

**U.S. Department of Veterans Affairs (VA)  
Special Medical Advisory Group (SMAG) Meeting Minutes  
August 5, 2025**

**Department of Veterans Affairs, 810 Vermont Avenue NW, Washington DC, 20420**

**ATTENDEES:**

**Committee Members Present:**

Dr. Gregg Meyer (Chairperson)  
Dr. Terry Fulmer (Vice Chairperson)  
Dr. Francis Crosson  
Dr. Bijiibaa Garrison (Virtual)  
Dr. Michael Mittelman (Virtual)  
Dr. John Prescott  
Dr. Carolina Reyes  
Dr. Lewis Sandy  
Dr. Christopher Saslo (Virtual)  
Dr. Misty Wilkie (Virtual)  
Dr. Robert Winn (Virtual)

**Committee Members Absent:**

Dr. Arthur Kellerman

**U.S. Department of Veterans Affairs Staff and Presenters:**

Dr. Steven Lieberman, Veterans Health Administration (VHA) Under Secretary for Health (Acting USH)  
Mr. Christopher D. Syrek, Veterans Affairs (VA) Chief of Staff  
Dr. LaTonya L. Small, Program Specialist, Advisory Committee Management Office (ACMO)  
Dr. Neil Evans, Acting Program Executive Director, EHRM-IO  
Dr. Shawn Liu, HPO National Homeless Program Manager  
Dr. Susan Kirsh, Deputy Assistant Under Secretary for Health for Discovery, Educational, and Affiliate Networks (DEAN)  
Dr. Carolyn Clancy, Assistant Under Secretary for Health for Discovery, Educational, and Affiliate Networks (DEAN)  
Dr. Lisa Arfons, Acting Deputy Assistant Under Secretary for Health for Integrated Veteran Care  
Mr. Mark Koeniger, Executive Advisor, Strategic Foresight  
Dr. Maria Llorente, Acting Assistant Under Secretary for Health for Integrated Veteran Care  
Ms. Tamika Malveo, Acting Executive Director Integrated Informatics and Analytics  
Dr. Matthew Miller, Director, Suicide Prevention Program  
Ms. Nadia Smith, Acting Chief, Digital Health Officer  
Ms. Valerie Mattison Brown, Chief Strategy Officer  
Mr. Ian Komorowski, Executive Director, Strategic Investment Management  
Dr. Erica M. Scavella, Assistant Under Secretary for Health for Clinical Services  
Ms. Rebecca Mimmall, Acting Executive Director, Office of Governance, Regulations, Appeals, and Policy  
Dr. Ronald Miller, Chief Officer, Support Operations  
Dr. Harrison Hines, Senior Advisor, Healthcare Operations  
Mr. Michael Fisher, Chief Officer, Readjustment Counseling Officer (Virtual)

Mr. Brandon Fureigh, Executive Director, Office of Communications (Virtual)  
Ms. Sally Haskell, Deputy Chief Consultant, Woman's Health Services (Virtual)  
Mr. Patrick Picardo, Executive Director, 10B VA DoD (Virtual)  
Mr. Josh Hillebrand, Supervisory Program Specialist, Office of Communications (Virtual)  
Mr. Jeff Moragne, Director, Advisory Committee Management Office (ACMO) (Virtual)  
Ms. Heather Carreiro, Director for External Accreditation Services and Program (Virtual)

**Other General Public Attendees:**

Mr. Marion Feta, Veterans of Foreign Wars (Virtual)  
Mr. Mario Torres (ManTech, Virtual)  
Mr. Jason Passabet, Maxim Healthcare Services (Virtual)  
Ms. Corey Siebers, Maxim Healthcare Services (Virtual)  
Ms. Allison Graves, Maxim Healthcare Services (Virtual)  
Ms. Ellen Milhiser, Synopsis (Virtual)  
Ms. Elizabeth Mackenzie, Leidos (Virtual)  
Mr. Adrian Atizado, TriWest Healthcare Alliance (Virtual)

**SMAG Support Staff:**

Mr. Brian Schoenhofer, Designated Federal Officer (DFO)  
Ms. Cheron Cole, Director, VHA Governance Board Office  
Mr. Keyvan Ebrahimi-Farokh, Health System Specialist  
Mr. Dennis Lahl, Management Analyst  
Ms. Lashawn Logan, Program Analyst  
Ms. Berenice Perez-Ruiz, Program Analyst  
Ms. Stephanie Seeley, Staff Assistant  
Ms. Doniece Wilkins, Administrative Officer

*August 5, 2025- Meeting Commencement: 8:04 A.M.*

**OPENING REMARKS**

***Summary of Opening Remarks by Dr. Gregg Meyer, Chairperson for VA SMAG Committee***

- The agenda was built to follow up on prior meeting topics, including the interaction between Direct Care and Community Care systems.
- In addition, it also includes a last-minute addition on the Elizabeth Dole Act Section 107.

***Summary of Opening Remarks by Dr. Steven Lieberman, Acting VHA USH***

- We are here to focus on our central responsibility, which is to provide the best possible care to veterans by ensuring the system they rely on responds to their needs.

- The goal of this meeting is to continue to strengthen partnerships that will translate policy into better health outcomes for Veterans.
- It is important to collaborate across levels of government and with the private sector to improve the quality of programs, services, and access for all Veterans.
- VA Secretary's core principles are access, suicide prevention, ending homelessness, fiscal responsibility, and the electronic health record modernization (EHRM).
- Access to timely high-quality care is the foundation of our mission in which VA is working to find new ways to reach all Veterans to receive healthcare.
- A top concern is suicide prevention, and the VA is working on expanding mental health resources and support networks. In addition, VA uses data, evidence-based approaches and partnerships to identify Veterans at risk and intervene early.
- VA is leveraging partnerships with state and local agencies, nonprofits, and private organizations to address housing instability. By the end of this fiscal year, we expect to help 46,000 Veterans secure permanent housing.
- VA is focusing on transparency and careful management of resources by reducing redundancies and concentrating on efficiencies.
- VA is making strides in implementing the EHRM, as six medical centers are currently under the new system and 13 more to join them next year.

## **ANNUAL ADVISORY COMMITTEE MANAGEMENT TRAINING**

### ***Summary of Presentation by Ms. LaTonya Small, Program Specialist for Advisory Committee Management Office***

- Advised Federal Advisory Committee Act 101 requirements for charter, public access, committee management best practices, and key resources.

## **RECAP OF PREVIOUS MEETING**

### ***Summary Presentation by Mr. Brian Schoenhofer, VA DFO for SMAG***

## **VA KEY TAKEAWAYS**

### ***Summary of Presentation by Mr. Christopher D. Syrek, VA Chief of Staff***

- The VA Secretary's goal is to give Veterans the best healthcare and encourages the committee to think outside the box and to challenge the status quo to solve problems.
- VA Secretary's priorities include:
  - Veteran's having access to care (Direct Care of Community Care)
    - Decrease appointment wait times

- Expand clinic hours
  - Increase resources to support Direct Care system
- Access to Care
  - Using the “best medical interest” standard to allow Veterans to more readily access Community Care
  - increase authorization time frame from six months to one year to decrease referral burden
- EHRM
  - Goal of implementing the EHRM in every VA site by the year 2031 to support clinicians, care in the community, and transition with the U.S. Department of Defense.
  - Hold the vendor, Oracle, accountable and work with them to complete this project.
- Homelessness
  - Despite making big strides over the past ten years, this continues to be a priority.
  - VA will work with partners across the government to decrease homelessness.
- Suicide Prevention
  - Have not seen much progress with suicide prevention with about twenty Veterans dying by suicide per day.
  - VA will collaborate with other services to make changes to decrease this number.

## **FOLLOW-UP: Federal EHR Deployment**

### **Summary of Presentation by Dr. Neil Evans, Acting Program Executive Director, EHRM-IO**

#### Current Status

- Commitment in December to restart deployment at four Michigan sites (VISN 10).
- Current live sites: six VA Medical Centers including Spokane, Walla Walla, Roseburg, White City, Columbus, and James A. Lovell Federal Health Care Center (FHCC).

#### Challenges and Achievements

- Successful deployment at the joint DOD-VA facility in North Chicago despite challenges.
- FHCC deployment highlighted the benefits of an integrated EHR for Servicemembers and Veterans.
- Many doubted the success at Lovell due to its joint operation by DoD and VA, which highlighted the need to align formularies and workflows.
- Standardization is a significant hurdle due to cultural and personal challenges.

#### Goals Established During Reset

- Improve EHR by addressing user dissatisfaction and technical issues.

- Conduct enterprise work for system-wide support, training, and change management.
- Successfully deploy EHR at FHCC.

#### Acceleration Strategy

- Switch to wave-based deployment for geographic and market synergies.
  - Example: Ann Arbor's network with Battle Creek, Saginaw, and Detroit.
- Engage site leadership for combined training and change management.
- Partner medical centers based on market considerations; all medical centers in one area going live simultaneously for unified training and deployment.

#### Deployment Timeline

- Aggressive schedule: six new sites within less than a year.
- Detailed schedule to 2031, with deployments every 10-12 weeks.
  - Example: Southern Ohio market to go live mid-June 2024.
- Peak of 33 sites in the final deployment year.
- Soon to announce a schedule specifying waves of four to six medical centers every 10 to 12 weeks, starting with 13 sites in 2026.

#### Standardization for Acceleration

- Maintain consistency within a compressed timeline.
- Three levels: deployment, ongoing change control, and enterprise-wide tech acquisition.
  - Example: Reduced site-specific deviations from 50 in Michigan to 13 in Southern Ohio due to standardization.
- Standardizing workflows and technological connections ahead of deployments to identify deviations early and correct them.

#### Stakeholder Engagement

- Early engagement with site leadership and stakeholders is crucial.
- Publication of the federal EHR VA baseline to guide standardization.
- Measuring and Optimizing End-User Experience
- Bi-annual end-user surveys to gauge satisfaction and improve.
- Positive trends in user satisfaction and confidence, notably at FHCC.
- New training and changing strategies, such as learning labs.
- Medical centers can lean on each other during the process through geographic synergies within VISNs.

#### Measuring and Optimizing End-User Experience

- Bi-annual end-user surveys to gauge satisfaction and improve.
- Positive trends in user satisfaction and confidence, notably at FHCC.
- Overall satisfaction rose from 13% to 24%, with Lovell included for the first time.
- New training and change strategies, such as learning labs.
- Changes in initial training and early deployment support based on lessons learned.

## Next Steps

- Continued commitment to accelerating EHR deployment for better patient care and efficiency.
- Begin thinking about purchasing or acquiring connected technologies at an enterprise level, moving away from VISN or center-based procurement.

## *Key Takeaways from SMAG Members*

- Oracle System Capabilities: VA faces difficulties in adapting Oracle's EHR capabilities, which are designed for the commercial sector.
- User Satisfaction and System Usage: Little resistance among VA employees, but interface issues and downtime contribute to dissatisfaction.
- Ticket submissions by super users and informatics committees have decreased by 40%.
- Local teams, empowered and adequately trained, improve user satisfaction.
- Approximately 20% of end users at each site are designated as super users, facing some operational pushbacks.
- Migrating data from VistA to the FEHR remains challenging due to lack of standardization across centers.
- Efforts focus on ensuring critical historical data, such as clinical progress notes, are included.

## *Key Recommendations*

- Enhance Standardization Efforts: Emphasize the importance of standardization and use the EHR transition to drive it.
- Improve Oracle Support: Strengthen the partnership with Oracle to address system gaps and improve user satisfaction.
- Empower Local Leadership: Continue and potentially expand the super user strategy to ensure robust local support. Engage and communicate with frontline staff early and effectively.
- Optimize Data Migration: Prioritize the migration of critical data and incorporate end user feedback in the process.
- Maintain Communication and Leadership Engagement: Tailor messages about the EHR transition values and keep leadership actively involved.
- Focus on Enhancing User Experience: Monitor and address user experience issues diligently. Utilize modern technologies such as AI to reduce training burdens.
- Highlight Veteran Impact: Integrate Veteran feedback to improve the EHR system and communicate benefits clearly.
- Prepare for Future Updates: Plan for ongoing updates from Oracle and maintain an agile approach for technology integration.
- Support Research Utilization: Ensure the new system generates valuable data for research.

## **ENDING HOMELESSNESS**

### **Summary of Presentation by Mr. Shawn Liu, HPO National Homeless Program Manager**

- Despite progress in reducing homelessness, there are nearly 33,000 homeless Veterans in America.
- Research indicates it is a mix of individual-level and community-level risk factors that contribute to homelessness.
- Individual-level risk factors include mental illness, substance use disorders, lack of stable income or employment, history of incarceration, lack of social support, and adverse childhood events.
- Community-level risk factors include lack of affordable housing, lack of economic opportunities, high crime neighborhoods, and cultural factors.
- There has been a 55.6% decrease in homeless Veterans since 2010.
- There is a correlation between the decline in Veteran homelessness and housing costs. An increase in housing cost/rent cost corresponds to a shallowing out in Veteran homelessness progress.
- Although Veteran homelessness is at the lowest level on record, the national homelessness level is at its highest. Being a Veteran is now a protective factor when it comes to homelessness due to VA programs and services offered.
- The Homeless Programs Office's mission is to assist Veterans and families in obtaining permanent and sustainable housing with access to high-quality health care and supportive services.
- FY 2025 outcomes as of June 30<sup>th</sup>:
  - 37,534 homeless Veterans are permanently housed
  - 97% of those permanently housed remain housed.
  - 31,517 unsheltered Veterans are now engaged with VA programs and health care.
- Getting Veterans Off the Street initiative has two key actions.
  - 1. Hosting dedicated outreach surge events at every VA Health care system.
  - 2. Move at least 20,000 unsheltered Veterans into interim or permanent housing this fiscal year.
- VA offers two programs within the Veterans justice program to provide outreach to Veterans in jail and in prison.
- Rates of homelessness are higher in certain geographical locations that include California, the Pacific Northwest, Florida and New York. However, we see a correlation with income inequality rather than homelessness being dependent on being in a poor state or a wealthier city.
- States that are doing well with decreasing homelessness show strong state leadership and good data tracking.
- We have seen success by making sure resources are being used effectively and are working in a coordinated manner with the system.

- When comparing Veteran homelessness and homelessness in the general population there are two major differences:
  - Interventions are scaled and implemented more effectively
  - Veterans have access to medical care, treatment, and counseling.
- Per VA's data, we largely serve enlisted service members and few officers. Consequently, correlating your rank at discharge to your socioeconomic status. In addition, we serve Army and Navy Veterans more than Marine Veterans, and few Air Force Veterans.

### *Key Takeaways from SMAG Members*

- With Stand-down events, we see increased enrollments into VA, increased disability claims that are filed and awarded, and an increase in use of the direct loan for Native Americans. How can we obtain more stand-down events across tribal communities to better serve the American Indian Alaska Native Veterans?
- SMAG members would like the VA to highlight their best practices to share with other cities and states that may benefit from this information.
- SMAG members would like to obtain resources and guidance on how they can help homeless Veterans they may encounter. These resources include:
  - Phone number for the National Call Center for Homeless Veterans
  - Affordable housing opportunities
  - Information for business owners
  - An article to become a transitional housing provider, contractor, etc.
- VA's approach saves health care costs in the long run with fewer Emergency Room and Urgent Care visits, citing there is a return on investment.

### *Key Recommendations*

- SMAG members did not make any recommendations

## **ELIZABETH DOLE ACT SECTION 107**

### **Summary of Presentation by Dr. Susan Kirsh, Deputy Assistant Under Secretary for Health for Discovery, Educational and Affiliate Networks (DEAN)**

- The Senator Elizabeth Dole 21<sup>st</sup> Century Veterans Healthcare and Benefits Improvement Act, (E. Dole Improvement Act) signed into law, dated January 2, 2025, requires the Department of Veterans Affairs to establish a working group (Non-Federal Advisory Committee Act; (FACA) on value-based care.
  - The group must submit to Congress a strategic plan to implement value-based care into VHA, and pilot value-based care models within VHA.
  - The group will consist of designated individuals from Academia, Industry and Federal Government. Section 107 listed "required" and "recommended" participants.

- Assessments are required, current quality and performance measures expected to be integrated into a strategy document with an aligned pilot by the end of the calendar year.
- Sections 105 and 108 of the act specifically detail pilots and emphasize the importance of retrieving electronic health records and obtaining data from our community partners.
  - Key reason for bringing this to SMAG for input.
- The key is to move together toward a standardized approach and focus on the outcomes.
- VA Value Based Care Framework
  - Veteran at Center
    - Engaged
  - Experience
    - Patient/Caregiver personalization and autonomy
    - Provider Satisfaction
    - Useability and Engagement
  - Outcomes
    - Emphasis on preventive care and well-being
    - Expand access to primary and home care
    - Consistent care at all locations
  - Efficiencies
    - Productivity
    - Cost-effectiveness
    - Access
  - Innovation and Technology
    - Emerging technology
    - Data interoperability
  - Organizational Readiness and Responsiveness
    - Physical Infrastructure
    - Personnel
    - Technology structure

### *Key Takeaways from SMAG Members*

- Examine a small set of meaningful measures:
  - Experience (net promotor score) for care being delivered
  - Clinical Care Quality Measures-Healthcare Effectiveness Data and Information Set (HEDIS)
- Study basic measures for utilization, for example emergency room and hospitalization utilization.
- Balance productivity demands for great outcomes.
- Work closely with partners in the federal government to learn from their experiences.
- Recommended use of patient feedback, as well as patient satisfaction scores.
- What alternative currencies might go beyond just financial levers?

- Ensure metrics are aligned and explore purchaser coalitions.
- Importance of data transparency and receiving data from all providers.
- Share data outcomes with providers and explain how these outcomes impact their scores. This increased transparency and understanding may encourage providers to pay more attention to the scores and work towards improving them.
- Request data that already exists rather than asking for new or unique data specific to the VA.
- Consider academic affiliations and continuous quality improvement incentives.
- Community care data is essential and should be built into the contracting mechanism. It is not unusual to request such provisions and should be an expectation.
- Develop a mechanism to collate and publish performance data to the physician community. This transparency can drive improvements by highlighting areas of success and opportunities for growth. Use this data to inform future contracting requirements, ensuring that better-performing providers have the opportunity to secure more favorable contracts.
- It is often challenging to integrate the culture of one organization into the practices of care providers who come from a different organizational background.
  - Kaiser Permanente attempted to create innovative incentive methods, such as expediting payments to external providers who assisted with the repatriation of patients to Kaiser Permanente hospitals. However, it was observed that this approach did not achieve long-term success.
- Utilize the existing maturity model for value-based care in community care.
  - The expectation of the Section 107 pilot next calendar year is to touch primary care, mental health, substance use disorder, poly trauma, spinal cord injury.
- Community Care budget continues to grow and enables additional spending within the community.

*Key Recommendations*

- Introduce a 'Gold Seal of Excellence' incentive program through the VHA, which recognizes community care providers and hospitals/clinics. This recognition would not only serve as a mark of distinction but also reinforce our shared mission of delivering the highest quality care to Veterans.

**OPEN PUBLIC COMMENTARY SESSION**

- No comments were made by the public during this open session.

## **DIRECT CARE ACCESS IMPROVEMENT EFFORTS**

### **Summary of Presentation by Dr. Lisa Arfons, Acting Deputy Assistant for Integrated Veteran Care and Mr. Mark Koeniger, Executive Advisor Strategic Foresight**

- VA's Access Choices and Excellence to Veterans (ACE) was established in response to the May 9<sup>th</sup> Executive Order focusing on all aspects of access to care.
- The Executive Order will provide Veterans with meaningful choice and participation in their health care journey, including options like extended office hours, weekend appointments and an increase in virtual healthcare options usage.
- Based on a survey question to VA Facilities the response indicated a preference for weekday extended appointments, with preference to early morning hours in routine outpatient care.
- Based on a survey question to Veterans regarding the use of Community Care they cited it was based on the VA not offering a convenient time for their appointment.
- VHA Demographics indicate that Veterans are almost three times more likely to be retired, 90% are male, and 33% live in rural areas.
- Based on today's conversation with the SMAG members, there is an opportunity to promote VA contact centers.

#### *Key Takeaways from SMAG Members*

- No key takeaways given by SMAG Members.

#### *Key Recommendations*

- Overall, in the private sector the consensus was early morning and evening hours were successful while Saturday appointments were not utilized as much.
- Telehealth appointments are valuable, particularly for those living in rural areas.
- Regarding the services offered, complete services were available at the main hospital and only basic services at the satellite facilities.
- A possible solution is for virtual providers on the east coast to cover early appointments on the west coast and then providers on the west coast to cover late appointments on the east coast while still working a nine to five shift.

## **VETERAN ACCESS WITHIN THE DIRECT CARE AND COMMUNITY CARE SYSTEMS**

### **Summary of Presentation by Dr. Maria Llorente, Acting Assistant Under Secretary for Health for Integrated Veterans Care, Dr. Lisa Arfons, Acting Deputy Assistant for Integrated Veteran Care and Ms. Tamika Malveo, Acting Executive Director Integrated Informatics and Analytics**

- The scheduling system is fragmented into three main areas:
  - Direct Care Scheduling: Schedulers make appointments with and for Veterans.
  - External Provider Scheduling (EPS): Some connected with the EPS system.
  - Veteran Self-Scheduling: Veterans can request and make their own appointments.
- VA schedulers deal with multiple screens and systems, causing complexity, and inefficiency.
- Veterans currently face difficulties scheduling appointments, contributing to frustration.
- The goal is to streamline all scheduling processes into a single, unified platform, to allow Veterans to schedule their own appointments electronically through a simplified system.

#### **Direct Care Scheduling System**

- Existing schedulers use up to five applications across multiple screens, leading to inefficiency. The process can involve consulting four screens simultaneously.
- Integrated Scheduling Solution (ISS): Being developed to consolidate all applications into one screen, covering both direct and community care, to simplify the process.
- A new platform allows Veterans to request and make appointments.
- It needs to be simple to navigate and ensure appropriate provider direction.
- Plans to include telephone and telehealth appointments by December 2026.
- The current policy limits specialty areas available for self-scheduling based on facility capability.
- Veterans can cancel appointments up to 24 hours in advance to avoid no-shows.

#### **EPS**

- EPS is a platform that enables real-time scheduling with community providers.
- Currently, EPS is at 51 VA sites, with plans to expand to all sites by the end of the calendar year.
- Over 10,000 provider services active in EPS across 67 specialties, representing about 80% of the provider network.
- Significantly reduces time to schedule appointments, averaging seven minutes per appointment.
- Reduces communication back-and-forth between schedulers and providers.

- Allow schedulers to work with Veterans on the phone to select suitable times and providers.
- Schedulers receive special training and ongoing real-time support.
- Regular reports to medical directors create positive competition among medical centers.
- Collaborative efforts with organizations like the National Rural Health Association to enroll more community providers.
- Crucial for getting community providers to adopt EPS.
- Providers benefit from fewer phone calls from VA schedulers.
- Required to engage large community practices and smaller providers.
- Aim to create a user-friendly, seamless scheduling system for both direct care and community care.
- Engagement with external providers and system effectiveness remain critical areas for improvement.

#### Next Steps

- Continued efforts to reduce the number of scheduling platforms and applications.
- Technology enhancements to leverage enhancements for broader, efficient scheduling.
- Effectiveness and refining systems based on Veteran and provider feedback.

#### *Key Takeaways from SMAG Members*

- **Low Utilization Rates:** Both in VHA and private sector, self-scheduling for medical appointments remains underutilized with significant room for improvement.
- VA needs to showcase the benefits to provider organizations, emphasizing they can handle more volume without extra burden on their schedulers.
- Current systems like Oracle do not fully meet VA's statutory requirements, particularly concerning metrics like the "third next available" appointment.
- **Patient Experience Metrics:** Increasing reliance on patient-reported satisfaction and feedback as primary metrics for evaluating access and care effectiveness.
- Ensuring transportation issues are addressed to reduce missed appointments and improve care delivery.

#### *Key Recommendations*

- These recommendations aim to enhance the scheduling system, improve access, and effectively meet the diverse needs of Veterans.
- Integrating community care providers into the VA scheduling system is a major challenge. Bulk engagement methods should be considered.
- Maintaining trust through clear communication when transitioning to new systems or reporting methods.
- **Engagement and Integration:**
  - Develop a broad strategy to involve professional associations, practice

- management systems, and integrated networks to streamline provider engagement with VA scheduling systems.
- Emphasize to providers the value proposition of using VA's scheduling systems, highlighting potential increases in patient volume with minimal additional effort.
- Patient-Centered Approach:
  - Continue shifting towards using patient satisfaction metrics as primary indicators of scheduling and access success.
  - Address concerns pertaining to "bait and switch" practices in self-scheduling and ensure Veterans are genuinely able to self-schedule appointments, not just request them.
- Maintain clear and transparent communication as the VA transitions to using new metrics or systems to retain stakeholder trust.
- Implement pilot programs to demonstrate the potential benefits of full deployment and foster internal competition to drive progress.
- Ensure scheduling systems are linked with transportation services to support Veterans in keeping their appointments, thus reducing missed opportunities.

## **SUICIDE PREVENTION**

### **Summary of Presentation by Dr. Matthew Miller, Director Suicide Prevention Program**

- Core tenets of Suicide Prevention
  - Suicide is preventable
    - Individual Level
      - Address patient diagnosis
      - Evidence-based care offered by VA
    - Community Level
      - Address homelessness, access to care, occupational access and readiness
  - Suicide prevention-public health approach (clinical aspects)
    - Address mental and medical health, social determinants of health, policy issues and advance research.
  - Everyone has a role to play
    - Build strategic plan roles for clinicians, peers, those who have lived the experience, family members, caregivers and Veterans themselves.
- Challenges
  - Suicide Prevention Training (not achieving the targeted metrics)
    - Important, all clinical providers across the VA are trained in suicide assessment and care.
    - Training for VHA care teams (lower than 95%-greater than 5 years)
    - Currently training for VHA employees is less than 75%.

- Clinicians and Non-Clinicians have different training criteria. Intended to increase informed situational awareness.
    - Training for Community care providers-who have received a Veteran referral (Only 2% completed VHA training in suicide risk assessment)
- Veteran Suicide Prevention: Community Engagement
  - Population Healthcare Management
    - Governors and Mayor's Challenge
    - Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program
      - The program has successfully built 2,700 community coalitions, with an additional 750 currently in development.
      - Community Engagement Program Coordinators out in the field every day.
- Questions for SMAG Members
  - What strategies have you seen, beyond policy implementation, to encourage staff engagement of suicide prevention training?
  - Only 2% of community network providers have participated in suicide prevention training offered by VA, parallel to that required of VHA staff. What strategies have you seen to encourage community network healthcare providers to participate in suicide prevention assessment and intervention training?
  - What suicide prevention strategies have been a success in your organization that could potentially be implemented in the VA?

### *Key Takeaways from SMAG Members*

- Timeframe is crucial to reach transitioning service members after discharge. Veterans with documented suicidal thoughts, substance use, or mental health conditions prior to transition from military service are at a 450% higher risk to die by suicide within 12 months of separation.
  - Advancing the support for transitioning service members has been a definite focus of this administration.
  - Request a standardized separation health assessment for all branches.
    - Solid Start Program is provided to all individuals. Three phone calls across 180-day time period to separating service members offering them VA services and helping connect them to local resources, VA and beyond VA.
      - DoD has an elevated priority list that they use to prioritize contacting as part of their process.
- Tracking suicide attempts and interventions used.
  - Suicide Prevention 2.0 encourages Veterans and health care facilities to refer Veterans who have recently attempted suicide to treatment, they are guaranteed a spot. Geography is never an access barrier.

- There was a significant decrease in suicide attempts among individuals who underwent therapy compared to the comparison group, which consisted of individuals who had attempted suicide but did not receive any subsequent treatment.
  - There is an increase in mental health engagement but decreases in emergency room visits and crisis care.
  - VHA can track suicide attempts, interventions, and deaths for veterans who are engaged with their services; however, they cannot track this data for Veterans who have no engagement with the VHA
- Systems in place for provider referrals when Veteran is recognized at high risk.
  - Standard operating procedures for connecting Veterans to care are provided to staff.
  - VHA moved to one stop shop approach in pain, sleep and primary clinics to help address when suicide risk assessments are triggered and the Veteran needs are met.
- Current Suicide rate numbers.
  - The current suicide rate per day is 17.6 down from 10 years ago when it was 22 and 18.6 in 2019.
- Physical pain versus mental pain and how it affects people differently.
  - Veterans with psychological pain are at higher risk than even physical pain to commit suicide.
  - The Veterans Health Administration (VHA) integrates suicide risk assessments into specific clinics when patients receive distressing medical news.
- Continuing public awareness of 988 Suicide and Crisis Hotline.
- Provide nurses and physicians with additional training for suicide risk assessment.
  - Currently, there are very few college courses focused on suicide risk assessment for clinicians, primary care providers, and nurses. Significant improvements could be made in this area.
- It is important to form and expand partnerships between tribes, IHS and VHA.
  - Expand invitations to tribal health and Indian Health Services (IHS) to participate in suicide prevention offered trainings.
  - VA outreach programs focus on mental health and suicide prevention for Navajo Veterans.
  - Warriors path program (Alaska), culturally informed therapy and Veterans peer support.
  - IHS integrates ceremonies and using elders, talking circles, peer support programs.
- It is important to address grief or suicide in a culturally acceptable way.
  - A recent innovative solution implemented in VHA is using talking circles in a peer-based approach across the Navajo Nation. Part of the solution was increased access to equipment and wireless services.
  - In some cultures, particularly some native and indigenous cultures saying the word suicide closes communication rather than opens communication. This highlights the importance of training across providers.
  - Asking the question can be considered and intervention.

- Firearm Safety
  - 75% of Veteran suicide deaths are the result of firearms, a rate that is 20% higher than non-Veteran US Adult peer populations
  - Create a triangle between a person, firearm and ammunition.
  - Focus on secure storage
  - Cable locks provided
- Suicide prevention is a priority for the Secretary of Veterans Affairs (SECVA), there should be both positive and negative incentives associated with the mandatory suicide prevention training.
- Suicide Prevention Budget
  - SECVA prioritizes addressing budget issues as they arise

### *Key Recommendations*

- Provide Buddy Check Week information to SMAG members.
- Provide the requested information regarding the amount of VHA-mandated training required for personnel.

## **CLOSING REMARKS**

### **Summary of Closing Remarks by Dr. Gregg Meyer, Chairperson for VA SMAG Committee**

- Please make note of potential future 2026 SMAG Meeting dates of March 17<sup>th</sup> and 18<sup>th</sup> in Washington D.C. and August 4<sup>th</sup> and 5<sup>th</sup> in a location to be determined, but perhaps Tulsa, Oklahoma. Also in 2027, March 16<sup>th</sup> and 17<sup>th</sup>, which will be back in D.C.
- Noted an increase in discussion as more individuals were able to be present at this meeting, hopes it is something we will continue to see in the future.
- Hopes the connection between agenda topics is apparent, with the EHRM discussion tying it into all other topics.
- The Elizabeth Dole Act will likely be revisited in future meetings.
- Gave a heartfelt appreciation for those that work for the VA and the National Cemetery Administration as he shared his father's experience with both agencies as he passed away a couple of weeks ago.

### **Summary of Closing Remarks by Dr. Steven Lieberman, Acting VHA USH**

- Expressed appreciation to all contributing discussion and suggestions to move forward in achieving our priorities and overcoming challenges.

## **AFTER ACTIONS**

### **Summary Presentation by Mr. Brian Schoenhofer, VA DFO for SMAG**

- The future spring SMAG meeting will be held in Washington D.C. in March 2026 with a specific date to be determined later.
- The summer/fall 2026 meeting's location has not been solidified, however; according to previous meeting discussions members would like to visit a rural facility.
- One potential location is Jack C. Montgomery Veterans Affairs Medical Center in Muskogee, Oklahoma. The hospital serves a large Native American population, heavily involved in rural health, and has a large Women's Health service. However, if you have any other site suggestions, please let Mr. Schoenhofer or staff know.
- Dr. Mittelman recommends the VA to hire a permanent National Program Director for Optometry as it has been vacant for the past two years.
- Follow-up on the nursing workforce and Women's Health was requested.

*August 5, 2025 – Meeting Adjournment 4:29 P.M. ET*

Meeting Minutes approved by:

**/s/ Gregg S. Meyer, M.D., MSc**  
**Chairman, VA Special Medical Advisory Group**

**/s/ Brian Schoenhofer**  
**Designated Federal Officer**