were greater than 5% per person for the same time period.

**Table 3**

Volume of mental health and substance use disorder services provided by the Department of Veterans Affairs, fiscal years (FY) 2000–2007 (in thousands)

Service type	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Per-year change (%)
<b>Mental health</b>									
Inpatient bed-days	1,683	1,486	1,364	1,290	1,281	1,267	1,203	1,228	−4.4
Residential bed-days	165	164	166	162	168	172	180	188	1.9
Outpatient visits	6,730	7,738	7,571	7,973	8,328	8,430	7,913	8,334	3.1
<b>Substance use disorder</b>									
Inpatient bed-days	203	161	146	130	128	115	116	138	−5.4
Residential bed-days	189	178	182	188	185	168	181	197	.6
Outpatient visits	2,607	2,672	2,388	2,345	2,265	2,099	1,913	1,916	−4.3
Domiciliary bed-days	1,881	1,922	1,856	1,817	1,729	1,689	1,594	1,612	−2.2



**Table 4**

Prevalence of chronic general medical conditions and mental and substance use disorders among users of Department of Veterans Affairs health care, fiscal years (FY) 2000–2007<sup>a</sup>

Condition	Rank <sup>b</sup>	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	Per-year change (%)
Hypertension	1	39,901	43,337	45,910	48,335	50,379	51,499	52,377	52,847	4.1
Ischemic heart disease	2	17,410	18,458	19,037	19,090	19,162	19,210	18,970	18,612	1.0
Diabetes	3	16,814	18,083	19,239	20,095	20,837	21,504	22,172	22,666	4.4
Arthritis	4	16,282	16,692	16,936	17,232	17,682	17,729	17,588	17,166	.8
Lower back pain	5	10,955	11,171	11,351	11,880	12,916	13,688	14,327	15,205	4.8
Depression	6	10,950	11,235	11,727	12,484	13,062	13,206	13,510	14,187	3.8
Tobacco-nicotine dependence	11	7,422	8,460	9,245	10,030	11,190	12,016	12,205	13,024	8.4
Alcohol use disorder or alcohol-related disorder	13	5,302	4,924	4,630	4,487	4,668	4,734	4,744	4,917	–1.1
Posttraumatic stress	14	4,992	4,875	4,945	5,202	5,659	6,360	6,838	7,702	6.4
Schizophrenia	20	3,048	2,628	2,325	2,150	2,010	1,928	1,853	1,809	–7.2
Drug use disorder <sup>c</sup>	21	3,020	2,808	2,653	2,606	2,702	2,743	2,804	2,953	–.3
Other psychosis	28	1,278	1,189	1,210	1,344	1,553	1,561	1,204	1,076	–2.4
Other personality disorder	29	996	864	759	707	684	687	660	660	–5.7
Borderline personality disorder	44	211	189	168	161	159	163	158	167	–3.3
Antisocial personality disorder	45	169	144	141	130	128	127	121	120	–4.7

<sup>a</sup> Authors' analysis of Department of Veterans Affairs (VA) Patient Treatment Files and National Patient Care Database. Prevalence per 100,000 veterans who used VA health care in the fiscal year. An individual may be counted twice.

<sup>b</sup> Rank is based on the prevalence in FY 2000 and is relative to the 56 conditions tracked.

<sup>c</sup> Excludes alcohol and tobacco

Mental health and substance use disorder spending by the VA did not keep pace with overall health care spending. This is most evident in the average per capita spending, which decreased from \$668 in FY 2000 to \$534 in FY 2006. FY 2007 bucked the trends in prior years with 8.1% and 8.6% increases in mental health and substance use disorder spending, respectively. These increases may be a result of the large proportion of veterans with mental health needs returning from OEF-OIF (10,21,22), because the number of veterans with depression and PTSD grew substantially over this time. These changes could also be responses to the Uniform Mental Health Services Act, which was enacted in 2006 to ensure that all veterans, regardless of where they receive care, have access to mental health services (including substance use disorder treatment) at VA hospitals and community-based outpatient clinics. According to internal VA data, full-time-equivalent mental health staff grew by 8% from 2005 to 2007; the growth was led by therapists (26% increase), followed by social workers (21%), psychologists (13%), physicians (5%), and nurses (<1%). We could not identify staffing data before 2005 to deter-

mine whether the staffing was relatively stable in the earlier years. Finally, costs may have increased in response to changes in the regional distribution of the veteran population or in provider efficiency, but such analyses were beyond the scope of this study.

The VA's mental health spending resembles Medicaid's spending as reported by Frank and colleagues (1). While private insurers experienced overall increases in spending on prescription drugs, Medicaid and VA saw smaller increases in spending for prescription drugs for mental health conditions. In the VA, spending on pharmaceuticals, both overall and for mental health medications, increased between FY 2000 and FY 2004 and then leveled off. It is not clear what caused this leveling off. One explanation is that the demand may have changed for Medicare-eligible veterans with the implementation of Medicare Part D in January 2006, but this would not explain why VA prescription spending slowed between FY 2004 and FY 2005. Demand could also reflect changes in the case mix of veterans with mental health conditions. The prevalence of schizophrenia decreased from 3,048 (per 100,000 veteran users) in FY

2000 to 1,809 in FY 2007 (an average decrease of 7.2% per year). In contrast, the prevalence of depression, which is less complex to manage, grew 3.8% per year from 10,950 (per 100,000 Veteran users) to 14,187, not including care provided in primary care clinics for patients with depression. However, the changes in case mix seem an unlikely explanation, because further examination shows that the prevalence of schizophrenia decreased more rapidly between FY 2000 and FY 2004, when drug spending was increasing.

A third explanation is that this leveling off could reflect the VA's ability to manage care. The VA uses a national formulary and encourages use of generics when possible. The VA Pharmacy Benefits Management Services provides guidance for managing depression and for using second-generation antipsychotics for schizophrenia. In the latter case, the physician is encouraged to identify an effective therapy for the patient, and if there is more than one equivalent option, the physician is directed to consider the less expensive agent. It is not clear whether clinicians use these recommendations when prescribing second-generation antipsychotics for patients with schizophrenia or in situa-

tions outside of the document's primary aim (for example, in treating depression). Although a number of generic medications became available around the time that spending leveled off (for example, citalopram), other common medications (for example, fluoxetine) were available as generics in earlier years, when the spending was increasing more rapidly. Therefore, with the data presented here, we do not have an explanation for why spending grew rapidly from FY 2000 and then leveled off. Further research would be needed to isolate the likely mechanisms.

This study has a number of important limitations. The VA, like other health care systems, is increasingly relying on primary care providers to offer a broad portfolio of services. Our data show the cost and services provided in specialized mental health clinics. This report also highlights the cost of drugs commonly used in psychiatric outpatient care, but the data do not include any health care services provided in primary care or general medical clinics. For example, if a veteran talked to his or her primary care doctor about a mental health concern or side effects related to a mental health medication that did not translate into a new prescription, then these consultations would be missing from our cost estimates. The spending estimates for mental health medications are also imperfect because we excluded some mental health drugs that are frequently used in non-mental health indications. Therefore, the figures for mental health spending, *per se*, should be viewed as conservative estimates.

Although it might be tempting to suggest, for the same reasons, that our estimates are conservative with regard to substance use disorder treatment (that is, an underestimation of the amount of substance use disorder services provided in the VA), recent research has shown that VA primary care providers are not providing substance use disorder services (23). Thus, as the nation's largest provider of substance use disorder treatment, this contraction could indicate that fewer veterans with a substance use disorder are seeking care in the VA or that more veterans are

paying out of pocket, are looking to other insurers to cover their costs, or are not getting needed care. Using data from 2003 and 2004, Petersen and colleagues (24) found that 80% of veterans under age 65 relied on VA for mental health and substance use disorder care; reliance on VA decreased to 55% for veterans over age 65 because of Medicare. Unfortunately, there are no data from more recent years to determine whether veterans are becoming more or less reliant on VA services.

One trend worth following is VA's payments to community providers (that is, contract care). Between FY 2000 and FY 2007, spending on contract care grew rapidly at 18.3% per year. Although such growth is likely to improve access to care for veterans who live in rural areas, it is not clear how providers are managing care across multiple systems, especially when most providers do not use an electronic medical record (25,26). A recent study found that contract care was frequently used for emergency care or treatment that requires recurrent visits to a clinic (for example, dialysis and physical rehabilitation) (27), while veterans received most (88%) of their outpatient psychiatric care and almost all of their alcohol and drug treatment at VA facilities. Use of contract providers could also have implications for outcomes, but like Frank and colleagues (1), we have not linked the spending data to outcomes. Therefore, we cannot make statements about whether the additional (or decreased) spending was associated with marginal benefits.

## Conclusions

Undoubtedly, some might look at trends in VA spending and decry the lack of increases in mental health and substance use disorder treatment. However, another perspective on these data is that the VA treated a growing population of chronically ill veterans while holding spending in check (.7% per person per year). The savings were correlated with decreases in inpatient care, an increase in outpatient mental health visits, and a decrease in outpatient substance use disorder visits.

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## Submissions for Datapoints Column Invited

Submissions to the journal's Datapoints column are invited. Datapoints encourages the rapid dissemination of relevant and timely findings related to clinical and policy issues in psychiatry. National data are preferred. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. The analyses should be straightforward, so that the figure or figures tell the story. The text should follow the standard research format to include a brief introduction, description of the methods and data set, description of the results, and comments on the implications or meanings of the findings.

Datapoints columns, which have a one-page format, are typically 350 to 400 words of text with one or two figures. Because of space constraints, submissions with multiple authors are discouraged; submissions with more than four authors should include justification for additional authors.

Inquiries or submissions should be directed to column editors Amy M. Kilbourne, Ph.D., M.P.H. ([amy.kilbourne@va.gov](mailto:amy.kilbourne@va.gov)), or Tami L. Mark, Ph.D. ([tami.mark@thomsonreuters.com](mailto:tami.mark@thomsonreuters.com)).