

# Peer-Review Transparency

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Federal health care providers live under a microscope, so it seems only fair that we at *Fed Pract* honor that reality and open ourselves up to scrutiny as well.<sup>1</sup> We hope that by shedding light on our peer-review process and manuscript acceptance rate, we will not only highlight our accomplishments, but identify areas for improvement.

Free access to *Fed Pract* content has always been our priority. While many journals charge authors or readers, *Fed Pract* has been and will remain free for readers and authors.<sup>2</sup> Advertising enables the journal to support this free model of publishing, but we take care to ensure that advertisements do not influence content in any way. Our advertising policy can be found at [www.mdedge.com/fedprac/page/advertising](http://www.mdedge.com/fedprac/page/advertising).

In January 2019, *Fed Pract* placed > 400 peer-reviewed articles published since January 2015 in the PubMed Central (PMC) database ([ncbi.nlm.nih.gov/pmc](http://ncbi.nlm.nih.gov/pmc)). The full text of these and all future *Fed Pract* peer-reviewed articles will be available at PMC (no registration required), and the citations also will be included in PubMed. We hope that this process will make it even easier for anyone to access our authors' works.

In 2018 about 36,000 federal health care providers (HCPs) received hard copies of this journal. The print journal is free, but circulation is limited to HCPs who work at the US Department of Veterans Affairs (VA), US Department of Defense (DoD), and the US Public Health Service (PHS). The [mdedge.com/fedprac](http://mdedge.com/fedprac) website, which includes every article published since 2003, had 1.4 million page views in 2018. After reading 3 online articles, readers in the US are asked to complete a simple registration form to help us better customize the reader experience. In some cases, international readers may be asked to pay for access to articles online; however, any VA, DoD, or PHS officer stationed overseas can contact the editorial staff ([fedprac@mdedge.com](mailto:fedprac@mdedge.com)) to ensure that they can access the articles for free.

In 2018 the journal received 164 manuscripts and published 94 articles written by

357 different federal HCPs. The 164 manuscript submissions represented a 45% growth over previous years. Not surprisingly, the increased rate of submissions began shortly after the May 2018 announcement that journal articles would be included in PMC. Most of those articles (83%) were submitted unsolicited.

*Fed Pract* has always prided itself on being an early promoter of interdisciplinary health care professional publications. Nearly half of its listed authors were physicians (48%), while pharmacists made up the next largest cohort (18%). There were smaller numbers of PhDs, nurses, social workers, and physical therapists. The majority were written by HCPs affiliated with the VA (95% of articles and 93% of authors), and no articles in 2018 were written by PHS officers. Physicians comprise about two-thirds of the audience, while pharmacists make up 17% and nurses 9%. PHS and DoD HCPs make up 19% of the *Fed Pract* audience, suggesting that the journal needs to do more work to encourage these HCPs to contribute articles to the journal.<sup>3</sup>

Articles published in 2018 covered a broad range of topics from "Anesthesia Care Practice Models in the VHA" and "Army Behavioral Health System" to "Vitreous Hemorrhage in the Setting of a Vascular Loop" and "A Workforce Assessment of VA Home-Based Primary Care Pharmacists." Categorizing the articles is a challenge. Few health care topics fit neatly into a single topic or specialty. This is especially true in federal health care where much of the care is delivered by multidisciplinary patient-centered medical homes or patient aligned care teams. Nevertheless, a few broad outlines can be discerned. Articles were roughly split between primary care and hospital-based and/or specialty care topics; one-quarter of the articles were case studies or case series articles, and about 20% were editorials or opinion columns. Nineteen articles dealt explicitly with chronic conditions, and 10 articles focused on mental health care.

Peer reviewers are an essential part of the process. Reviewers are blinded to the identity

of the authors, ensuring fairness and reducing potential conflicts of interest. We are extremely grateful to each and every reviewer for the time and energy they contribute to the journal. Peer reviewers do not get nearly enough recognition for their important work. In 2018 *Fed Pract* invited 1,205 reviewers for 164 manuscript submissions and 94 manuscript revisions. More than 200 different reviewers submitted 487 reviews with a median (SD) of 2 reviews (1.8) and a range of 1 to 10. The top 20 reviewers completed 134 reviews with a median (SD) of 6 reviews (1.2). The results stand in contrast to some journals that must offer many invitations per review and depend on a small number of reviewers.<sup>1,4,6</sup>

The reviewers recommended to reject 14% and to revise 26% of the articles, which is a much lower rejection rate than many other journals (Table).<sup>4</sup> Eighty-six authors completed 1 revision, 17 authors completed 2 revisions, and 1 author completed 3 revisions. It took the journal, on average, 58 days to submit the first decision to authors. For authors with revised manuscripts it took even longer: 75 days for the decision on the first revision and 100 days for a decision on the second revision. Often articles are approved about 1 month before publication.

These data suggest that *Fed Pract* and its peer-review process is on a sound foundation but needs to make improvements. Moving into 2019, the journal expects that an increasing number of submissions will require a higher rejection rate. Moreover, we will need to do a better job reaching out to underrepresented portions of our audience. To decrease the time to publication for accepted manuscripts, in 2019 we will publish more articles online ahead of the print publication as we strive to improve the experience for authors,

**TABLE** Peer-Review Data

Decision Types	Reviewer Decision, No. (%) <sup>a</sup>	Journal Decision, No. (%) <sup>b</sup>
Accept	138 (27.8)	76 (32.7)
Revise/Resubmit	290 (58.3)	124 (53.4)
Reject	69 (13.9)	32 (13.7)
Total	497	232

<sup>a</sup>Each article has > 1 review per article.

<sup>b</sup>95 articles had ≥ 1 decision.

reviewers, readers, and the entire *Fed Pract* audience.

None of this work can be done without our small and dedicated staff. I would like to thank Managing Editor Joyce Brody who sent out each and every one of those reviewer invitations, Deputy Editor Robert Fee, who manages the special issues, Web Editor Teraya Smith, who runs our entire digital operation, and of course, Editor in Chief Cynthia Geppert, who oversees it all. Finally, it is important that you let us know how we are doing and whether we are meeting your needs. Visit [mdedge.com/fedprac](http://mdedge.com/fedprac) to take the readership survey or reach out to me at [rpaul@mdedge.com](mailto:rpaul@mdedge.com).

## References

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## LETTERS

### National Suicide Strategy

**To the Editor:** Even one death by suicide is too many. Suicide is complex and a serious national public health issue that affects people from all walks of life—not just veterans—for a variety of reasons. While there is still a lot we can learn

about suicide, we know that suicide is preventable, treatment works, and there is hope.

At the US Department of Veterans Affairs (VA), our suicide prevention efforts are guided by the *National Strategy for Preventing Veteran*

*Suicide*.<sup>1</sup> Published in 2018, this long-term strategy expands beyond crisis intervention and provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among veterans through a broad public health approach with an emphasis on comprehensive, community-based engagement.

This approach is grounded in 4 key areas: *Primary prevention* focuses on preventing suicidal behavior before it occurs; *whole health* considers factors beyond mental health, such as physical health, alcohol or substance misuse, and life events; *application of data and research* emphasizes evidence-based approaches that can be tailored to the needs of veterans in local communities; and *collaboration* educates and empowers diverse communities to participate in suicide prevention efforts through coordination.

A recent article by Russell Lemle, PhD, noted that the National Strategy does not emphasize the work of the VA, and he is correct.<sup>2</sup> Rather than perpetuate the myth that VA can address suicide alone, the strategy was intended to guide veteran suicide prevention efforts across the entire nation, not just within VA's walls. It is a plan for how we can ALL work together to prevent veteran suicide. The National Strategy does not minimize VA's role in suicide prevention. It enhances VA's ability and expectation to engage in collaborative efforts across the nation.

Every year, about 6,000 veterans die by suicide, the majority of whom have not received recent VA care. We are mindful that some veterans may not receive any or all of their health care services from the VA, for various reasons, and want to be respectful and cognizant of those choices. To save lives, VA needs the support of partners across sectors. We need to ensure that multiple systems are working in a coordinated way to reach veterans where they live, work, and thrive.

Our philosophy is that there is no wrong door to care. That is why we focused on universal, non-VA community interventions. Preventing suicide among all of the nation's 20 million veterans cannot be the sole responsibility of VA—it requires a nationwide effort. As there is no single cause of suicide, no single organization can tackle suicide prevention alone. Put simply, VA must ensure suicide prevention is a part of every aspect of veterans' lives, not

just their VA interactions. At VA, we know that the care and support that veterans need often comes before a mental health crisis occurs, and communities and families may be better equipped to provide these types of supports.

Activities or special interest groups can boost protective factors against suicide and combat risk factors. Communities can foster an environment where veterans can find connection and camaraderie, achieve a sense of purpose, bolster their coping skills, and live healthily. And partners like the National Shooting Sports Foundation help VA to address sensitive issues, such as lethal means safety, while correcting misconceptions about how VA handles gun ownership.

Data also are an integral piece of our public health approach, driving how VA defines the problem, targets its programs, and delivers and implements interventions. VA was one of the first institutions to implement comprehensive suicide analysis and predictive analytics, and VA has continuously improved data surveillance related to veteran suicide.

We began comprehensive suicide monitoring for the entire VA patient population in 2006, and in 2012, VA released its first report of suicide surveillance among all veterans in select partnering states. Though we are able to share data, we acknowledge the limitations Dr. Lemle highlighted in implementing predictive analytics program outside the VA. However, VA continues to improve reporting and surveillance efforts, especially to better understand the 20 veterans and service members who die by suicide each day.

As Lemle noted, little was previously known about the 14 of 20 veterans who die by suicide every day who weren't recent users of VA health services. Since the September 2018 release of the National Strategy, VA has obtained additional data. In addition to sharing data, VA will focus on helping non-VA entities understand the problem so that they can help reach veterans who may never go to VA for care. Efforts are underway to better understand specific groups that are at elevated risk, such as veterans aged 18 to 34 years, women veterans, never federally activated guardsmen and reservists, recently separated veterans, and former service members with Other Than Honorable discharges.

To end veteran suicide, VA is relentlessly working to make improvements to existing

suicide prevention programs, develop VA-specific plans to advance the National Strategy, find innovative ways to get people into care, and educate veterans and family members about VA care. Through Executive Order 13822, for example, VA has partnered with the Departments of Defense and Homeland Security, which allows us to educate service members about VA offerings before they become veterans. We also are making it easier for them to quickly find information online about VA mental health services.

We acknowledge VA is not a perfect organization, and a negative image can turn away veterans. VA is actively working with the media to get more good news stories published. We have many exciting things to talk about, such as a newly implemented Comprehensive Suicide Risk Assessment, and it is important for people to know that VA is providing the gold standard of care. Sometimes, those stories are better messaged and amplified by partners and non-VA entities, and this is a key part of our approach.

Lemle also raised a concern around funding this new public health initiative. While we recognize the challenges in advancing this new public health approach without additional funding, we are hopeful we can energize communities to work with us to find a solution.

The National Strategy is not the end of the conversation. It is a starting point. We are thankful for Lemle's thoughtful questions and are actively pursuing and investigating solutions regarding veteran suicide studies, peer support, and community care guidelines for partners as we seek to improve our services. We also are putting pen to paper on a plan to strengthen family involvement and integrate suicide prevention within VA's whole health and social services strategies.

The National Strategy is a call to action to every organization, system, and institution interested in preventing veteran suicide to help do this work where we cannot. For our part, VA will continue to energize communities to increase local involvement to reach all veterans, and we will continue to empower and equip ALL veterans with the resources and care they need to thrive.

To learn about the resources available for veterans and how you can #BeThere as a VA employee, family member, friend, community partner, or clinician, visit [www.mentalhealth](http://www.mentalhealth.va.gov/suicide_prevention/resources.asp)

[.va.gov/suicide\\_prevention/resources.asp](http://www.mentalhealth.va.gov/suicide_prevention/resources.asp). If you or someone you know is having thoughts of suicide, contact the Veterans Crisis Line to receive free, confidential support and crisis intervention available 24 hours a day, 7 days a week, 365 days a year. Call 800-273-8255 and press 1, text to 838255, or chat online at [VeteransCrisisLine.net/Chat](http://VeteransCrisisLine.net/Chat).

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**Author disclosures:** Keita Franklin participated in the development of the *National Strategy for Preventing Veteran Suicide*.

**Disclaimer:** The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

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**Author Response:** Keita Franklin, PhD, offers a valuable response to my December critique of the VA National Strategy to Prevent Veteran Suicide. Dr. Franklin thoughtfully articulates why public health approaches to prevent suicide must be a core component of a multifaceted strategy. She is right about that.

While I see considerable overlap between our statements, there are 2 important points where we diverge: (1) Unless Congress appropriates sufficient funds for extensive public health outreach, there is a danger that funds to implement it would be diverted from VA's extant effective VA suicide prevention programs. (2) A prospective suicide prevention plan requires 3 prongs of universal, group, and individually focused strategies, because suicide cannot be prevented by any single strategy. The VA National Strategy as well as the March 2019 Executive Order on a National Roadmap to Empower Veterans and End Suicide, focus predominantly on universal strategies, and I believe its overall approach would be improved by also explicitly supporting VA's targeted programs for at-risk veterans.

**Russell B. Lemle, PhD**

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