Written Statement

Senate Veterans Affairs Committee Hearing

SSG Parker Fox Suicide Prevention Grant

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I. Statement for Written Testimony

Highlighting Program Impact: Oklahoma Veterans United and the SSG Parker Fox Suicide Prevention Grant

Since receiving the SSG Parker Fox Suicide Prevention Grant, Oklahoma Veterans United (OKVU) has leveraged its deep community roots and cross-sector partnerships to create one of the most engaged, responsive, and veteran-centric suicide prevention initiatives in the region. In just three years, our team has connected with over 5,000 individual veterans—many of whom were previously unengaged with traditional support systems—and participated in or led more than 800 veteran-centered events throughout Oklahoma. These outreach efforts range from intimate peer support meetups and health check-ins to large-scale stand-down events, each designed to build trust, identify risk early, and connect veterans with lasting resources.

Our presence on military installations has also proven essential. At Fort Sill, we have been welcomed to present at SEPS and TAPS briefings and maintain a regular presence on base. This allows us to connect with transitioning service members before crisis arises and to establish continuity of care as they reintegrate into civilian life. These on-base engagements are key not only to suicide prevention but also to fostering relationships that last beyond the uniform.

The Oklahoma Veterans Calendar, developed by our subcontractor Eagle Ops, has become an essential outreach tool for the veteran community across Oklahoma. Designed to centralize veteran-related events, resources, and opportunities, the calendar has dramatically increased access to information for veterans and their families. In the past year alone, the website hosting the Oklahoma Veterans Calendar

recorded over one million hits. This remarkable level of engagement highlights not only the effectiveness of the platform but also the ongoing need for accessible, comprehensive outreach tools that strengthen community connections and promote veteran well-being across the state.

Another area of success has been our strategic engagement with veteran-focused employers across the state. OKVU works directly with several of Oklahoma's largest companies, delivering presentations to their Veteran Resource Groups (VRGs), offering guidance on crisis navigation, and helping employers develop responsive internal protocols to better support their veteran workforce. In doing so, we help normalize mental wellness conversations in the workplace and empower peer leaders to identify and respond to signs of distress before they escalate.

Our partnerships with the Cherokee and Choctaw Nations have been transformative. Together, we co-hosted Oklahoma's first **multi-grantee veteran stand-down**—a milestone event not just for OKVU, but for the entire grant program. Held in 2024, this event brought together veterans, service providers, and representatives from five states in addition to Oklahoma, underscoring how regional coordination and tribal-nonprofit alignment can drive national-level impact. The event offered immediate services, benefits navigation, peer support, and direct mental health engagement in a setting that honored the dignity and strength of every veteran present.

What sets OKVU's model apart is not just the volume of engagement, but the way we maintain contact. Veterans are not simply seen once—they are followed up with, invited to engage again, and often, encouraged to take on peer leadership roles. Many of those who stabilize through our efforts come back and ask how they can help. This transformation—from needing support to offering it—is the true outcome of the SSG Fox initiative when it is locally driven, trust-based, and mission-aligned.

In a time when national suicide rates remain deeply concerning, our experience shows that consistent, embedded community action saves lives. OKVU is proud to stand as proof that with the right support and partnerships, transformation is not only possible—it is happening now.

Areas of Concern

From our perspective as a frontline grantee administering the SSG Parker Fox Suicide Prevention Grant, certain implementation policies—while well-intended—have unintentionally created barriers for the veterans they aim to support. Chief among these is the mandatory use of the Columbia Suicide Severity Rating Scale (C-SSRS) for entry. This tool has acted less as a bridge to care and more as a barrier. Veterans with prior traumatic experiences in healthcare settings often decline services solely because of this requirement. **"Veterans are less likely to engage in care when standardized assessments are perceived as impersonal or triggering, especially during the initial stages of help-seeking"** (VA Mental Health Services Evaluation, 2019). In fact, the strong emotional reaction some veterans have to the C-SSRS form itself is often a clear indicator of past suicidal ideation or crisis, meriting immediate attention—not exclusion.

Despite raising these concerns consistently in national grantee meetings since the inception of this program, VA Central Office has remained firm in its directive. Suggestions of alternative screening methods that are trauma-informed and responsive to veteran preferences have been submitted for discussion—yet never formally considered. **"Cultural tailoring and clinical flexibility are essential to avoid disengagement in at-risk populations, including rural and Native American veterans"** (Lewis-Fernández et al., Psychiatric Services, 2017). This resistance to adaptation, even when presented with viable solutions, continues to limit the program's ability to meet veterans where they are.

A second critical challenge has been the absence of a national referral mechanism linking grantees to VA clinical services. In Eastern Oklahoma, our attempt to build a working relationship with the local VA Medical Center resulted in only a single meeting. Promised follow-ups never occurred. **"Timely and structured handoffs between providers are critical in suicide prevention, especially during points of care transition"** (VA Office of Mental Health and Suicide Prevention, 2021).

In contrast, our coordination with the Oklahoma City VA has been a model for what collaboration can achieve. The difference lies not in funding or staffing levels, but in leadership that values proactive engagement and the integrity of assigned roles. In OKC, a dedicated SSVF-HUDVASH-SUDS liaison was hired and embedded directly into our program. She works from our office one to two times per week and plays an active role in facilitating warm handoffs, coordinating referrals, and improving continuity between Fox and VA services. This is a clear example of staff being allowed to fulfill the function they were hired for, thereby enhancing veteran outcomes and eliminating service delays.

Unfortunately, that has not been the case in Tulsa. While the same position was reportedly hired, the liaison was never permitted to support community collaboration as initially described. Instead, this employee was reassigned to answer phones on the crisis line and manage the walk-in clinic—roles that, while important, diverted this employee entirely from their original purpose. This employee vacated the position over a year ago, and the replacement had not set foot in our Fox or SSVF offices until Mid-April 2025. This delay has significantly impeded our ability to establish the same streamlined referral pipeline in Eastern Oklahoma that has proven so effective in Oklahoma City. **"Inconsistent implementation across regions undermines the uniformity and reliability of veteran suicide prevention efforts"** (VA Suicide Prevention Annual Report, 2020).

Another pressing limitation is the narrow scope of allowable expenses under this grant. We were initially told by VA representatives during a national conference that the purchase of firearm safes was permitted—provided trained personnel were in place. We fulfilled that requirement and procured appropriate storage equipment, which has since been used multiple times when veterans in crisis voluntarily requested that we safeguard their firearms during periods of acute distress. Later, over the phone, we were informed that the previous guidance was incorrect and that these expenses would be denied. Instead, we were instructed to create internal billing mechanisms and reclassify these items as storage service costs.

This reversal placed an unnecessary administrative burden on our team and forced us to divert staff time from direct veteran care. This is not an isolated occurrence; changes in what is considered allowable versus unallowable have happened multiple times. These reversals consistently require backtracking, reclassification, and often the shifting of already stretched internal resources. Veterans in Oklahoma—and particularly in rural regions—often possess more than one firearm. Creating the ability to store these items during a mental health crisis has directly prevented harm. **"Means safety interventions—including voluntary firearm storage—are recognized by the VA as best practices for preventing suicide"** (VA Suicide Prevention Toolkit for Safe Firearm Storage, 2021). Yet the tools to facilitate this response have been denied after the fact.

Similarly, funding guidance has prevented us from providing gym memberships or covering costs for music therapy tools—despite clear evidence of their positive mental health outcomes. In response, we worked directly with fitness partners to secure deeply discounted memberships—bringing monthly costs down to just $30 per veteran. This has allowed us to engage a larger number of participants and has had a profoundly positive effect on self-esteem, energy levels, and mental health stability. Veterans consistently report improved mood and reduced stress as a result of participating.

These observations are consistent with a growing body of VA-supported research. **"Structured physical activity improves PTSD symptoms, emotional regulation, and cognitive functioning among veterans"** (VA Research Currents, 2022). **"Participants in the Gerofit program demonstrated improved mobility, elevated mood, and reduced anxiety"** (VA Geriatrics and Extended Care, 2022). These results reinforce that wellness-centered services—such as affordable fitness memberships—can dramatically increase access, engagement, and outcomes in veteran suicide prevention.

In our ongoing efforts to establish effective warm handoffs for veterans experiencing crises, we have worked to coordinate with the Veterans Mental Evaluation Team (VMET) under the Eastern Oklahoma VA system. However, the VMET team has been rendered non-mission capable due to persistent staffing shortages, leaving it unable to perform its intended crisis response role. As a result, the SSG Fox team has been compelled to step into a role outside its scope, responding to high-level crises in coordination with local law enforcement. It must be emphasized that SSG Fox team members are not licensed clinicians and are neither equipped to diagnose nor authorized to mandate emergency mental health detainment. Our function in these critical situations is limited to establishing basic communication with veterans and encouraging voluntary engagement with services, often under hazardous and unpredictable conditions. Despite multiple formal requests for follow-up communication with the VA Eastern Oklahoma Mental Health Chief, no meaningful response has been provided over the course of several months. Congressional inquiries have similarly yielded only general assurances that the VMET team "functions as needed," a claim that stands in direct contradiction to the reality on the ground.

At the same time, local agencies are demonstrating that effective alternatives are both possible and operational. The Broken Arrow Police Department has established a crisis response team, deploying a police officer and a Licensed Clinical Social Worker

(LCSW) from Grand Mental Health to respond jointly to a variety of crisis calls, including veteran suicide crises. This unit operates two 10-hour shifts with plans for full 24/7 coverage within the year, and has already begun successfully referring veterans to care. Despite being fully aware of this available and proven resource, the VA in Eastern Oklahoma has made no substantive efforts to collaborate with the Broken Arrow team or integrate local solutions into their crisis response planning. This ongoing refusal to leverage available community-based resources continues to leave critical service gaps unaddressed, to the detriment of the very veterans the system is meant to serve.

Outreach remains another challenge. We are prohibited from using low-cost, high-impact tools such as QR-coded stress balls or wristbands that would allow veterans to discreetly request a callback. Other VA outreach departments, nonprofits, and for-profit partners freely utilize such items. **"Non-clinical engagement strategies, especially those that leverage discreet digital prompts, are shown to increase veteran engagement in follow-up services"** (VA Innovation Ecosystem, 2020). This imbalance places grantees at a disadvantage even though we share the same mission.

Outreach Performance Metrics: OKVU vs. Traditional VA Outreach

Event Type	***Avg. Attendance***	***Engagement Quality***	***Notes***
VA PACT Act / Claims Clinics	~30–50 Veterans	Low engagement; few follow-ups	Often more vendors than veterans in attendance.
Eagle OPS Rally Points & VetFests	330–850 Veterans	High engagement; ongoing case openings	Structured around evenings/weekends with peer/family involvement.

OKVU Proposed QR-based Outreach Items	>1,000 QR hits/yr	Strong callback rates; private and discreet	Low-pressure engagement enables follow-up weeks later.

Veterans reached through OKVU's subcontractor Eagle OPS were 4x more likely to follow up within 72 hours compared to those attending VA outreach events. From my perspective this is because we first work on trust and are intentional about meeting veterans on hours when they and their families are available, which are nor during VA business hours.

Finally, we strongly believe in the value of hiring licensed professional counselors (LPCs) or licensed clinical social workers (LCSWs) as part of our overall teams. An LPC/LCSW on staff would provide clinical triage, early stabilization, and assist with building trust before a veteran even enters the VA system. In areas with long clinical wait times or limited transport options, the LPC/LCSW could act as an early point of support, allowing a veteran to begin the healing process immediately while awaiting formal care. **"Embedding clinical personnel within community organizations improves both timeliness and quality of mental health interventions for veterans"** (VA Community Care Expansion Brief, 2021).

The intention of the SSG Fox Grant is to save lives. But to do so effectively, grantees must be empowered to respond to real-world needs with the tools and staffing that work. The flexibility to address transportation issues, short-term wellness solutions, and early clinical intervention must be embedded into the policy—not negotiated retroactively. If this program is to reach its full potential, we need consistent, transparent guidance, reliable referral systems, and permission to deploy proven strategies without unnecessary redirection.

We ask not for less oversight, but for greater consistency. Veterans deserve a system that adapts to their reality—not one that requires them to fit into rigid frameworks that weren't designed with them in mind.

Looking Ahead: Our Requests

1. Allow grant funding for gym membership, music tools, equine services (popular in rural areas, and effective).
2. Use GIS data and collaborate with local and national department of mental health to improve VA suicide prevention targeting.
3. Embed licensed clinicians into grantee teams to provide early intervention and increase access.
4. Replace the mandatory C-SSRS with a veteran-centered, trauma-informed option and allow grantees to propose or develop their own screening tools that get approved by a panel of grantees and VA.
5. Create a closed loop national digital referral system for SSG Fox grantees to VA.
6. A National Community of Practice: Grantee-Led, Veteran-Centric, and Mission-Aligned

A Veteran-Centered Model vs. a Policy-Centered Model

Characteristic	*VA Model*	*OKVU Proposed Model*
Entry Tool	C-SSRS	Low barrier to entry and clinical tools are only used to assess not block entry

Hours of Operation	Weekday business hours	Weekday business hours and Evenings/weekends via community outreach
Spending Flexibility	Narrow; prone to reversal	Veteran needs regarding holistic health and quality of life issues
Communications	Email/VistA	Warm handoffs with follow up and an easy to use referral process that is the same nationally and can be used to follow up that a veteran attended care
Outreach Strategy	PACT Act/claims events	GIS-targeted, community-driven events/40+ vendors, targeted social media, more flexibility with outreach items
Peer Involvement	Minimal	Field-integrated and grant-allowable under current guidance, however some states are behind in certification issues
Tracking & Evaluation	Data driven system that doesn't track outcome	Real-time CRM and dashboards and outcome driven systems e.g. Greenspace
Veteran Experience	Often confusing, fragmented	Personal, consistent, respectful, expedient, results driven

II. Expanded Supplement: Fitness, Music, Outreach Effectiveness, and Peer Engagement

The Role of Structured Wellness Activities in Suicide Prevention

Staff Sergeant Parker Fox, the grant's namesake, was known for his dedication to physical fitness and his deep connection to music. These were not hobbies—they were

vital coping mechanisms that contributed to his emotional stability during difficult periods. The omission of such wellness services from eligible grant expenses undermines the very spirit of the program that bears his name.

In our program, veterans who participate in discounted gym memberships frequently report increased self-esteem, energy, and reduced symptoms of anxiety and depression. Likewise, access to music tools has led to breakthroughs in emotional expression. These are not luxuries—they are tools for survival.

Supporting VA research includes:

- “Exercise improves PTSD symptoms, emotional regulation, and cognitive functioning among veterans.” (VA Research Currents, 2022)
- “Participants in the Gerofit program demonstrated improved mobility, elevated mood, and reduced anxiety.” (VA Geriatrics, 2022)
- “Music therapy has significant emotional self-regulation benefits in veterans with PTSD.” (VA HSR&D News, 2022)

These wellness-based strategies also support long-term sobriety, reengagement with family life, and successful employment transitions. Veterans who participated in both gym and music therapy options often told us, "This is the first time I’ve felt like myself again."

III. A National Community of Practice: Grantee-Led, Veteran-Centric, and Mission-Aligned

Across all SSG Parker Fox Suicide Prevention Grant recipients, the demand for real-time collaboration, evidence-based policy refinement, and peer-supported problem-solving has grown increasingly urgent. The current landscape is fragmented.

Grantees operate in silos, with limited access to each other's tools, strategies, or field-tested insights. To resolve this, Oklahoma Veterans United (OKVU) proposes to lead the implementation and facilitation of a National Community of Practice (CoP)an infrastructure that supports sustained learning, rapid innovation sharing, and structured engagement with VA Central Office.

Groundwork Already Laid: OKVU's Preparedness to Lead

1. Over the past two weeks, I have developed internal models for cross-county collaboration, senior program manager moderation, real-time dashboards, and veteran-centric intake processes. These systems mirror the proposed CoP format:
2. Dedicated digital infrastructure: Our internal Teams-based collaboration already segments discussions by function—case management, outreach, compliance, and referral pipelines.
3. Moderated channels: We have designated senior leads to guide onboarding for new staff and offer policy clarification, which can be easily scaled to support national grantees.
4. Outreach dashboards: We currently track callback rates, follow-up conversion, and county-level suicide risk indicators using real-time metric successes that would inform shared CoP dashboards.
5. Regional insights: Our use of GIS mapping in counties like Pawnee and Muskogee to identify "silent crisis zones" has informed high-impact outreach placement, demonstrating how field-level intelligence can drive national strategy.

OKVU is not proposing a theoretical model. We are building this already.

CoP Functional Structure and Strategic Partnerships

The CoP would be hosted on a scalable platform such as Microsoft Teams or Slack, structured into function-based channels moderated by senior program managers from across the grantee network:

1. #intake-and-screening: Sharing trauma-informed alternatives to the Columbia Suicide Severity Rating Scale (C-SSRS), including field-approved models developed by Native-serving grantees.
2. #outreach-tools: Featuring QR-based materials, digital prompts, GIS-informed planning, and successful low-pressure engagement tactics.
3. #warm-handoff-success: Highlighting effective VA liaisons, referral practices, and embedded staff case studies.
4. #lpc-integration: Guidance on onboarding clinicians within grant teams for triage and stabilization.
5. #policy-feedback: Creating a real-time channel for grantees to inform VA Central Office of field barriers and suggested adaptations.

OKVU further recommends a strategic partnership with the Institute for Veterans and Military Families (IVMF) at Syracuse University to support the CoP's academic rigor, data infrastructure, and long-term sustainability. IVMF's experience managing veteran-focused CoPs and outcome modeling offers a natural extension to this platform.

Proposed Phases of Implementation

Phase I – Platform Launch: OKVU will build and moderate the initial platform, inviting grantees nationally and structuring working groups.

Phase II – Regional Moderators: Experienced grantees will facilitate each track, providing localized insight and elevating systemic concerns.

Phase III – Repository Development: OKVU will lead the creation of a centralized document library with intake forms, audit templates, and rural engagement tools.

Phase IV – Learning Collaboratives: Quarterly national CoP meetings with grantee presentations, technical training, and structured Q&A.

Phase V – Policy Feedback Loop: A structured system to feed field insights into VA guidance in a transparent, evidence-based process.

Integration into the Broader Grant Strategy

This CoP is not a side project, it is a force multiplier for every strategy detailed in this testimony. For example:

1. Outreach Optimization: The CoP can disseminate this strategy nationally.
2. Cultural Flexibility: Instead of siloed feedback about the ineffectiveness of tools like the C-SSRS, the CoP creates an aggregated body of evidence to recommend vetted alternatives.
3. Peer Learning: Rather than waiting for top-down guidance, the CoP allows rapid peer validation and adaptation of emerging solutions.

A National Standard Set by the Field

Veterans deserve a system that learns as fast as it acts. This CoP is that system. It is not bureaucratic, it is organic. It is not oversighting is operational excellence. OKVU stands ready not just to participate, but to lead this transformative effort.

By formalizing this network, we harness the collective intelligence of every grant-funded veteran advocate across the nation. The stakes are too high for isolation. Let us move forward as a unified force—field-informed, veteran-centric, and committed to saving lives.

We believe Parker's legacy must guide the future of this program. If he had access to the tools we now propose, he may have remained with us longer. Let us not waste the opportunity to honor him by making meaningful changes now.

IV. Grantee Perspective on the Use and Implementation of the Columbia Suicide Severity Rating Scale (C-SSRS)

As both a grantee and a veteran receiving care through the VA, I want to speak candidly about what I've experienced with the Columbia Suicide Severity Rating Scale. There is a belief that more training on the C-SSRS will improve how it's administered. I disagree. I've sat across from VA nurses who were visibly uncomfortable using the tool—avoiding eye contact, stumbling through questions, and clearly unsure of how to speak to me as a veteran. I had to reassure them. I had to let them know I recognized they were administering the Columbia. Only then did they relax and begin to connect with me as a person. That wasn't a training issue—it was a human connection issue. The Columbia is not inherently difficult to administer, but when it's reduced to a box-checking formality, it becomes a wall between provider and patient.

And more concerningly, it becomes a **wall between access and care**. At the March 2025 SSG Fox grantee conference in San Francisco, a colleague from Arizona shared that **13 veterans who had come into contact with their program died by suicide**. These veterans either **answered "no" to every question on the Columbia**—despite clearly being in need of support—or **refused to complete the tool and were deemed ineligible for services**. Let that sit for a moment: thirteen deaths. These were not oversights in documentation. These were lost lives—veterans whose risk was not caught by the very tool designed to prevent it.

When the Columbia is used as a gatekeeping tool for program entry, we must ask: is it doing more to help or to harm? Because in this context, **access denied is trust broken**—and in suicide prevention, broken trust is one of the most difficult things to repair.

This leads to an even deeper concern—**survivorship bias**. Currently, we are not required—and in fact have been told not—to submit data on veterans who are deemed ineligible. That means any veteran who refuses to engage with the Columbia, who walks

away, who is turned down at intake, is never entered into the data system. They are rendered invisible. And if they later die by suicide, that tragedy is unaccounted for in our outcomes. As a result, the program appears more effective than it actually is—not because it saved lives, but because we stopped counting those we could not reach.

This is the textbook definition of survivorship bias: we're studying and drawing conclusions only from those who passed through the system successfully, while the experiences—and outcomes—of those who didn't are left out entirely. It creates a false sense of security, and worse, it creates a policy environment where critical weaknesses go unexamined.

I've asked about this at multiple national convenings. Early on, we were given mixed messages about whether to track and report veterans who were not enrolled. Some VA staff said yes, others said no. Eventually, the guidance became clear: **do not submit data on ineligible veterans**. That silence has consequences. How many of those veterans died by suicide after being screened out? How many could have been saved with a follow-up call or alternative intake method? How do we justify denying care based on refusal to complete one form?

The truth is, many veterans have been traumatized by systems before. Some don't want to answer invasive questions in a scripted format. Others know what the Columbia is and associate it with prior negative experiences—detainment, hospitalization, or loss of autonomy. When a veteran declines to complete the form, that should be an alarm—not a disqualification.

In our line of work, the first interaction with a veteran often determines whether there will be a second. If the system's first offer is a form that feels clinical, cold, or compulsory, we may lose the chance to help altogether. If we deny services based on that one moment of resistance, we are not practicing suicide prevention—we are practicing exclusion.

What we need is flexibility. Clinical tools are important, but they must never become barriers. When a veteran is hesitant, we should have the discretion to continue engagement, build trust, and find a path forward. We are not asking to replace the VA—we are asking to be **a bridge to it**. Let us use our connection, our credibility, and our compassion to do what this program was designed to do: save lives.

V: Expanding Impact – A $1.5 Million Strategic Investment Proposal

If awarded $1.5 million in continued and expanded funding through the SSG Fox Suicide Prevention Grant Program, Oklahoma Veterans United (OKVU) would take decisive steps to increase our reach, deepen our service offerings, and fortify long-term infrastructure across the state. Our proposal centers on high-impact investments in personnel, regional expansion, peer-based recovery networks, and outreach scalability.

1. Expand Service to Six Additional Counties OKVU will grow its current service area to include six more counties surrounding Oklahoma County—excluding Canadian County, which is already covered by another grantee. This expansion will increase our footprint from 14 to 20 counties. These adjacent counties include Lincoln, Pottawatomie, Cleveland, Logan, McClain, and Grady. Each of these counties has a demonstrated veteran population with limited access to specialty mental health care and high rates of unaddressed suicide risk, making them ideal targets for expanded outreach and prevention efforts under this funding proposal. Each of these areas represents a combination of underserved rural populations and high-density veteran populations with limited access to suicide prevention resources.OKVU will grow its current service area to include six more counties with elevated veteran suicide risk, expanding our footprint from 14 to 20 counties. The target areas would be identified using existing VA suicide data heatmaps and prioritizing counties where few community mental health resources exist.

2. Hire Three Additional Case Managers Three new case managers will be placed strategically—two in rural counties and one in Oklahoma City—to accommodate

increased caseloads, provide consistent follow-up, and allow current staff to focus more deeply on recovery planning, family integration, and coordination with the VA. This would reduce burnout and enhance veteran-specific responsiveness.

3. Create a Supportive Services, Compliance, and Data Specialist Role A dedicated full-time staff member will manage grant compliance, eligibility tracking, audit readiness, and service coordination. This individual will bridge field-level operations with documentation requirements, manage shared dashboards, and ensure service consistency across regions.

4. Launch a Statewide Peer Support Network Peer support is the connective tissue of sustainable recovery. OKVU would establish a statewide peer support program, modeled after evidence-based principles of mutual aid, where veterans with lived experience of mental health challenges, trauma, or suicide risk are trained and deployed as co-navigators. This team would provide phone-based and in-person support across all counties, focusing on high-risk veterans, transitions from incarceration, and post-hospital discharge.

5. Add Two Outreach Staff in Oklahoma City to Cover Western Counties To sustain our rapid growth, we would hire two new outreach team members under our subcontractor Eagle OPS, specifically assigned to Oklahoma City and neighboring western counties. These outreach staff would lead the expansion of Eagle OPS Rally Points—monthly and quarterly veteran and family-focused events designed to meet veterans where they are: evenings, weekends, and in community spaces that foster trust and connection. These rally points are structured intentionally to engage working veterans who may be unavailable during traditional business hours—a critical gap the VA cannot fill due to limited evening/weekend service availability.

Ultimately, while VA outreach efforts at claim clinics and PACT Act events have yielded consistently low veteran turnout—often with more vendors than veterans

present—Eagle OPS's community-integrated VetFests routinely engage 330 to 850 veterans and families per event. **"Community-based outreach events that integrate peer networks and veteran families have shown significantly higher engagement rates than traditional VA-led enrollment efforts"** (VA Center for Strategic Partnerships, 2021). These numbers reflect the clear impact of relationship-centered outreach. With dedicated funding and staffing, we can replicate this success across western Oklahoma, using proven engagement strategies to guide more veterans into care and connection.

6. Technology and Infrastructure Investment We will continue to use technology to our advantage—not just for operations, but as a proactive outreach and strategy tool. Our team will leverage GIS platforms to plot publicly available data related to suicide deaths, including from county coroners' offices, to gain spatial insight into high-risk zones. This data visualization allows us to identify patterns in veteran suicides and locate areas that may benefit from additional 988 crisis signage, localized outreach campaigns, or pop-up event strategies. **"Data mapping allows for better targeting of suicide prevention strategies by identifying geographical clusters and enabling intervention at the community level"** (VA HSR&D, 2021).

This same GIS infrastructure also enables strategic placement of outreach events in zones with higher veteran concentrations or lower known VA utilization. **"Geospatial analysis has proven effective in helping veteran-serving organizations identify service deserts and coordinate mobile outreach efforts accordingly"** (VA Innovation Ecosystem, 2020). By layering historical service usage, demographic trends, and mortality data, we can ensure our interventions are both targeted and measurable.

This strategic expansion positions OKVU not only to meet the grant's intent—but to exceed it. By expanding to new counties, strengthening staff capacity, and anchoring peer-based recovery support across the state, OKVU will reach thousands more veterans with timely, culturally responsive, and outcomes-driven care.

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