**Joint Military Task Force**
21 June, 2018
9:30 AM - 11:30 AM
DHHS Brown Building, Room 460

*The mission of the Joint Military Task Force is to enhance awareness and advocacy as well as improve access to affordable, relevant alcohol and other drug related services for military members and their families through education and collaboration.*

## ***Agenda/Notes***

⇒ **Present:**

*Brigadier General David J. Mikolaities (NHNG)*
*Dr. Andrew Breuder (MOAA)*
*Chris Chant (CHI/Center for Excellence)*
*Dick Castrucci*
*Roy Hunter (Easter Seals)*
*Gary D'Amour (NH Army National Guard)*
*Staff Sgt. Rick Frost (NHNG)*
*Nancy Triantafyllou (Broadleaf, Inc.)*
*Eric L. Golnick (VFR Healthcare)*
*Elizabeth Duffy (South Central RPHN)*
*Craig Sanderson (NHNG)*
*Amy Pepin (CHI/Center for Excellence*

⇒ **Welcome and introductions:**

Welcome, Dick Castrucci!

⇒ **Leadership changes:**

Dr. Andrew Breuder will now serve as Co-Chair for JMTF

⇒ **April minutes approved**

⇒ **Updates from Priority Areas/old business:**

| Priority Area | Lead(s) | TF Tasks/Other | Updates/notes |
|---|---|---|---|
| **Strategic plan/Direction of JMTF** | **JMTF** | | ⇒ TAG: In thinking/talking about JMTF strategic plan: **What's next?**<br><br>⇒ ATQ has value, but what's next? Is prevention our focus, and, if so, why is JMTF separate from Prevention Taskforce? Where does prevention fit in with veterans' services, given that there is a heavy focus on veteran population? E.g., NH National Guard has prevention program (community outreach and analysis) – does task force need a shift in direction?<br><br>⇒ Roy Hunter: Prevention/ risk reduction for military families could be link between prevention/veterans. Easter Seals seeing older veterans/those with mental health issues having issues with substance misuse.<br><br>⇒ Sgt. Frost: Focusing efforts on younger populations to hopefully have a preventative effect. Prevention efforts, however, are very difficult to measure as far as outcomes are concerned. Different definitions exist as to what "prevention" means. Reactive vs. proactive. What attributes contribute to overall health – similarities to youth protective factors. Work on improving supports before problems crop up. Parallels to be drawn with Community Coalition work.<br><br>⇒ JMTF looking to address substance use issues that surround service members throughout the State, regardless of status (vets/active/etc). Work focused on access to treatment thus far, but could expand to more prevention efforts to reduce needs for services in the first place.<br><br>⇒ TAG concerned with stigmatization of military ("This population is more likely to…")<br><br>⇒ Sgt Frost: Draft letter to Humana (review of current draft with feedback from Dr. Breuder's son, Phil, who helped make letter more direct). Question: letter indicates obstacles to accessing treatment – **do we have data to demonstrate this?** Would be good to add service members' perspectives to support claims.<br><br>⇒ However, this runs the risk of becoming unwieldy as a letter. Heller School of Public Policy at Brandeis is currently doing a study to determine whether Tricare changes have been prohibitive to service members. Not sure how far along study is, but could be useful at some stage. DHA has contracted with them to do the study. Letter could go to DHA as well.<br><br>⇒ Does JMTF exist because of higher level of substance misuse or just because it is a particular subset of the population?<br><br>**⇒ Should strategic plan/overall goals be discussed/reconsidered?**<br><br>⇒ Might be worth sitting down together as a task force to assess current position. What are other task forces covering? (e.g., Prevention and Treatment TFs). Could military reasonably be absorbed into those task forces?<br><br>⇒ Military task force a bit different than others, as it addresses a specific population rather than a specific issue, and is therefore relevant to all. **Could** |

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| | | | **Data Taskforce help with military data aspects?**<br><br>⇒ Are specific populations being covered already? Would have to ensure coverage before making any changes.<br><br>⇒ Nancy: there is work with looking into provider access and outreach efforts. Amy: Discussions have happened with Governor's Commission regarding strategic planning. Announcement will be postponed until Fall in order for new Head of GC, Patrick Tufts, to obtain further input regarding number of task forces needed.<br><br>⇒ Commission used to have three task forces, of which only two were really active (Prevention and Treatment, plus systems reform for ACA). Since then, more have been added pursuant to proposals from various stakeholders. JMTF formed following recognition of statistically higher substance misuse rates than general population. Perinatal is another population-based taskforce. Potential to make recommendation to the Chair about how to proceed.<br><br>⇒ JMTF could feed needs of our community to the relevant taskforces to act upon, but without JMTF, those needs may not be identified.<br><br>⇒ YRBS 2015 showed significant differences in substance use rates between those who reported having a family member actively serving and those who did not.<br><br>⇒ Nancy: **What about needs of first responders, or others exposed to trauma (e.g., law enforcement)?** Similar issues with that population causing many effects.<br><br>⇒ There are federal programs for supporting military families – are we duplicating efforts?<br><br>⇒ Elizabeth: Lots of risk factors in this particular population. No other task forces that Elizabeth has sat on have mentioned military concerns.<br><br>⇒ Deployment is not a risk factor, but things that happen during a deployment are (absence of parent, loss of communication, etc.).<br><br>⇒ Discussion of specific population must be structural, intentional. Whether JMTF continues to exist or not, they should be structurally infused into other task forces and there should be ample communication.<br><br>Leadership changes among task forces have impacted discussion of GC infrastructure and of how task forces communicate with each other and with commission as a whole.<br><br>**⇒ Suggestions for going forward:** |

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| | | | - **Have data to look at for next meeting. Why the military?**<br>- **Structurally/organizationally, where does JMTF go?**<br>- **Emphasis on other committees/here/expand to include first responders? Review specific tasks/output, e.g., ATQ.** |
| **Ask The Question** | | **Sheena and Rob have worked together on one-sheet for providers. Aim of producing a card of guidelines. Other members will help to disseminate this information, once completed.** | ⇒ Review of ATQ one-pager developed by Rob and Sheena. What happens after ATQ? **Rob O' Hannon will present one-pager in detail in next meeting.**<br><br>⇒ Other states have embedded military status into their screening process – could JMTF advocate for that in NH? IDNs have developed core assessment tool that is very comprehensive but likely doesn't include this question. **Potential advocacy avenue.** Could make ATQ more of a resource.<br><br>⇒ Col. Hunter will get more info regarding other states' systems to share at next meeting.<br><br>⇒ Might need to seek inclusion in IDN meetings. Military status is asked by state-funded providers. Could this also be brought to treatment task force and/or NH Providers Association/ Licensing Board: Who is providing treatment? Providers Association could be a good starting point. New treatment contracts being drafted – potential for inclusion? IDN assessments, as well for broad coverage. Must be prepared with follow-up guidance.<br><br>⇒ Federal funds to NH $23m targeted to opioid epidemic. State will be submitting plan in August. Good time to get involved via new contracts. |
| **Military Culture Training** | **JMTF** | | ⇒ Military Culture Training (for providers: one of core goals of JMTF)<br><br>⇒ Services not as concentrated into military areas, so more disparate and not as likely to be a provider that understands military issues compared to at a military base.<br><br>⇒ MCTs have historically been provided by several different bodies/organizations. Highly successful.<br><br>⇒ JMTF wants to provide and influence content, incorporate ATQ.<br>⇒ When will JMTF start coordinating with CEUs on content? Should be done as a team. Would be good for JMTF's voice to be heard in whatever trainings are being delivered.<br><br>⇒ Veterans/combat veterans to deliver training? Ask Col. Oberman what's going on with Military Orientation/Traumatic Brain Injury. Last conducted three years ago.<br><br>⇒ Does anyone within the JMTF have experience/connections/ways in which they can advocate on this issue? **Col. Hunter will reach out to Col. Oberman.**<br><br>⇒ What will be the frequency for training/coordination? If turned over to Training Institute, they would have control of all of those aspects. Could Sarah |

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| | | | Ward from New Futures help with marketing? |
| **Encourage multisystem changes in federally-funded insurance programs to ensure parity.** | **Eric Golnick** | **Letter to Humana** | Humana letter edits:<br><br>⇒ Key points moved to start<br><br>⇒ Addressed to specific individual(s)<br><br>⇒ Have validating information/details ready for follow-up.<br><br>⇒ Reminder that letter must be from Commission.<br><br>⇒ Letter ready to be presented to Governor's Commission.<br><br>⇒ Co-signed by other taskforces – specify letter is final draft (looking for endorsement of content, not edits). Ask Patrick Tufts if this should go to congressional delegates as well. |

⇒ **New business:**

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| | **JMTF** | **Confirm new/existing JMTF members** | ⇒ Official membership of voting members<br><br>⇒ Must be confirmed by Chair; this happens every year in January, usually.<br><br>⇒ Gary D'Amour confirmed. |

**Our 2018 Meeting Schedule:**

~~**15 FEB, 2018**~~
~~**19 APR, 2018**~~
~~**21 JUN, 2018**~~
**18 OCT, 2018**
**20 DEC, 2018**

**All meetings will be held in the DHHS Brown Building, room 460, from 9:30 AM - 11:30 AM*. October and December meetings are being proposed to change to 9 AM if acceptable to all.**

A call-in number will be provided at the top of each agenda.