VA Greater Los Angeles
Healthcare System Update
VCOEB

West LA Campus Master Plan IPT
Status Update

April 16, 2019
9:15 – 10:30am

Updates Since Last Meeting

Agenda Topics

1. Principal Developer Community Plan
2. Innovative Funding Opportunities
3. Enterprise District Planning
4. OIG Implementation Progress
5. Mission Act Market Assessment

Original 1888 Conveyance

West LA VA Campus

Principal Developer Community Planning

Update

- As an input to the PEIS, VA has asked the West LA Veterans Collective to recommend a community plan that meets the needs of homeless and other vulnerable Veterans and their families, identifies options for adaptive reuse of existing buildings, and provides feasible funding and phasing plans that expeditiously deliver housing.

Discussion Topics

- How should VA work with the Principal Developer to deliberately plan housing groupings (i.e., sort by acuity, mobility, family/caregivers vs. singles, service era, etc.)?
- What structure is appropriate for community governance (i.e., Homeowner's Association, Neighborhood Council, etc.)?
- What process should VA undertake to name neighborhood(s)?
- How should VA plan policing and safety for community?

Funding Challenges and Opportunities

Update

- Developer financing of Enhanced Use Leases (EULs) requires a myriad of funding sources and innovative approaches from public and private-sector partners.

Discussion Topics

- What are the pros/cons of broadening definition of Veteran to allow for EUL developers to tap into potential California State funding sources?
- Should VA healthcare eligibility criteria be a pre-requisite for placement in housing on the West LA campus?
- What innovative funding sources might expedite the delivery of housing and/or facilitate delivery of services not covered by EULs?
- What potential legislative changes might expedite financing and delivery of permanent supportive housing and/or other services?

Enterprise District Planning

Update

- VA is exploring service partnership opportunities for Veteran training, employment, and cultural opportunities in the area designated as the Enterprise District in the Draft Master Plan
- Homeless Veterans most often express interest in employment in these fields:
  - Food Services
  - Securit
  - Office/Administrative
  - Transportation

Discussion Topics

- What potential partnership opportunities should VA consider in planning the Enterprise District?
- What other external stakeholder groups should be included in this planning process?

Engineering/Enterprise District Buildings

OIG Recommendation Implementation Progress

Update

- VA is considering the full range of options, to include terminating third-party land uses the OIG found to be improper, renegotiating land uses to bring them in compliance with applicable law, and re-documenting certain land uses OIG flagged as improperly documented.
- Implementing the OIG's recommendations requires continued coordination with VA Central Office to ensure the proposed strategy for each agreement aligns with applicable law, the Draft Master Plan, and VA's mission to serve Veterans.

Discussion Topics

- What are the litigation risks, financial risks, reputational risks, and benefits to Veterans associated with each potential approaches to implementing the OIG land use recommendations?
- How might VA best identify Veterans' highest-priority needs that might be met by existing and future third-party land users?

MISSION Act Requirements

Update

- The VA MISSION Act requires VA to perform regional market assessments studying the demand for VA healthcare in various localities and the average time it takes Veterans to reach VA facilities for primary and specialty care appointments
- The MISSION Act also authorizes the President to appoint a BRAC-style VA Asset and Infrastructure Review Commission.
- The market assessments and AIR Commission recommendations will be used for long-term planning and rightsizing future VA healthcare services and locations.

Discussion Topics

- What are the potential impacts of the MISSION Act market assessments and AIR Commission on the West LA Campus healthcare operations and housing?
- What recommendations might VCOEB consider making to ensure VA continues to meet Los Angeles-area Veterans' healthcare and housing needs?

VA Greater Los Angeles
Healthcare System Update
VCOEB

Strategic Communication Briefing

April 16, 2019
12:45 – 1:45pm

Updates

VA Improvements to Transparency re: WLA Land Use and Services

- FOIA Reading Library
- GovDelivery Enhancements
- Expanded Opportunities for Veteran Input
- Proactive Communications

VA Public Affairs Process

- VA Central Office Process
- National vs. Local Media Outlets
- Responsiveness and Agile Communications

Draft Master Plan Website

VA Greater Los Angeles
Healthcare System Update
VCOEB

Lease Revenue Fund Briefing

April 17, 2019
10:00 – 11:00am

Agenda Topics

1. West LA Leasing Act
2. Lease Revenue Account Forecast
3. Potential Project: Domiciliary Garden Improvements
4. Other North Campus Infrastructure Needs: Building 156

West Los Angeles Leasing Act of 2016 (Public Law 114-226)

(d) Revenues From Leases at the Campus.--Any funds received by the Secretary under a lease described in subsection (b) shall be credited to the applicable Department medical facilities account and shall be available, without fiscal year limitation and without further appropriation, exclusively for the renovation and maintenance of the land and facilities at the Campus.

VA Enhanced Use Leasing Authority – 38 U.S.C. 8122

3) (A) For any enhanced-use lease entered into by the Secretary, the lease consideration provided to the Secretary shall consist solely of cash at fair value as determined by the Secretary.

(B) The Secretary shall receive no other type of consideration for an enhanced-use lease besides cash.

(C) The Secretary may enter into an enhanced-use lease without receiving consideration.

(D) The Secretary may not waive or postpone the obligation of a lessee to pay any consideration under an enhanced-use lease, including monthly rent.

Lease Revenue Account Forecast

Summary	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
	2016	2017	2018	2019	2020	2021
Brentwood School	$283,333	$850,000	$850,000	$857,083	$871,250	$871,250
UCLA	$25,000	$300,250	$303,253	$306,285	$309,348	$312,441
EUL Program (B209)	$0	$19,440	$20,023	$20,624	$21,243	$21,880
Total	**$308,333**	**$1,169,690**	**$1,173,276**	**$1,183,992**	**$1,201,840**	**$1,205,571**

Summary	Year 6	Year 7	Year 8	Year 9	Year 10	
	2022	2023	2024	2025	2026	Total
Brentwood School	$878,510	$893,031	$893,031	$893,031	$595,354	$8,735,875
UCLA	$315,566	$318,721	$321,909	$325,128	$300,763	$3,138,664
EUL Program (B209)	$22,536	$23,212	$23,909	$24,626	$25,365	$222,858
Total	**$1,216,612**	**$1,234,965**	**$1,238,849**	**$1,242,785**	**$921,482**	**$12,097,397**

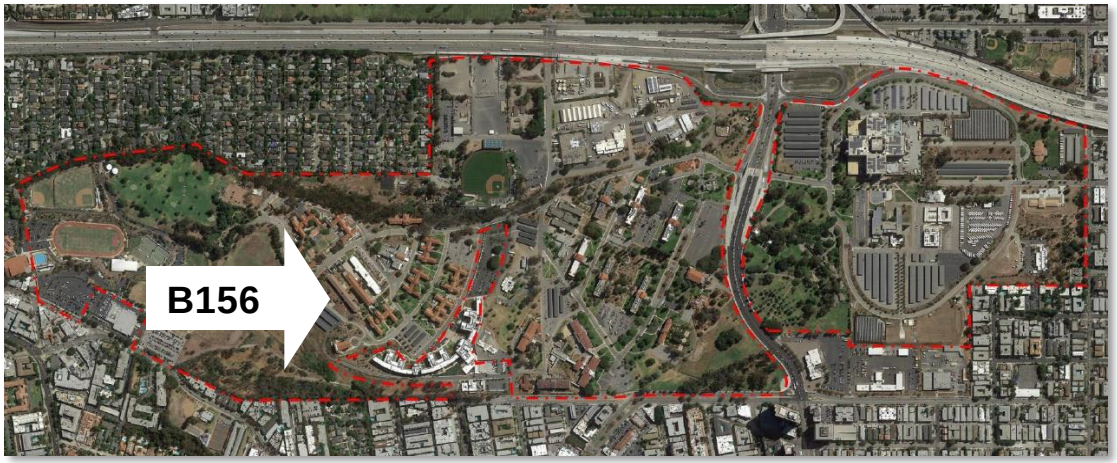
Note: EUL terms, including rent payment amounts, have not yet been set for Buildings 205/208, 207, MacArthur Field, or other future Principal Developer projects

Potential Project: Domiciliary Garden Improvements

Other Campus Renovation/ Maintenance Needs

Case Study: Building 156

- Built in 1921, Building 156 is a rectangular two story structure with partial basement designed in the Mission Revival style.
- Building 156 is connected to Building 157 by a stucco arcaded breezeway with multilight arched windows and gabled terra cotta tile roof.
- This is a vacant building in significant disrepair. The building formerly functioned as a hospital but is currently unoccupied and is not upgraded for accessibility. The painted concrete and stucco façade is in poor condition and a complete renovation is required prior to building re-occupation.



SAIL Briefing

Veterans Community Oversight and Engagement Board (VCOEB)
Federal Advisory Committee Act (FACA)

Our Journey towards Excellence

VA Greater Los Angeles Healthcare System

Ann R. Brown, FACHE
Medical Center Director

April 16, 2019

Why Are We Here?

VHA Mission

- Honor America's Veterans by providing **exceptional health care** that improves their health and well-being.

VHA Vision

- VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient centered and evidence based.
- This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.
- It will emphasize prevention and population health and contribute to the nation's well-being through education, research and service in National emergencies.

What is “**exceptional health care**”?

What is “exceptional health care”?

Six Domains of Health Care Quality (Institute of Medicine)

1. Safe
2. Effective
3. Patient-Centered
4. Timely
5. Efficient
6. Equitable

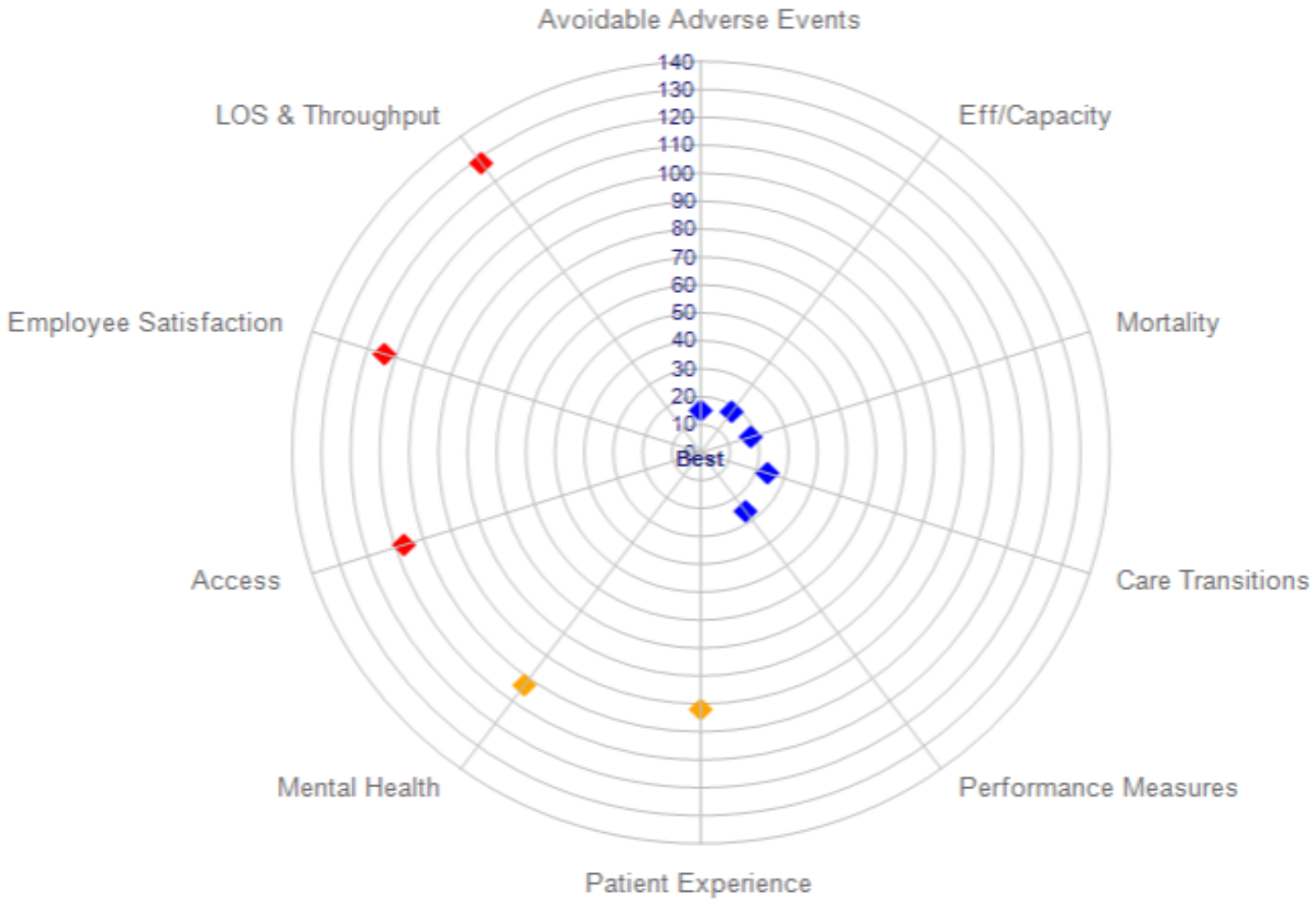
SAIL

- **S**trategic **A**nalytics for **I**mprovement and **L**earning
- Balanced Scorecard Model for 130 VA facilities
- Primarily uses 12 month rolling averages
  - One good/bad month will not cause a drastic change
- Scores/Ranking are reported as a direct comparison to other VA's
  - You don't have to run faster than the bear to survive. You just have to run faster than the guy next to you.
  - Recent *Annals of Internal Medicine* study noted VA hospitals outperform private hospitals in most health care markets throughout the country. Community benchmarks not a factor for SAIL.
- Survey Instruments incorporated
  - Examples: Survey of Healthcare Experiences of Patients (SHEP), All Employee Survey (AES)

SHEP

- Provides a system-wide assessment of Veterans' experiences with VA health care in the Inpatient and Outpatient Care settings
- Administers surveys based on the industry-standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of survey questionnaires to assess patients' perceptions of care
- Utilizes data-driven analyses to inform decision-making aimed at improving patients' healthcare experiences and quality of care
- Supports transparency through external benchmarking and public reporting
- **~25% of SAIL based on SHEP results**

Los Angeles VAMC (FY2018Q4) (Domain)



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Avoidable Adverse Events

- In-Hospital Complications
  - Studies support relationship to quality of nursing care
  - Examples: hospital acquired pneumonia, wound infection after admission
- Healthcare associated infection
  - Becoming “never events”
  - Examples: central line bloodstream infection (CLABSI), catheter associated urinary tract infections (CAUTI)

Efficiency/Capacity

1. Cost Domain to measure operational efficiency
2. Physician Capacity
   - Similar to Private Sector use of Relative Value Units (RVUs)

- Note this domain does not factor in the overall Quality rating for GLA

Mortality

- Reported as a Ratio
- Compares number of deaths (either during hospitalization or 30 days following hospitalization) to predicted deaths
  - Predicted Deaths is based on an algorithm that factors in severity of illness

Care Transitions

- Ambulatory Care Sensitive Conditions Hospitalizations
  - We get “dinged” when a Veteran is admitted to the hospital for something that ideally should have been treated as an outpatient
    - Examples include high blood pressure, COPD, UTI, CHF
    - Nationally recognized systems of care measure
- All-Cause 30 day Readmission Rate
  - If you got your car back from the mechanic, you hope you don’t have to take it back right away unless it was planned

Performance Measures

- ORYX – Inpatient Quality Measures
  - Examples: Flu immunizations during hospitalization, tobacco cessation, addressing substance abuse
- HEDIS – Outpatient Quality Measures
  - Examples: Diabetic retinal screening, timely cancer screening, Depression, PTSD screening
- HEDIS eQMs – Outpatient *electronic* Quality Measures
  - New measures that are computer extracted
  - Heavily reliant on the information being in the "right" spot for the computer to find
  - Focus on Diabetes and Heart Disease

Patient Experience

- Veteran survey based (SHEP)
- Overall Rating of the hospital
- Rating of Primary Care Provider
- Rating of Specialty Care Provider
- Primary Care Mental Health Care Coordination
- Specialty Care Coordination
- Discharge from Hospital
  - Veteran preferences were accounted for by staff
  - Good understanding of plan to manage health
  - Understanding medications at discharge
- Stress Discussed in last 6 months

Mental Health

- **Population Coverage**: Measuring accessibility of Uniformed Mental Health Services Handbook required mental health services for the population of patients with a potential indication for care.
- **Continuity of Care**: Measuring the extent to which mental health services are proactive, coordinated, and able to engage patients in evidence-based episodes of care.
- **Experience of Care**: Measuring patient and provider experience in terms of access to, quality of, and patient-centered delivery of mental health services.
  - Annual Provider Survey and On-going Veteran Satisfaction Survey

Access

- Perception of Veteran Based (SHEP based)
  - Veteran rating of experience getting routine timely appointments and information from PCP, Mental Health, or Specialty care
  - Veteran rating of experience getting urgent timely appointments and information from PCP, Mental Health, or Specialty care
- Call Center
  - Average speed to answer
  - Abandonment Rate

Employee Satisfaction

- All Employee Survey Best Place to Work
  - Annual Survey – coming up in June 2019

- Registered Nurse (RN) turnover rate
  - Quit & Termination Rate excluding retirements

LOS & Throughput

LOS = Length of Stay

- Severity Adjusted
- Limited to the inpatient hospital setting

Throughput

- % of Admissions meeting InterQual Criteria
- % of Continue Stays meeting InterQual Criteria

Does SAIL get us to “exceptional health care”?

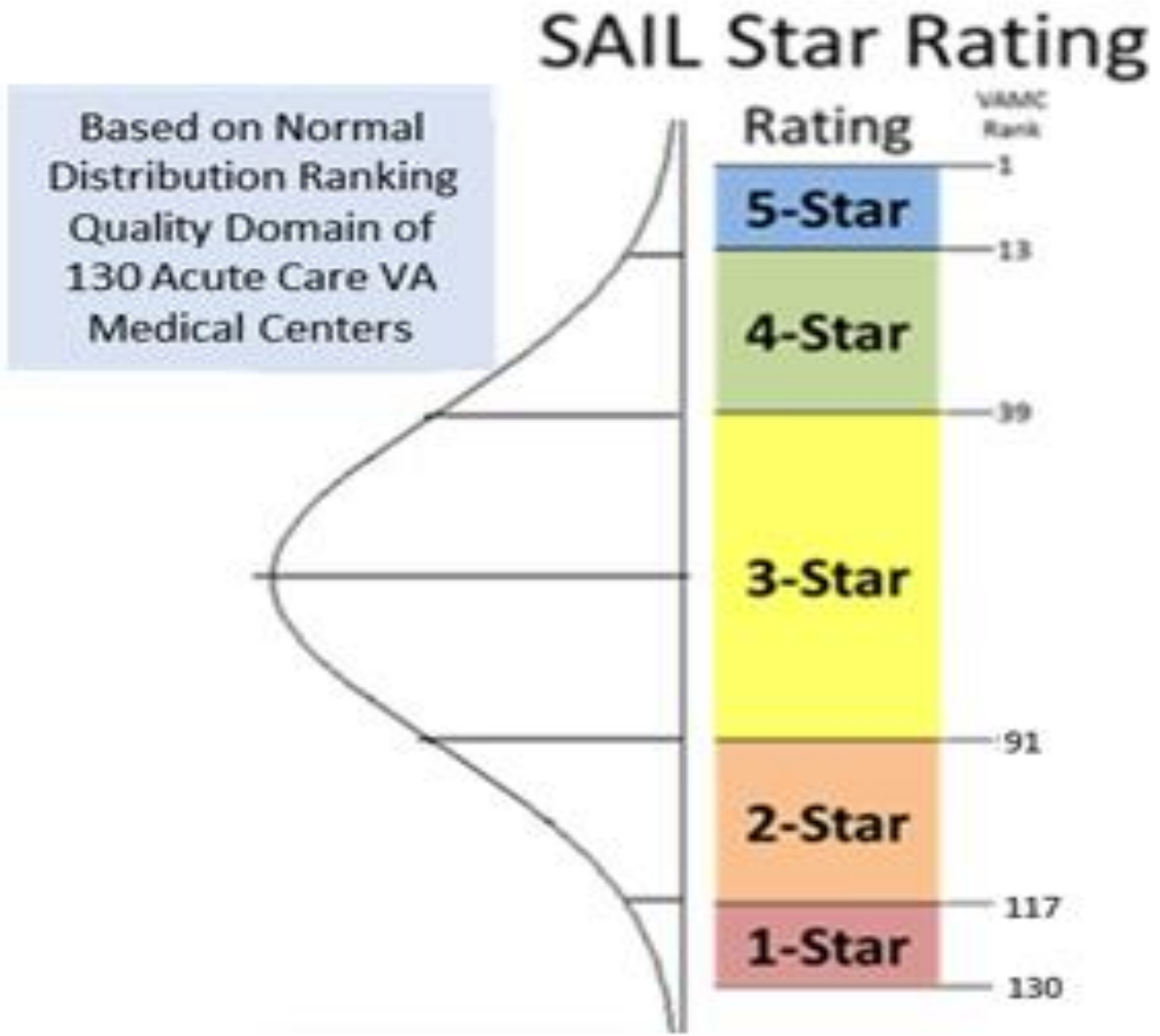
6 Domains of Health Care Quality (IOM)

1. Safe
2. Effective
3. Patient-Centered
4. Timely
5. Efficient
6. Equitable

SAIL Domains Crosswalk

1. Avoidable Adverse Events
2. Performance Measures, MH
3. Access, Patient Experience, MH
4. Access, MH, Care Transitions
5. Efficiency/Capacity, Employee Satisfaction
6. Care Transitions

Forced Distribution of VA Medical Centers



Our Road Map

Current State

- Doing well on “traditional” performance metrics
  - Inpatient, outpatient, adverse events
  - Reviewer able to use all parts of the medical record to assess performance
- Access to care
  - If Veteran calls on Monday morning
    - Seen by PCP same day for urgent issues
    - Routine appts: on average have a scheduled appointment by Friday

Future State

- New Focus on population health using electronic quality measures
  - Computer generated measures
  - Issues with proper documentation and coding
- Challenges in the “soft” metrics
  - Perception measures -> Veteran Experience
    - Did the Veteran get the care when expected?
    - If I want to be seen Tuesday -> Not Satisfied if I am seen on Friday
- Employee Engagement
  - Here for the Veterans first through exceptional care delivered by our employees -> increasing recognition

Important Upcoming Milestones & Events

- Roll-out of Mission Act
  - Challenge in coordinating care and providing exceptional health care
- SAIL focus
  - Increase comparison to the community standard and not just relative to performance of other VA facilities
- Master Plan
  - Improving integration of healthcare delivery and equitable treatment for special populations (homeless, MH, geriatric)
- All Employee Survey
  - June 2019
- GLA's improvement in HR functions to ensure a workforce that is ready, willing, and able to best serve our Veterans

VETERANS HEALTH ADMINISTRATION

Whole Health

Presentation for: Veterans and Community Oversight and Engagement Board

Presented by: Tracy W. Gaudet, MD, Executive Director,
Office of Patient Centered Care & Cultural Transformation

Date of Briefing: April 16, 2019

The Opportunity

- **The Opportunity** - to change the WAY we deliver healthcare to partner with Veterans and improve their whole health, something that other systems cannot do. VA is already leading this movement nationally.

- **We meet a huge need for our Veterans** - we improve well-being, clinical outcomes, access to our system with additional points of entry, AND we serve as the model for the future of healthcare for our nation.

The Transformation of Healthcare

AS IS

- Focused on disease
- Problem based
- Physician-directed
- Disease management
- Find it, fix it
- Reactive
- Sporadic
- Biomedical interventions
- Individual left to enact

TRANSFORMED

- Focused on the person
- Aspiration based
- Person partners with team
- Health optimization
- Identify risk, minimize it
- Proactive
- Lifelong planning
- Whole person approaches
- Skill building and support

The Core Problem?

We have put the disease
at the center,
not the person.

Dr. Stone's Support of Whole Health

"We are about cultural change –
this is the Whole Health approach.
THAT is the foundation of what we are about.
We will lead American medicine
as we transform."

Veterans Affairs, Executive in Charge, Richard A. Stone, MD

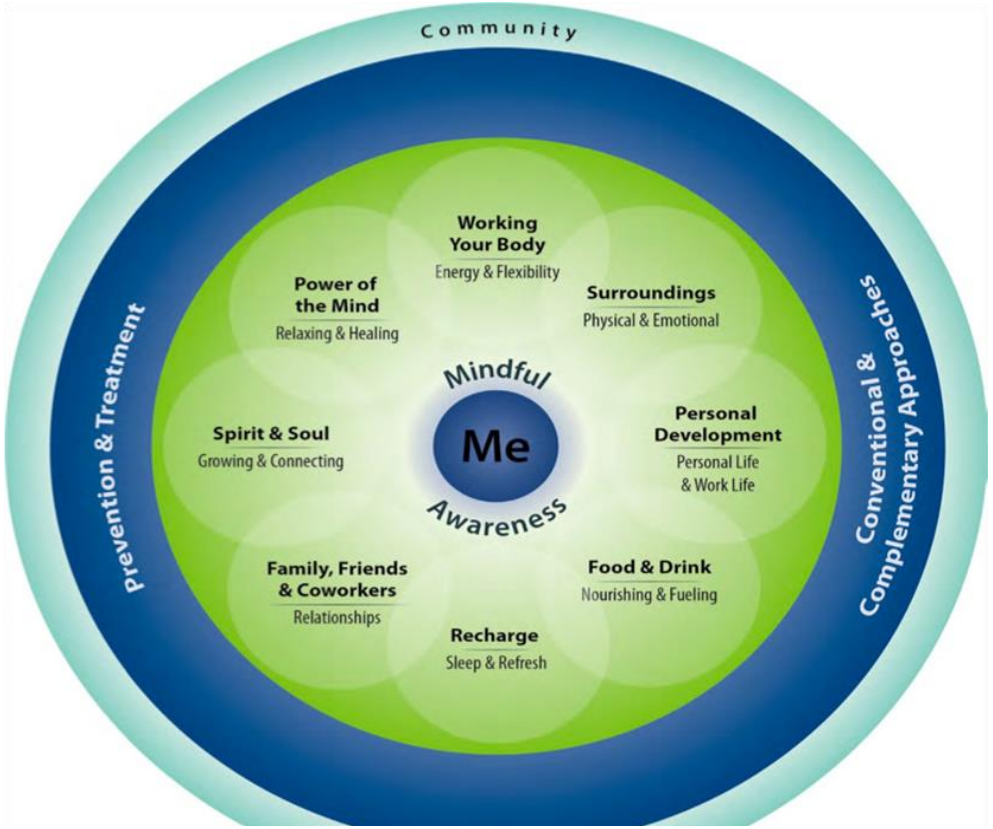
History of VHA Commitment to Whole Health

- **2012:** VHA Strategic Plan FY 2013-2018, Personalized, proactive, patient-driven care designated number one strategic goal. New Directions Design Summit (national thought leaders envision this model), 8 Centers of Innovation (COI's) established and more than 200 Innovation Grants.
- **2013:** NLC Approved this as the VA Model of Care (01/22/13), Executive Decision Memo signed by USH.
- **2014:** COI's and Innovation grants evolve the model; Integrative Health Coordinating Center established.
- **2015:** SEC VA approved Whole Health as VA's approach to Personalized, Proactive, Patient-Driven Care.
- **2016:** Whole Health Design Sites launched; CARA legislation signed into law; delivery model refined; aligned with Opioid Safety and Suicide Prevention.
- **2017:** 18 Flagship Facilities identified; Secured funding; CARA required report specific to Whole Health delivered to Secretary.
- **2018:** IHI Learning Collaborative Initiative practice adopted and kicked off via virtual and face-to-face sessions.

VHA Plan for Modernization

Lane of Effort	VHA Co-Lead	VISN Co-Lead
Commit to Zero Harm	Gerry Cox (10E)	Bill Patterson (VISN 15)
Streamline VHA Central Office Organization	Lu Beck (10P)	DeAnne Seekins (VISN 6)
Reduce Unwarranted Variation Across Integrated Clinical and Operational Service Lines	Teresa Boyd (10NC)	Jeff Milligan (VISN 17)
Deliver 21st Century Whole Health and Mental Health	David Carroll (10NC5) Tracy Gaudet (10NE)	Miguel Lapuz (VISN 8)
Revise Governance Processes and Align Decision Rights	Dee Ramsel (10A2C)	Skye McDougall (VISN 16)
Develop Responsive Shared Services	Jessica Bonjorni (10A2)	Denise Deitzen (VISN 10)
VA MISSION Act: Improving Access to Care	Kameron Matthews (10D) Valerie Mattison-Brown (10P1)	Cynthia Breyfogle (VISN 9) Ralph Gigliotti (VISN 19)
Modernize Electronic Health Records	Charles Hume (10A7)	Mike Murphy (VISN 20)
Transform Financial Management System	Rachel Mitchell (10A3)	Michael Fisher (VISN 22)
Transform Supply Chain	Tammy Czarnecki (10NA) Harry Oldland	Rob McDivitt (VISN 23)

The Whole Health Approach: Mission, Aspiration, Purpose



MyStory: Personal Health Inventory (PHI)

To start a conversation about Whole Health with your PACT team, it helps to identify areas in your life that affect your health and well-being. The PHI identifies your strengths and areas to work on. Complete the PHI below, or you may simply choose to reflect on these questions before attending a Whole Health orientation class. (Online versions are available at **www.va.gov/patientcenteredcare/resources/personal-health-inventory.asp**.)

Rate where you feel you are on the scales below from 1-5, with 1 being miserable and 5 being great.

Physical Well-Being	1	2	3	4	5
Mental/Emotional Well-Being	1	2	3	4	5
How is it to live your day-to-day life?	1	2	3	4	5

What do you live for? What matters to you? Why do you want to be healthy?

For each area below, consider "where you are" and "where you want to be." Then, write in a number between 1 (low) and 5 (high) that best identifies what you think.

Area of Whole Health	*Where I am Now (1-5)*	*Where I Want to Be (1-5)*
Working the Body: "Energy and Flexibility" Moving and doing physical activities.		
Recharge: "Sleep and Refresh" Getting enough sleep and relaxation.		
Food and Drink: "Nourish and Fuel" Eating healthy meals and beverages with plenty of fruits and vegetables each day.		
Personal Development: "Personal life and Work life" Developing abilities and talents. Balancing responsibilities where you live, volunteer, and work.		
Family, Friends, and Co-Workers: "Relationships" The quality of your communication with family, friends and people you work with.		
Spirit and Soul: "Growing and Connecting" Having a sense of purpose and meaning in your life. Feeling connected to something larger than yourself.		
Surroundings: "Physical and Emotional" Feeling safe. Having comfortable, healthy spaces where you work and live.		
Power of the Mind: "Relaxing and Healing" Tapping into the power of your mind to heal and cope. Using mind-body techniques like meditation or guided imagery.		
Professional Care: "Prevention and Treatment" Staying up to date on prevention and understanding your health concerns, care options, and treatment plan.		

What Does This Mean for Veterans, Family and Caregivers?

- The approach that focused on ‘the diseased body part” is phasing out
- With Whole Health, the Veteran, their family, and caregivers are invited into a conversation about their life overall
- All aspects that impact our health and well-being are explored – our communities, our relationships, our environment
- This approach at long last aligns the healthcare delivery system with what Veterans, family, and care givers have always known.

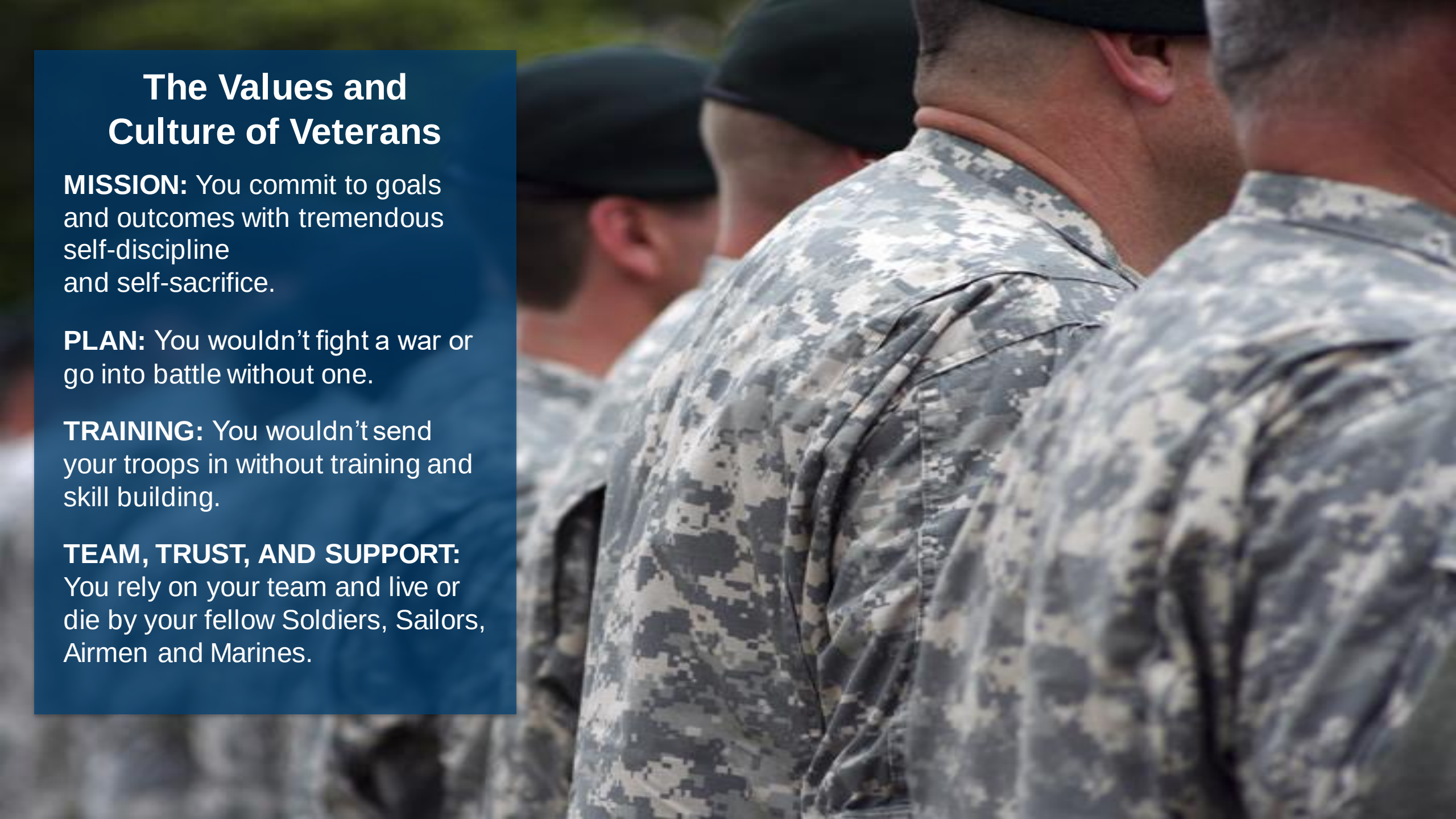
The Values and Culture of Veterans

MISSION: You commit to goals and outcomes with tremendous self-discipline and self-sacrifice.

PLAN: You wouldn't fight a war or go into battle without one.

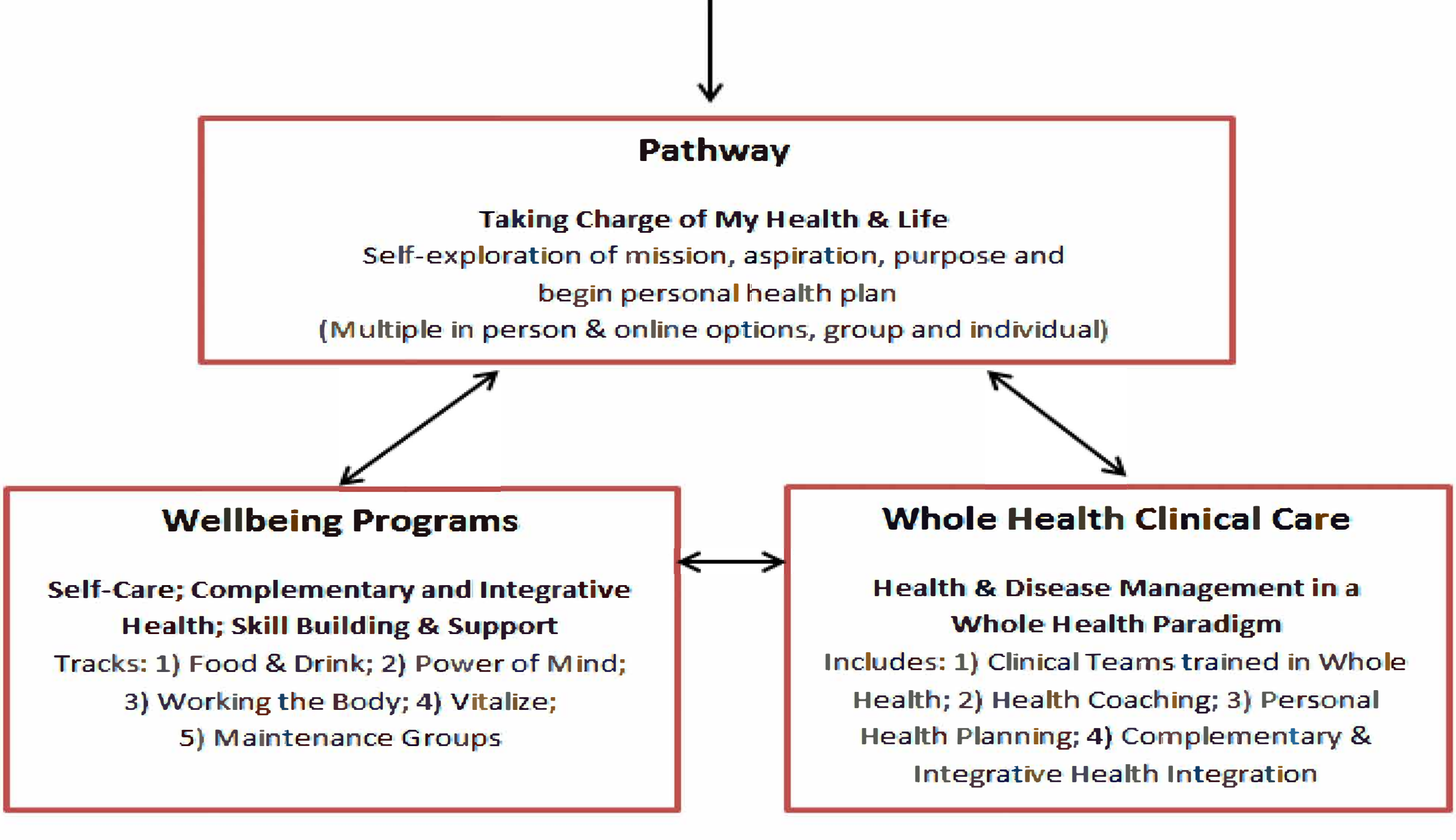
TRAINING: You wouldn't send your troops in without training and skill building.

TEAM, TRUST, AND SUPPORT: You rely on your team and live or die by your fellow Soldiers, Sailors, Airmen and Marines.

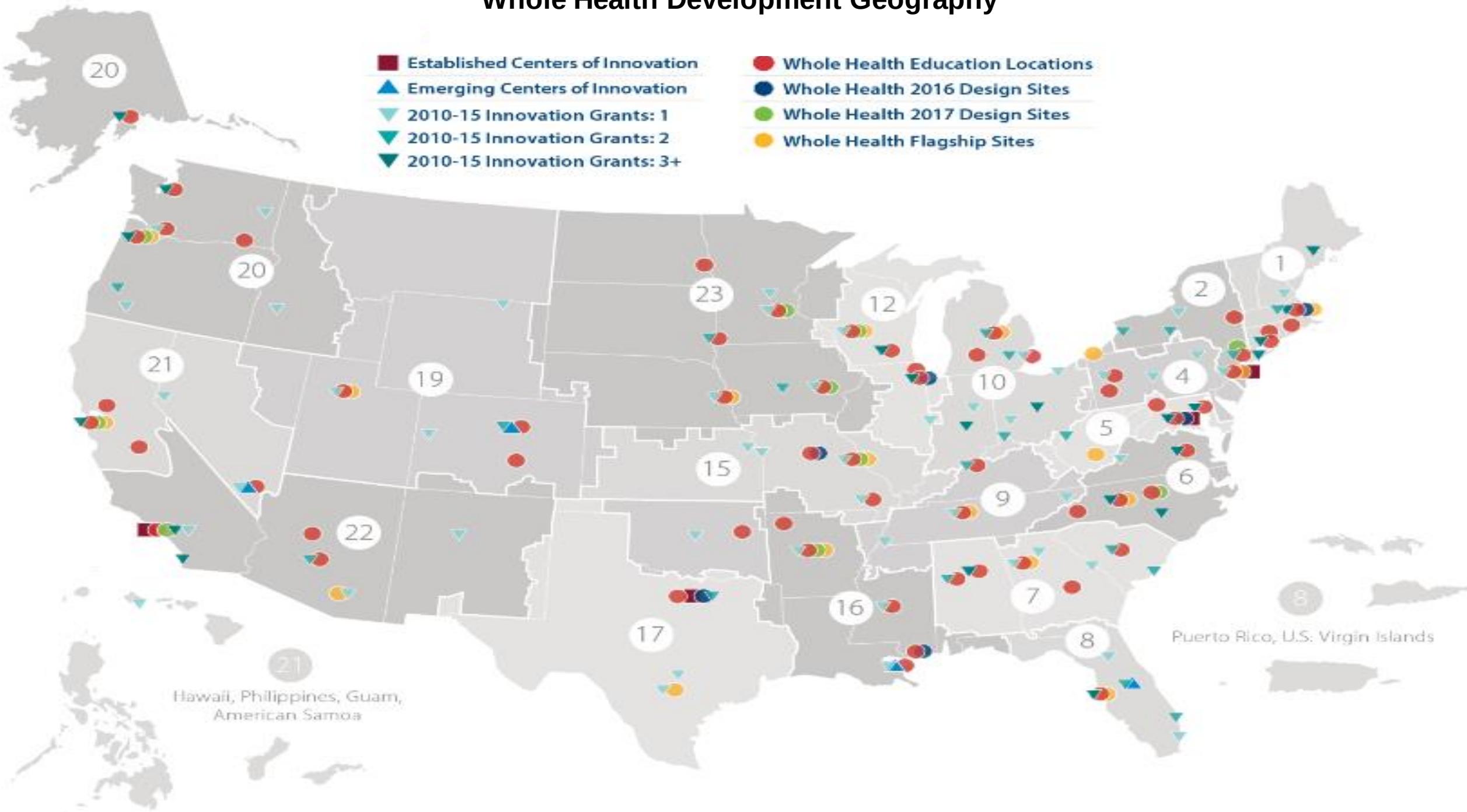


Whole Health
is an approach
to health care that
empowers AND equips
people to take charge
of their health and well-being,
and live their life to the fullest.

The Whole Health System


Pathway
Taking Charge of My Health & Life
Self-exploration of mission, aspiration, purpose and begin personal health plan
(Multiple in person & online options, group and individual)
Wellbeing Programs
Self-Care; Complementary and Integrative Health; Skill Building & Support
Tracks: 1) Food & Drink; 2) Power of Mind; 3) Working the Body; 4) Vitalize; 5) Maintenance Groups
Whole Health Clinical Care
Health & Disease Management in a Whole Health Paradigm
Includes: 1) Clinical Teams trained in Whole Health; 2) Health Coaching; 3) Personal Health Planning; 4) Complementary & Integrative Health Integration

Whole Health Development Geography

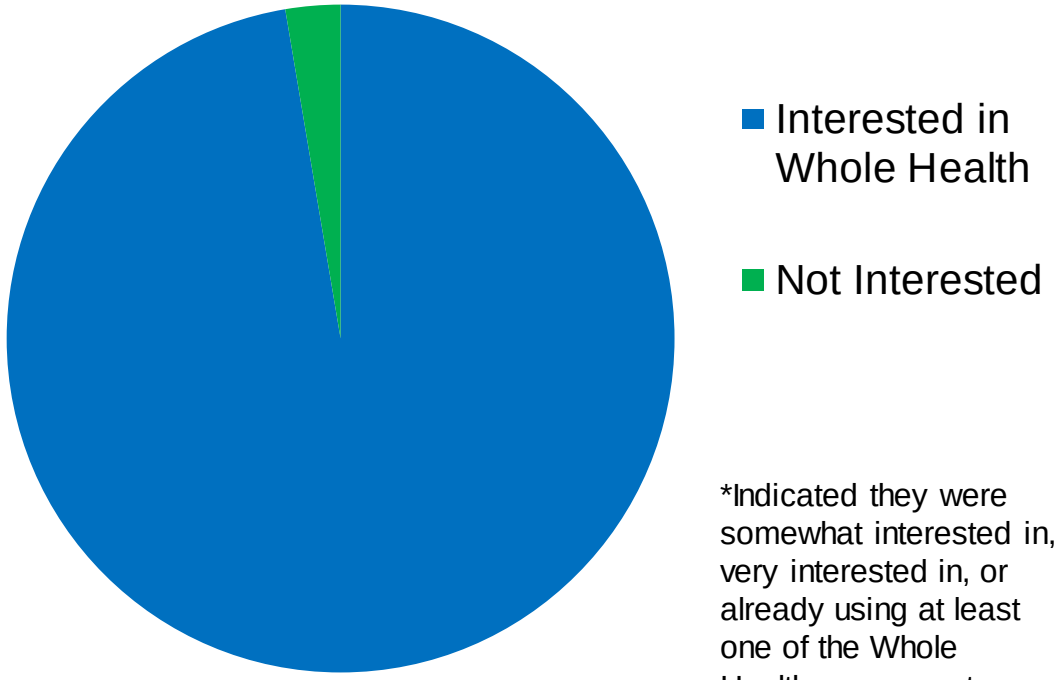


Whole Health – Veteran Demand for WH Approach

Veterans Health and Life Survey (18 flagship sites): Patient-Reported Interest in Whole Health

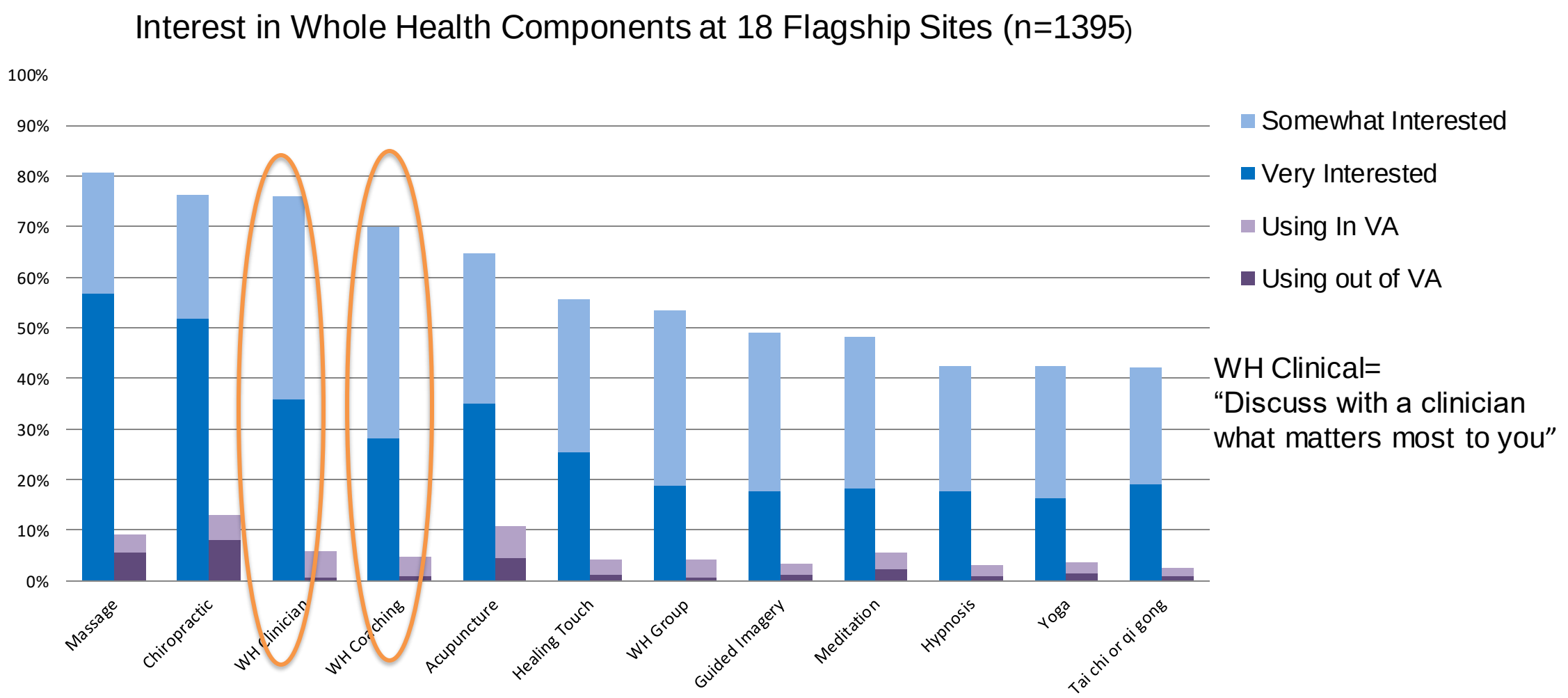
- Veterans Health and Life survey item asking about patients' interest in Whole Health Services (target n=10000)
- Results based on analysis of 1395 returned surveys
- 97% responded they were either somewhat interested, very interested or already using at least one WH service listed.

97% of respondents interested in Whole Health* (n=1395)

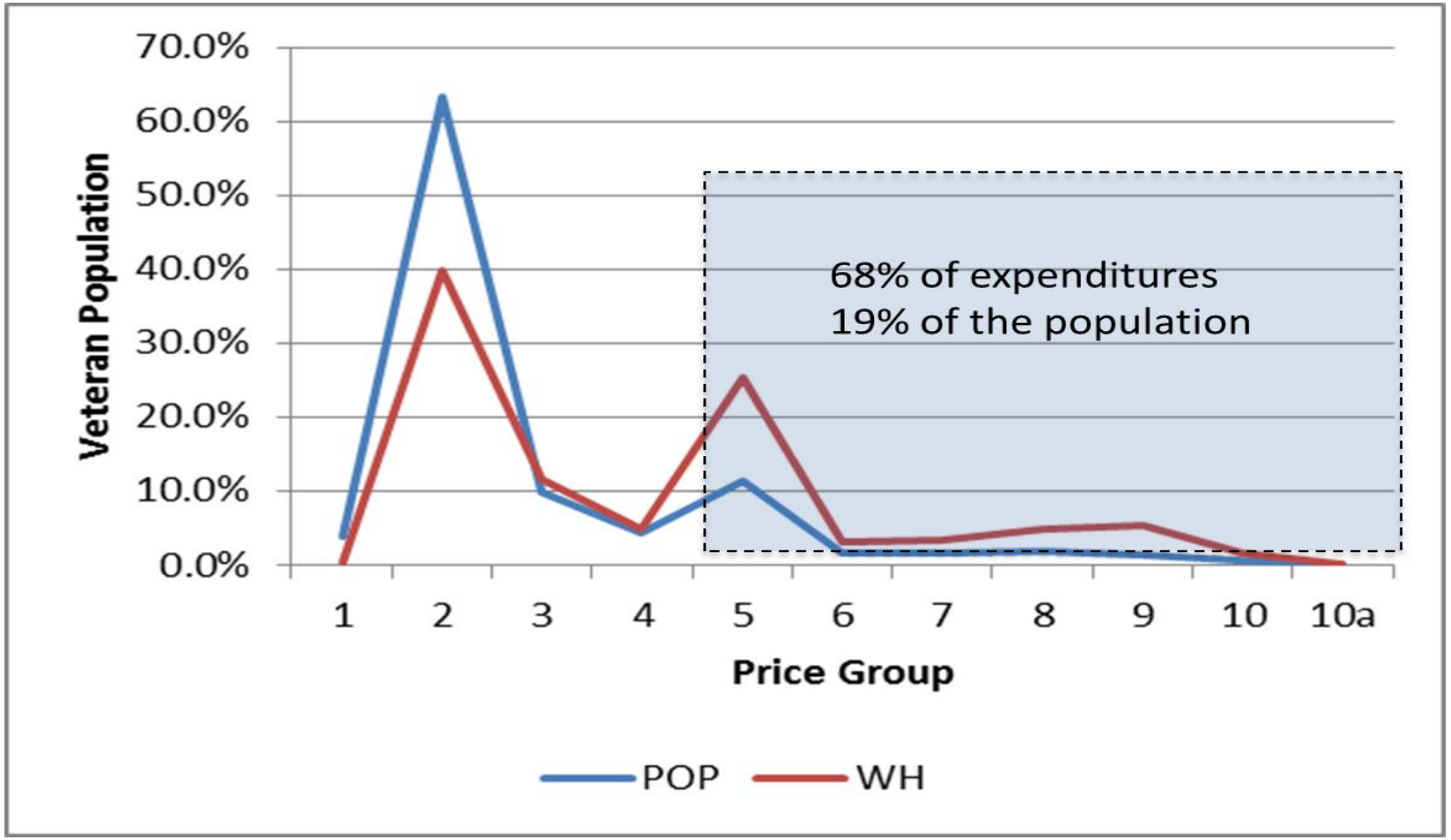


*Indicated they were somewhat interested in, very interested in, or already using at least one of the Whole Health components

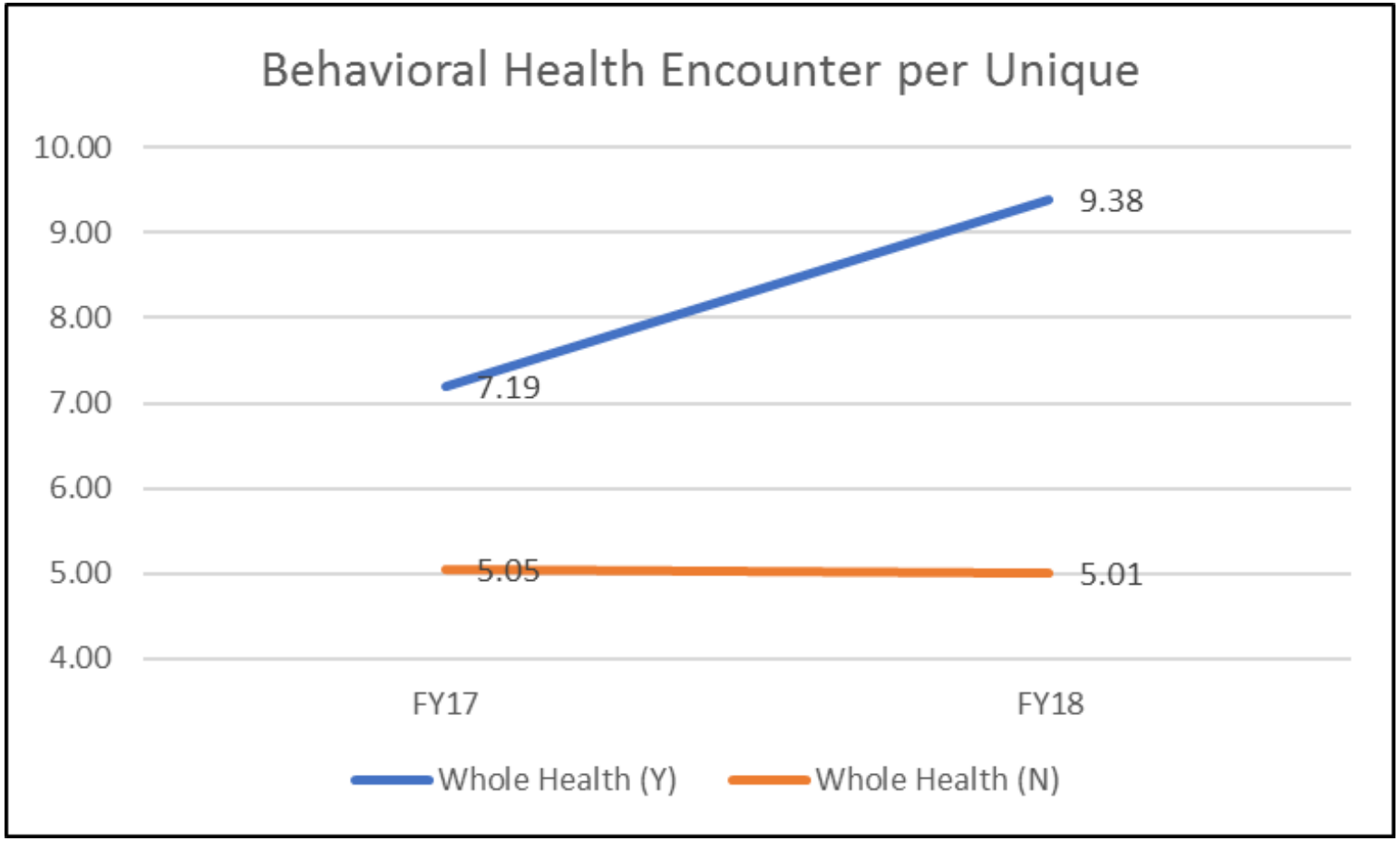
Whole Health-Veteran Demand



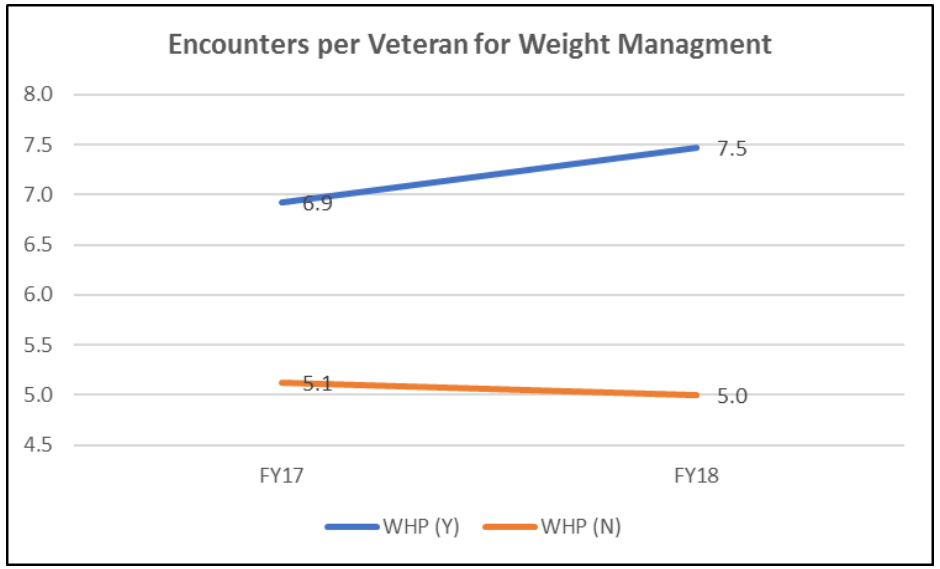
Early Findings: WH Impact on Cost

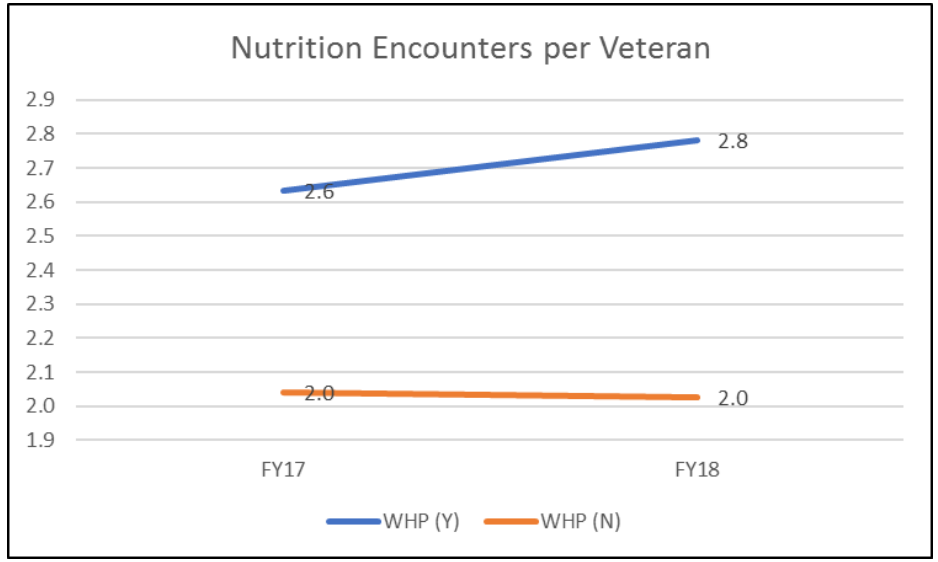


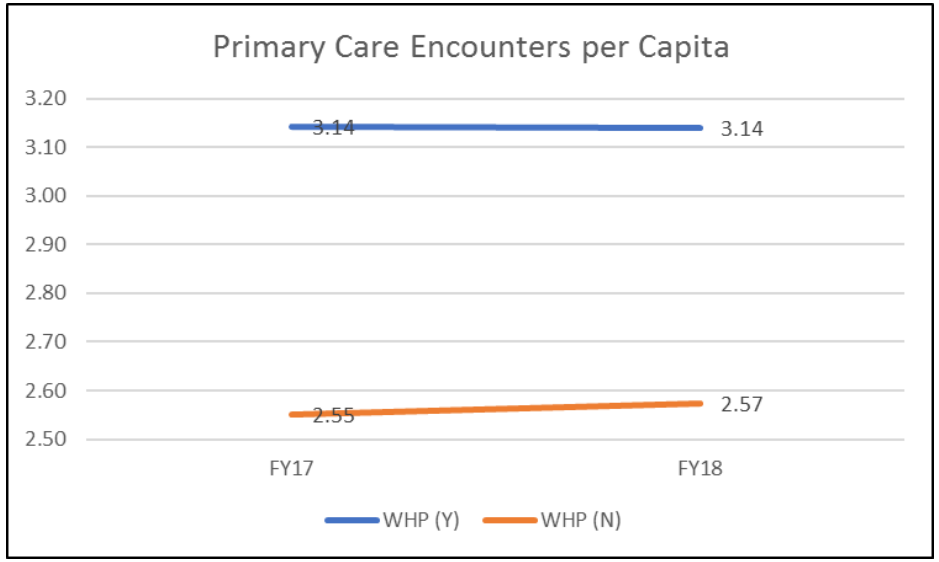
Whole Health Users Receiving More Behavioral Health



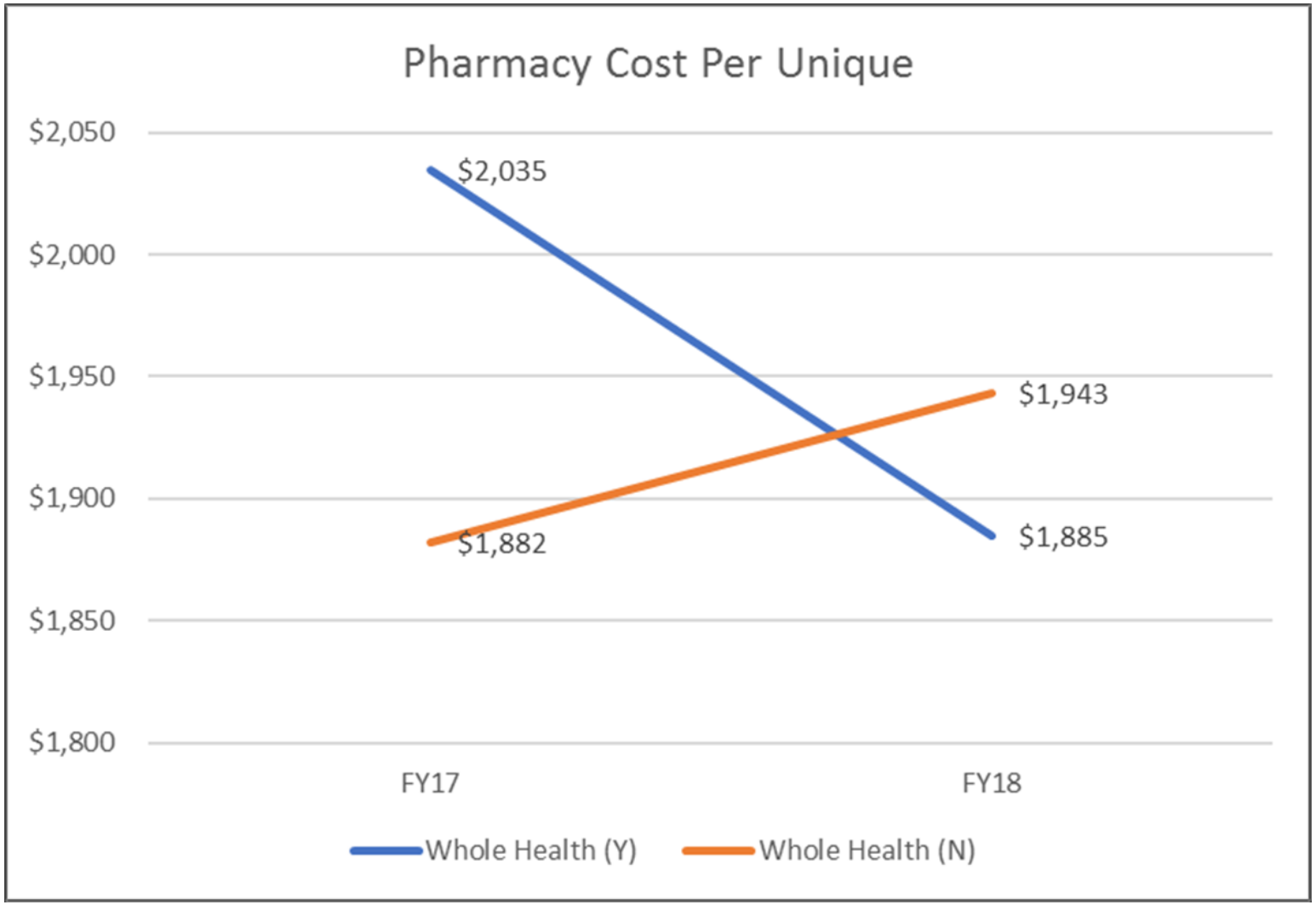
FY 17-18 Other Utilization



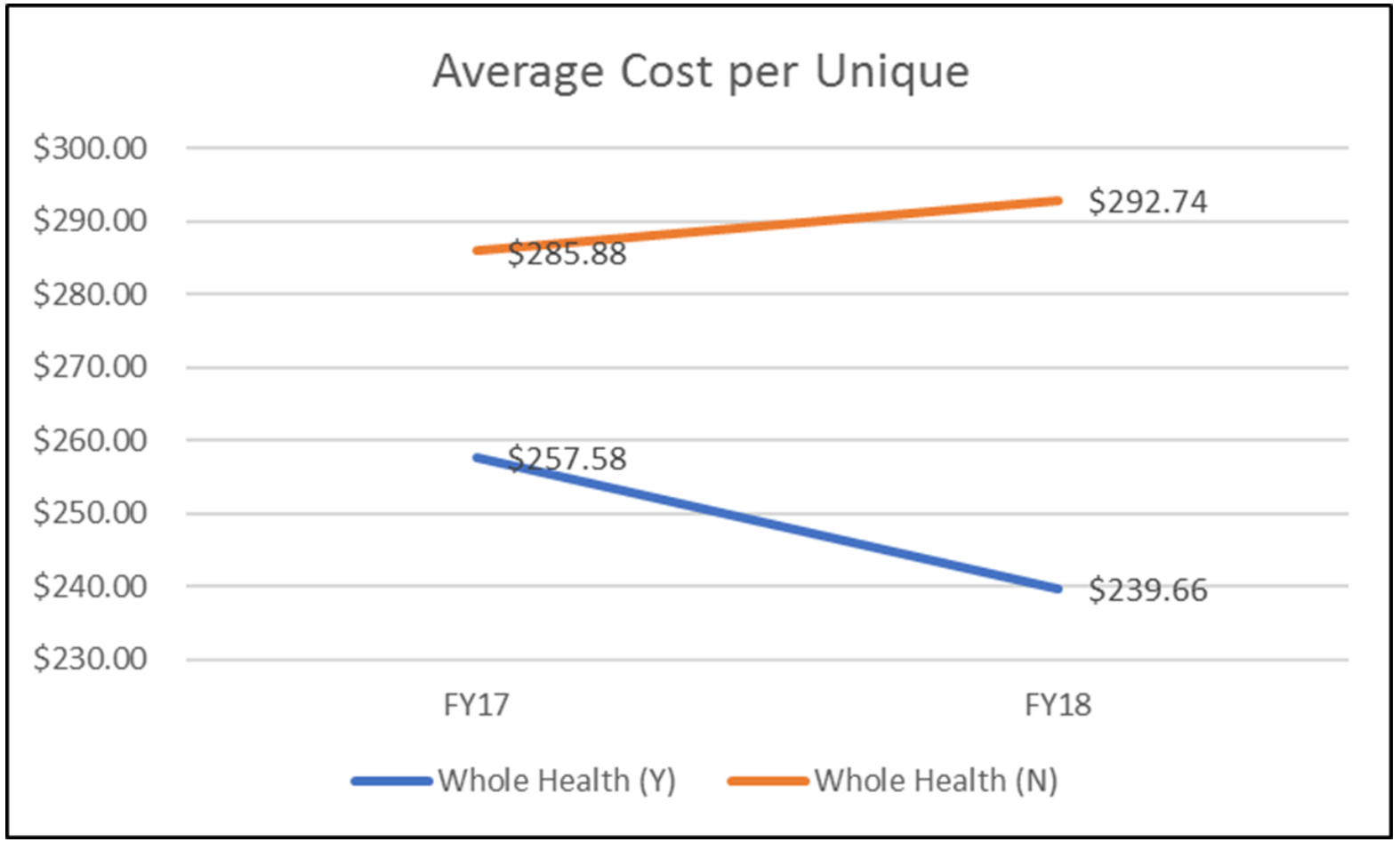




FY 17-18 National Pharmaceutical Costs



FY 17-18 National Opioid Use/Cost



Employees: Preliminary Findings

- High percentage of dieticians, psychologists, physical therapists, and SW using and referring patients; involvement among MD/NP/PA was modest suggesting opportunities for growth
- Primary care, mental health and rehabilitation services had highest involvement, but wide variation among other clinics
- Clinical employees involved in WHS activities reported more favorable workplace perceptions
  - Best places to work index (part of SAIL)
  - Drivers of engagement; turnover intentions

The Voices of the Veterans

Whole Health began my journey to joy, I am a changed person. I no longer need my cane. The Whole Health group has become my family. My neurologist says he doesn't need to see me anymore!"

J.H., 52 year old male

"I have lost 33 pounds. I go to FIT class, nutrition class, Battle-field acupuncture, and regular acupuncture. My wife says I have a positive attitude now! And my diabetes is under control, blood pressure down and lipids good. I see my primary care doctor much less"

R.C., 71 year old Male

I used to drive over the Mississippi River Bridge, to Jefferson Barracks VA, and think about jumping every time. The whole health system has helped me explore my purpose, find ways to use nutrition to reduce my pain, and use iRest and Tai Chi to get moving again. Now I drive over that bridge and think about tomorrow…. I have hope"

K. H., 37 year old Female

The Whole Health Impact We Hope to See

- **Improve Veteran and family satisfaction and well-being**, by offering a true partnership across time, focusing on all aspects of health and well-being.
- **Improve immediate access** by creating new Whole Health portals into VA that do not bottle neck primary care.
- **Improve long term access** by increasing engagement and self care, reducing clinical demand.
- **Improve coordination with community care** by establishing a Veteran-driven Personal Health Plan.
- **Improve health outcomes and reduce costs**, by redesigning what healthcare to invest in the Veteran's Whole Health.
- **Improve employee health and well-being,** by bring Whole Health to them.
- **Rebuild trust in VA** by doing the right thing for our Veterans.
- **Create the future** of healthcare for our Veterans and for our Nation.

The Voice of the Veterans

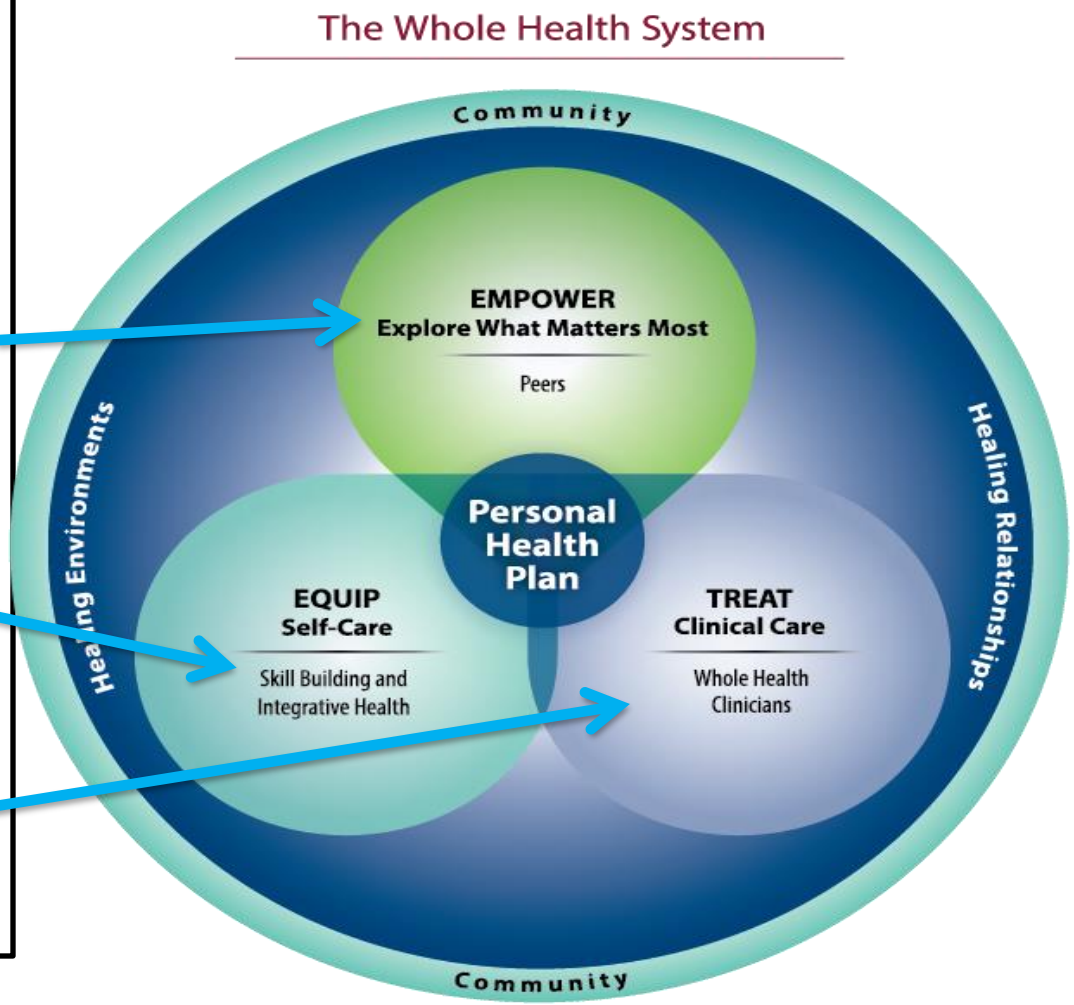
Redesigning Health Care to Promote One's Whole Health: An Overview of the Whole Health System

Whole Health Comes to Life: An animated motion story depicting the Whole Health journey of Veterans.

The Pathway to Whole Health: A look at peers reaching out to Veterans across the country and the impact it has.

Skill Building to Promote Wellbeing: Hearing from Veterans, leaders and staff across VA, who benefit from skill building and support in their self-care.

The Whole Health Approach to Clinical Care: Clinicians and Veterans share how this approach to clinical care has impacted them.



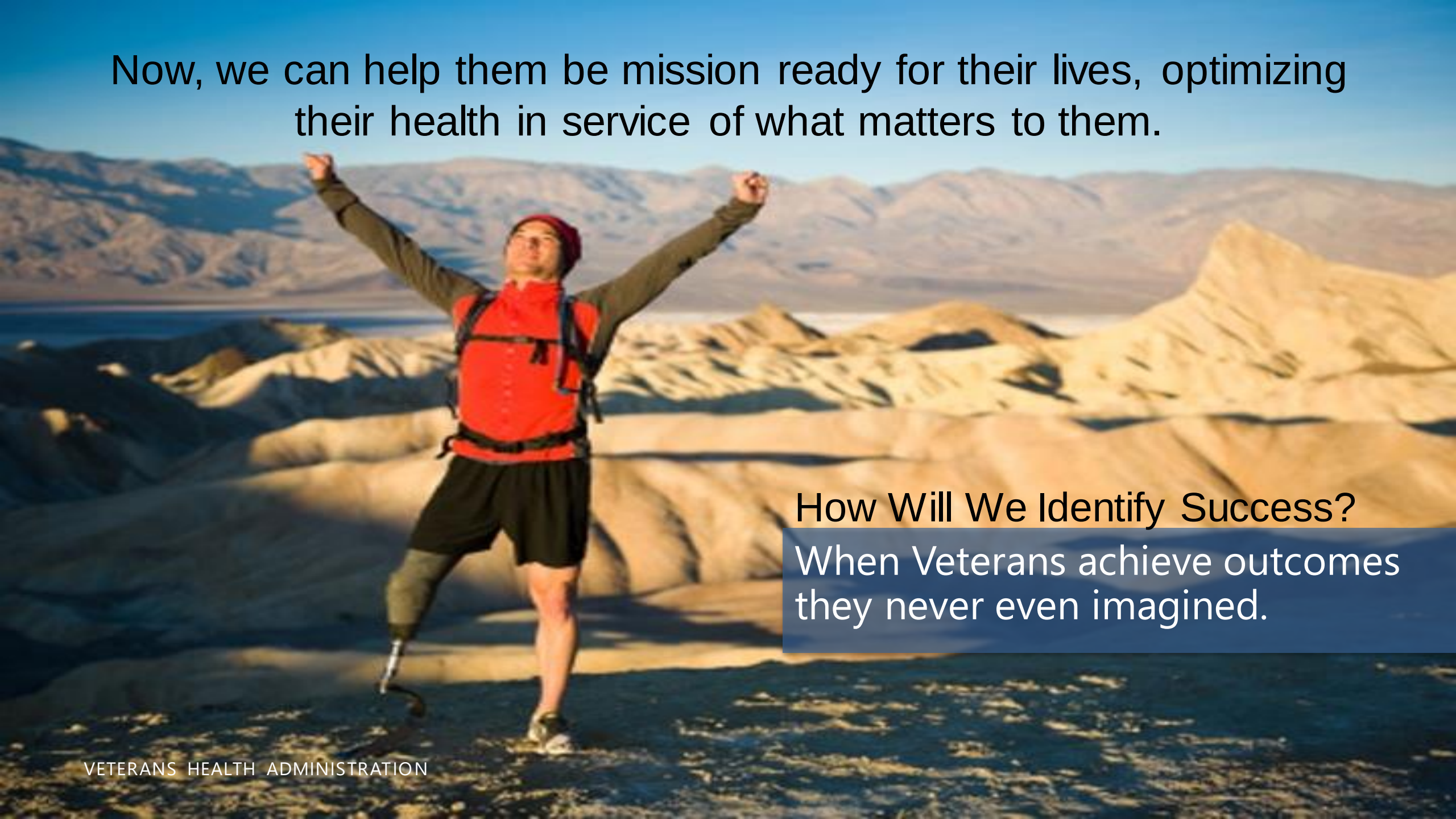
Media Coverage and the Voice of the Veterans

Recent Whole Health Media

- Columbia, MO: More than Medicine: Veteran's Hospital Takes Wellness Approach to Combat Veteran Health Problems
- Tomah, WI: Tomah VA Whole Health Program Gives Options to Veterans
- Tampa, FL: VA, YMCA Team Up to Boost Veterans' Health
- Clarksburg, WV: Staff, Patients Embrace Whole Health Initiative at Clarksburg V.A.
- Iron Mountain, MI: VA Hospital, associated clinics offering holistic approach to care
- Insider VA: VA Uses Whole Health to Prevent Veteran Suicide
- West LA: Warrior pose: On the front lines of the VA's wellness transformation
- Boston, MA: VA turns to alternative pain treatments amid opioid crisis
- Oklahoma City, OK: Oklahoma City VA yoga participants look to help others
- Invited to present to The Giving Pledge, participants included Bill Gates, Warren Buffet, and Richard Branson

And oh,
by the way,
clinical outcomes improve
and costs decrease


Veterans committed their lives, health, and well-being to Mission Success in defense of our country.



Now, we can help them be mission ready for their lives, optimizing their health in service of what matters to them.

How Will We Identify Success?

When Veterans achieve outcomes they never even imagined.

Thank you!

For more Information:

OPCC&CT Internet Website: https://www.va.gov/patientcenteredcare

OPCC&CT Intranet Website: https://vaww.va.gov/patientcenteredcare/

GLA Whole Health

- Number of Unique Patients – steady at 2,200 a quarter since FY17 with an annualized number of Veterans at 3,300
- Number of Encounters – steady around 41,000 a quarter
- Using Clinical Video Telehealth to provide CIH Services to outlying sites of care
- Group/Shared visits are commonly used to provide these services
- Expanding acupuncture to treat chronic pain
- Expanding into Mental Health, Suicide Prevention, and Community Outreach programs

Purple Line Extension

Veterans Community Oversight & Engagement Board

April 17, 2019

Agenda

- Project Overview and Construction Schedule
- Advance Utility Relocation
- Westwood/VA Hospital Station
- Q&A

Metro

Purple Line Extension

Project Alignment

Sections 1, 2 & 3 Status

**Subject to change. The PLE project team is working to deliver the project consistent with Measure M*

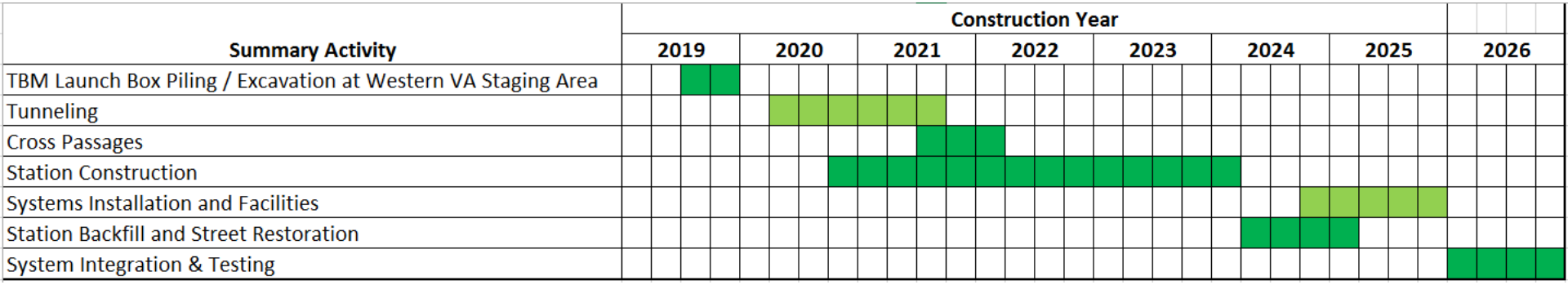
	Forecasted Schedule		
Section	Section 1	Section 2	Section 3
Length	3.92 Miles	2.59 Miles	2.56 Miles
New Stations	Wilshire/La Brea Wilshire/Fairfax Wilshire/La Cienega	Wilshire/Rodeo Century City/ Constellation	Westwood/UCLA Westwood/VA Hospital
Pre-Construction Activities	2014 – 2015	2016 – 2018	2018 – 2019
Construction	2015 – 2023	2018 – 2025	2019 – 2027
Operations	2023	2025	2027

Purple Line Extension

Section 3 Alignment

Section 3 Tentative Schedule

**Dates are preliminary and subject to change*



Metro

Advance Utility Relocation

Wilshire Bl

- Advance Utility Relocation ongoing through May 2020
- Work at night and on weekends

Station/TBM Power Connection

Upcoming SCE Underground Electrical Work

Anticipated start: Spring 2019
Anticipated completion: Spring 2020

Weekdays

- Ohio/Federal: 6:00am – 4:00pm
- Wilshire Bl: 9:00pm – 6:00am

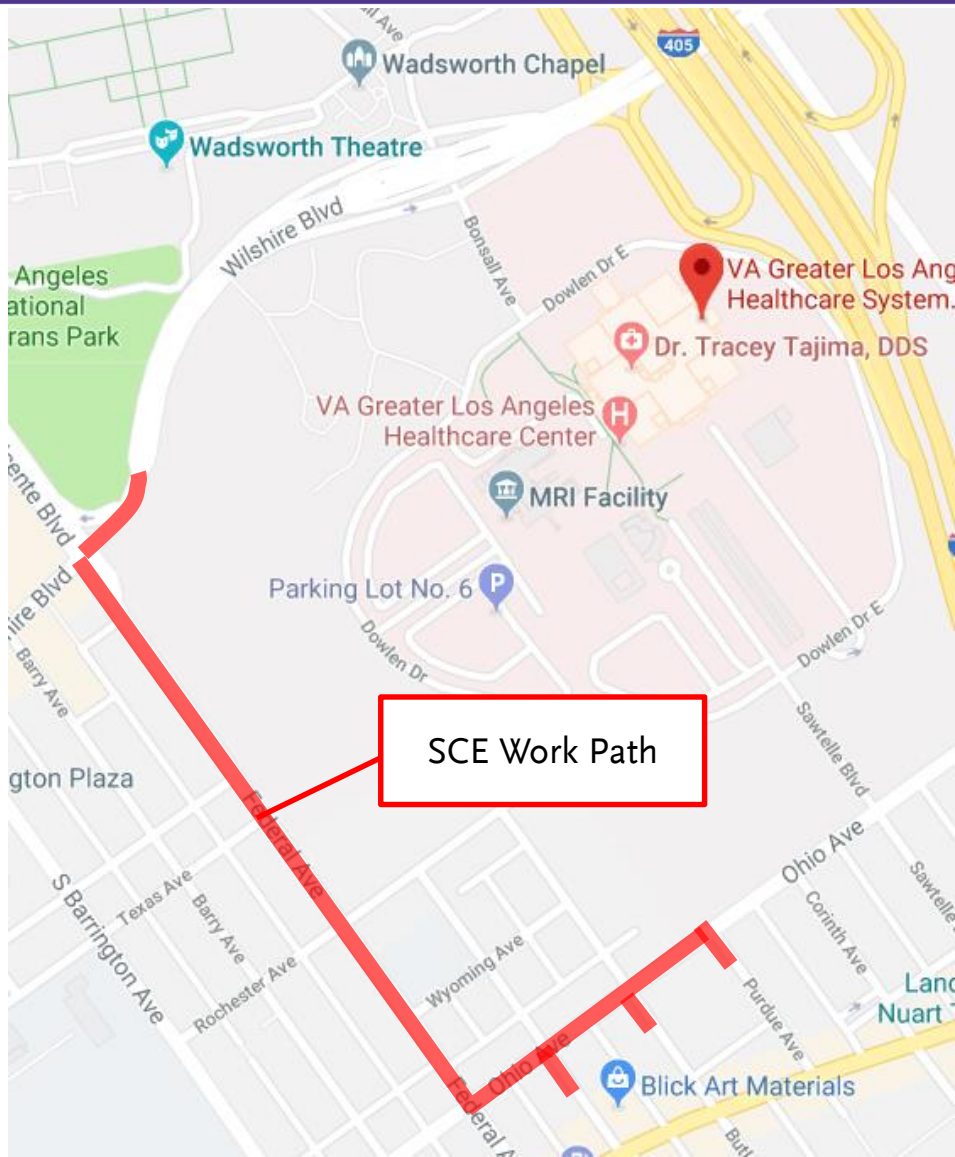
Weekends

- Ohio/Federal: 8:00am – 9:00pm
- Wilshire Bl: 9:00pm – 6:00am

- Intermittent lane closures
- Temporary parking restrictions and possible detours

**Hours subject to change*

Metro

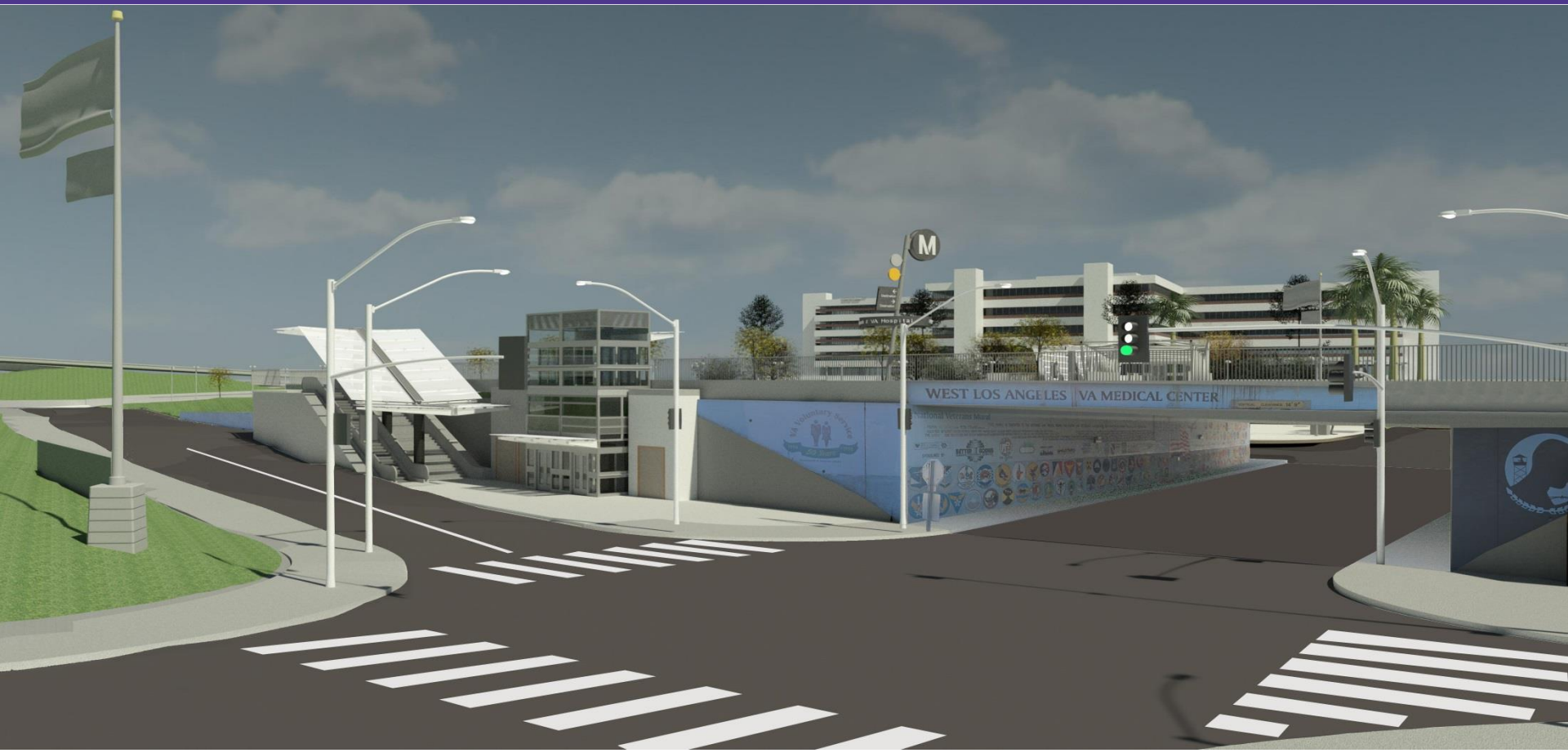


Westwood/VA Hospital

Current Station Rendering

3-D Rendering Westwood/VA Station

View from Bonsall Ave - North to South



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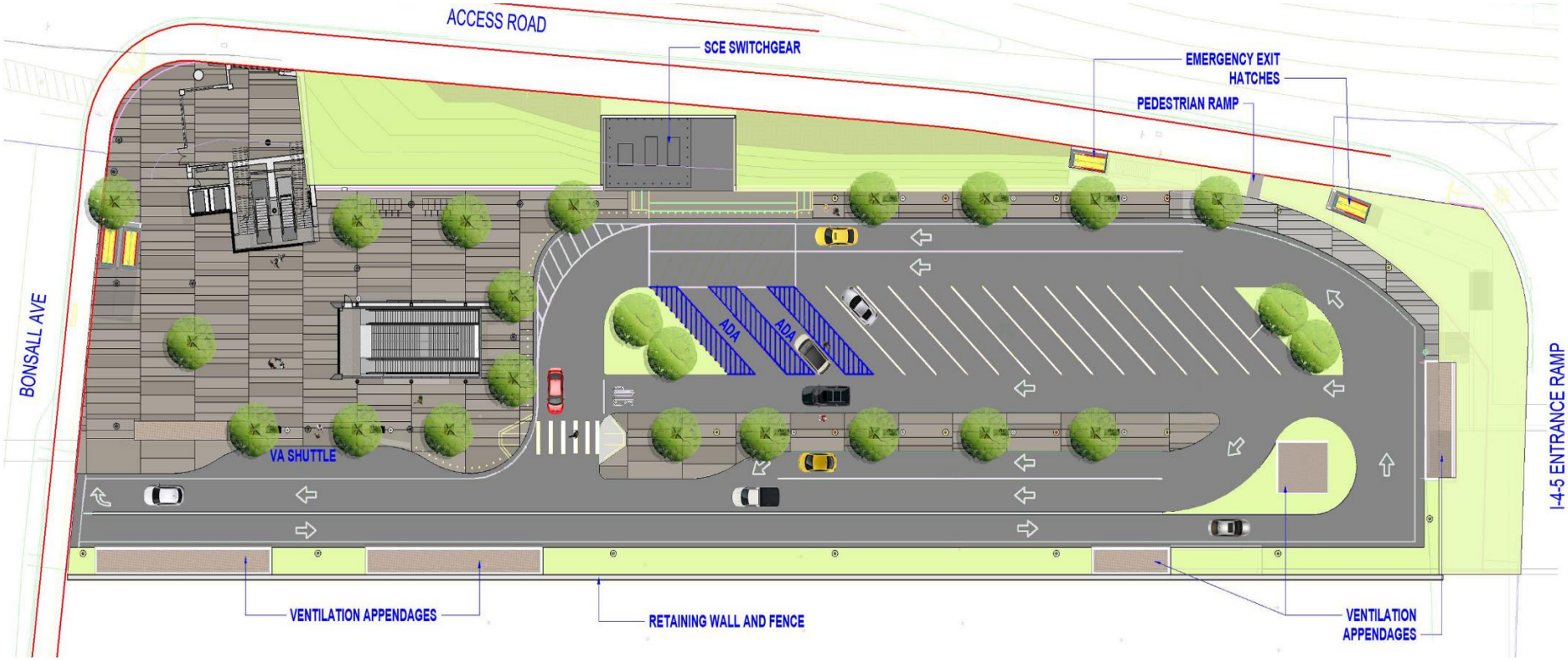
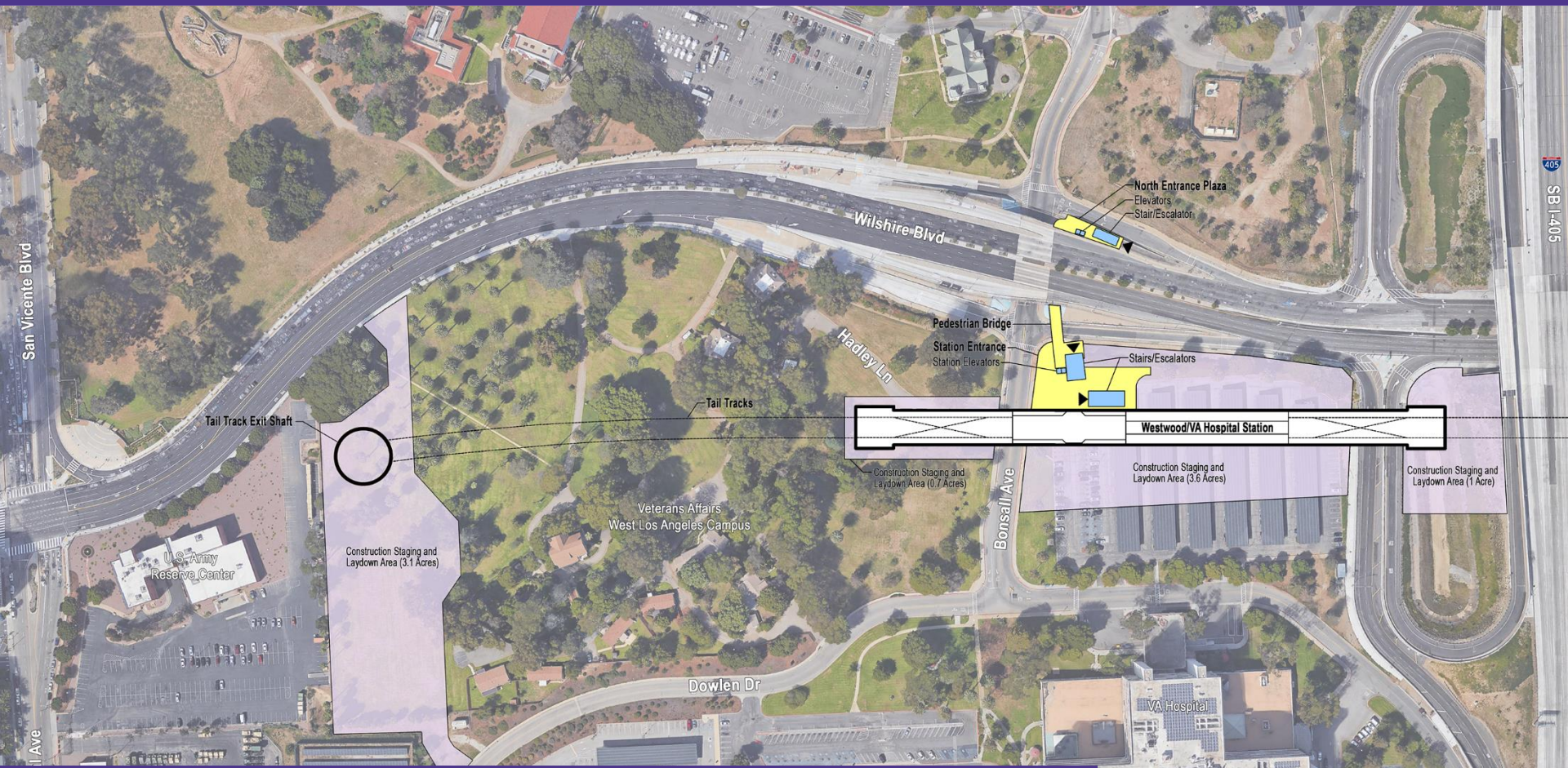
Passenger Pick-up/Drop-off

Current Design



- Short term passenger drop-off and pick up (15-30 minutes max)
- Designed to minimize traffic congestion while maintaining pedestrian and commuter access

Westwood/VA Hospital Station Box

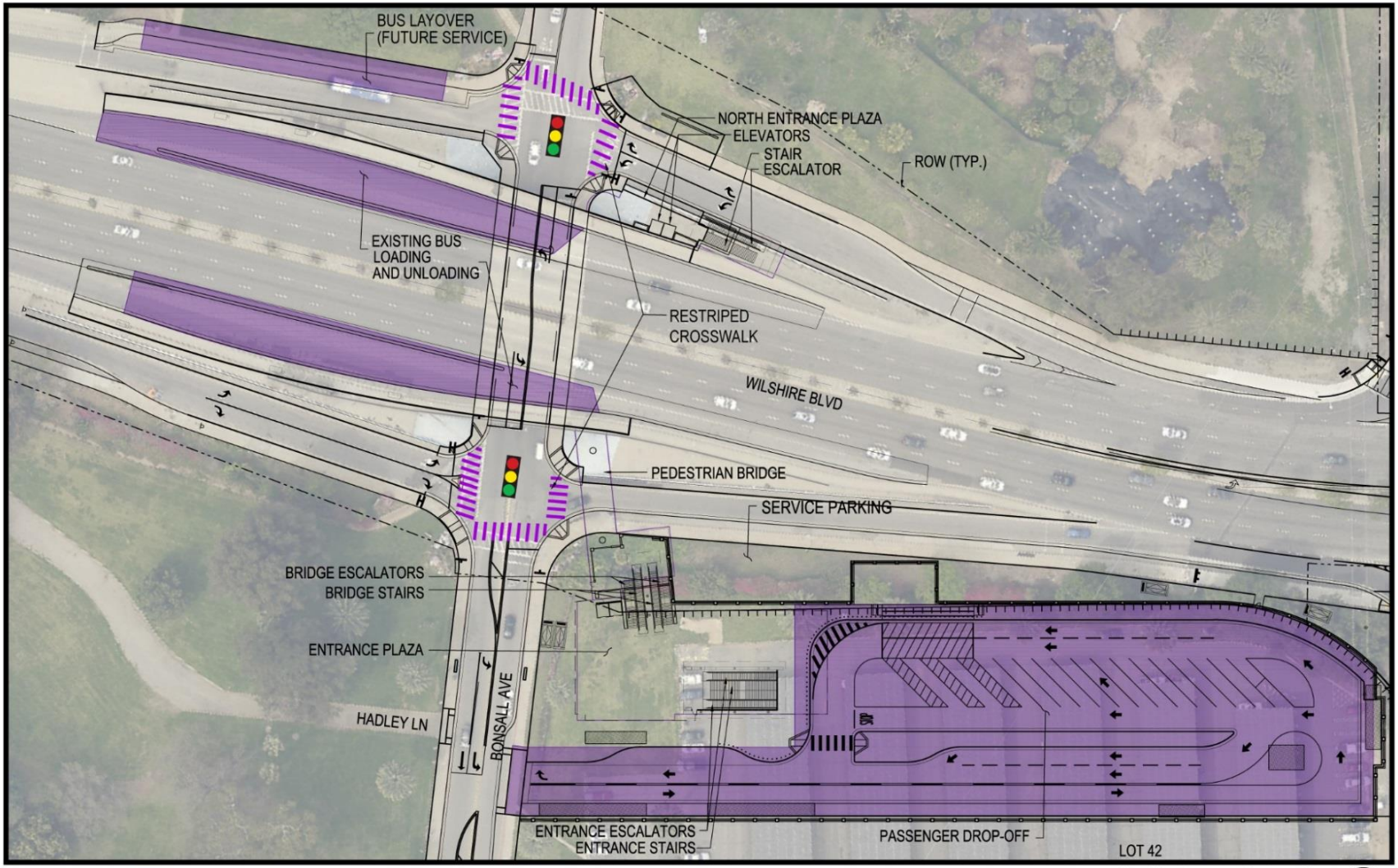


Rendering shows length of the underground station box on Wilshire Bl and Bonsall Av

VA Hospital Station

Proposed Station Access

** Subject to change*



VA Hospital Station

Mural

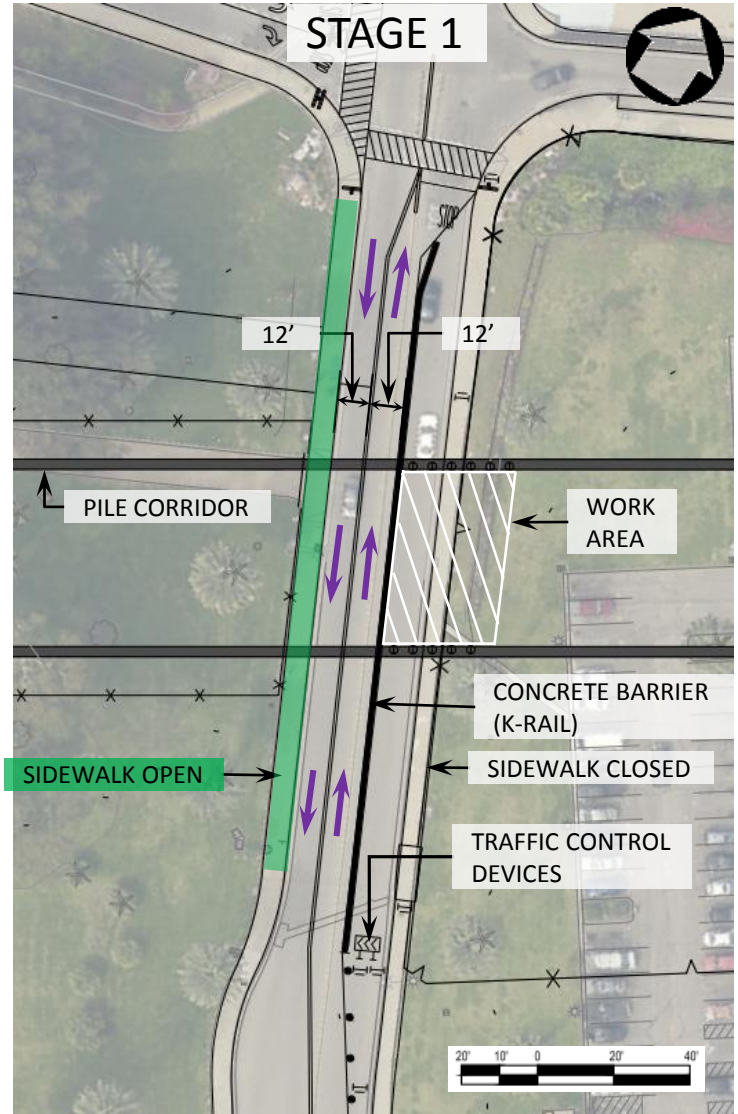
** Subject to change*

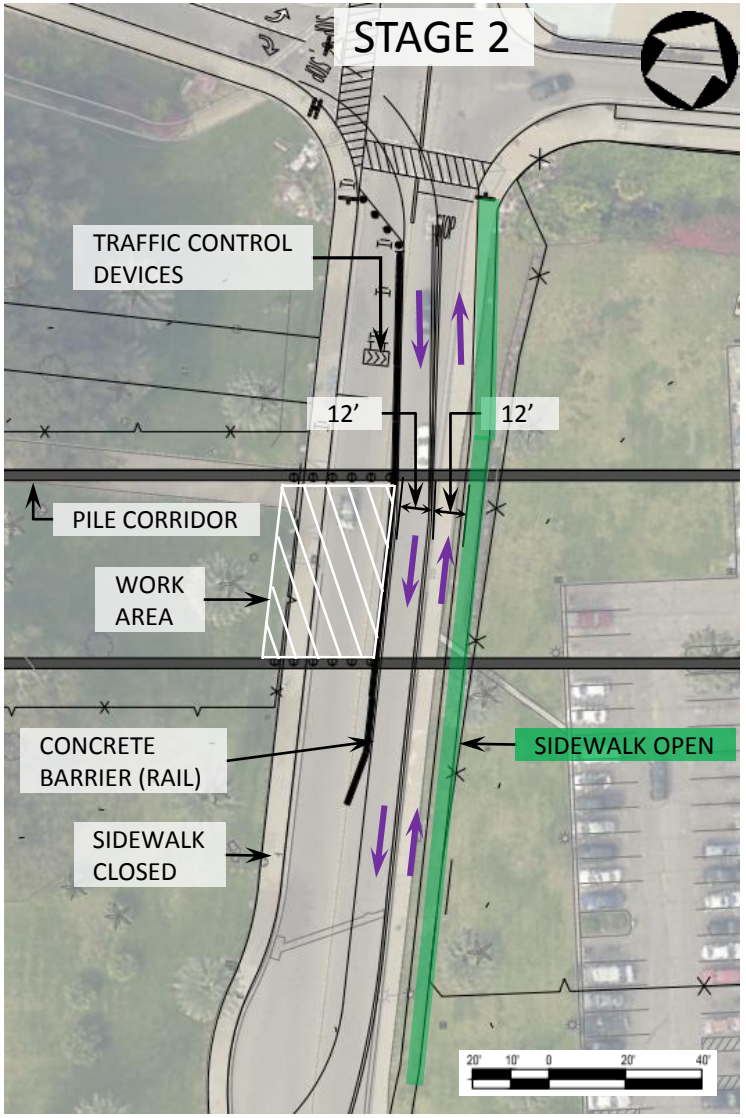
Proposed Schedule for County Approvals

- January: Department of Public Works
- February: Civic Art Committee
- March: County Arts Commission
- May: Board of Supervisors
- July: Dept of Military and Veterans Affairs

Pedestrian and Vehicular Access to Bonsall Avenue Maintained

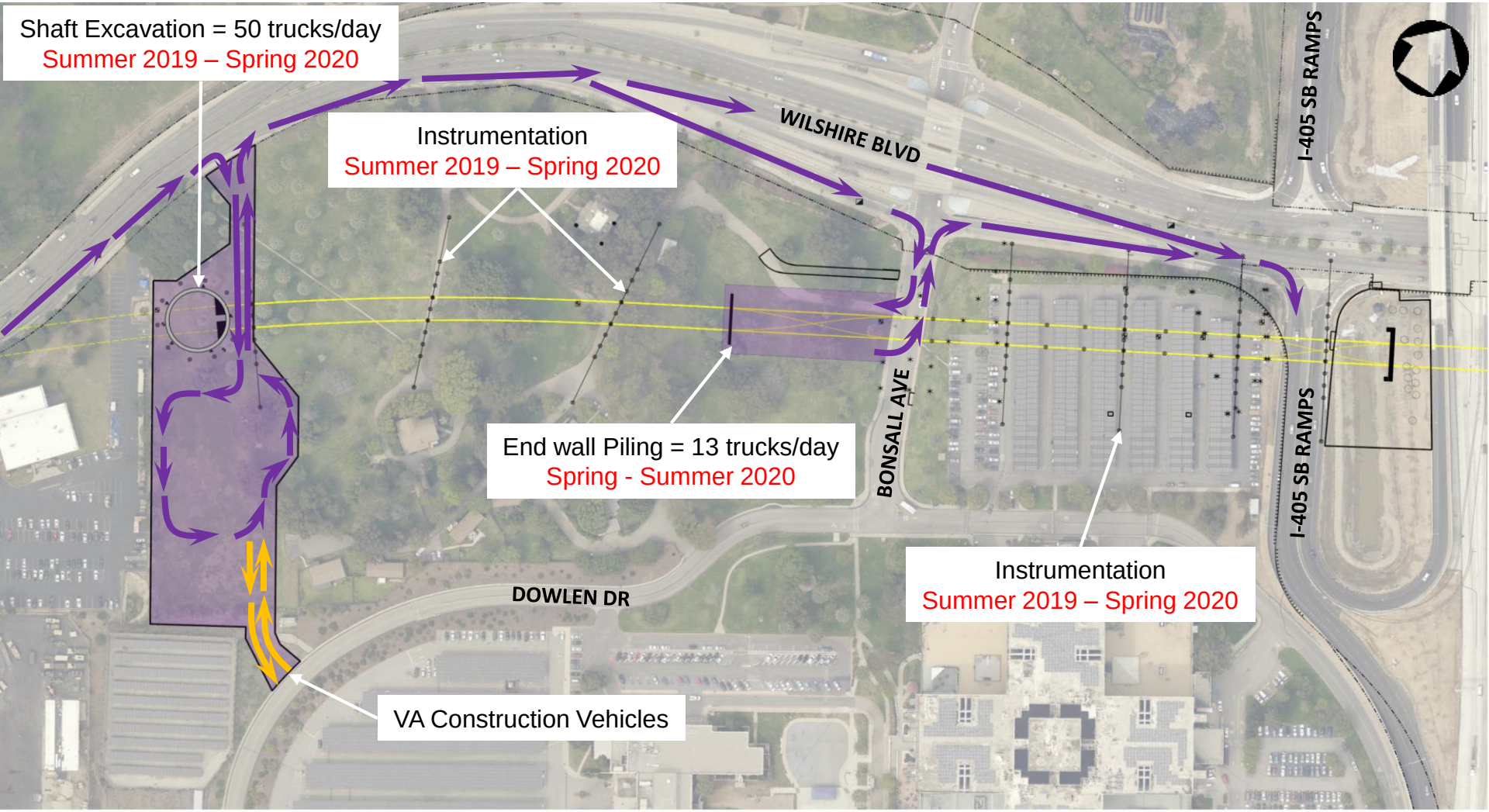
** Subject to change*





Stage 1 – Major Truck Trips

** Subject to change*



Tree Relocation

Tree Relocation

Metro's Green Construction Policy

Purple Line Extension design-build contractors must adhere to strict guidelines contained in Metro's **Green Construction Policy**.

- Establish haul truck staging zones where least impact on general public
- Covered haul trucks to reduce dust and dirt
- Haul routes away from congested streets or near sensitive receptors
- Off-road diesel-powered equipment of 50 hp and greater must meet the most stringent EPA emission standards
- Restricted idling of construction equipment to a maximum of five consecutive minutes
- On-road diesel vehicles will have newer engine models

Metro Services for Veterans

Metro's Veterans Hiring Initiative Program

- 7% Annual Veteran Hiring Initiative
- Support and promote economic development for veterans
- Attract qualified talent and their spouses for the many positions & apply transferrable skills to Industry
- Leverage those skills, knowledge, & attributes to showcase military experien
- Educate Veteran Community of Broad/Diverse Opportunities
- Advocate for Veteran Employees & Jobseekers

Application for Discounted TAP Cards for Service Connected Veterans

Translation of Military Experience into Civilian Job Skills

Metro

Next Community Meeting

Section 3

Section 3: Pre-Construction

Community Meeting

Thursday, June 20, 2019

6:30pm – 8pm

Belmont Village Senior Living

10475 Wilshire Bl

Los Angeles, CA 90024

Free on-site parking available

Metro

Stay Informed

213.922.6934

purplelineext@metro.net

metro.net/purplelineext

@purplelineext

facebook.com/purplelineext

Metro

MISSION Act Scorecard – 1 of 4

As of 3/28/19

Section	Name	Due Date	Overall	Funding	IT	HR	Regs
Ch. 1: Establishing Community Care Programs							
	New Community Care Program	06/06/2019			n/a		n/a
	Decision Support Tool	06/06/2019					n/a
101	Establishment of Veterans Community Care Program	06/06/2019					
102	Authorization of Veterans Care Agreements	06/06/2019					
103	Conforming amendments for State Veterans Homes	02/13/2020			n/a		
104	Access standards	06/06/2019			n/a		
104 (cont'd)	Quality standards	06/06/2019					
105	Access to urgent care	06/06/2019					
106a	Market assessments	06/06/2022					n/a
106b	Strategic plan	06/06/2019		n/a	n/a		n/a
107	Applicability of Directive of Office of Federal Contract Compliance Programs	---		n/a	n/a	n/a	n/a
108	Provider performance management	04/24/2019					n/a
109	Remediation of Medical Service Lines	06/06/2020					n/a
Ch. 2 - Paying Providers and Improving Collections							
111	Prompt provider payment	06/06/2019			n/a		
112	Payment of uncontracted providers	05/16/2019			n/a		
113	Authority to recover costs	12/19/2018					n/a
114	Third party electronic claims processing	11/07/2018					n/a
Ch. 3 - Education and Training Programs							
121	Education program to Veterans on health care options	06/06/2019			n/a		n/a
122	Community Care training programs	06/06/2019					n/a
123	Provide continuing medical education for non-VA medical professionals	06/06/2019					n/a

Complete On Track Moderate risk; being addressed Significant risk; major barriers must be overcome

As of 3/28/19

MISSION Act Scorecard – 2 of 4

Section	Name	Due Date	Overall	Funding	IT	HR	Regs
Ch. 4 - Other Matters Relating to Non-VA Providers							
131	Safe opioid prescribing practices by non-VA health care providers	06/06/2019					n/a
132	Improving information sharing with community providers	---					
133	Establish competency standards for non-VA health care providers in areas where VA has special expertise (including PTSD, TBI, and MST)	06/06/2019		n/a		n/a	n/a
134	VA in national network of state based participation in prescription drug monitoring programs	---					
Ch. 5 - Other Non-VA Health Care Matters							
141	Requires Justification for Use of Supplemental Appropriations if Requested	---		n/a	n/a	n/a	n/a
142	Allows Veterans Choice Fund flexibility	03/01/2019			n/a		n/a
143	Sunset of Veterans Choice Program	06/06/2019					n/a
144	Conforming amendments to reflect new CCP – admin only	---		n/a	n/a	n/a	n/a
Subsection B: Telehealth authority, VA Center for Innovation for Care and Payment, treatment for live organ transplant donors							
151	Licensure - professionals providing treatment via telemedicine	06/06/2019			n/a		
152	Authority of VA Center for Innovation for Care and Payment	12/06/2019					
153	Authorization to provide for operations on live donors for purposes of conducting transplant procedures for veterans	---			n/a	n/a	
Subsection C: Caregivers							
	Caregiver Support Program	---					
	Caregivers – Program Stabilization (Pre MISSION Act Work)	---			n/a		
161	Expansion of VA Program of Comprehensive Assistance for Family Caregivers	10/01/2019					
162	Implementation of VA IT system to support the family caregiver program	10/01/2019				n/a	n/a
163	Modifications to annual evaluation report on VA caregiver program	05/31/2019		n/a	n/a	n/a	n/a

Complete On Track Moderate risk; being addressed Significant risk; major barriers must be overcome

As of 3/28/19

MISSION Act Scorecard – 3 of 4

Section	Name	Due Date	Overall	Funding	IT	HR	Regs
Title II – Asset and Infrastructure Review (AIR) Act							
201	Admin Only – Change title	---		n/a	n/a	n/a	n/a
202	Establish AIR Commission – nominations to Senate	05/31/2021		n/a	n/a		n/a
203	Develop Criteria / Procedures for AIR Commission Recommendations; seek public feedback; several regulations and reports required	02/01/2021			n/a		n/a
204	Implement AIR Commission recommendations NLT 3 years following report	03/30/2026					n/a
205	AIR Commission Implementation Authorities – no VA action	---		n/a	n/a	n/a	n/a
206	Establish VA AIR Account to track funding	02/28/2019		n/a	n/a	n/a	n/a
207	Defines terms / conditions Congress must follow for Commission recommendations	---		n/a	n/a	n/a	n/a
208	Requires VA to publish any AIR Commission information within 24 hours	---		n/a	n/a	n/a	n/a
209	Definitions: Defines various terms for purposes of the AIR Act. (no VA action)	---		n/a	n/a	n/a	n/a
211	Improve training for construction personnel	09/30/2019			n/a		n/a
212	OMB Review of enhanced use leases for compliance (no VA action required)			n/a	n/a	n/a	n/a
213	Assessment of VA health care in the territories of the United States	03/01/2019			n/a	n/a	n/a
Title III: Recruitment							
301	Award at least 50 scholarships for physicians and dentists / require service to VA; provide info material to schools	07/31/2020			n/a		
302	Increase maximum amount of debt under VA EDRP; study of demand for debt reduction	06/06/2019			n/a		n/a
303	Establish VA Specialty Education Loan Repayment Program / require service to VA; determine staffing needs	04/30/2020			n/a		
304	"Veterans healing Veterans" – pilot program for 18 Veterans – education funding	12/31/2020			n/a		
305	Increase bonus pool for recruitment, relocation and retention from CHOICE				n/a		n/a
306	Ensure Vet Center staff are eligible for EDRP; report number EDRP recipients working at Vet Centers	06/06/2019			n/a		n/a

Complete On Track Moderate risk; being addressed Significant risk; major barriers must be overcome

As of 3/28/19

MISSION Act Scorecard – 4 of 4

Section	Name	Due Date	Overall	Funding	IT	HR	Regs
Title IV: Underserved Areas							
401	Designate Underserved Facilities; Report on action plan	06/06/2019					n/a
402	Pilot program- furnish mobile deployment teams to underserved facilities	06/06/2019					n/a
403	Pilot program - graduate medical education and residency	06/06/2019			n/a		
Title V: Other Matters							
501	Annual report on performance awards to high-level VA employees	01/08/2019			n/a		n/a
502	Modify Podiatrist Pay Schedule to achieve parity with VA Physicians	07/08/2018	DOJ Issue		n/a		n/a
503	Change definition of major medical facility project to $20M			n/a	n/a	n/a	n/a
504	Authorization of specific VA medical facility projects (East Bay, Central Valley)	09/04/2018			n/a		n/a
505	VA personnel reports – posted to public website	06/06/2019					n/a
506	Program on establishment of peer specialists in PACT settings within VA medical centers / focus on female specialists; report due every 6 months	05/31/2019			n/a		n/a
507	Increase use of Medical Scribes at 10 VA Medical Centers as pilot	---			n/a		n/a

Complete On Track Moderate risk; being addressed Significant risk; major barriers must be overcome

Executive Order 13822 Fact Sheet

Bottom Line Up Front (BLUF)

The first year of transition is critical for Service members and Veterans moving from the military to civilian life. VA research shows the year following discharge from active duty military service can pose many transition-related challenges — such as homelessness, family reintegration, employment, post-traumatic stress disorder, and substance misuse — that can increase the risk for suicide. To address these transition-related challenges, provide seamless high-quality mental health care, and reduce suicide rates among the Service member and Veteran population, President Trump signed Executive Order 13822, "Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life" on January 9, 2018.

The Executive Order directs the U.S. Departments of Veterans Affairs (VA), Defense (DoD), and Homeland Security (DHS) to work together to ensure newly discharged Service members and Veterans have access to any needed mental health care for at least one year following their discharge from military service. To achieve this, the Executive Order required the agencies to develop a Joint Action Plan. The "Joint Action Plan for Supporting Veterans During their Transition from Uniformed Service to Civilian Life" was submitted to the White House on May 3, 2018.

Collaborative Goals

The Joint Action Plan targets three key, collaborative goals, as follows:

- **Goal 1:** Improve actions to ensure ALL transitioning Service members are aware of and have access to mental health services.
- **Goal 2**: Improve actions to ensure the needs of at risk Veterans are identified and met.
- **Goal 3:** Improve mental health and suicide prevention services for individuals that have been identified in need of care.

Strategic Efforts

To meet these goals, several strategic efforts are being developed, including:

- **Outreach:** Establishing early and consistent contact through several activities, such as communication campaigns, peer support groups, community outreach, and using multiple channels via VA, DoD, DHS, Veterans Service Organizations (VSOs), and other partnerships.

- **Transition:** Offering VA health care registration pre-transition and supporting registration by modifying the Transition Assistance Program (TAP) guidelines and increasing VSO involvement.
- **Monitoring:** Identifying those most at risk with improved monitoring through mental health screening and predictive analytics.
- **Access:** Increase access via various VA and DoD programs and partnership expansion, creating a "no wrong door" approach.

What this Means for Veterans

- Service members will learn about VA benefits and start the application process *before* becoming Veterans.
- Any newly transitioned Veteran who is eligible can go to a VA medical center (VAMC), Vet Center, or community provider and start receiving mental health care *right away.*
- Former Service members with other than honorable (OTH) discharges may receive emergent mental health care from VA, and certain former Service members with OTH discharges are eligible for mental health care for conditions incurred or aggravated during active duty service.
- Some DoD resources available to Service members, such as Military OneSource, will now be available to Veterans for one year following discharge.
- Veterans will have access to Whole Health Orientation groups, giving them the opportunity to connect with the Veterans Health Administration (VHA) and, if needed, receive a referral for VA mental health care.
- After the first year, eligible Veterans may *still receive mental health care support* through VA, Vet Centers, the Veterans Crisis Line, or from a referred community resource.
- Veterans will be able to receive support through VA partners, like Vet Center referrals, and community resources outside of VA, like Veterans Service Organizations (VSOs).

Learn More

For more information please visit: https://www.mentalhealth.va.gov/transitioning-service/resources.asp

Understanding the changes in **Community Care for Veterans**

U.S. Department of Veterans Affairs

This will help you understand how community care will work when the new **VA MISSION Act** goes into effect **in June 2019**. Veterans can expect better access and greater choice in their health care, whether they receive it at VA or through a community provider.

▶ ***This information is current as of March 1, 2019. Additional details regarding the new program and how you can use it are expected in the coming months so please check back here at www.va.gov for updated information.***

What is the VA MISSION Act?

On June 6, 2018, President Donald J. Trump signed landmark legislation known as the VA MISSION Act of 2018. The Act affects many VA programs, including changes that make dramatic improvements to how Veterans receive health care provided outside of VA facilities.

Will I be eligible for community care under the Mission Act?

You may be eligible for community care if:

- You need a service that's not available at VA (e.g. maternity care).
- You reside in a U.S. state or territory without a full-service VA medical facility.
- You met previous distance criteria or live in one of the least populated states (ND, SD, MT, AK, WY), received care prior to June 6, 2018, and receive care within two years after June 6, 2018.
- You meet average drive time or appointment wait-time requirements.
- It's in your best medical interest to be referred to a community provider.
- You need care from a VA medical service line that isn't providing care that complies with VA's quality standards.

When will these changes occur?

The new program will start when VA publishes final regulations. This is expected to occur in the summer of 2019. At that time, all existing community care programs, including the Veterans Choice Program, will end.

Proposed Access Requirements

Drive Time

You may be eligible if your average drive time to a specific VA medical facility exceeds:

- *30 minutes for primary care, mental health, and non-institutional extended care services (including adult home day care)*
- *60 minutes for specialty care*

Average drive time is based on the distance from your permanent residence to the closest VA medical facility offering the care or service you need. It is based on geo-mapping software that accounts for a variety of factors, such as rush hour traffic.

Appointment Wait Time

You may be eligible if the wait time for an appointment at a specific VA medical facility exceeds:

- *20 days for primary care, mental health care, and non-institutional extended care services*
- *28 days for specialty care from the date of request with certain exceptions*

FAQS:

Will VA still need to officially authorize the care I receive through a community provider?

Yes, usually. Regardless of which eligibility criterion you meet, community care must be formally authorized in advance by VA before you can make an appointment and receive care from a community provider. However, you may not need to come to a VA facility to obtain the authorization. The law requires that VA provide authorization before they can pay for non-VA care. There may be exceptions for emergency and urgent care.

Who will schedule my community care appointments?

As VA implements its new Community Care Network (CCN) in 2019 and 2020, community care appointments will be scheduled directly by VA, not a third party. In some instances, you will continue to be able to schedule your own community care appointments.

Will I be able to go to any community provider I want?

If you are eligible for community care, you will be able to receive care from a community provider who is part of VA's Community Care Network (CCN).

Will the process for getting prescription medication change?

There are no changes to how prescriptions are processed. You'll be able to get urgent prescription medication in your community, while long-term prescription medication will be provided by a VA pharmacy.

Will I have a copayment for community care?

Copayment charges work the same way with community care as they do if you receive care at a VA medical facility. Usually, this means you'll be charged a copayment for non-service connected conditions. Copayment charges and payments are made through VA, not through your community provider.

Will VA pay beneficiary travel expenses if I am referred to a community provider?

If you're eligible for beneficiary travel, your eligibility will not change. It's paid the same way whether the care is provided at a VA medical facility or through a community provider.

Is this information final?

Since some parts of the new eligibility criteria aren't final and must formally be established in a Federal regulation, this is a preview of the final eligibility criteria. The final criteria are expected in the summer of 2019.

Can I provide feedback?

As part of the Federal regulatory process, Veterans and the public are encouraged to provide feedback during the public comment period. VA wants to take into consideration as many views and perspectives as possible in finalizing the regulation that contains the access standards (RIN 2900-AQ46). The regulations will be formally published for public comment by the Federal Register at http://www.federalregister.gov.

▶ ***This information is current as of March 1, 2019. Additional details regarding the new program and how you can use it are expected in the coming months so please check back here at www.va.gov for updated information.***

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 3, 2018

The President
The White House
Washington, DC 20500

Dear Mr. President:

Executive Order 13822 of January 9, 2018, establishes requirements for a Joint Action Plan to be submitted by the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security, that describes actions to provide to the extent consistent with law, seamless access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following discharge, separation, or retirement.

Enclosed is the updated Joint Action Plan, dated April 18, 2018, with White House edits incorporated, designed to improve transition from active military service to Veteran status. This plan will provide the framework for a July 9, 2018, report.

Respectfully,

Robert L. Wilkie
Acting

Enclosure

JOINT ACTION PLAN FOR SUPPORTING VETERANS DURING THEIR TRANSITION FROM UNIFORMED SERVICE TO CIVILIAN LIFE

March 9, 2018 (revised April 18, 2018)

Executive Summary

On January 9, 2018 President Trump signed Executive Order (EO) 13822 directing the Department of Veterans Affairs (VA), Department of Defense (DoD), and Department of Homeland Security (DHS) to address the complex challenges faced by our transitioning uniformed Service members and Veterans. The EO requires VA, DoD, and DHS to submit to the President a Joint Action Plan that describes actions to provide seamless access to mental health care and suicide prevention resources for transitioning Service members. The EO specifically emphasizes access to services during the critical first year period following discharge, separation, or retirement from military service. Additionally, the EO requires that within 180 days of the date of the Order, the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security submit to the President, a status report on the implementation of the Joint Action Plan detailing how the proposed reforms have been effective in improving mental health care for all transitioning uniformed Service members and Veterans.

While the ultimate goal remains zero suicides, this Plan seeks systematic reductions in the number of Veteran suicides with progress measured by year-after-year reductions to zero. Recognizing that sometimes the warning signs for suicide do not appear until after a Service member transitions from military to civilian life, this Plan seeks to eliminate the gaps in access to mental health and suicide prevention services. This Plan also seeks to eliminate barriers to care. While Service members possess unique protective factors related to their military service, such as resiliency or a strong sense of belonging to a unit; they may also possess risk factors related to their military service, such as service-related injury or stressors that stem from a recent transition from military service to civilian life (employment, housing) or relationship issues. Put simply, preventing Veteran suicide requires strategies that maximize protective factors while minimizing risk factors at all levels throughout communities nationwide.

The framework for this report is built on National Academy of Medicine classifications for prevention. This framework prescribes the targeting of interventions or services based on where risk exists, a population, sub-group, or individual. A comprehensive service delivery system aimed at ensuring that all Veterans (universally) have knowledge of and access to mental health and suicide prevention services can help buffer risk for suicide. In addition to addressing universal populations, this Joint Action Plan framework calls for additional supports for those groups of Veterans that have identified risks (e.g., mental health or substance abuse issues, relational issues, financial issues, or legal struggles). Finally, our Plan targets individuals (or indicated Veterans) by ensuring that those individuals who are in need of immediate care get access to the best quality care available. A comprehensive framework that ensures services across all three domains (universal, selected, indicated) recognizes that identifying risk and engaging in early interventions is our most effective defense against suicidal thoughts and behaviors.

Introduction

The Department of Veterans Affairs (VA), Department of Defense (DoD), and Department of Homeland Security (DHS) share the responsibility of ensuring successful transitions of Service members and Veterans, while preventing suicides and ensuring access to mental health care. The purpose of the Executive Order (EO) is to ensure that mental health care is available to all eligible transitioning Service members and Veterans. We will not relent in our efforts to connect Veterans experiencing an emotional or mental health crisis with life-saving support. Collectively the work of VA, DoD, and DHS seeks to continuously improve services by: providing a full continuum of evidence-based mental health care; anticipating and responding to Veterans' needs; and supporting all returning Service members as they reintegrate into their communities. Mental health services are critical for people showing signs of suicide risk in their thoughts or behavior, but we must go beyond engaging mental health providers and involve the broader community.

Purpose

EO 13822 provides an opportunity for the three Departments to collaboratively address the complex challenges faced by our transitioning uniformed Service members and Veterans; specifically ensuring seamless access to a continuum of high-quality mental health care and suicide prevention resources during the transition from uniformed service to civilian life, especially during the first year following transition.

The high operational tempo that Service members and their families have endured during nearly two decades of war have left some Service members and Veterans struggling with physical, psychological, and emotional issues. It is essential that the Departments work together to understand these issues and early engagement provides an opportunity to mitigate psychological stress and employ preventative measures. A comprehensive review of completed suicides across VA and DoD reveal many precipitating factors, such as challenges with transition to civilian life. Families, peers, military units, and communities should all be engaged to prevent suicide. VA, DoD, and DHS endorse multi-tiered public health strategies targeted at universal populations, as well as interventions targeted at known risk groups and individuals.

A few of the precipitants of suicide during this transition period are social disconnection and disruption with interpersonal relationships. Complicating rapid identification of risk is that often the signs and symptoms that stem from the challenges experienced during transition do not appear or begin until well after transition from military service. Delayed onset of symptoms presents challenges for VA, DoD, and DHS, as there are times when the Departments do not have regular contact with the transitioning Service member/Veteran. In keeping with our enduring commitment to those who have worn the uniform, the Departments will provide a seamless hand-off from the hands of the DoD/DHS to the hands of the VA.

This Joint Action Plan describes the actions that will occur to ensure knowledge of, and access to, mental health care and suicide prevention resources for transitioning Service members and Veterans. Recognizing the unique needs of each transitioning Service member and Veteran, this Plan details actions across three broad categories of transitioning Service members:

1. Universal (all transitioning Service members) – roughly 245,000 Service members leave the DoD every year. This report will outline actions aimed at the entire universal population.

2. Selected (high-risk groups) – this report will detail actions specifically targeting and increasing our understanding of those groups that are at high risk and offering evidence-based services designed for known risk populations.
3. Indicated (at risk individuals) – this report will target specific cross-agency actions necessary for engaging with individuals who are at highest risk.

VA, DoD, and DHS recognize that federal entities, while well equipped, cannot achieve meaningful or lasting reductions in suicide acting independently or through departmental action alone. The three Departments will need to rely on the expertise of Military Service Organizations (MSO) and Veteran Service Organizations (VSO), non-profit groups, academic institutions, and community partnerships. These non-government entities offer valuable insights, innovative interventions, and unique capabilities that bolster mental health and suicide prevention services for Service members and Veterans.

NOTE: VA, DoD, and DHS hosted a one-day summit on April 10, 2018 for the purposes of learning and consulting with a variety of researchers and industry experts on how to improve risk identification and essentials of successful transition during periods of risk.

VA, DoD, and DHS, as directed, will provide a status report within 180 days of the date of the EO, relaying the status of the Joint Action Plan's implementation and how the proposed reforms have been effective in improving access to mental health care and working toward the goal of preventing suicide for all transitioning Service members and Veterans.

There are a number of metrics and target goals included in this Joint Action Plan. To be clear, our ultimate goal is to get to zero Service member and Veteran suicides and to contribute to a reduction in the national rate of suicide. The metrics and targets provided in this Plan are intermediary measures, intended to be examined both individually and as a bundle, that collectively aim to identify risk early and reduce suicidal behavior. VA, DoD, and DHS support the nation's goal, put forth by the National Action Alliance, of the reduction of suicide by 20 percent by 2025. We will not stop in our efforts to exceed this goal by pushing the timeline with year-over-year reductions.

Joint Action Plan

To support Service members and Veterans during the time of transition and mitigate suicide risk, simplified and assured access to mental health care and suicide prevention resources is a priority. The necessary reformatory actions associated with this effort are organized in accordance with the most appropriate mix of prevention efforts needed to reach all transitioning Service members and Veterans. This Joint Action Plan is guided by a prevention framework developed by the National Academy of Medicine (formerly the Institute of Medicine) that sorts prevention strategies into three levels (Figure 1):

1. ***Universal* Strategies aim to reach *all* Veterans in the U.S.** and include actions focused at entire populations.
2. ***Selective* Strategies are intended for *some* Veterans** that fall into subgroups that may be at increased risk for suicidal behaviors. These include targeted actions toward known groups of Veterans at risk such as female Veterans, Veterans with identified mental health conditions, Veterans struggling with substance abuse/addiction, or Veterans who have recently transitioned from military service.

3. ***Indicated* Strategies are designed for the relatively *few* individual Veterans** identified as having a high risk for suicidal behaviors, including those who have made a suicide attempt, have a known mental health or substance abuse issue, or any other identified risk.

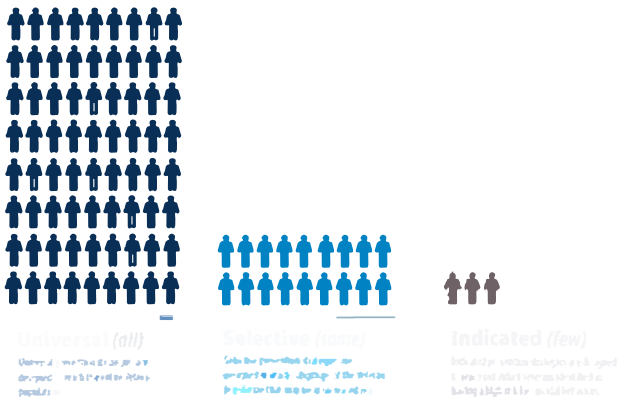


Figure 1: National Academy of Medicine (NAM) Classification Framework

Goal 1: Improve actions to ensure ALL transitioning Service members are aware of and have access to mental health services.

A review of DoD data indicates an average of 245,000 Service members transition out of military service each year. Ensuring evidenced-based universal suicide prevention approaches targeted toward this entire population are essential. To accomplish this goal the following actions are proposed:

1.1 – Early and Consistent Contact: Conduct outbound calls to all Service members within 90 days of their expected date of separation from military service and at key intervals after separation (e.g., 90-, 180-, 365-days). Appropriately trained callers will follow a script providing information on access to peer support, availability of mental health care after separation, eligibility for health care, and eligibility for VA benefits; a list of available local and national resources; and a name and a point of contact for any immediate needs. In addition to calls, Service members will receive information on benefits and eligibility in written format (e.g., email or mailing).

Metric: Total number of Service members contacted within 90 days prior to their separation from military service. Total number of Veterans contacted within 90-, 180-, and 365-days after separation who are receiving VA mental health care. Of those Veterans called, satisfaction and the total number reached will be tracked. **Target:** July 2018: 30% contact during 90 days prior to separation. 80% of recently transitioned Veterans will be called at each interval (90-, 180-, and 365-days) within one year of implementation date.

Lead Agency: VA/DoD **Start Date:** April 2018 **Full Implementation:** October 2018

1.2 – Pre-transition VA Health Care Registration: Implement capability for transitioning Service members to apply on-line for VA health care (to the extent possible) during VA's Transition

Assistance Program (TAP) briefing. Transformative new process will result in eligible Veterans having their applications adjudicated immediately after military discharge.

Metrics: (A) Percentage of transitioning service member respondents on the TAP Participant Assessment who report being informed on health care options. (B) Percentage of TAP participants who elect to apply for health benefits during TAP course. Baseline will be zero for both metrics as this is a new capability. Data will be collected quarterly on the TAP Participant Assessment beginning July 2018, and monthly for elections to apply for health benefits. **Target**: For FY 2018 Q4 data: (A): 55% of transitioning service member respondents on the TAP Participant Assessment will report being informed on health care options. In addition, an increase by 10% for each consecutive quarter until the 12-month mark. (B) 25% of transitioning Service members who participate in TAP after April 2, 2018 will complete an application for VA health care during the VA TAP course. In addition, an increase by 10% for each consecutive quarter until the within 12-month mark.

Lead Agency: VA **Start Date**: April 2018 **Full Implementation**: September 2018

1.3 – Modification of TAP: Modify the VA's TAP briefing to ensure transitioning Service members are aware of mental health resources available during the first-year post-separation and beyond. Ensure transitioning Service members are aware of protective factors associated with social connectedness, belongingness, and social support and community resources available.

Metric: Percentage of transitioning Service member respondents on the TAP Participant Assessment data who report being informed on accessing mental health services (including Military OneSource) post-separation. Data will be collected quarterly on the TAP Participant Assessment beginning July 2018. **Target**: For FY 2018 Q4 data: 55% of transitioning Service member respondents on the TAP Participant Assessment will report being informed on accessing mental health services. In addition, an increase by 10% for each consecutive quarter until the 12-month mark.

Lead Agency: VA **Start Date:** April 2018 **Full Implementation:** July 2018

1.4 – Messaging Campaign: A broad communications campaign targeting all Service members, Veterans, and family members with key messaging about access to mental health care

Metric: Increase in the total percentage of surveyed Veterans reporting improved awareness of mental health care options after 30 days of separating from military service (documented by peer caring outreach). Data will be gathered from the semi-annual national survey that assesses Veteran awareness/knowledge of resources, perceived barriers, and unmet needs. **Target**: 50% of those surveyed report awareness of mental health care options within one year of execution of new strategy. The goal is to increase this metric to 75% in the second-year survey execution.

Lead Agency: VA **Start Date**: June 2018 **Full Implementation**: Nov 2018

1.5 – Increased VSO Engagement Pre-Transition: Ensure transitioning Service members are aware of protective factors such as social connectedness that can be facilitated through access to non-governmental organizations, faith-based organizations, sports leagues, volunteer governmental organizations, and VSOs in the communities where Service members will live.

Metric: Percentage of transitioning Service members respondents on the TAP Participant Assessment data that report being informed of social connectedness support systems available in

civilian communities. Data will be collected quarterly on the TAP Participant Assessment beginning July 2018, which will provide baseline data prior to implementation of the initiative. **Target**: 55% of transitioning Service member respondents on the TAP Participant Assessment will report being informed on social connectedness support systems available in civilian communities starting in January 2019. Goal is to increase this metric by 10% for each consecutive quarter until the 12-month mark.

Lead Agency: VA **Start Date**: June 2018 **Full Implementation**: January 2019

Goal 2: Improve actions to ensure the needs of at risk Veterans are identified and met.

The below actions are aimed at identifying and engaging known groups of Veterans in need of mental health care and/or at risk for suicide (selected populations).

2.1 - Warm Hand-off for Peer Support: Implement a warm hand-off for transitioning Service members in need of (or requesting) additional psychosocial support to follow-on peer support offered through the "BeThere" call center.

Metric: Total number of contacts made by "BeThere" peer support specialists in response to referrals. **Target:** Goal is for follow-on peer engagement, within 180 days post-transition, for 90% of transitioning service members who received a warm hand-off to "BeThere." Targeting achievement of goal within one year of execution of new strategy.

Lead Agency: DoD **Start Date:** December 2018 **Full Implementation:** May 2019

2.2 – Screening and Identification: Conduct mental health screening on all transitioning Service members prior to separation. Use results to determine level of suicide risk to proactively intervene. Continue to assess individuals with standardized measures at key intervals once enrolled in care.

Metric: DoD will screen 100% of Service members prior to separation; 100% of Service members and Veterans identified as needing care and electing to participate in VA Health Care are enrolled in care. Symptom reduction based on follow-up scores on standardized measures. **Target**: 100% of Service members screened; 100% of those needing care and electing care enrolled.

Lead Agency: VA/DoD **Start Date**: May 2018 **Full Implementation**: December 2018

2.3 – Readiness Standards: Refine career readiness tool where necessary to capture potential risks for transitioning Service members across multiple life domains (e.g., social, relational, employment, housing, mental health, hope, sense of belonging). Implement a warm hand-off to follow-on peer support and clinical care offered through the "BeThere" call center and a host of VA, DoD, and community-based partnerships (as determined by the Veteran) in response to positive screenings for social, mental health, hope, and risk factors.

Metric: Total number of contacts made by peer support specialists in response to referrals, and total number of warm hand-offs to clinical care. Patient satisfaction self-report on peer and clinical care. **Target**: Goal is for peer engagement with 70% of referrals between 90- to 180-days post-separation (to assist with transition readiness issues) within 1 year of execution of new strategy.

Lead Agency: VA **Start Date:** April 2018 **Full Implementation:** July 2018

2.4 – Whole Health Peer Groups: Provide twice monthly open access (i.e., no appointment necessary) Whole Health orientation groups at every VA facility. These orientations will be advertised directly to transitioning Service members and their families through TAP and post-separation phone calls to offer an opportunity to connect with VA and to be referred into VA mental health care if needed or interested.

Metric: Collect data on percentage of recently transitioned Service members who attend monthly orientation groups, satisfaction with groups, and the number of those attending who are referred into mental health care. **Target**: Month-over-month increase in number of transitioning Service members participation in Whole Health Groups within first 12 months of execution. Of all Veterans attending, there will be an 80% satisfaction rate within the first 12 months of execution.

Lead Agency: VA **Start Date**: April 2018 **Full Implementation**: July 2018

2.5 – Peer Support Outreach: Conduct peer support outbound calls to all Veterans at specified intervals (e.g., 30-, 60-, 90-days) during the first-year post-separation from service. Provide on-going peer support and non-medical counseling if needed through the "BeThere" peer support call center. Strong linkages will be made between peer support capability and VA's concierge for care capability (the capability responsible for executing early and consistent contact; 1.1 above) in an effort to ensure warm handoffs and intensive follow-through between the two capabilities.

Metric: Number of Veterans reached by a peer support specialist between 90 – 180-days post-separation. **Target**: 60% of Veterans will be reached by a peer support specialist at key determined intervals. Additional goal of month-over-month increases are expected with this metric until 80% of Veterans are reached within one year of executing this new strategy.

Lead Agency: VA/DoD **Start Date**: July 2018 **Full Implementation**: December 2018

2.6 – Peer Specialist Community Outreach Pilot: Develop community peer support networks in additional locations that have a high number of transitioning Veterans, utilizing best practices and lessons learned through the current Clay Hunt Pilot Program on Community Outreach resulting from Section 5 of the Clay Hunt Suicide Prevention for American Veterans (SAV) Act.

Metric: VA currently has Clay Hunt SAV Act Section 5 pilot sites in five Veterans Integrated Service Networks (VISN) and will expand the pilot to five additional VISNs.

Lead Agency: VA **Start Date:** June 2018 **Full Implementation:** May 2019

2.7 – Predictive Analytics: Develop and implement a proof of concept initiative that builds the necessary data streams and infrastructure to support advanced analytics in a single predictive model that serves Service members and Veterans. This model will ensure rigorous approaches throughout the process including: identification of new variables in models and strong data processes and methods that facilitate reuse of its data for other analytic models that serve the public good.

Metric/Target: VA/DoD/DHS will share all predictive analytics models by July 2018. Departments will document any gaps to improve predictive analytics models (e.g., data sources, data integrity) by September 2018. Departments will document a way forward for an integrated data environment

and interagency analytical platform that could adequately support development of a single predictive model by April 2019.

Lead Agency: VA/DoD **Start Date:** July 2018 **Full Implementation:** July 2019

Goal 3: Improve mental health and suicide prevention services for individuals that have been identified (indicated populations) in need of care.

3.1 – Easy Button: Provide immediate and continuous access to VA health care for all transitioning Service members during the first 12 months post-transition. The Easy Button will provide resources and a straight path into mental health care for those who are eligible (Figure 2).

Metric: The percentage of new Veterans using the Easy Button to enroll in mental health care or to contact VA (new initiative, baseline is zero). Length of time until first appointment, appointments kept, length of treatment (total number of appointments kept), standardized clinical measures on symptom reduction and stabilization. **Target:** ≥15% of Veterans utilize capability within the first year.

Lead Agency: VA **Start Date:** July 2018 **Full Implementation:** December 2018

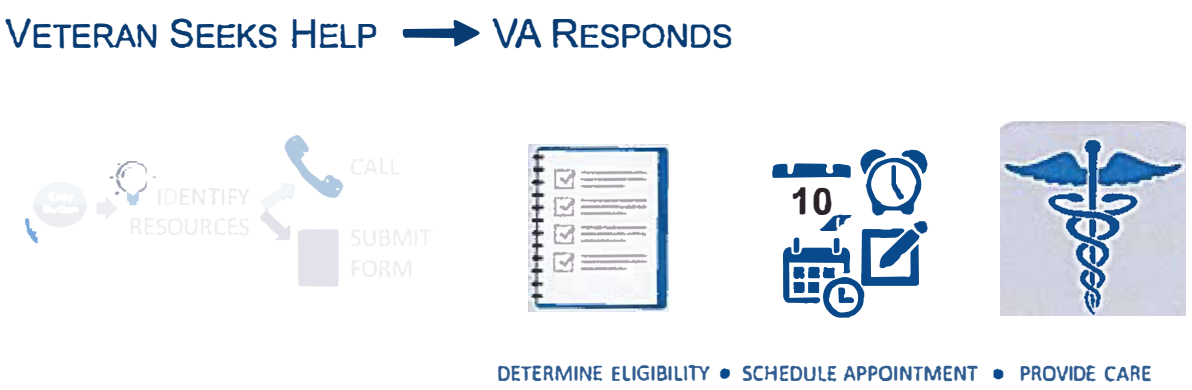


Figure 2: VA "Easy Button"

3.2 – Improved Monitoring: Increased monitoring of care through standardized tools and evidence-based treatment practices for Veterans engaged in VA mental health care during the first 12 months post military separation—with a focus on transition stressors. Utilize standard assessments throughout care addressing depression, sleep, chronic pain, and suicide risk.

Metric: Percentage of Veterans reporting improvement on individual measures (specific focus on transition stressors) and symptoms assessed over time throughout care. **Target:** 70% of Veterans in VA mental health care will have at least two assessments of their progress in care within the first year following separation from active duty.

Lead Agency: VA **Start Date:** April 2018 **Full Implementation:** August 2018

Metric: Follow-up phone calls at key intervals 30-60-90-365-days to ensure Veterans are receiving the services they need. **Target:** July 2018: 20% of Veterans in the first year following separation

from active duty will be contacted to ensure care needs are met. Goal is to increase this metric by 10% each month working towards 80% of Veterans referred are reached within one year of execution of new strategy.

Lead Agency: VA **Start Date**: April 2018 **Full Implementation**: August 2018

3.3 – Expand Military OneSource: Expand availability of a familiar resource for Service members and Veterans from 180- to 365-days post-separation; provide non-medical counseling services, such as specialty consultations in areas such as finance, employment and wellness and comprehensive information and referral support. Enhance case management system to identify clinical mental health care referral data, which can be analyzed for trends.

Metric: Percentage of Veterans accessing Military OneSource post-service. Percentage referred to medical services and to clinical mental health care upon enhancement of case management system. **Target:** Month-over-month increase in the number of those in the first year following separation from active duty who contact Military OneSource and who are 7-12 months post-separation.

Lead Agency: VA/DoD **Start Date**: July 2018 **Full Implementation**: August 2018

3.4 – Build and Expand Partnership Models: Develop and ensure local community models that demonstrate effectiveness in increasing access to and coordination of care between VA Health Care Systems, DoD, and community-based support resources. Through these models, transitioning Service members who need mental health care but who are barred from VA care, otherwise ineligible, or not interested in VA care can be referred to Vet Centers when appropriate or to other community providers with follow-up out-going calls (actions 1.1 and 2.4) occurring to ensure their needs are being met.

Metric: Percentage of applicable Department personnel that are trained on availability and referral process to community-based support resources. Follow-up phone calls at key intervals (30-,60-, 90-, 365-days) to ensure Veterans are receiving needed community-based services. **Target:** Baseline of trained personnel will be zero as this is a new initiative. Within 6 months of execution, ensure 50% of providers are trained. July 2018: 20% of transitioning Service members referred to community mental health care will be contacted to ensure care needs are met. Goal is to increase this metric by 10% each month working towards 80% of Veterans that are referred are reached within one year of execution of new strategy.

Lead Agency: VA/DoD/DHS **Start Date**: June 2018 **Full Implementation**: June 2019

Governance

In 2017, in recognition of Veteran suicide risk during transition from military service, VA and DoD signed a Memorandum of Agreement to improve coordination related to suicide prevention. The MOA created an executive level Strategic Decision Team (SDT) which is chaired by Senior Executive Service level VA and DoD leaders, reporting to the Joint Executive Committee (JEC). The SDT will oversee the implementation of the activities outlined in this Joint Action Plan. To appropriately align the work of the

SDT with the goals of EO 13822, the MOA will be expanded by June 9, 2018 to ensure DHS is a partner for addressing uniformed member transitions.

Resources

In accordance with the directive outlined in the EO, a status report on the implementation of these objectives will be submitted by July 9, 2018. As of November 7, 2017, DoD had an Active Duty end strength of 1.3M with a Reserve force of ~1.1M. The USCG had an Active Duty end strength of 42,000 with a Reserve force of 7,000. Based on those numbers and the history of Service members transitioning from uniformed service, it is estimated that up to 32,000 additional former Service members may seek VA mental health services as a result of this EO. The cost of this initiative is dependent on the actual number of Veterans who will seek care and the severity of their conditions, and an estimate will be provided in the July status report.

Appendix: Evolving Metrics Efforts

This Joint Action Plan serves as a continuation of ongoing VA, DoD, and DHS suicide prevention efforts. To enhance existing efforts, this Joint Action Plan contains actions and metrics that have never been collected or measured by the Departments. Because these actions and associated metrics are new, it will take time to determine efficacy of both. In order to determine efficacy, the Departments will need to:

- Identify reliable data sources
- Verify data stability
- Establish baseline data
- Adjust metrics based on efficacy
- Determine a data and results presentation format
- Set targets for future efforts

The Departments have identified initial data sources, as outlined in Table 1.

Action	Data Sources
1.1 – Early and Consistent Contact	Concierge 4 Care (C4C)
1.2 – Pre-transition VA Health Care Registration	Transition Assistance Program (TAP)
1.3 – Modification of TAP	TAP
1.4 – Messaging Campaign	Office of Public and Intergovernmental Affairs
1.5 – Increased VSO Engagement Pre-Transition	TAP (Participant Assessment)
2.1 – Warm Hand-off for Peer Support	DoD "BeThere"
2.2 – Screening and Identification	DoD Separation Health Assessment; Veterans Benefits Administration (VBA)
2.3 – Transition Readiness	DoD Health Affairs "Health Readiness Standards"
2.4 – Whole Health Peer Groups	Whole Health
2.5 – Peer Support Outreach	C4C; "BeThere"
2.6 – Clay Hunt Peer Specialist Pilo	Section 5 Clay Hunt SAV Act
2.7 – Predictive Analytics	VA/DoD/DHS
3.1 – Easy Button	Digital Service at VA; VBA
3.2 – Improved Monitoring	Strategic Analytics for Improvement and Learning (SAIL)
3.3 – Expand Military OneSource	Military OneSource
3.4 – Build and Expand Partnership Models	Community Care Metrics

Table 1: Data Sources

National Strategy for Preventing Veteran Suicide

2018–2028

U.S. Department of Veterans Affairs

Table of Contents

Table of Figures

Preface From Dr. Carolyn Clancy

Executive in Charge, Office of the Under Secretary for Health

We are pleased to share with you the National Strategy for Preventing Veteran Suicide, which provides a road map for how the U.S. Department of Veterans Affairs (VA) intends to address the tragedy of suicide among Veterans.

Suicide is a national public health issue that impacts people from all walks of life, regardless of whether or not they have served in the military. According to data released by the Centers for Disease Control and Prevention (CDC), suicide was the 10th leading cause of death across all ages in 2016, claiming the lives of nearly 45,000 people.[1] It is estimated that Veteran suicides represent approximately 22 percent of all suicide deaths in the U.S.

In the Department of Veterans Affairs FY 2018–2024 Strategic Plan, we have identified preventing Veteran suicide as our highest clinical priority, one that will require all of government, as well as public-private partnerships, to achieve. We know that suicide is preventable, and we all have a role to play in saving lives. We must act now to save lives and help those who have served our nation live healthy, productive lives.

Suicide is a complex problem, and it requires coordinated, evidence-based solutions that reach beyond the traditional medical model of prevention. Ensuring access to quality mental health services for those in need is one part of a broader solution, but not sufficient on its own.

VA has embraced a comprehensive public health approach to reduce Veteran suicide rates, one that looks beyond the individual to involve peers, family members, and the community. Yet we know we cannot do it alone, as roughly half of all Veterans in the U.S. do not receive services or benefits from VA. This means we must collaborate with partners and communities nationwide to use the best available information and practices to support all Veterans, whether or not they're engaging with VA.

It is our hope that the National Strategy for Preventing Veteran Suicide will serve as a road map to all stakeholders that share our determination to prevent Veteran suicide.

Thank you to all those working with us to achieve our mission.

Carolyn M. Clancy, M.D.
Executive in Charge

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2016). Accessed March 2, 2018, at www.cdc.gov/injury/wisqars.

A Letter From Dr. David Carroll

Executive Director, Office of Mental Health and Suicide Prevention

As the Executive Director of the Office of Mental Health and Suicide Prevention at the U.S. Department of Veterans Affairs (VA), I am honored to present this strategy for preventing suicide among Veterans.

VA is determined to reduce the number of Veteran deaths by suicide, saving lives by using prevention strategies that are based on the best evidence available. This plan offers guidance to VA and its stakeholders — other federal agencies, state and local governments, health care systems, community organizations, and other public and private institutions — so that we can begin making progress toward reducing suicide rates among Veterans in the next several years.

VA has made great strides in Veteran suicide prevention, especially in crisis intervention. But if we are going to end Veteran suicide, then we must continuously work to prevent it before Veterans reach a crisis point. This will require VA to expand our treatment and prevention efforts to address issues that arise well before a suicidal crisis, while also continuing to expand our crisis intervention services. And that is exactly what we aim to achieve with this strategy.

This strategy has been modeled after the 2012 National Strategy for Suicide Prevention, released by the Office of the Surgeon General and the National Action Alliance for Suicide Prevention. VA executive leadership participates in the Action Alliance, a body of professionals across the public and private sectors that collectively work toward zero suicide nationwide. In conjunction with our goal to prevent Veteran suicide, VA supports the national goal of reducing suicide in the U.S. by 20 percent by the year 2025.

In this National Strategy for Preventing Veteran Suicide, the goals and objectives of the 2012 National Strategy have been adapted to address suicide prevention among Veterans. This plan reflects VA's vision for a coordinated national strategy to prevent suicide among *all* Veterans — one that maintains VA's focus on high-risk individuals in health care settings but also incorporates broad public health approaches for prevention, with an emphasis on comprehensive, community-based approaches. We want to underscore two key themes of this strategy:

- **Collaboration:** A coordinated effort at the federal, state, and local levels is key to preventing Veteran suicide.
- **Urgency:** The magnitude of the loss of Veteran life to suicide is not acceptable, and urgent action is needed to prevent these tragic deaths.

Together, we can and will save Veterans' lives, and we will not stop in our efforts to work to end suicide among Veterans.

David Carroll, Ph.D.
Executive Director

Dedication

To Veterans who have lost their lives by suicide,

to Veterans who have thoughts of suicide,

to Veterans who have made an attempt on their lives,

to those caring for a Veteran,

to those left behind after a death by suicide,

to Veterans in recovery, and

to all those who work tirelessly to prevent Veteran suicide and suicide attempts in our nation.

We believe that we can and will make a difference.

Introduction

Background

Suicide is a public health challenge that causes immeasurable pain among individuals, families, and communities across the country. Suicide is also preventable. Veteran suicide is an urgent issue that the U.S. Department of Veterans Affairs (VA), along with its stakeholders, partners, and communities nationwide, must address. VA supports the national goal of reducing the annual suicide rate in the U.S. 20 percent by the year 2025 and is implementing a public health approach to achieve this mission.

Suicide prevention is VA's highest priority, and VA has made great strides in Veteran suicide prevention, especially in crisis intervention. We will not relent in our efforts to connect Veterans who are experiencing an emotional or mental health crisis with lifesaving support. Mental health and crisis support services are critical for people showing signs of suicide risk in their thoughts or behavior, but we must go beyond engaging mental health providers, to involve the broader community and reach Veterans where they live and thrive — before they reach a crisis point.

As a national leader in suicide prevention and the nation's largest integrated health care system, the Veterans Health Administration has unparalleled experience in preventing Veteran suicide. But the agency by itself cannot adequately confront the issue. While VA encourages Veterans to seek and use its services and benefits, the reality is that many Veterans do not engage with VA. To serve all Veterans, VA must build effective networks of support, communication, and care across the communities in which Veterans live and work every day. With resources and services working in a coordinated manner, we as a nation can prevent these tragic deaths by suicide.

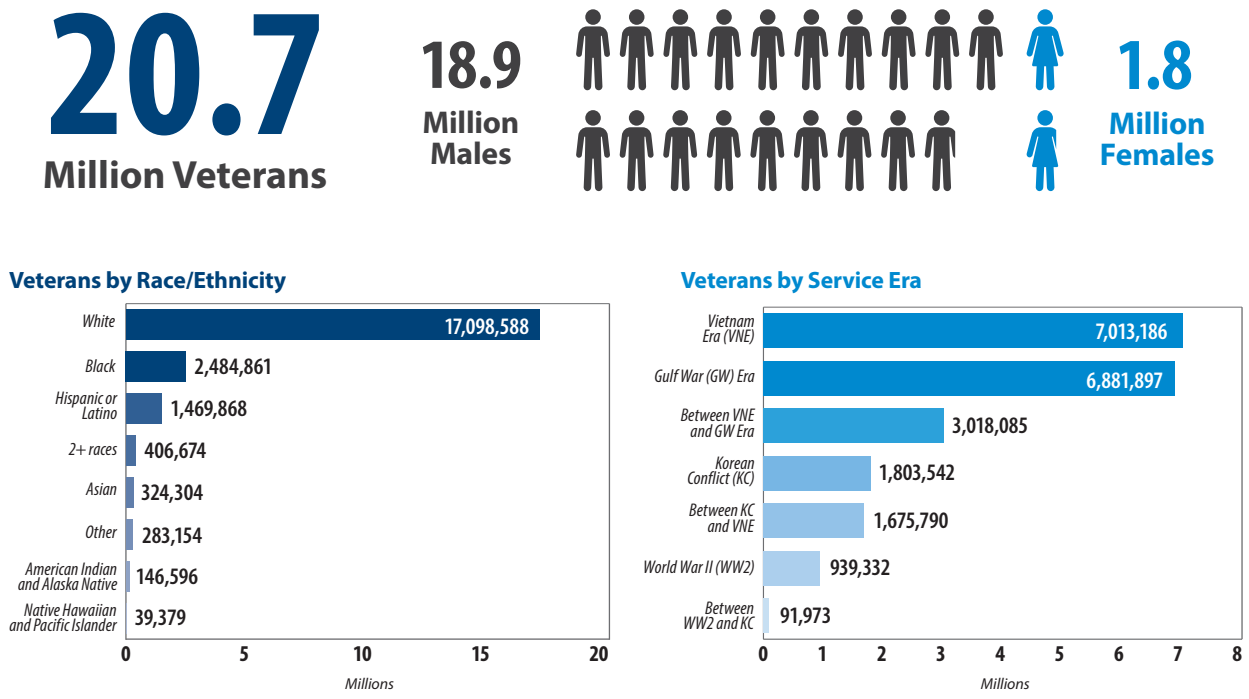
To accomplish this, VA has developed the National Strategy for Preventing Veteran Suicide in alignment with the 2012 National Strategy for Suicide Prevention. The purpose of the National Strategy for Preventing Veteran Suicide is to provide a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention over the next several years. Data and figures referred to in this strategy reflect the most current, publicly available data at the time of publication.

Key Facts About Veterans

There are approximately 20 million Veterans in the U.S.[2]

Figure 1 depicts the composition of the Veteran population in the U.S. based on gender, race and ethnicity, and service era.

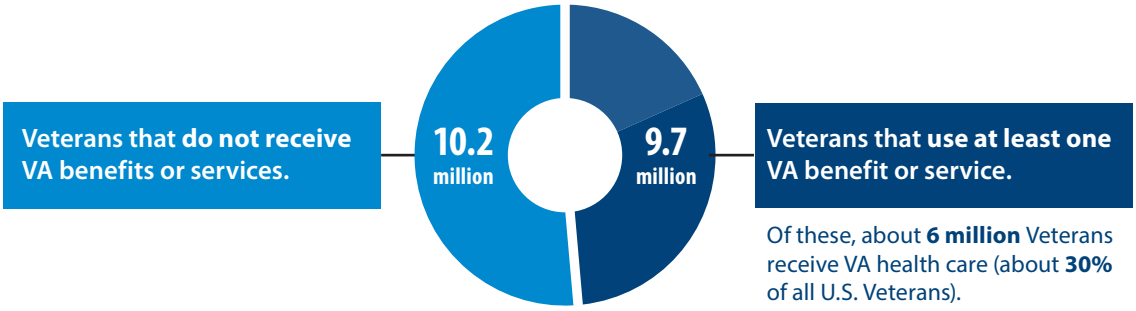
Figure 1: *The U.S. Veteran Population*



Of the approximately 20 million Veterans in the U.S. — who include almost 2 million women — less than 10 million[3] receive one or more benefits or services from VA. Of these, approximately 6 million receive VA health care, as depicted in Figure 2.[4]

2. U.S. Department of Veterans Affairs, *Table 1L: VETPOP2016 Living Veterans by Period of Service, Gender, 2015-2045, 9/30/2015* (n.d.). Accessed March 2, 2018.
3. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Statistics at a Glance* (Dec. 31, 2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/Stats_at_a_glance_2_2_18.PDF.
4. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *VA Utilization Profile FY 2016* (2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile.pdf.

Figure 2: *Number of Veterans Who Do and Do Not Receive VA Benefits or Services*



Veterans between the ages of 25 and 34 and over the age of 65 are more likely to use VA benefits compared with Veterans of other ages.[5]

Although only about 30 percent of Veterans receive VA health care and fewer than 50 percent use any VA benefits or services at all, VA believes it is our responsibility to work with partners, communities, and like-minded organizations to prevent suicide among all Veterans — even those who do not use VA health care, services, or benefits.

Key Facts About Veteran Suicide

There is no single cause of suicide. Suicide deaths reflect a complex interaction of risk and protective factors at the individual, community, and societal levels.

Risk factors are characteristics associated with a greater likelihood of suicidal behaviors. Some risk factors for suicide include:

- A prior suicide attempt
- Mental health conditions
- Stressful life events such as divorce, job loss, or the death of a loved one
- Availability of lethal means

Protective factors can help offset risk factors. These are characteristics associated with a lesser likelihood of suicidal behaviors. Some protective factors for suicide include:

- Positive coping skills
- Having reasons for living or a sense of purpose in life
- Feeling connected to other people
- Access to mental health care

In addition to the protective factors described above, Veterans may possess unique protective factors related to their service, such as resilience or a strong sense of belonging to a unit. They may also possess risk factors related to their military service, such as service-related injury or a recent transition from military service to civilian life. Preventing Veteran suicide requires strategies that maximize protective factors while minimizing risk factors at all levels throughout communities nationwide.

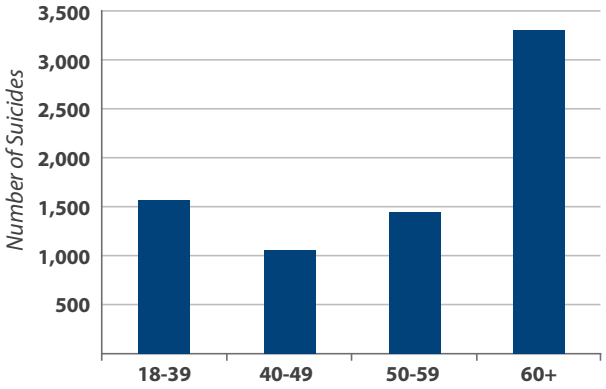
5. U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *VA Utilization Profile FY 2016* (2017). Accessed March 2, 2018, at www.va.gov/vetdata/docs/Quickfacts/VA_Utilization_Profile.pdf.

Veteran suicide rates and numbers of deaths vary across regions and demographics. Recent data suggest that:

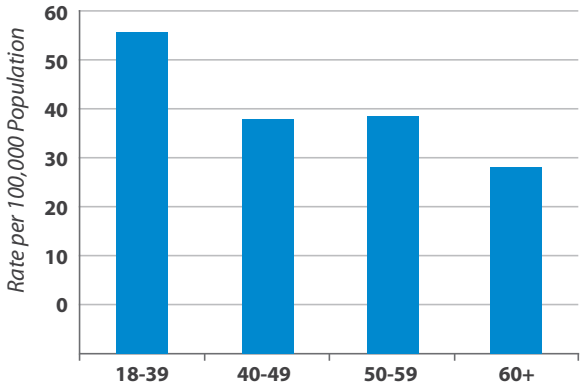
- **An average of 20 Veterans die by suicide each day.**[6] About six of the 20 are recent users of Veterans Health Administration services. On average, there are 93 suicides among the general U.S. non-Veteran adult population per day.[7]
- **Overall, the trend among rates of Veteran suicide mirrors those of the general population across geographic regions**, with the highest rates in western states. While rates of suicide are higher in some states with smaller populations, the largest numbers of Veteran suicides are in the heaviest populated areas of the nation.
- **The burden of suicide resulting from firearm injuries is high.** About 67 percent of all Veteran deaths by suicide were the result of firearm injuries.
- **Rates of suicide are highest among younger Veterans** (ages 18–29) and lowest among older Veterans (ages 60 and older).
- **Despite comparatively lower rates, the largest number of deaths by suicide is among middle-age and older adult Veterans.** Approximately 65 percent of all Veterans who died by suicide were age 50 or older.

The distinction between rates and counts of deaths is illustrated in Figure 3 below. While *rates* are lower among the older Veteran population, the bulk of the *count* of suicide deaths occurs in this age group due to the large size of the population. The younger Veteran population, which includes more recently transitioned Veterans, is smaller. This population has a smaller *count* of suicide deaths, but a higher *rate* of suicide.

Figure 3: *Veteran Suicide Deaths: Count vs. Rate*



Older Veteran population accounts for the bulk of suicide deaths. This is because of the population's size.



Younger Veteran population includes more recently transitioned Veterans and has a higher rate of suicide.

VA works to provide the best-quality, most timely data about Veterans and Veteran suicide so that all stakeholders interested in preventing suicide may benefit from the insights.

6. U.S. Department of Veterans Affairs, Office of Suicide Prevention, *Suicide Among Veterans and Other Americans 2001–2014* (2016). Accessed March 2, 2018, at www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf.
7. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2016). Accessed March 2, 2018, at www.cdc.gov/injury/wisqars.

A Public Health Approach to Preventing Veteran Suicide

VA's Commitment to All Veterans

VA is advancing a public health approach to reduce deaths by suicide among the greatest number of Veterans possible.

Guidance from the CDC offers four key components of the public health approach, which uses science to address multiple risk factors for suicide and prevent suicidal thoughts and behaviors from occurring.[8]

These components are:

- **Population Approach:** Public health uses a population approach to improve health on a large scale. A population approach means focusing on prevention approaches that impact groups or populations of people, as opposed to treatment of individuals.
- **Primary Prevention:** Public health focuses on preventing suicidal behavior before it occurs and addresses a broad range of risk and protective factors.
- **Commitment to Science:** Public health uses science to increase our understanding of suicide prevention so we can develop new and better solutions.
- **Multidisciplinary Strategies:** Public health advocates for multidisciplinary collaboration, bringing together many different perspectives to engineer solutions for diverse communities.

The public health perspective asks questions such as: Where does the problem begin? How could we prevent it from occurring in the first place? To answer these questions, VA follows a systematic approach used by the CDC in preventing suicide[9]:

Step 1: Define the problem. This involves collecting data to determine the "who," "what," "where," "when," and "how" of suicide deaths.

Step 2: Identify risk and protective factors. Scientific research methods are used to explore the factors that increase risk for suicide, as well as the protective factors that serve as buffers against suicide risk.

Step 3: Develop and test prevention strategies. Suicide prevention strategies are developed and tested to see if they succeed in preventing suicide and/or suicidal behaviors.

Step 4: Assure widespread adoption. Strategies shown to be successful in Step 3 are broadly disseminated and implemented by a variety of stakeholders who play a role in preventing Veteran suicide.

8. Centers for Disease Control and Prevention, *Enhanced Evaluation and Actionable Knowledge for Suicide Prevention Series. Suicide Prevention: A Public Health Issue* (n.d.). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/ASAP_Suicide_Issue2-a.pdf.
9. Centers for Disease Control and Prevention, *The Public Health Approach to Violence Prevention* (n.d.). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/ph_app_violence-a.pdf.

Adherence to this framework ensures that suicide prevention strategies are developed based on sound data and research, and that effective strategies backed by science are promoted and adopted by practitioners, intermediaries, and other stakeholders who have the ability to save Veteran lives.

To advance the goal of eliminating Veteran suicide, VA and its stakeholders must reduce the burden of suicide among *all* Veterans, whether or not they are receiving benefits or services from VA.

Not all Veterans are connected to VA or other agencies, so VA and its stakeholders must find innovative strategies to serve Veterans who do not — and may never — seek care, benefits, or services within its system. In addition, many risk factors related to suicide are influenced by community and societal factors outside the bounds of VA's influence. This will require VA to reach beyond the health care setting, through which it has traditionally supported Veterans' health, and empower actors to prevent Veteran suicide in other sectors, including:

- Non-VA health care
- Veterans and Military Service Organizations
- Faith communities
- Higher learning
- Law enforcement and criminal justice
- Employment
- Community service
- Nonprofits and nongovernmental organizations
- Media and entertainment
- Private sector industries
- Public-private partnerships
- Federal, state, and local government

No one organization can tackle Veteran suicide prevention alone. To save lives, multiple systems must work in a coordinated way to reach Veterans where they are.

A Framework for Prevention

Not all Veterans have the same risk for suicide, and prevention strategies are most effective when they are matched to a Veteran's or group of Veterans' level of risk.[10]

To better understand the most appropriate mix of prevention efforts needed to reach all Veterans, VA has relied on a prevention framework developed by the National Academy of Medicine (formerly the Institute of Medicine) that sorts prevention strategies into three levels (as depicted in Figure 4):

- ***Universal* strategies aim to reach *all* Veterans in the U.S.** These include public awareness and education campaigns about the availability of suicide prevention resources for Veterans, promoting responsible coverage of suicide by the news media, and creating barriers or limiting access to hot spots for suicide, such as bridges and train tracks.
- ***Selective* strategies are intended for *some* Veterans** who fall into subgroups that may be at increased risk for suicidal behaviors. These include outreach targeted to women Veterans or Veterans with substance use challenges, gatekeeper training for intermediaries who may be able to identify Veterans at high risk, and programs for Veterans who have recently transitioned from military service.
- ***Indicated* strategies are designed for the relatively *few* individual Veterans** identified as being at high risk for suicidal behaviors, including someone who has made a suicide attempt. These include referring Veterans in crisis to the Veterans Crisis Line, putting time and space between a Veteran who has expressed thoughts of suicide and a firearm or prescription medication, and providing a Veteran survivor of a suicide attempt or loss with enhanced support and expedited access to care.

10. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for the Application of Prevention Technologies, *Risk and Protective Factors* (2015). Accessed March 2, 2018, at www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors#universal-prevention-interventions.

Figure 4: *National Academy of Medicine Classifications of Prevention*

Universal *(all)*
Universal prevention strategies are designed to reach the entire Veteran population.

Selective *(some)*
Selective prevention strategies are designed to reach subgroups of the Veteran population that may be at increased risk.

Indicated *(few)*
Indicated prevention strategies are designed to reach individual Veterans identified as having a high risk for suicidal behaviors.

The goals and objectives of the National Strategy for Preventing Veteran Suicide are broad and can be adapted to fit specific settings and meet the distinctive needs of groups of varying levels of risk, including new settings and groups that may be identified in the future.

Research from the CDC asserts that, just as suicides are not caused by a single factor, suicide cannot be prevented by any single strategy or approach. Rather, suicide prevention is best achieved across the individual, relationship, family, community, and societal levels and across the private and public sectors.[11]

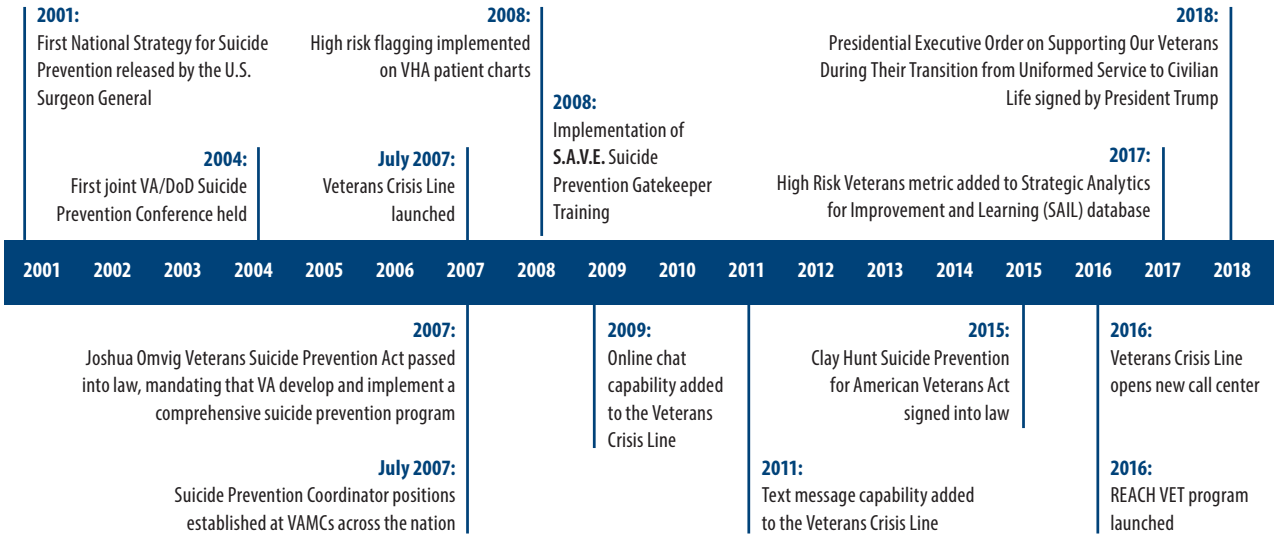
11. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Preventing Suicide: A Technical Package of Policy, Programs, and Practices* (2017). Accessed March 2, 2018, at www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

VA's Suicide Prevention Program

Since the Suicide Prevention Program launched in 2007, VA has been leading innovative, research-driven suicide prevention efforts.

The Veterans Health Administration is the largest integrated health care system in the country, providing care at more than 1,200 health care facilities, including 170 medical centers and more than 1,000 outpatient clinics, and serving 9 million enrolled Veterans each year. Over the last decade, the administration has implemented numerous programs, policies, and initiatives related to suicide prevention (see Figure 5), VA's top clinical priority.

Figure 5: *VA Suicide Prevention Timeline*



VA works continuously to expand suicide prevention initiatives, including by:

- Bolstering mental health services for women Veterans
- Broadening telehealth services
- Developing free mobile apps to help Veterans and their families
- Improving access to care by providing mental health screening and treatment services through Vet Centers and readjustment counselors
- Using telephone coaching to assist families of Veterans

VA partners with hundreds of organizations at the national and local levels — including the U.S. Department of Defense (DoD) — to raise awareness of VA's suicide prevention resources and to educate people about how they can support Veterans and Service members in their communities. VA also partners with community mental health providers to expand the network of local treatment resources available to Veterans who need them. Veterans Service Organizations (VSOs) are likewise important partners, as they are integral to reaching all Veterans, wherever they are. VSO-run programs make a difference in Veterans' lives every day by helping them find employment, manage claims and benefits, stay socially connected, and more. These factors all protect against suicide risk.

As VA advances a public health approach to preventing Veteran suicides, it is using the best evidence available to promote broad, bundled strategies across many sectors. VA is committed to furthering research, gathering quality data, identifying and sharing best practices, and transforming the delivery of care and support to Veterans, with the ultimate goal of eliminating Veteran suicide. As efforts evolve to better meet Veterans' needs, the previously outlined concepts and frameworks will continue to guide VA's Suicide Prevention Program as it uses best practices and evidence to save Veteran lives.

Using the Strategy for Preventing Veteran Suicide

VA recognizes the need for a comprehensive, coordinated approach to ending Veteran suicide, and we know that our experience, expertise, and leadership make us well-positioned to lead this cause. **However, VA alone cannot end Veteran suicide.** The 14 goals described in this document outline our vision for what the nation must collectively achieve by 2028. To realize these goals, VA is broadening its efforts to best align with this vision. But we need partners and like-minded groups across all sectors — including health care, faith-based, and community organizations — to work with us in reaching all Veterans, wherever they may be.

The National Strategy for Preventing Veteran Suicide is modeled after the 2012 National Strategy for Suicide Prevention and encompasses four interconnected strategic directions:

1. Healthy and Empowered Veterans, Families, and Communities
2. Clinical and Community Preventive Services
3. Treatment and Support Services
4. Surveillance, Research, and Evaluation

The 14 goals and 43 objectives included in the National Strategy for Preventing Veteran Suicide are meant to work together in a synergistic way to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery.

This strategy is intended to serve as a framework for identifying priorities, organizing efforts, and contributing to a national focus on Veteran suicide prevention.

It represents a comprehensive, long-term approach to Veteran suicide prevention. The goal of saving Veteran lives can be achieved only by bundled science-based actions that complement each other. It is designed to be accessible to all stakeholders interested in preventing suicide, including individuals, groups, communities, organizations, institutions, and every level of government. VA's hope is that everyone connected to Veterans will assume collective ownership of the strategy and use it to guide suicide prevention efforts. With a diverse group of stakeholders acting together and using the strategy as a common point of reference, we increase the likelihood of success in preventing suicide among Veterans.

The strategy can assist in identifying priorities for individuals and groups as they develop an organizational strategic plan, an annual work plan, or specific action plans for an organization's efforts in suicide prevention. Developing and adhering to a plan is important, as it allows organizations to chart their progress against the overall goals of the strategy. Coordination with other organizations that are working toward the same or complementary goals, as presented in the strategy, is highly encouraged.

The field of suicidology uses common words that have specific definitions relevant to suicide diagnosis, intervention, and prevention. Such words used in this document are defined in Appendix A.

Strategic Direction 1: Healthy and Empowered Veterans, Families, and Communities

The goals and objectives that constitute this strategic direction seek to create supportive environments that promote the general health of Veterans and reduce the risk for suicidal behaviors, as well as associated risks. Suicide shares risk and protective factors with mental health and substance use disorders, trauma, and other types of violence, such as bullying and domestic violence. As a result, a wide range of partners can contribute to suicide prevention, including organizations and programs that promote the health of children, youths, families, working adults, older adults, and others in the community. All these partners should integrate suicide prevention into their work.

Eliminating stigma associated with suicidal behaviors, mental health and substance use disorders, and exposure to violence is a key area of concern within this strategic direction. In particular, there is a need to raise awareness that prevention and treatments for mental health and substance use disorders are effective and that recovery is possible.

Communication efforts, such as campaigns and social marketing interventions, play an important role in changing knowledge, attitudes, and behaviors to help prevent suicide. Safe and positive messaging addressing mental illness, substance abuse, and suicide can help reduce stigma and promote help-seeking. These types of messages help create a supportive environment in which someone who is experiencing problems feels comfortable seeking help, and where families and communities feel empowered to link a person with care before, during, or after a crisis and assist the person in regaining a meaningful life.

Goal 1. Integrate and coordinate Veteran suicide prevention activities across multiple sectors and settings.

Veterans are an integral part of every community. While some organizations specifically serve Veterans, it is important to recognize that effective outreach to Veterans requires programs that are carried out in diverse settings and systems. Greater coordination of efforts among different stakeholders and settings can increase the reach and impact of suicide prevention activities, while preventing duplication of efforts and promoting greater cost-effectiveness. In particular, it is important to take advantage of existing programs and efforts that address risk and protective factors for suicidal behaviors, including programs that may not yet include suicide prevention as an area of focus. For example, many employee assistance programs seek to promote resilience among employees by building problem-solving skills. These types of strategies can also be useful for suicide prevention.

Objective 1.1: Foster the integration of Veteran suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to play in supporting suicide prevention activities.

Because Veterans are also members of their communities, suicide prevention should be integrated into the activities of all organizations and programs that provide services and support in the community. While all national, state or regional, and local organizations can play a role in preventing Veteran suicide, examples include:

1. Veterans and Military Service Organizations
2. Federal government agencies
3. State and local government entities

4. Workplaces
5. Chambers of commerce
6. Faith-based organizations
7. Health care organizations (e.g., providing physical, mental health, and substance abuse treatment)
8. Lethal means education and suicide prevention organizations
9. Communication and media organizations
10. Technology companies
11. Law enforcement and criminal justice agencies
12. Legal support service providers
13. Community service providers
14. Institutions of higher learning and other educational settings

Helping these community partners understand military and Veteran culture and integrate suicide prevention into their work will promote greater understanding of suicide and help counter the stigma that can prevent Veterans from seeking help. It also will support the delivery of suicide prevention activities that are culturally appropriate for Veterans. Strategies for involving these stakeholders include infusing suicide prevention into key professional meetings, developing public-private partnerships, and establishing suicide prevention coalitions, which can help facilitate and advance suicide prevention efforts in a particular geographic area.

Objective 1.2: Support the establishment of effective, sustainable, and collaborative suicide prevention programming for Veterans at the national, state/territorial, tribal, and local levels.

Services for Veterans are often spread across multiple agencies at the national, state/territorial, tribal, and local levels. This can make it difficult for the agencies and programs involved in suicide prevention to work collaboratively. Increased coordination of suicide prevention activities among these various partners could help improve services and outcomes for Veterans, while making suicide prevention efforts more sustainable in the long term.

Identifying the agencies that participate in Veteran suicide prevention and clarifying each agency's role is an important first step. This clarification can make it easier for different agencies to identify gaps and overlaps in their services and to obtain support for their respective suicide prevention efforts. This collaboration can also aid in sharing information, establishing and standardizing best practices, and developing registries of programs or resources that can benefit the broader community. It may be useful to identify lead agencies at the state and local levels that can help bring together new and different partners with a role to play in suicide prevention.

Objective 1.3: Sustain and strengthen collaborations across federal agencies to advance Veteran suicide prevention.

Because suicide affects many different groups and is related to mental health, substance abuse, trauma, violence, injury, and other issues, many federal agencies have a role to play in suicide prevention. The Federal Working Group on Suicide Prevention is an important mechanism for maintaining collaboration across these agencies. Formed in 2000, the group shares information and coordinates efforts across:

- Department of Veterans Affairs
- Department of Defense
- Department of Health and Human Services
- Department of Homeland Security
- Department of Justice
- Department of Education
- Department of Transportation

The Federal Working Group on Suicide Prevention meets regularly and publishes a Compendium of Federal Activities. As an example of a group outcome, VA works closely with DoD on several joint initiatives, such as distributing firearm locks and organizing the VA/DoD Suicide Prevention Conference, which occurs every other year.

Improved coordination of funding priorities at the federal level could help strengthen the infrastructure for delivering suicide prevention services to Veterans at the state/territorial, tribal, and local levels.

Objective 1.4: Promote the development of sustainable public-private partnerships to advance Veteran suicide prevention.
Suicide is a complex issue that affects Veterans from all backgrounds, and not all Veterans are connected to VA or other agencies. Hence, no single agency, organization, or governmental body can have sole responsibility for suicide prevention.

The National Action Alliance for Suicide Prevention is a public-private partnership to advance and coordinate the implementation of suicide prevention in the United States. A subcommittee of the Action Alliance that focuses on suicide prevention among Veterans could draw the attention needed to unique aspects of this population while also integrating Veterans issues into the broader work of the Action Alliance. In addition, VA encourages creation of public-private partnerships that focus specifically on preventing Veteran suicide at the local, state/territorial, and national levels.

Objective 1.5: Support the integration of Veteran suicide prevention into all relevant policy decisions.
Changes in health care systems and policies provide important opportunities for integrating, enhancing, and transforming suicide prevention efforts. Policy decisions that increase access to care for mental health and substance use disorders can greatly contribute to Veteran suicide prevention. Examples include federal and state parity laws requiring equal health insurance coverage for behavioral health care as for physical health care.

VA is working to increase access to VA services for transitioning Service members by facilitating registration and enrollment for health care. VA encourages all health systems and providers to consider how access to care and suicide prevention efforts for Veterans can be improved.

Goal 2. Implement research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes, and behaviors.

Communication efforts targeting Veterans need to be culturally appropriate and recognize that while Veterans may share some common experiences, they are a diverse and unique group. Communication efforts addressing Veteran suicide prevention should be research-based and reflect safe messaging recommendations specific to Veteran suicide.

Effective communication with Veterans about suicide prevention requires a wide range of efforts, such as communication campaigns and social marketing interventions. These efforts can help shift knowledge, attitudes, and behaviors among Veterans, their loved ones, and intermediaries such as service providers, including by dispelling misconceptions about mental health treatment, raising awareness of available resources, and encouraging help-seeking and healthy behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach Veterans.
The field of communications and social marketing has developed research-informed principles for effective communication. Communication campaigns addressing Veteran suicide prevention should incorporate the principles for effectiveness identified in the literature. These principles include:

1. Conducting formative research
2. Using behavior theory
3. Segmenting the audience
4. Identifying and using effective channels and messages
5. Conducting process evaluation to ensure high message exposure
6. Using an appropriate design for outcome evaluation

Communication efforts should target defined audiences — for example, Veterans with a particular set of risk factors, or the friends and families of Veterans at high risk. Demographic factors, such as age, income, and gender, may be used to identify different audience segments, along with factors related to the call to action being promoted. Efforts promoting behavior change should convey a clear call to action and provide specific information for executing the action. All communication efforts should be evaluated to measure their reach and determine their effectiveness in achieving the intended audience behavior.

Objective 2.2: Connect policymakers with resources for communicating about Veteran suicide prevention.
An important step in educating policymakers is proactively reaching out to them to increase their understanding of Veteran suicide, its impact on their constituents and stakeholders, and effective solutions. These outcomes can counter narratives about distressed Veterans that perpetuate stereotypes and stigma, and can motivate leaders to take action by promoting initiatives, policies, and programs to prevent Veteran suicide. Describing effective Veteran suicide prevention programs of federal, state/territorial, tribal, and nonprofit agencies and local coalitions will help build support for these efforts. It also may be useful to share evaluation data that show communities that have been successful in reducing risk and increasing protective factors for suicide.

Communication efforts designed to educate policymakers are especially important because policy and systemic changes are effective and long-lasting ways to advance suicide prevention. These policymakers may include federal, state, and local officials; tribal council members; and institutional and organizational leaders and their research and policy staff. To be most effective, messages should link to specific actionable requests and reflect an understanding of broader issues of concern to the policymaker. Communication efforts should be framed in ways that will speak to diverse policymakers at the national, state, tribal, and local levels and build broad support for suicide prevention.

Objective 2.3: Increase multiplatform communication efforts that promote positive messages and support safe crisis intervention strategies.
With changes in technology and social media, Veterans are increasingly using interactive and dynamic technology such as social networking websites, email, blogs, web applications, video chat, mobile apps, and text messages. These technologies provide new opportunities for Veteran suicide prevention. For example, VA is using telehealth (telehealth.va.gov) to provide services to Veterans in rural areas. Another example is the chat line (VeteransCrisisLine.net/Chat) and text messaging service (text to 838255) operated by VA's Veterans Crisis Line call center (1-800-273-8255 and Press 1).

Efforts to prevent Veteran suicide must consider the best ways to use existing and emerging communication tools to encourage help-seeking and provide support to individuals with varying levels of suicide risk, as well as their friends, families, and intermediaries. The CDC recommends carefully planning how new communications channels fit into an overall communications effort, understanding the level of effort needed to maintain these channels, and using these tools strategically by making choices based on audience. While more research is needed on how to best use emerging communication tools in suicide prevention, some guidance is available on best practices for using social media in health promotion:

1. Action Alliance Framework for Successful Messaging: suicidepreventionmessaging.org
2. Recommendations for Reporting on Suicide: reportingonsuicide.org
3. Recommendations for Blogging on Suicide: www.bloggingonsuicide.org
4. Social Media Guidelines for Mental Health Promotion and Suicide Prevention: www.eiconline.org/teamup/wp-content/files/teamup-mental-health-social-media-guidelines.pdf
5. CDC Social Media Tools, Guidelines, and Best Practices: www.cdc.gov/socialmedia/tools/guidelines

Suicide prevention programs that incorporate emerging technologies have a responsibility to ensure the safety of users. They should consider in advance how to monitor these channels regularly and respond to disclosures of suicidal thoughts or behaviors. These programs should include links to online crisis resources, such as the Veterans Crisis Line. In addition, because many of these media include user-generated content, it is important to think about how to moderate online conversations to ensure that public-facing messages are positive and that they promote hope, connectedness, social support, resiliency, and help-seeking.

Objective 2.4: Develop and promote educational materials about the warning signs for Veteran suicide and how to connect individuals in crisis with assistance and care.

Family members, friends, co-workers, and others can play an important role in recognizing when a Veteran is in crisis and connecting the Veteran with sources of help. However, many of these people may not know the warning signs of suicidal behavior or where a distressed person can go for help. It is crucial to widely disseminate information on warning signs, guidance on how to interact with Veterans in crisis, and available resources. In doing so, it is important to use communication strategies that are research-based, thoughtfully planned, and designed to meet the needs of specific groups. Incorporating stories of individuals who received and benefited from help may motivate others to take action.

In particular, there is a need to increase awareness of the role of crisis lines, such as the Veterans Crisis Line, in providing services and support to Veterans in crisis. Providing follow-up calls and services after an acute crisis can also enhance safety and connect Veterans with appropriate care and services.

Goal 3. Increase knowledge of the factors that offer Veterans protection from suicidal behaviors and that promote their wellness and recovery.

Many Veterans pride themselves on being able to take care of themselves and serving as protectors to their loved ones and communities; for some, seeking support from others can be a challenge. While effective treatment for mental health and substance use disorders has increased over the years, stigma associated with these disorders and suicidal behaviors, as well as misconceptions about the nature of treatment, continues to prevent some Veterans from seeking help.

There is a need to eliminate cultural biases toward help-seeking behavior and to increase awareness of the factors that can serve as a buffer against suicide risk. Connectedness to others — including family members, co-workers, community organizations, and social institutions — has been identified as an important protective factor. These positive relationships can help increase a Veteran's sense of belonging, foster a sense of personal worth, and provide access to sources of support.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk for Veterans.
While the focus of Veteran suicide prevention is predominantly on counteracting risk factors, strengthening protective factors can help prevent suicide by promoting physical, mental, emotional, and spiritual wellness. For example, building the problem-solving skills and social support of Service members transitioning from the military can help them better cope with future challenges as Veterans. A focus on strengthening protective factors should be the norm rather than the exception.

Many groups and organizations in the community, including faith-based organizations and aging services networks, can contribute to Veteran suicide prevention by enhancing connectedness, especially among Veterans who may be isolated or marginalized. These organizations can help ensure that social support is more widely available from peers and others. Specific training addressing Veteran suicide prevention could enhance these providers' ability to deliver support to individuals at risk and make appropriate referrals. The DoD BeThere Peer Support Call and Outreach Center (BeTherePeerSupport.org) is an example of a resource designed to promote connectedness among both Service members and Veterans.

Objective 3.2: Work to reduce stigma associated with suicidal behaviors and mental health and substance use disorders among Veterans.
Military culture emphasizes strength, resilience, and unit cohesion. Some of these aspects can serve as protective factors by strengthening a sense of connectedness; however, they can also reinforce stigma toward mental health challenges that affect Veterans after they have transitioned from the military. In addition, Service members may have concerns about the impact that seeking help for mental health issues could have on their careers.[12] These factors may discourage many Veterans from seeking help, or even from talking about the psychological distress that could lead to suicidal behaviors. Strategies for addressing cultural beliefs related to Veteran suicidal behaviors will be most effective when they are grounded in a full understanding of and respect for the cultural context of these beliefs.

Veterans would benefit from broad communication, public education, and public policy efforts to promote mental health, increase understanding of mental health and substance use disorders, and eliminate barriers to help-seeking. A cultural shift is needed for more Veterans to view seeking treatment as a natural and acceptable behavior and not a sign of weakness.

Objective 3.3: Promote the understanding that recovery from mental health and substance use disorders is real and possible for all Veterans.
Social attitudes, bias, and discrimination often present barriers to treatment and undermine the recovery of Veterans with mental health or substance use disorders. A better understanding of crisis,

12. Tanielian, et al., "Barriers to Engaging Service Members Within the U.S. Military Health System." *Psychiatric Services 67*, No. 7 (2016). Accessed March 2, 2018, at https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500237?code=ps-site.

trauma, and recovery can help the community promote resilience and wellness among Veterans. It is important to increase awareness that, in most cases, Veterans with a mental health or substance use disorder can recover and regain meaningful lives. Family members, peers, mentors, individuals who have attempted suicide, individuals who have experienced a suicide loss, and members of the faith community can be important sources of support. These individuals can impart hope and motivation for achieving recovery; provide support for addressing specific stressors, such as the loss of a job; and help foster a sense of meaning and purpose.

Goal 4. Promote responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide.

Media and the internet play a significant role in shaping the public perception of Veterans, mental illness, and suicide. Entertainment and technology can contribute to suicide prevention by combating prejudice, providing opportunities for peer-to-peer support, and linking Veterans in crisis with sources of help. In contrast, when not used responsibly, media can have a negative effect, resulting in cluster suicides, suicide contagion, and a negative perception of Veterans. It is important to encourage media influencers to present accurate and responsible portrayals of Veteran suicide and related issues (e.g., mental health and substance use disorders, violence).

Portrayals of Veteran suicide in the news and entertainment media too often perpetuate the misconception that a Veteran's suffering from mental trauma is always the result of combat exposure and that suicide cannot be prevented. There is a need to shift the focus of these portrayals to stories of Veterans who have faced a mental health challenge, sought help and appropriate treatment, and recovered. Stories addressing Veteran mental illness, substance abuse, and suicidal behaviors should promote hope, resiliency, and recovery. This approach can motivate family, friends, and others to provide support and protection to Veterans who may be at risk for suicide and make it easier for a Veteran in crisis to seek help and regain a meaningful life.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of Veteran suicide and other related behaviors.

Responsible, culturally competent coverage of Veteran suicide and other related behaviors can play an important role in preventing suicide contagion. Recommendations for media reporting of suicide were issued in April 2011 and are posted online (www.reportingonsuicide.org). In addition, the Associated Press has recently added entries covering mental health and suicide to its stylebook. Disseminating these guidelines to all media outlets that report on the issue of Veteran suicide can improve the quality of these reports.

Objective 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the accurate and responsible portrayals of Veteran suicide and other related behaviors.

Depictions of Veteran mental health issues and suicide are common in the entertainment media. In 2009, the Entertainment Industries Council created a guide for the entertainment industry titled "Picture This: Depression and Suicide Prevention" (available at www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf). The guide can help creators of entertainment content provide responsible portrayals of Veteran suicidal behaviors, mood disorders, and related issues.

Recognition programs and other incentives can help promote greater awareness and adoption of these recommendations. There are a few such awards programs for the general population, such as the Voice Awards, which honor those who give voice to stories of recovery, and the PRISM Awards, which recognize accurate depictions of mental health and substance use issues, treatment, and recovery. It may be helpful to highlight Veteran-specific awards in these programs or develop awards and recognition dedicated to accurate and responsible portrayals of Veteran suicide.

Strategic Direction 2: Clinical and Community Preventive Services

The factors that contribute to suicide deaths are multiple and complex. Preventing these deaths requires that support systems, services, and resources work together to promote wellness and help Veterans successfully navigate these challenges.

Clinical and community-based programs and services play a key role in promoting wellness, building resilience, and preventing suicidal behaviors among Veterans. Screening for depression and alcohol misuse has been endorsed by the U.S. Preventive Services Task Force, and suicide assessment and preventive screening, along with other clinical preventive services, are provided by VA and community health care providers. For Veterans who are not eligible for VA care, these screenings are now covered as preventive services under Medicare. The Columbia-Suicide Severity Rating Scale (C-SSRS) is an example of an evidence-based suicide risk assessment tool used by VA and non-VA health care systems, as well as in other community and clinical settings.

A wide range of community partners also have an important role to play in delivering prevention programs and services to Veterans at the local level. These community-based professionals and organizations should be competent in serving Veterans in a way that is culturally appropriate and uses their preferred language. Greater coordination among community and clinical preventive service providers and VA health care providers can have a synergistic effect in preventing Veteran suicide and related behaviors.

Goal 5. Develop, implement, and monitor effective programs that promote wellness and prevent Veteran suicide and related behaviors.

Preventing Veteran suicide requires that appropriate community-based and preventive clinical supports be available at the state/territorial, tribal, and local levels to assist those with suicide risk. These programs should support the active participation of a diverse range of community members in Veteran suicide prevention programs, including care providers. Clinical and community-based services for Veterans should seek to promote wellness, eliminate risk factors, increase resilience and protective factors, link Veterans in crisis with appropriate services and support, and address the environmental and social conditions that can contribute to suicidal behaviors.

In developing, implementing, and monitoring programs, it is critical to use suicide prevention strategies that have been shown to be effective among Veterans. Two important resources for identifying evidence-based programs and best practices are the National Registry of Evidence-based Practices and Programs Learning Center and the Suicide Prevention Resource Center website. As these registries currently have only a few evidence-based programs for Veterans, it is important to continue evaluating programs and adding high-quality programs to the registries.

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial, tribal, and local Veteran suicide prevention programming.

The goal of saving lives can only be achieved with a combination of efforts at multiple levels. In addition to VA and other federal agencies, states, territories, tribes, and communities can play an important role in implementing Veteran suicide prevention programs that meet the diverse needs of Veterans. In doing so, it is important to involve multiple partners, including agencies and organizations involved in public health, behavioral health, injury prevention, and related areas.

Suicide prevention efforts should engage multiple partners and sectors and provide services that are culturally and geographically appropriate for Veterans across the country. It is also important to make certain that Veteran suicide prevention efforts reach a diverse mix of Veterans and their families at the community level. In addition, these efforts should be evaluated and modified accordingly to ensure effectiveness.

Objective 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent Veteran suicide and related behaviors.

As Veterans are integrated members of their communities, many institutions, agencies, and organizations play a role in promoting health, reducing risk factors, increasing protective factors, training personnel who are in contact with Veterans at risk for suicide, and providing support to Veterans in crisis. Some of these organizations are health care systems, faith-based organizations, justice system institutions, law enforcement institutions, organizations serving older adults, Veterans Service Organizations, workplaces, and educational institutions. Engaging these and other community groups can greatly expand the reach of Veteran suicide prevention efforts, making it possible to provide assistance and support to Veterans who may be most vulnerable, underserved, or difficult to reach.

Objective 5.3: Deliver interventions to reduce suicidal thoughts and behaviors among Veterans with suicide risk.

Suicide risk and protective factors for Veterans can vary across communities and change over time. Different interventions are needed to meet the diverse needs of Veterans. State and local suicide prevention programs must continuously identify at-risk Veterans and develop and implement programs tailored to their unique needs. Each program should also include a thorough evaluation that rigorously assesses outcomes and impact. C-SSRS is a suicide risk assessment tool used by VA and non-VA health care systems, as well as other organizations, to identify risk and determine the appropriate level of care. This tool can be used across diverse settings and does not require special training.

Objective 5.4: Strengthen efforts to increase access to and delivery of effective programs and services for mental health and substance use disorders for all Veterans.

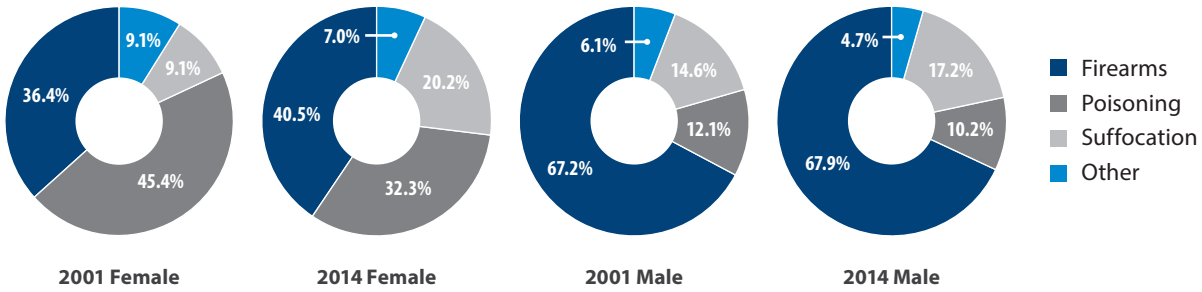
Having a serious mental health disorder such as major depression or bipolar disorder is a recognized risk factor for suicidal behaviors. This is particularly true if the person also has a substance use disorder. Yet many Veterans with these disorders lack access to behavioral health care. Health care systems should recognize and respond to mental health and substance use problems in the same way they respond to physical health problems. Greater coordination among the different programs that provide services addressing Veterans' mental health, substance use, and physical health can increase access to care. This coordination can range from sharing information between service providers to delivering different services in the same setting. These linkages will help provide Veterans with multiple access points to behavioral health care, thereby helping ensure that Veterans who may be at risk for suicidal behaviors are connected to appropriate sources of care.

Goal 6. Promote efforts to reduce access to lethal means of suicide among Veterans with identified suicide risk.

Reducing access to suicide methods that are highly lethal and commonly used is a proven strategy for decreasing suicide rates. While some suicidal crises last a long time, most last minutes to hours. Limiting access to lethal means during periods of crisis can make it more likely that the person will delay or survive a suicide attempt. Furthermore, the overwhelming majority (about 90 percent) of those who survive a suicide attempt do not go on to die by suicide.[13] Of those who do die by suicide, the rates differ by gender and by mechanism:

- Among male Veterans who die by suicide, about **68 percent** die from firearm injury, about **17 percent** die by suffocation, about **10 percent** die by poisonings, which includes intentional drug overdoses, and about **5 percent** die by other methods of intentional self-harm.
- Among female Veterans who die by suicide, about **41 percent** die from firearm injury, about **20 percent** die by suffocation, about **32 percent** die by poisonings, and **7 percent** die by other methods of intentional self-harm.

Figure 6: *Veteran Suicide Deaths by Mechanism and Gender in 2001 and 2014*



For Veterans whose recent history includes a suicidal crisis, or for Veterans who are experiencing suicidal ideation or significant distress, suicide risk is reduced by safely storing potential means for suicide, including firearms and other weapons, medications, illicit drugs, household chemicals, poisons, and materials used for hanging or suffocation. Installing bridge barriers or otherwise restricting access to popular jump sites may also prevent Veteran suicides, depending on specific local conditions.

Objective 6.1: Encourage providers who interact with Veterans at risk for suicide to routinely assess for access to lethal means. Professionals who provide health care and other services to Veterans at risk for suicide as well as their families and other caregivers are in a unique position to ask about the availability of lethal means and work with these Veterans and their support networks to reduce access. These professionals include health care providers, social workers, members of the clergy, first responders, professionals working in the criminal justice system, and others who may interact with Veterans in crisis. These providers can educate Veterans with suicide risk — and their loved ones — about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons. Outreach efforts can also educate Veterans and other care providers about reducing the stock of medicine in the medicine cabinet to a nonlethal quantity and locking up medications that are commonly abused (e.g., prescription painkillers and benzodiazepines, which are used to induce sleep, relieve anxiety and muscle spasms, and prevent seizures). A useful resource to support this goal is the Suicide Prevention Resource Center's Counseling on Access to Lethal Means (CALM), a free online course designed for providers who counsel people at risk for suicide, including mental health and medical providers (available at www.sprc.org/resources-programs/calm-counseling-access-lethal-means).

13. Harvard School of Public Health https://www.hsph.harvard.edu/means-matter/means-matter/survival/

Objective 6.2: Partner with firearm dealers and firearm owner groups to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

Most Veterans own firearms and are familiar with their use. Among Veterans who attempt suicide, those who use firearms are more likely to die than those who use other means. Reaching out to firearm owners, firearm dealers, shooting clubs, hunting organizations, and others to promote firearm safety and increase their involvement in suicide prevention is an important strategy for reducing Veteran suicide risk. Brochures and websites promoting firearm safety to firearm owners could be tailored to Veterans and include a statement regarding the importance of being alert to signs of suicide risk in a loved one and keeping firearms out of the person's reach.

When a Veteran is at risk for suicide, it is recommended that all firearms in the household be temporarily stored with a friend or relative or in a storage facility. At a minimum, all firearms should be securely locked away from the vulnerable person's access until he or she has recovered. Partnering with firearm owner groups and Veterans to distribute firearm locks and educate people about safe storage will help ensure that firearm safety education is culturally relevant and technically accurate, that it comes from a trusted source, and that it does not have an anti-firearm bias. As an example, VA partners with DoD to distribute free firearm locks to Veterans during Suicide Prevention Month.

Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

All community-based and clinical suicide prevention professionals whose work brings them into contact with Veterans at risk for suicide should be trained on military culture, how to address suicidal thoughts and behaviors, and how to respond to those who have been affected by suicide. These professionals include:

1. Adult and child protective service professionals
2. Bank, mortgage, and financial service providers
3. Crisis line staff and volunteers
4. Divorce, family law, criminal defense, and other attorneys (and those in criminal/civil justice system)
5. Employee assistance programs and other human resource professionals in the workplace
6. Faith-based professionals
7. First responders, including law enforcement, fire department, and emergency medical services
8. Funeral home directors and staff
9. Health care providers, including behavioral health care professionals
10. Professionals who serve the military and Veterans
11. Providers of aging services
12. Social service and human service providers

Training programs should be tailored to the specific needs and roles of the providers and regularly updated to reflect new knowledge in the field.

Objective 7.1: Provide training on suicide prevention to community groups that have a role in the prevention of Veteran suicide and related behaviors.

Thousands of first responders, crisis line volunteers, law enforcement professionals, members of clergy, individuals working in the justice system and law enforcement, and others who are on the front lines of preventing Veteran suicide should be trained on military culture and suicide prevention. Publicly available toolkits and trainings address the needs of these various groups:

1. **Military Culture School:** Online training on military and Veteran culture offered by PsychArmor Institute, an accredited nonprofit that provides free education and support to help all Americans engage with the military community. The online Military Culture School is available at https://psycharmor.org/military-culture-school.
2. **S.A.V.E. Training:** Training designed to help anyone who interacts with Veterans learn to identify the **Signs** of suicide, **Ask** questions, **Validate** the Veteran's experience, and **Escort** the Veteran to care and **Expedite** treatment. S.A.V.E. training is provided through VA suicide prevention resources across the country, which can be found using VA's resource locator at www.VeteransCrisisLine.net/ResourceLocator.

These trainings should continue to be implemented, evaluated, and updated. Additional gatekeeper training should be developed to ensure that every gatekeeper understands their unique role when it comes to preventing suicide. In addition, there is a need to make educational programs available to family members and others who are in close relationships with Veterans at risk for suicide or who have been affected by suicidal behaviors.

Objective 7.2: Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior among Veterans, and the delivery of effective clinical care for Veterans with suicide risk.

Mental health and substance use providers should have the foundational attitudes, knowledge, and clinical prevention skills to reduce Veterans' suicide risk and increase their protective factors. Caring for Veterans with suicide risk requires being able to work collaboratively with the Veteran. Skill development and practice by providers and a culture of shared responsibility can help build comfort, confidence, and competence in engaging and caring for Veterans. Training programs for mental health and substance use providers should seek to:

1. Increase feelings of confidence and empowerment in working with Veterans at risk for suicide.
2. Address the emotional and legal issues associated with adverse patient outcomes, including death by suicide.
3. Equip practitioners with attitudes, knowledge, and skills for coping with sentinel events (unexpected events in a health care setting, not connected with a patient's illness, that result in the patient's death or serious physical or psychological injury), along with knowledge of the VA/DoD clinical practice guidelines for suicide prevention.
4. Educate practitioners about how to exchange confidential patient information appropriately to promote collaborative care while safeguarding patient rights.
5. Address the value of a team-based approach to managing suicide risk.
6. Provide practitioners with clinical preventive skills to engage in shared services for Veterans with suicide risk, including by addressing the value of shared responsibility and collaborative care and increasing knowledge and skills for communicating collaboratively with Veterans, families, significant others, and other providers to ensure continuity of care.
7. Include cultural competence training components focused on Veterans and high-risk Veteran groups.
8. Address the provision of effective support services for those who have experienced a suicide loss.

VA's Community Provider Toolkit can provide helpful guidance to providers who are working with Veterans, including information about screening for military experience, understanding military culture, and referring Veterans to VA care, as well as tools for addressing a variety of behavioral health concerns. The Community Provider Toolkit is available at www.mentalhealth.va.gov/communityproviders.

Objective 7.3: Promote the adoption of core education and training guidelines on the prevention of Veteran suicide and related behaviors by all health professions, including graduate and continuing education.

All education and training programs for health professionals, including graduate and continuing education programs for these professions, should adopt core education and training guidelines addressing the prevention of Veteran suicide and related behaviors. All degree-granting undergraduate and graduate programs in relevant professions should include these guidelines as part of their curricula. Programs should also ensure that graduates have an understanding of military culture and Veteran suicide prevention as appropriate for their respective disciplines.

Objective 7.4: Promote the adoption of core education and training guidelines on the prevention of Veteran suicide and related behaviors by credentialing and accreditation bodies.

The inclusion of core education training in recertification or licensing programs can help ensure that professionals who have completed training have knowledge of military culture and addressing Veteran suicidal behaviors and that they remain competent over time. Within the Veterans Health Administration and in most states and territories, physicians, psychologists, social workers, nurses, and other health professionals must complete licensing examinations or recertification programs in order to maintain active licenses or professional certifications. Accrediting and credentialing organizations should promote evidence- and best practices-based suicide prevention training and military culture training for the organizations and practitioners they accredit or credential. In addition, because suicide shares risk and protective factors with mental health and substance use disorders, as well as with trauma and interpersonal violence, suicide-related curricula should be linked with training on these topics. State governments and professional organizations can help support the incorporation of suicide prevention and military culture topics into the training of professionals in various disciplines.

Objective 7.5: Develop and disseminate protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing Veteran suicide risk.

Communication and collaboration across multiple levels of care are key to successfully managing suicide risk among Veterans. Clinical preventive and communication protocols for clinicians and clinical supervisors, emergency workers, crisis staff, professionals providing adult and child protective services, and others providing support to Veterans at risk for suicide can help improve communication and collaborative management of suicide risk. The VA/DoD clinical practice guidelines for suicide prevention offer guidance on implementing effective strategies for improving communication and collaboratively managing suicide risk. The guidelines are available at www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf.

Strategic Direction 3: Treatment and Support Services

Veterans at high risk for suicide require clinical evaluation and care to identify and treat behavioral and medical conditions and to specifically address suicide risk. The VA/DoD clinical practice guidelines describe the critical decision points in managing suicidal risk behavior for self-directed violent behavior and provide clear and comprehensive evidence-based recommendations for practitioners throughout VA. The guidelines can serve as recommendations for other health care systems and are intended to improve patient outcomes and local management of patients with suicidal risk behavior.

Goal 8. Promote suicide prevention as a core component of health care services.

The use of comprehensive, systems-level strategies that make suicide prevention a core goal has been shown to improve outcomes for patients with suicide risk. VA, for example, has adopted a comprehensive approach in which suicide prevention is a core component of mental health and substance use services. As part of this approach, a Suicide Prevention Coordinator is placed at every VA medical center in the country. Preliminary data suggest that these programs have been associated with a reduction in suicide rates among those in certain high-risk subgroups who are receiving health care through VA, including middle-age men. This strategy could be useful for other health care systems that make suicide prevention a core goal.

Objective 8.1: Promote the adoption of "zero suicides" as an aspirational goal by VA medical centers and community support systems that provide services and support to defined Veteran populations.

Managing the VA system of care, as well as non-VA systems, to achieve the goal of zero suicides requires that medical centers and facilities evaluate performance rigorously and use adverse events as opportunities to improve their capacity to save lives. It also requires putting into place mechanisms to support clinicians in the aftermath of a patient's death by suicide. Part of the zero-suicides strategy requires health systems to conduct a root cause analysis (a structured process used to determine causes) of suicide attempts and deaths, and to use findings to improve service quality by focusing on systemic issues rather than individual blame.

Objective 8.2: Promote timely access to assessment, intervention, and effective care for Veterans with a heightened risk for suicide.

Timely access to care is critically important to Veterans in crisis. Crisis hotlines, online crisis chat and intervention services, self-help tools, crisis outreach teams, and other services play an important role in providing needed care to Veterans with high suicide risk. Virtual or remote care — such as telephone calls to crisis hotlines and counseling by telephone, text message, or online chat — allows individuals in crisis to access help 24 hours a day, 7 days a week. An example is VA's Veterans Crisis Line, which provides free, 24/7 confidential support to Veterans, Service members, and their loved ones by phone (1-800-273-8255 and Press 1), online chat (VeteransCrisisLine.net/Chat), or text message (text to 838255).

This type of care is typically available at little to no cost to Veterans in crisis and provides more immediate access and greater convenience and anonymity than face-to-face therapy. Providing detailed instructions about how to access round-the-clock care is a critical part of safety planning for providers working with high-risk Veterans. Providing Veterans with information about how and when to access care through an emergency department is necessary but not sufficient. Access to virtual or remote care is critical for augmenting the care provided at clinics and private practices, which usually have limited hours of operation, and can be useful for reaching Veterans in rural and underserved areas.

Objective 8.3: Promote continuity of care to support the safety and well-being of all Veterans treated for suicide risk in emergency departments and inpatient units.

Patients leaving an emergency department or hospital inpatient unit after a suicide attempt, or otherwise at high risk for suicide, require immediate, proactive follow-up. Having survived a suicide attempt is one of the most significant risk factors for later death by suicide. The risk is particularly high in the weeks and months following the attempt, including the period after discharge from acute care settings such as emergency departments and inpatient psychiatric units. Among patients with high suicide risk, particularly those who have attempted suicide, continuity of care is crucial for promoting positive outcomes. The VA/DoD clinical practice guidelines provide recommendations for following up with Veterans in the aftermath of a suicide attempt. Peer support and caring outreach should be included in all aftercare plans.

Objective 8.4: Encourage collaboration between providers of mental health and substance use services and community-based programs, including peer support programs.

To be effective in suicide prevention, providers of mental health and substance use services must coordinate services with each other and with other service providers in the community. Timely and effective cooperation, collaboration, and communication between mental health and substance use providers and sources of support in the community are critical to promoting Veteran safety and recovery. VA-based providers, as well as others who work frequently with Veterans, should develop connections to community-based supports, such as community agencies for substance abuse prevention and treatment, suicide prevention and mental health advocacy organizations, aging services organizations, Veterans Service Organizations, and programs providing peer support services. These programs can help foster a sense of connection and belonging and provide critically needed services, including employment and vocational help, housing assistance, social interactions that are not focused on illness, and peer support.

Goal 9. Promote and implement effective clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors.

Effective clinical and professional practices in assessing and treating Veterans with high suicide risk can help prevent these individuals from harming themselves. These practices should be grounded in evidence-based care or in best practices, in cases where promising approaches have been identified but where more research is needed.

Objective 9.1: Support the development and implementation of guidelines for delivering services to Veterans with suicide risk in the most collaborative and responsive settings.

The proper documentation of assessment and treatment can improve the care of Veterans with high suicide risk and, at the same time, protect providers from allegations of malpractice. The VA/DoD clinical practice guidelines for suicide prevention are intended to reduce current discrepancies between practices, provide facilities with a structured framework for improving patient outcomes, provide evidence-based recommendations, and identify outcome measures to support the development of practice-based evidence that can be used to improve clinical guidelines. These guidelines should be implemented across health care settings, including all VA facilities, and updated on a regular basis to reflect the latest evidence in suicide prevention.

All Veterans who are admitted to an inpatient mental health unit require follow-up mental health services after discharge, as well as connections to community-based support. Health care systems should seek to dramatically shorten the time between inpatient discharge and follow-up outpatient treatment. Continuity of care following a suicide attempt should represent a collaborative approach between the Veteran and provider that gives the Veteran a feeling of connectedness. Strategies may include appointment telephone reminders, providing a "crisis card" with emergency phone numbers and safety measures, and sending a letter of support.

Objective 9.2: Support the development and implementation of guidelines to effectively engage families and other concerned individuals, when appropriate, throughout entire episodes of care for Veterans with suicide risk.

Family members, significant others, and close friends can play an important role in enhancing the safety of Veterans with suicide risk. These individuals should be trained to understand, monitor, and intervene with loved ones who are at risk for suicide. Because the exact timing of suicidal behaviors is very difficult to predict, it is important that key members of the family unit and social support network be knowledgeable about risk factors and about how to help protect a Veteran from suicide. They should know when to contact treatment providers or emergency services and how to take reasonable precautions and reduce access to lethal means. Family members must feel able to ask directly about suicidal thoughts but should not be placed in the position of providing around-the-clock "suicide watches." Involving the patient's family members or close friends is an important way to help ensure that Veterans leaving the emergency department after a suicide attempt or those being discharged after inpatient care keep their follow-up appointments. These individuals also can help support patient adherence to important treatment decisions.

Contact and collaboration between providers and the patient's family members or friends usually requires consent from the Veteran. The VA/DoD clinical practice guidelines provide recommendations on involving family members and loved ones in caring for a Veteran.

Goal 10. Provide care and support to individuals affected by suicide deaths and suicide attempts to promote healing, and implement community strategies to help prevent further suicides.

Veterans who have made a suicide attempt may receive insufficient care in the community. Similarly, those who have experienced a suicide loss may receive little or no guidance or support related to the traumatic impact of this occurrence. While most who have been bereaved by suicide recover from the trauma, many people may suffer alone and experience harmful effects that can be devastating and sometimes long-lasting. For these reasons, it is crucial to pay attention to the needs of these vulnerable and underserved groups.

Objective 10.1: Support the development of guidelines for effective comprehensive support programs for individuals bereaved by suicide, and promote the full implementation of these guidelines at the national, state/territorial, tribal, and community levels.

Veterans may experience bereavement due to the suicide of a loved one or a fellow Veteran. In addition, a community experiences grief when a Veteran dies by suicide. Guidelines for providing care and support to those who have experienced a suicide loss are needed. Communities vary tremendously in the extent to which they provide these types of support services. People bereaved by suicide often have difficulty finding the services they need when they are ready to access them.

Developing comprehensive national guidelines for effective support will provide a road map for the kinds of services communities can provide to those affected by suicide. This support can include, but is not limited to:

- Trained outreach teams to support those who are bereaved by suicide
- Face-to-face and online support groups
- Memorial services
- Interactions among survivors of suicide loss

VA is part of the Action Alliance's Survivors of Suicide Loss Task Force, which is developing consensus guidelines for creating and implementing effective, comprehensive support programs for individuals affected by a suicide loss. VA has also partnered with the Tragedy Assistance Program for Survivors, a nonprofit organization dedicated to meeting the needs of bereaved survivors who have lost a Service member or Veteran loved one.

Objective 10.2: Provide appropriate clinical care to Veterans affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

Exposure to a suicide attempt or death, particularly of someone close, can have harmful effects on Veterans, including putting them at increased risk for suicide. The reactions can be intense, complex, and long-lasting and may be accompanied by powerful emotions such as denial, anger, guilt, and shame. Each person will experience this grief in a unique way. Because of the stigma attached to suicide, family members and friends may not know how to help a Veteran who has been affected by a suicide loss or attempt. Shame and embarrassment may prevent the Veteran from reaching out for help. While support groups can be very helpful, Veterans affected by suicide must also have access to knowledgeable professional services and support.

Objective 10.3: Increase efforts to engage Veteran suicide attempt survivors in suicide prevention planning, including peer-to-peer support services, treatment, community suicide prevention education, and the development of guidelines and protocols for survivor support groups.

A history of prior suicide attempts is a risk factor for later death by suicide. Promoting the positive engagement of Veterans in their own care among those who have attempted suicide is crucial in successfully reducing risk for suicide. In addition, these Veterans can be powerful agents for challenging stigma and inspiring hope in others. Peer support is an underused intervention in suicide prevention. Appropriate peer support plays an important role in treating mental health and substance use disorders and helping those at risk for suicide. Guidelines and protocols are needed to support the development of such services for Veterans who have attempted suicide, as is technical assistance for disseminating and implementing these tools.

Objective 10.4: Provide health care providers, first responders, and others with care and support when a Veteran under their care dies by suicide.

Clinicians, first responders, emergency personnel, and other medical professionals who lose a Veteran to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Such support should address trauma and grief reactions and potential suicide risk among caregivers. Mechanisms for review of such deaths should avoid blaming the caregiver. Instead, the goal should be to respond to the caregiver's need for support and help the provider respond to Veterans who may be at risk for suicide in the future.

Strategic Direction 4: Surveillance, Research, and Evaluation

Public health surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in Veteran suicide prevention.

The collection and integration of surveillance data on Veterans' suicidal behavior should be expanded and improved. In addition, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of practices that specifically address Veterans.

Goal 11. Increase the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide and improve the ability to collect, analyze, and use this information for action.

The regular collection and rapid dissemination of Veteran suicide-related data are needed to guide appropriate public health action. The time between when an event takes place and when the data are ready for dissemination must be shortened. This is no simple task, as it involves collecting information on several behaviors (e.g., suicidal thoughts, attempts, deaths) that may be available at different levels (e.g., local, state, national). The information may come from several different sources, including vital statistics, emergency departments, inpatient hospital records, urgent care centers, and death reviews, and may not be connected.

It is important to strengthen systems and improve the quality of the Veteran suicide data collected for surveillance purposes. It is equally necessary to enhance the ability of jurisdictions to use available information for strategic planning to prevent suicidal behaviors.

One public data source that contains information on suicidal behaviors among Veterans is "Suicide Among Veterans and Other Americans (2001–2014)," a VA report on the most comprehensive analysis of Veteran suicide in our nation's history. It examines more than 55 million records from 1979 to 2014 from all 50 states, Puerto Rico, and Washington, D.C.

Examples of existing nationally representative data sources containing information regarding suicidal behaviors include:

1. **CDC's National Vital Statistics System:** Annual data on all suicide deaths occurring in the U.S., available from WISQARS (www.cdc.gov/injury/wisqars)
2. **CDC's National Violent Death Reporting System:** Annual data on suicide deaths from 18 states, available from WISQARS (www.cdc.gov/injury/wisqars/nvdrs.html)
1. **CDC's Youth Risk Behavior Surveillance System:** Data released every two years on suicide ideation and attempts among high school students (www.cdc.gov/healthyyouth/yrbs/index.htm)
2. **SAMHSA's National Survey on Drug Use and Health:** Annual survey that, since 2008, has included questions on suicidal thoughts and behaviors among adults (www.oas.samhsa.gov/nsduh.htm)

Objective 11.1: Continue to make advances in the precision and quality of Veteran suicide-related data.

Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor the effects of suicide prevention programs. However, existing data regarding Veteran suicide and suicidal behavior continue to have many limitations. Deaths from suicide may be misclassified as homicides, accidents, or even deaths from natural causes. Information available from death certificates is limited and provides an incomplete picture of the risk factors for suicide. Death scene investigations can reveal

important information about the circumstances of a suicide and its method. This information can be used to improve understanding of suicide and enhance prevention efforts. Emergency medical technicians, police, medical examiners, and coroners may all contribute to the collection of these data. There is a need to improve the quality and accuracy of death scene investigations by providing training to these responders.

Efforts to link and analyze information coming from separate data sources — such as law enforcement, emergency medical services, and hospitals — are also needed. Linked data can provide much more comprehensive information about an event, its circumstances, the occurrence and severity of injury, the type and cost of treatment received, and the outcome in terms of both morbidity and mortality.

Objective 11.2: Support state/territorial, tribal, and local public health efforts to routinely collect, analyze, report, and use Veteran suicide-related data to implement prevention efforts and inform policy decisions.
Staff members in states/territories, tribes, and local governments require training on how to analyze and interpret Veteran suicide data for policy and prevention purposes. Although national data provide an overall view of the problem, local data are key to effective prevention efforts. State/territorial, tribal, and local suicide rates vary considerably from national rates. There is a need to promote the development of local reports on Veteran suicide and suicide attempts, and to integrate data from multiple data management systems. These reports should describe the magnitude of the Veteran suicide problem and how suicide affects particular groups of Veterans. The reports should also address the use of mental health and substance use services. These publications are useful in tracking trends in Veteran suicide rates over time, identifying changes in groups at risk and methods used, and evaluating suicide prevention efforts. At the local level, they could serve as a resource for developing timely and targeted interventions to prevent Veteran suicidal behaviors. State epidemiologists and Suicide Prevention Coordinators could play an important role in supporting and providing assistance for these local efforts.

Goal 12. Promote and support research on Veteran suicide prevention.

Research on Veteran suicide prevention has increased considerably during the past 20 years. Findings have contributed to the development of assessment tools, resiliency-building interventions, and treatment and symptom-monitoring techniques. Continued advancements will lead to the development of better assessment tools, treatments, and preventive interventions.

Objective 12.1: Develop a national Veteran suicide prevention research agenda with comprehensive input from multiple stakeholders.
The Veteran suicide research agenda builds on existing knowledge of suicide prevention and surveillance findings to identify priority research areas. Topics could include Veterans with increased suicide risk, gender and ethnic differences, social and economic factors, genetic contributions, protective factors, promising interventions for suicide prevention and treatment, and interventions for Veterans who have been affected by suicide.

Objective 12.2: Promote the timely dissemination of suicide prevention research findings.
Emerging suicide prevention research findings that are relevant to Veterans must be translated into recommendations and suggestions for practical application in multiple settings. Researchers should be encouraged to publish their findings so that practitioners can incorporate them into the development of new interventions targeting particular groups of Veterans. There is also a need to disseminate these findings more widely while targeting specific groups, such as health care providers, public health officials, and providers of aging services.

Goal 13. Evaluate the impact and effectiveness of Veteran suicide prevention interventions and systems, and synthesize and disseminate findings to inform future efforts.

Program evaluation is a driving force in planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments. Interventions to prevent Veteran suicide should be guided by specific testable hypotheses and implemented among groups of sufficient size to yield reliable results. Given the state of the field, program evaluations should emphasize measurable behavioral outcomes in addition to other outcomes (e.g., changes in knowledge or attitudes) and process measures (e.g., number of people attending program sessions).

Programs for disorders that share risk factors with Veteran suicide should be encouraged to incorporate suicide prevention components and related measures in their program design and evaluation plans. For example, suicide shares risk and protective factors with substance abuse. The evaluation of Veteran substance abuse interventions should incorporate suicide-related outcome measures as a way of assessing the potential effect of such programs on preventing Veteran suicidal behaviors.

Objective 13.1: Evaluate the effectiveness of Veteran suicide prevention interventions.
A broad range of interventions can be used for Veteran suicide prevention. Examples include education and awareness programs, life skills development, media reporting guidelines for suicide, community programs, clinical provider training, screening for individuals at high risk, crisis lines, medications, psychotherapy, and follow-up care for suicide attempts. Program evaluations and other studies must evaluate the effectiveness of these interventions and their impact on the prevention of Veteran suicide attempts and deaths. In particular, there is a need to implement and evaluate the effectiveness of interventions for Veterans who have experienced a suicide loss, as few studies have focused specifically on this population.

Objective 13.2: Assess, synthesize, and disseminate the evidence in support of Veteran suicide prevention interventions.
Although the number of evaluated Veteran suicide prevention strategies has increased over the years, findings from individual studies must be assessed and synthesized in order to understand the strength of the evidence in support of particular interventions. Systematic reviews are important in the assessment and synthesis of research findings. These reviews can help identify effective interventions and provide recommendations for future programs and research.

More research is needed to better understand the strength of the evidence in support of Veteran suicide prevention interventions. After findings are synthesized, they should be disseminated to promote the broader implementation of the specific types of interventions that have been found to be effective in preventing Veteran suicide.

Objective 13.3: Evaluate the impact and effectiveness of the National Strategy for Preventing Veteran Suicide in reducing Veteran suicide morbidity and mortality.
The National Strategy for Preventing Veteran Suicide represents a comprehensive, long-term approach to Veteran suicide prevention. It is a road map that, when followed, will bring us closer to a nation free of Veteran suicide. Different stakeholder groups (e.g., associations, government agencies, health systems) related to Veteran suicide may find it useful to review the goals and objectives in the strategy and identify their own priority areas for action.

Goal 14. Refine and expand the use of predictive analytics for at-risk Veterans and for known upstream risks such as opioid use.

New uses of analytics, such as in social media and other public data sets, are beginning to be explored but will need careful consideration and evaluation to balance risk and benefit. One potential important use is leveraging social media and digital data to improve surveillance and implement targeted, bundled interventions to subpopulations at risk.

Objective 14.1: Explore the use of predictive analytics to produce insights supporting upstream prevention efforts.
Predictive analytics has the potential to provide insights for any system that has access to large sets of data. Within VA, current use of predictive analytics for suicide risk, such as VA's REACH VET program, shows significant potential but needs continued refinement and evaluation to improve efficiency and impact. This risk-based approach is also limited in use to individual-level impacts for relatively small numbers of Veterans and cannot significantly reduce the overall Veteran suicide rate.

Additional predictive risk approaches, such as VA's Stratification Tool for Opioid Risk Management (STORM), have the potential to identify key upstream risks for suicide and can be combined with REACH VET and other clinically relevant data to inform clinical decision-making. This approach has been launched through the CAPRI, REACH VET, Risk Indicators, and STORM Tool for Analytic Look-up (CRISTAL) dashboard for Veterans Crisis Line responders and is beginning to be used by VA clinicians. However, predictive analytics as a support tool for clinical decision-making in mental health is still in its infancy.

Closing

Suicide is a serious public health issue that impacts not just the Veteran population — approximately 20 million people — but entire communities. A complex challenge like Veteran suicide will only be solved with a comprehensive, coordinated approach that reaches across many sectors. The 14 goals discussed in this strategy represent the best evidence-based approach to solving this problem.

But VA cannot do it alone. We *all* have a role to play in preventing Veteran suicide. As we put this strategy into practice, we ask everyone to join us in this commitment to support the Veterans in *your* community. In turn, we make a commitment to you — to provide best-in-class, evidence-based resources, tools, and education to help you do it.

We *can* end Veteran suicide, and by working together, we *will*.

Appendix A: Key Terms

Affected by suicide. All those who may feel the effect of suicidal behaviors, including those bereaved by suicide, community members, and others.

Behavioral health. A state of mental and emotional being, along with choices and actions, that affects wellness. Behavioral health problems include mental health and substance use disorders and suicide.

Bereaved by suicide. Family members, friends, and others affected by the suicide of a loved one (also referred to as survivors of suicide loss).

Means. The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Methods. Actions or techniques that result in an individual inflicting self-directed injurious behavior (e.g., overdose).

Suicidal behaviors. Behaviors related to suicide, including preparatory acts, suicide attempts, and deaths.

Suicidal ideation. Thoughts of engaging in suicide-related behavior.

Suicide. Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt. A nonfatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

These definitions reflect how the terms are used in this Strategy for Preventing Veteran Suicide.

Appendix B: Resources

Resources for Veterans and Their Loved Ones

Coaching Into Care

Coaching Into Care is a national telephone service from VA that aims to educate, support, and empower family members and friends who are seeking care or services for a Veteran.

Make the Connection

MakeTheConnection.net is an online VA resource designed to connect Veterans, their family members and friends, and other supporters with information, resources, and solutions to issues affecting their lives.

VA Telehealth Services | Page 16

VA Telehealth Services uses health informatics, disease management, and telehealth technologies to target care and case management — improving access to care and Veterans' health.

Veterans Crisis Line | Pages 9, 16–17, and 26

The Veterans Crisis Line connects Veterans in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat service, and text messaging service.

Veterans Crisis Line Resource Locator | Page 24
A locator tool for VA, National Resource Directory, and SAMHSA Behavioral Health Treatment Services resources, hosted by the Veterans Crisis Line.

Community Engagement

Community Provider Toolkit | Page 25
The Community Provider Toolkit links community providers with information and resources that are relevant to Veterans' health and well-being.

Veterans Outreach Toolkit
The Veterans Outreach Toolkit links community members with information and resources that help them send the message that they value Veterans and their service.

#BeThere for Veterans
The #BeThere campaign emphasizes that everyday connections can make a big difference to someone going through a difficult time and that individuals don't need special training to safely talk about suicide risk or show concern for someone in crisis. #BeThere provides resources, ideas, and support for Veterans and Service members as well as their families and friends.

Department of Defense #BeThere Peer Support and Outreach Center | Page 18
The #BeThere peer assistance line is the only dedicated DoD peer support call and outreach center available to all Service members across the Department (including the National Guard and Reserve) and their families. The program is staffed by peer coaches who are Veterans, Service members, and spouses of Veterans and Service members, and is available 24/7 through chat, email, phone, and text.

Department of Defense Transition Assistance Program (TAP)
The Transition Assistance Program was established to meet the needs of separating Service members during their period of transition into civilian life by offering job search assistance and related services.

Military OneSource
Military OneSource offers Service members, military families, and the entire global military community a wide range of individualized consultation, coaching, and counseling services for many aspects of military life.

Military Crisis Line
The Military Crisis Line connects Service members in crisis and their families and friends with qualified, caring VA responders, through a confidential, toll-free hotline, online chat service, and text messaging service.

Resources for Survivors of Suicide Loss

American Foundation for Suicide Prevention – Resources for Loss Survivors
Established in 1987, the American Foundation for Suicide Prevention is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education, and advocacy to take action in preventing suicide.

Task Force for Survivors of Suicide Loss (Action Alliance for Suicide Prevention) | Page 29

The goal of the Task Force for Survivors of Suicide Loss is to develop consensus guidelines for creating and implementing effective, comprehensive support programs for those who have lost someone by suicide.

Tragedy Assistance Program for Survivors (TAPS) | Page 29

The Tragedy Assistance Program for Survivors offers compassionate care to all those grieving the loss of a Veteran or Service member loved one.

Public Health Approach to Suicide Prevention

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action | Pages 2, 4, and 12

The National Strategy for Suicide Prevention provides the framework for suicide prevention in the United States. First published in 2001 and then updated in 2012, the national strategy represents the combined work of advocates, clinicians, researchers, survivors, and others. It lays a framework for action to prevent suicide and guides the development of an array of services and programs.

Department of Defense Strategy for Suicide Prevention

The Defense Strategy for Suicide Prevention uses the framework laid out in the 13 goals and 60 objectives of the 2012 National Strategy for Suicide Prevention. The strategy guides the DoD's efforts as it strives to reach the aspirational goal of zero suicides.

CDC Technical Package for Implementing a Public Health Approach to Suicide Prevention

The technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent suicide.

CDC Public Health Approach to Violence Prevention

The Public Health Approach to Violence Prevention offers a framework for asking and answering the right questions. To address these questions, the public health approach uses a systematic, scientific methodology for understanding and preventing violence.

SAMHSA Center for the Application of Prevention Technologies: Practicing Effective Prevention

The Center for the Application of Prevention Technologies: Practicing Effective Prevention resource allows visitors to find information on how to plan, implement, and evaluate evidence-based interventions and learn how prevention relates to behavioral health.

Suicide Prevention Best Practices and Clinical Guidance

VA/DoD Clinical Practice Guideline | Pages 24–28

The clinical practice guidelines on suicide prevention recommend a framework for the assessment of a person thought to be at risk for suicide — and for the immediate and long-term management that should follow once risk has been determined.

Mental Illness Research, Education and Clinical Centers (MIRECCs)

The MIRECCs were established by Congress with the goal of researching the causes and treatments of mental health disorders and using education to put new knowledge into routine clinical practice at VA.

National Registry of Evidence-based Programs and Practices (NREPP) Learning Center | Page 20
The NREPP Learning Center offers dozens of new resources to support the selection, implementation, evaluation, and sustainment of evidence-based programs and practices, along with case studies, stories, and videos.

Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) | Page 33
In 2017, VA launched an innovative program called REACH VET. Using a new predictive model, REACH VET analyzes existing data from Veterans' health records to provide pre-emptive care and support — in some cases before a Veteran has suicidal thoughts.

Stratification Tool for Opioid Risk Management (STORM) | Page 33
STORM is a tool developed within the Veterans Health Administration that prioritizes patients for review and intervention according to their modeled risk for overdose/suicide-related events and displays risk factors and risk mitigation interventions obtained from VHA medical records.

Columbia-Suicide Severity Rating Scale (C-SSRS) | Page 20
The C-SSRS — the most evidence-supported tool of its kind — is a simple series of questions that anyone can use anywhere in the world to prevent suicide.

Training, Counseling, and Educational Resources

Action Alliance Framework for Successful Messaging | Page 17
The Framework for Successful Messaging is a resource to help people communicating about suicide to develop messages that are strategic, safe, and positive, and that make use of relevant guidelines and best practices.

Counseling on Access to Lethal Means (CALM) | Page 22
The CALM course explains why means restriction is an important part of a comprehensive approach to suicide prevention.

Operation S.A.V.E: VA Suicide Prevention Gatekeeper Training | Page 24
Operation S.A.V.E. is a one- to two-hour gatekeeper training session provided by VA Suicide Prevention Coordinators to Veterans and to those who serve Veterans.

Picture This: Depression and Suicide Prevention (Entertainment Industries Council guide) | Page 19
Picture This is a guide for content creators in the entertainment industry that addresses issues related to depression and suicide prevention, which include those as identified by mental health experts, advocates, policymakers, and others working to improve public awareness about and reduce instances of depression and suicide.

CDC's Social Media Tools, Guidelines, and Best Practices | Page 17
To assist in planning, developing, and implementing social media activities, the CDC developed guidelines to provide critical information on lessons learned, best practices, clearance information, and security requirements.

Social Media Guidelines for Mental Health Promotion and Suicide Prevention | Page 17
As part of its TEAM Up initiative, the Entertainment Industries Council developed guidelines to provide tips for organizations and individuals communicating about mental health and suicide on social media to reduce stigma, increase help-seeking behavior, and help prevent suicide.

Recommendations for Reporting on Suicide | Page 17
This website presents research-based recommendations for reporting on suicide, including suggestions for online media, message boards, bloggers, and "citizen journalists."

PsychArmor Institute Military Culture School | Page 24
PsychArmor is a nonprofit that provides free education and support for all Americans to engage effectively with the military community.

Federal Partners

Centers for Disease Control and Prevention | Pages 8, 10, and 17
The CDC works 24/7 to protect America from domestic and foreign threats to health, safety, and security by fighting disease and supporting communities and citizens in doing the same.

U.S. Department of Defense (DoD) | Pages 11 and 14
The DoD provides a lethal joint force to defend the security of the United States and to sustain American influence abroad.

The Federal Working Group on Suicide Prevention | Pages 14–15
The Federal Working Group on Suicide Prevention includes staff members from agencies and operating divisions within the departments of Defense, Health and Human Services, Homeland Security, Justice, Education, Transportation, and Veterans Affairs.

Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

United States Preventive Services Task Force | Page 20
The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The task force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services.

National Action Alliance for Suicide Prevention | Pages 2 and 15
The National Action Alliance for Suicide Prevention is the public-private partnership advancing the National Strategy for Suicide Prevention. The Action Alliance envisions a nation free from the tragic experience of suicide.

Data Resources

CDC National Vital Statistics System | Page 30
The National Vital Statistics System is the oldest and most successful example of intergovernmental data sharing in public health.

CDC National Violent Death Reporting System | Page 30
The National Violent Death Reporting System provides states and communities with a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time.

CDC Youth Risk Behavior Surveillance System | Page 30
The Youth Risk Behavior Surveillance System monitors six types of health risk behaviors that contribute to the leading causes of death and disability among youth and adults.

CDC National Center for Health Statistics (NCHS)
NCHS compiles statistical information to guide actions and policies to improve the health of Americans.

National Death Index (NDI)
The NDI is a centralized database of death record information on file in state vital statistics offices.

SAMHSA's National Survey on Drug Use and Health | Page 30
The National Survey on Drug Use and Health provides up-to-date information on tobacco, alcohol, and drug use, mental health, and other health-related issues in the United States.

VA National Center for Veteran Analysis and Statistics (NCVAS)
NCVAS develops statistical analyses and reports on a broad range of topics, disseminates Veteran data and statistics, and develop estimates and projections on Veteran populations.

Veteran Population (VetPop)
VetPop2016 provides the latest official Veteran population projection from VA.

EXECUTIVE ORDERS

Presidential Executive Order on Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life

VETERANS

Issued on: January 9, 2018

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Policy. It is the policy of the United States to support the health and well-being of uniformed service members and veterans. After serving our Nation, veterans deserve long, fulfilling civilian lives. Accordingly, our Government must improve mental healthcare and access to suicide prevention resources available to veterans, particularly during the critical 1-year period following the transition from uniformed service to civilian life. Most veterans' experience in uniform increases their resilience and broadens the skills they bring to the civilian workforce. Unfortunately, in some cases within the first year following transition, some veterans can have difficulties reintegrating into civilian life after their military experiences and some tragically take their own lives. Veterans, in their first year of separation from uniformed service, experience suicide rates approximately two times higher than the overall veteran suicide rate. To help prevent these tragedies, all veterans should have seamless access to high-quality mental healthcare and suicide prevention resources as they transition, with an emphasis on the 1-year period following separation.

Sec. 2. Implementation. (a) In furtherance of the policy described in section 1 of this order, I hereby direct the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security to collaborate to address the complex challenges faced by our transitioning uniformed service members and veterans.

(b) Within 60 days of the date of this order, the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security shall submit to the President, through the Assistant to the President for Domestic Policy, a Joint Action Plan that describes concrete actions to provide, to the extent consistent with law, seamless access to mental health treatment and suicide prevention resources for transitioning uniformed service members in the year following discharge, separation, or retirement.

(c) Within 180 days of the date of this order, the Secretary of Defense, the Secretary of Veterans Affairs, and the Secretary of Homeland Security shall submit to the President, through the Assistant to the President for Domestic Policy, a status report on the implementation of the Joint Action Plan and how the proposed reforms have been effective in improving mental health treatment for all transitioning uniformed service members and veterans. The report shall include:

(i) preliminary progress of reforms implemented by the Joint Action Plan;

(ii) any additional reforms that could help further address the problems that obstruct veterans' access to resources and continuous mental healthcare treatment, including any suggestions for legislative and regulatory reforms; and

(iii) a timeline describing next steps and the results anticipated from continued and additional reforms.

Sec. 3. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP

THE WHITE HOUSE

January 9, 2018

Get started with **Mental Health Services**

U.S. Department of Veterans Affairs

This guide will help you access mental health services, which may include treatment and support for mental health problems like post-traumatic stress disorder (PTSD), the effects of military sexual trauma (MST), depression, grief, substance use problems, and anxiety-related conditions.

I need help now.

Call, text, or chat online with our caring, qualified responders at the **Veterans Crisis Line**. Many of the responders are Veterans themselves. The confidential line is open 24 hours, 7 days a week, 365 days a year.

→ **Call** 1-800-273-8255, press 1

→ Send a **text** message to 838255

→ **Online** veteranscrisisline.net, click "chat"

For emergency mental health care, you can also **go directly to your local VA medical center**—regardless of your discharge status or enrollment in other VA health care.

I'm not in crisis, I'm just having problems sleeping, controlling my anger, or readjusting to civilian life.

You are not alone. Over 1.7 million Veterans received mental health care at VA last year. Mental health professionals at VA specialize in the mental health needs of Veterans. Services range from peer support with other Veterans to counseling with a mental health professional to medication. You may be eligible for these services from VA or VA may be able to connect you with mental health resources in your community.

Am I eligible for VA mental health care?

Most former service members can access VA mental health care services, but costs may vary. Here are some common scenarios:

I separated recently from uniformed service with an honorable discharge.

- All former service members can access emergency VA mental health care. Call or visit your local VA medical center to determine your eligibility for non-emergency VA mental health care. Many programs and services do not require a payment. When payment is required, cost depends on many factors.

I am a recently separated combat Veteran with an honorable discharge.

- You may be eligible to enroll in VA health care and receive care for conditions related to your combat service at no cost for 5 years after your date of discharge.

I separated from uniformed service many years ago.

- All former service members can access emergency VA mental health care. Call or visit your local VA medical center to determine your eligibility for non-emergency VA mental health care. Many programs and services do not require a payment. When payment is required, cost depends on many factors.

I am a current or former member of the National Guard or Reserves.

- You may be eligible for VA mental health care services.

If you have any questions, please give us a call at 1-877-222-VETS (1-877-222-8387).

HOW DO I SCHEDULE MY FIRST APPOINTMENT?

If you are already signed up for VA health care, **call or visit your local VA medical center.**

→ Find locations and phone numbers **online** va.gov/find-locations

Depending on what best meets your needs, you will receive a face-to-face visit with a clinician, or a phone or video call with a nurse, or a prescription filled the **same day.** If you are not already signed up for VA health care, **call** us or visit your local VA medical facility to find out what services may be available to you.

→ 1-877-222-VETS (1-877-222-8387) Mon.–Fri., 8 a.m. – 8 p.m. (EST)

HOW MUCH WILL IT COST?

VA considers a combination of your **disability rating, service history, medical need,** and **income level** when determining how much you might have to pay for services.

Please don't let the possibility of paying "out-of-pocket" stop you from getting mental health care.

What if I have an Other-than-Honorable (OTH) or "bad paper" discharge?

You may receive emergency VA mental health care. You may also be eligible for non-emergency VA mental health care. Call or visit your local VA medical facility to find out what services may be available to you.

Do I have to be enrolled in VA health care to access VA mental health services?

No. There are some VA mental health services you can access without being enrolled in VA health care. For example, regardless of disability claim or enrollment status, community-based **Vet Centers** offer free individual and group counseling for Veterans and their families, if the Veteran served in a combat zone or area of hostility, or served as part of a mortuary affairs or drone crew. Vet Centers also provide counseling for survivors of military sexual trauma (MST), and their families, regardless of when or where you served and may provide other services; such as,

- Readjustment counseling
- VA benefits assistance
- Bereavement (grief) counseling
- Employment counseling
- Substance abuse assessment and referral

→ **Call** 1-877 WAR VETS (1-877-927-8387), confidential and open 24 hours, 7 days a week, 365 days a year

→ **Find** a Vet Center at va.gov/find-locations

If you do enroll in VA health care, you will have access to VA's full range of health care services. Even if you do not enroll, you may be eligible for other VA **benefits**, such as, housing, employment, job training and education – all of which can affect mental health. We encourage all former service members to contact us so we can determine how to best support you.

→ Give us a **call** at 1-877-222-VETS (1-877-222-8387)

Will using mental health services at VA put my career at risk?

Medical records are protected by privacy laws. A mental health diagnosis or seeking mental health care does not automatically jeopardize work-related credentials such as security clearances. Generally, employers recognize that healthy employees who get help if they need it are more productive and effective in their jobs.

OTHER QUESTIONS YOU MAY HAVE

It can be difficult for me to visit VA facilities. Are there services I can access online?

VA's Telehealth is a program where you can talk to a mental health provider on a mobile device, a computer in your home, or at a local VA Community Based Outpatient Clinic (CBOC). VA can provide the necessary equipment if you don't already have it. Ask any of your VA health care providers for help connecting you with the Telehealth program.

What other options do I have?

Make the Connection is an online resource where you can hear stories from other Veterans who sought help with mental health challenges.

→ **Online** maketheconnection.net

Military OneSource provides many resources for active duty Servicemembers, Veterans (up to one year after separation), and their immediate family members.

→ **Call** 1-800-342-9647

→ **Online** militaryonesource.mil click to chat

What if I have lost my housing or I am in danger of losing it?

The National Call Center for Homeless Veterans can help.

→ **Call** 1-877-4AID VET (1-877-424-3838) 24 hours, 7 days a week, 365 days a year

Are there VA mental health resources for family and caregivers of Veterans?

Caregiver Support Coordinators are social workers and nurses with extensive knowledge of VA benefits and services. They can help you connect with the resources you need.

→ **Call** the Caregiver Support Line 855-260-3274, Monday– Friday 8 a.m.– 8 p.m. (EST)

→ **Online** www.caregiver.va.gov/help_landing.asp

→ **Find** a Caregiver Support Coordinator in person at a VA Medical Center

Last updated: 1/16/19

Mental Health Executive order: The Executive Order has several major impacts for Veterans.

• Service members will learn about VA benefits and start the application process for enrollment before becoming Veterans.
• Any newly transitioned Veteran who is eligible can go to a VA medical center (VAMC), Vet Center, or community provider and start receiving mental health care right away.
• Former Service members with other than honorable (OTH) discharges may receive emergent mental health care from VA, and certain former Service members with OTH discharges are eligible for mental health care for conditions incurred or aggravated during active duty service.
• Some DoD resources available to Service members, such as Military OneSource and the #BeThere peer support line, will now be available to Veterans for one year following separation.
• Veterans will have access to Whole Health Orientation groups, giving them the opportunity to connect with the Veterans Health Administration (VHA) and, if needed, receive a referral for VA mental health care.
• After the first year, eligible Veterans may still receive mental health care support through VA, Vet Centers, the Veterans Crisis Line, or from a referred community resource.
• Veterans will also be able to receive support through VA partners, like Vet Center referrals, and community resources outside of VA, like Veterans Service Organizations (VSOs).

- The Executive Order mandated the development of a Joint Action Plan by the Departments of Defense (DoD), Veterans Affairs (VA), and Homeland Security (DHS) to provide transitioning Service members and new Veterans with mental health and suicide prevention services, focusing on the first year after separation.
- Implementation of the Joint Action Plan by the three departments includes 16 important services. Below are three examples:
    - Expanding peer community outreach and group sessions in the VA Whole Health initiative from 18 Whole Health Flagship facilities to all facilities. Whole Health includes wellness and establishing individual health goals.
    - Extending DOD's "Be There Peer Support Call and Outreach Center" services to provide peer support for Veterans in the year after separation from the uniformed services
    - Expanding DOD's Military One Source, which offers resources to active-duty members, to include support to separating service members up to one year after separation.

<u>Suicide Prevention:</u>
The National Strategy for Preventing Veteran Suicide is modeled after the 2012 National Strategy for Suicide

- **Prevention and encompasses four interconnected strategic directions:**
    1. **Healthy and Empowered Veterans, Families, and Communities**
    2. **Clinical and Community Preventive Services**
    3. **Treatment and Support Services**
    4. **Surveillance, Research, and Evaluation**

The 14 goals and 43 objectives included in the National Strategy for Preventing Veteran Suicide are meant to work
together in a synergistic way to promote wellness, increase protection, reduce risk, and promote effective treatment and recovery.