Task Force on Veterans' Health

Task Force Meeting Summary

Monday, August 18, 2025 – 1:00 – 4:00

Attendees:

- *NCIOM staff:* Deidre Bishop, Brady Blackburn, Ruby Brinkerhoff, Austyn Kobs, Brieanne Lyda-McDonald, Michelle Ries, Ayana Simon, Patrick Tang
- *Co-chairs*: Paul Berry, Sec. Jocelyn Mitnaul Mallette, Peggy Wilmoth
- *Steering Committee:* Andréa Allard, Kayreen Gucciardo, Kami Perez, David Sevier
- *Task Force Members*: Sen. Val Applewhite, Nick Bailey, Scott Barker, Rosalie Calarco, Todd Carlson, Corey Dunn, Emiliano Enea, Rebecca Freeman, Gina Giorgio, Larry Greenblatt, Tina Hendricks, Robin Hurley, Tatyana Kelly, Cherry Kilby, Harold Kudler, Rep. Donnie Loftis, Aimee McHale, Carol Meyer, Crystal Miller, Dawn Moreland, Charlisa Powell, Kevin Rumley, Maggie Sauer, Samantha Sliney, Peter Tillman, Jose Vasquez, Lucas Vrbsky, David Webb, Heather Wells, Karee White, Dan Wyman
- *Guests:* Kaysie Smith

Click here for presentation slides

Click here for meeting recording
This recording includes all presentations during the meeting; smaller group discussions are not included.

Welcome
Brieanne Lyda-McDonald, Project Director, NCIOM
Ms. Lyda-McDonald welcomed task force participants, provided details about using Zoom, reviewed task force process, and summarized ideas generated from the first task force meeting. She invited smaller groups of participants to introduce themselves to each other.

Agenda
Ms. Lyda-McDonald reviewed the agenda for the meeting:

1. Presentation: NC Department of Military and Veteran Affairs role and scope in the state
2. Panel: VA Care in the Community Program
3. Breakout discussion: Analysis of challenges/barriers that work groups can continue to discuss
4. Stretch break
5. Presentation: UNC Building Veteran Healthy Communities Project
6. Breakout discussion: Continue brainstorming solutions
7. Meeting conclusion

Presentation: NC Department of Military and Veteran Affairs role and scope in the state
Sec. Jocelyn Mitnaul Mallette, Secretary, NC Department of Military and Veteran Affairs

See recording at 9:45

Secretary Jocelyn Mitnaul Mallette outlined the mission, structure, and priorities of the North Carolina Department of Military and Veterans Affairs. She emphasized that unlike the federal VA, her agency is a small state-level department with limited staff and budget, tasked with serving service members, veterans, their families, military installations, and surrounding communities. The mission is to ensure access to earned benefits and resources.

Secretary Mallette identified three top priorities: (1) sector collaboration—breaking down silos among organizations, aligning legislative advocacy, and using communications (like social media reels) to highlight effective partners; (2) transition support services—improving on the shortcomings of the federal Transition Assistance Program by ensuring personalized follow-up with state or county Veteran Service Officers to bridge the "deadly gap" that leads to higher suicide rates among recently separated Veterans; and (3) economic development—expanding Veteran-owned businesses, strengthening workforce development, improving spousal employment and licensing, and reframing employers' understanding of Veterans' transferable skills.

She also described NC DMVA's key functions:

- Military Affairs - liaison with installations
- Veteran Services - 13 service centers
- Outreach and Transition Support - including suicide prevention and homelessness initiatives
- Legislative Affairs
- Five state Veterans' homes
- Four state Veterans' cemeteries

Secretary Mallette stressed the small size of the NC DMVA relative to other cabinet agencies, the need for additional funding and staffing, and plans to establish a foundation to expand capacity. Throughout, she called for cross-agency collaboration, community partnerships, and honest recognition of current challenges as the path toward making North Carolina a true leader in supporting military members, Veterans, and their families.

Panel: VA Care in the Community Program

Peter Tillman, Chief Operating Officer, Durham VA Healthcare system; Dawn Moreland, Mental Health Counselor, Tree of Life Counseling; Scott Barker, Co-Chair, East Carolina Veterans Coalition, Chairman, Pitt County Veterans Council, Chairman (Coastal Region), NC Army Retiree Council

See recording at 34:40

Mr. Tillman opened by situating the program historically, noting the VA's shift from a "fee-based" system to today's large-scale model, strengthened by legislative reforms such as the Mission Act. He emphasized that community care is also considered VA care as it is funded, authorized, and coordinated by VA. He acknowledged persistent challenges, especially around care coordination and medical record sharing. He also highlighted regional shortages of providers, particularly in rural areas, and the need to balance Veterans' access, timeliness, and choice while VA facilities expand to meet demand.

Ms. Moreland, speaking as a community mental health provider, described her path into the VA's Community Care Network and noted that credentialing is fairly straightforward, though not well publicized. She praised the program for expanding Veterans' access to specialized, consistent mental health care in underserved regions but pointed out significant difficulties with medical record integration and delays in authorizations. Ms. Moreland contrasted her experiences with different VA medical centers: Fayetteville excels at pulling records quickly but communicates less, while Durham communicates well but lags in processing records and requests. She did, however, affirm that payment to providers has become far more reliable since earlier fee-based days.

Mr. Barker provided the Veteran perspective, recounting both positive and negative experiences. He praised the VA's responsiveness in authorizing community-based photobiomodulation therapy for his knee, but described deep frustration when the community provider was never reimbursed, leaving him to continue treatment out of pocket. While he has encountered supportive community providers who understand and honor Veterans' needs, his story underscored lingering administrative and payment breakdowns that can undermine trust in care referred from the VA to community-based settings.

Together, the panel painted a picture of progress with expanded access, faster payments, and greater choice. Yet, this is tempered by ongoing systemic challenges that include care coordination, inconsistent processes across VA centers, and occasional failures in provider reimbursement. The discussion reinforced that while VA Community Care can offer flexibility for Veterans, Veteran and provider satisfaction depends on strengthening communication, reducing administrative delays, and ensuring Veterans' experiences are seamless between VA and community systems.

Small group discussion: Analysis of challenges/barriers that work groups can continue to discuss

Breakout groups were asked to discuss the following questions:

- What challenges related to access, quality, and experience of health care for Veterans or Veteran family/caregivers do you most hope this task force will address?
- What challenges are most prime for change?
- What are barriers to change?
- Why hasn't change been made already?
- What is needed to overcome those barriers?

Priorities raised from this discussion were:

- Connecting to existing resources
  - Increase the number of Veteran Service Officers (VSOs)***
  - Ask the question, followed by resource sharing/navigation
  - For transitioning Veterans, reinforce where to go for services and how to connect
  - Have Veterans receive a call with a VSO after transition
  - Improve identification and connections with Veterans who have not sought out care or resources and/or those who most need care
- Mental and behavioral health
  - Timely access to mental health care

  - Timely response to mental health crisis
  - Increasing access to suboxone for those experiencing substance use disorder, especially from primary care provider
  - Whoever is connecting with vets needs to be actively listening to what they need
- Reduce administrative barriers to care
  - Increase the number of Veteran Service Officers (VSOs)
  - Streamline accessibility of Veteran-directed care
  - Understand and prepare for changes in Medicaid eligibility requirements (e.g., work reporting requirement)
  - Require health systems to track status and allow for sharing and integration of health records with the VA system
  - More help for vets navigating the health care system
- Improving quality of care
  - Ask the question, followed by resource sharing/navigation
  - Whoever is connecting with vets needs to be actively listening to what they need
  - Requiring health systems to track status and allow for sharing and integration of health records with the VA system
  - Reimagining a veteran-centered system
- Improving access to care
  - Availability of technology for telehealth
- Coordination of efforts
  - A way to bring everyone working in the Veterans space to the table and remove compartmentalization of work and services
- Data
  - A way to track active duty service members vs the Veteran population
  - Requiring health systems to track status and allow for sharing and integration of health records with the VA system

Presentation: UNC Building Veteran Healthy Communities Project
Aimee McHale, Assistant Professor, UNC-CH Gillings School of Global Public Health

See recording at 1:15:45

Ms. McHale presented on the Veteran Healthy Communities Project, a public health initiative launched about five years ago to improve Veteran well-being by strengthening community support systems. She emphasized that while the project began under the VA's suicide prevention priority, its broader focus is Veteran health, resilience, and quality of life, with suicide prevention as a natural outcome of healthier communities. Unlike medical or clinical approaches, the project is community-driven, flexible, and prevention-oriented, and is intended to tailor to local needs rather than imposing a "one-size-fits-all" model.

Ms. McHale outlined the framework of "vital conditions" (like housing, transportation, work, education, safety, and social connection) as community-level factors critical to Veterans' well-being. Phase 1 of the project included a literature review, GIS mapping of Veteran demographics and resources, and community engagement sessions. These efforts produced creative, locally-driven solutions such as a Veterans' art show, a library resource table, free or discounted bus fare, and faith-based partnerships.

Building on that, Phase 2 of the project has four aims:

1. Develop a registry guide to make local resources more accessible.
2. Expand GIS mapping statewide to highlight both resources and gaps.
3. Create an ecosystem map showing how different community roles (e.g., pastors, employers, educators) can contribute to Veteran health.
4. Produce a community facilitation guide and recognition system so towns, organizations, and businesses can be formally designated as "Veteran Healthy Communities."

Ms. McHale stressed that healthier communities for Veterans are healthier for everyone, and that this work can unify people across political and social divides. The project's goals include reducing mental health crises and suicides, increasing veteran visibility and integration, and fostering community pride in supporting those who served.

Small group discussion: Current activities to improve Veteran services in North Carolina

Breakout groups were asked to respond to one, or all, of the following prompts:

- How do we improve connections between the silos of groups and services working to address Veteran needs?
- What types of efforts need to be locally-led vs. state-led and why?
- What strategies would work best to connect with Veterans in need of services, but unaware of where to go?
    - How should strategies differ based on groups of Veterans (e.g., recently-transitioned from military, rural vs. urban, older vs. younger, underrepresented groups)?
- What qualities make a health care provider successful at meeting the needs of Veterans? This could be VA or non-VA providers and will help us think about how to build a more competent health workforce.

Key points from this breakout:

- Efforts must be collaborative and involve non-Veteran stakeholders to strengthen the opportunity for success. There is a strong need for collaboration to bridge silos. However, it is important to acknowledge that there is a certain language, trust, and bond among Veterans' that can be a barrier to non-Veterans.
- Would be useful to integrate the Veteran perspective into all state level advisory committees (ex. All Ages All stage, Healthy Communities)
- Would be useful to identify and strengthen opportunities that exist for Veterans to serve in peer support or navigator roles for fellow Veterans as peer-to-peer learning is the most commonly-sited way to learn about programs and services.

- Justice-involved Veterans and Veterans with opioid use disorder need programs and services specific to their needs. Examples include Incarcerated Transition Program, NCFit, and medication for opioid use disorder.
- Identify existing community leaders for partnership and education about Veteran needs and services (e.g., faith leaders and example of Durham VA community clergy days).
- Concerns shared about "claim sharks" taking advantage of vulnerable Veterans, particularly older adults in assisted living facilities with promises of getting VA disability rating.
- Significant issues of access to transportation and technology in rural areas of the state (e.g., mountains); would be helpful to increase community-based sites such as American Legion posts where people can access the technology needed for medical appointments.
- Rural solutions must be locally led, however the biggest issue with a locally led solution is the lack of funding, especially when compared to the state or federal access to funds.

Wrap-Up
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a reminder of the next meeting on December 5 from 9:00-12:00 and the beginning of work groups in September. These meetings will all be held via Zoom.