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It's Not Access. It's Reach.

What Years of Peer-Led
Outreach Taught Us
About Actually
Supporting Veterans

Most veteran suicide prevention programs assume the barrier is access to care.

The real barrier, especially for rural, tribal, and underserved veterans, is reach, and it's what Televeda has spent years closing.



The Reach Problem

SEVENTEEN VETERANS DIE BY SUICIDE EVERY DAY.

Federal investment keeps growing. The number hasn't moved.

If your reach metrics have plateaued despite more funding, the gap is often hiding in plain sight: American Indian and Alaska Native veterans, one of the populations hardest to reach and most in need.

AI/AN veterans serve at five times the national rate and face the country's highest rates of PTSD and suicide, yet 67% don't use VA mental health services.

Most peer support pilots show early promise, then stall under staff turnover, cultural barriers, and reporting gaps. The pilots never become programs. This guide shares what years of peer-led outreach taught us, and what it means for your program.

[See the platform in action](#)



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The Hidden Barrier

If your outreach numbers have flattened, the fix likely isn't more funding into the same channel.

It's a different first point of contact.

Three patterns show up again and again in stalled programs.

WHO GETS MISSED

- AI/AN veterans serve at **5x** the national rate
- **Highest rates of PTSD and suicide** in the country
- **67%** don't use VA mental health services

If AI/AN veterans fall in your service area, this is the gap your current model **probably isn't closing**.

WHY PILOTS STALL

- **Staff turnover.** The one person who built trust with the community leaves, and the relationship leaves with them.
- **Cultural barriers.** Generic outreach materials and mainstream mental health framing don't land with AI/AN veterans, so engagement quietly drops off.
- **Reporting gaps.** Without real-time data, agencies can't show funders what's working until it's too late to fix what isn't.

Pilots rarely become programs. It's rarely because the need disappeared. It's because no one built the infrastructure to carry the work past year one.

Three Things That Make Peer Outreach Programs Work

When peer outreach works, it's usually because of **three** things: who makes first contact, how much friction the technology adds, and whether the infrastructure was already there to build on.

PROOF IN THE FIELD

2,100+ AI/AN Veterans reached
34% month-over-month retention
250K reached in 6 months

"Veterans helping veterans has been **the most effective form of support.**"

— Veteran Participant, Hero's Story Talking Circles

01

PEER TRUST AS INFRASTRUCTURE

A fellow veteran with shared lived experience is more effective at first contact than a clinician. Talking Circles create space clinical appointments can't. Participants come back voluntarily.

02

TECHNOLOGY THAT REDUCES BURDEN

Device-agnostic, HIPAA-compliant, no app download required, with digital literacy training built in. The program doesn't collapse when one staff member leaves.

03

INFRASTRUCTURE ALREADY IN PLACE

Starlink is deploying across 22 tribes. The trust, technology, and institutional relationships that typically take 18–24 months to build already exist and can be extended, not rebuilt.

Proof That Holds Up to Scrutiny

Field results only matter if they survive your agency's own evaluation standards. Here's how the three elements from the previous section perform against RE-AIM, the framework VA and federal health agencies already use to assess readiness for replication and scale.

Data from May 2025-2026

01

REACH

2,100+ AI/AN veterans reached across AZ, NM, NY, SD, NJ. Proof that peer-led first contact closes gaps clinical referral doesn't.

02

EFFECTIVENESS

34% month-over-month retention, >90% found the program helpful, 100% connected to requested resources. Evidence that low-burden technology keeps people coming back.

03

ADOPTION

4 VA Medical Centers, 19 MOUs signed. The infrastructure already extends into existing systems rather than competing with them.

04

IMPLEMENTATION

VA-contracted in AZ and NM, device-agnostic platform, Starlink deploying to 22 tribes.

05

MAINTENANCE

Recurring Talking Circles, CHW follow-up, closed-loop referral tracking. The parts of a program that usually fail once initial funding or attention fades.

This Isn't Self-Reported. The VA Already Vetted It.

In 2023, Televeda won first place in **VA Mission Daybreak**, a \$20M national competition to find breakthrough approaches to veteran suicide prevention.

The Hero's Story program received **\$3.25M**, the highest award in the competition, evaluated on innovation, evidence base, cultural responsiveness, and scalability, the same four things any agency would scrutinize before adopting a new model.

What happened next?

250,000 veterans and community members reached

26 states in six months (now proudly in all 50)

No advertising spend. Community referral only.

[See the platform in action](#)

That's what peer trust and low-friction technology produce once the infrastructure is in place: growth that doesn't require a growth budget.

You're not the first to vet this model. It works.

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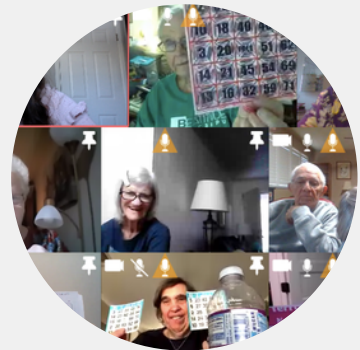
The Model Was Built for All Veterans

The three elements that made this work, trust, technology, infrastructure, aren't specific to one population. They transfer to any agency facing the same operational reality: limited staff, high reporting requirements, and a mandate to prove outcomes.

THE PROBLEM IS SHARED

Isolation and disconnection from care affect D-SNP members for CMS, resilience programs for DHA, and hard-to-reach veterans across VISNs.

Same root cause, different letterhead.



THE PLATFORM IS POPULATION-AGNOSTIC

Peer programming for rural Medicare members. Resilience support.

The underlying infrastructure holds even when the population in front of you looks nothing like the pilot.



Where Does Your Program Stand?

Use this checklist to see how much of the infrastructure above your program already has, and how much you'd still need to build.

- ☐ *Community-based first contact, peer-led, not clinical referral*
- ☐ *HIPAA-compliant, device-agnostic, no app download required*
- ☐ *Digital literacy training built into onboarding*
- ☐ *Platform-embedded staff training that survives turnover*
- ☐ *Closed-loop referral tracking for every resource request*
- ☐ *Real-time outcomes dashboard for the contracting agency*
- ☐ *MOUs in place with tribal nations, VSOs, and VA sites*
- ☐ *RE-AIM evaluation framework ready for federal reporting*

If you're missing more than two or three of these, that's likely where your reach or retention numbers are leaking, and it's usually the gap between a pilot and a program.

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"This is the most innovative and impactful program I have seen in my 30 years working with the Navajo Nation. The program has reached veterans in our communities who we thought we had lost."

— Bobbie Baldwin, Director, Navajo Nation Veterans Administration

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Ready to Close Your Reach Gap?

You now have the framework, the data, and a checklist to evaluate your own program against. The next step is mapping it against your specific reach gap, reporting structure, and population.

BOOK A 20-MINUTE CALL with our partnerships team.

Start where the gap is. Build on infrastructure that already exists. Scale what the VA already validated.