Utah Behavioral Health Commission
Draft Meeting Minutes
September 18, 2025, 1:00 - 3:00 p.m.
Utah State Capitol Complex
Senate Building Room 210

Commission Chair: Ally Isom
Vice Chair: Tammer Attallah
Second Vice Chair: Kyle Snow

Commission Members:

Tracy Gruber
Evan Done - virtual
Elaine Navar - virtual
Jim Ashworth - virtual
Jordan Sorenson - virtual
Adam Cohen
Mike Deal

Staff: Mia Nafziger, Dr. Stacy Eddings, Kimberlie Raymond

	Time/Presenter	Discussion Topics	Notes
1	**1:00 - 1:05 pm**: Ally Isom	Welcome Approval of August 21, 2025 meeting minutes (*Action required: Vote*)	The meeting was called to order by Ally, who welcomed both in-person and virtual participants. She thanked all participants for their continued commitment and expressed appreciation to staff for their preparation and coordination of materials for what was described as a "full" and important agenda. A motion was made by Adam to approve the minutes of the August 21 meeting, seconded by Mike. Vote passed unanimously.
Workstream 1: Strategic planning			
2	**1:05 - 1:30 pm:** Leah Blevins, Nick Varney	A Performance Audit of the All-Payer Claims Database *(Action required: Vote)*	Leah explained that the All-Payer Claims Database was the subject of their third completed audit within a series focusing on the state's behavioral health system. Upcoming audits, she added, would cover behavioral health funding and finances, service delivery in prisons, behavioral health beds and facilities, and finally a

capstone report integrating the full body of findings across all audits.

Leah explained that the APCD audit was prompted by recurring questions from legislators and community stakeholders about how to measure the performance and effectiveness of behavioral health investments. The Legislature and public agencies were seeking ways to determine whether spending decisions were achieving intended outcomes.

Nick described the APCD as a repository of nearly all health insurance claims data within Utah, encompassing roughly 85 to 90 percent of total claims spending statewide according to data verified by the One Utah Health Collaborative. The database had been in operation since 2009 and was among many similar state-level systems across the country.

The audit, Nick said, examined three primary areas:

- Whether the database was being used effectively for decision-making;
- Whether data-sharing policies were optimized to support that use; and
- Whether the database had an established strategic plan to guide its development and use going forward.

He noted that Utah's APCD contained a vast quantity of useful information but remained underutilized as a tool for policy making, particularly in behavioral health. Nick reviewed the three central findings:

- The database is underused in informing state decision-making on behavioral health policy.
- Data-sharing policies should be reevaluated to maximize accessibility while ensuring appropriate privacy protections.
- The APCD currently lacks a strategic plan, leaving its operations fragmented and inconsistent with best practices.

He described how the audit team found that the database could significantly enhance policymaking by allowing the

			state to identify which investments were effective, which populations were being served, and where gaps persisted. Leah emphasized that the Department of Health and Human Services (DHHS) had been a strong and cooperative partner throughout the process, and that the audit's purpose was to improve functionality rather than critique the agency. Nick gave several examples of how the APCD could be applied: ● Developing outcome metrics: For instance, by tracking emergency department visits for behavioral health crises, housing stability, employment duration, incarceration frequency, educational attainment, or income changes—measures that together could approximate overall recovery and well-being. ● Supporting workforce planning: The APCD could supplement workforce data to help understand provider availability, distribution, and capacity. ● Facility planning: The University of Utah Health system already uses APCD data to identify areas of need for new behavioral health clinics, by analyzing where patients travel for services and where geographic deserts exist. Nick said stakeholders interviewed for the audit emphasized interest in proxy outcome measures—observable, data-based indicators of recovery—rather than purely survey-based measures. The auditors discussed why APCD data were valuable: they reflect actual recorded behavior (such as visits, treatments, or diagnoses) rather than self-reports; they allow longitudinal tracking of treatment patterns over time; and they can be linked with other administrative datasets for a more comprehensive view of patient outcomes. Commission members asked detailed questions about which data were captured. Nick and Leah explained that private insurance claims are required to be

			submitted, Medicaid fee-for-service and capitated managed care data are included, but self-funded insurance plans are not required to report. Nevertheless, through voluntary submissions and data triangulation, the audit estimated the dataset still represented about 85–90% of all health spending in the state. One member cautioned that "representative" has a specific technical meaning and asked about validation methods. Nick responded that the One Utah Health Collaborative had compared aggregate spending totals between independent data and the APCD, finding high concordance, suggesting the dataset was broadly representative even if incomplete. Nick shared trend data illustrating the leading causes of behavioral health-related emergency room visits over several years. Alcohol-related disorders, he noted, remained among the top reasons for ER visits, while certain other categories showed slight declines. These trend analyses, while descriptive, demonstrated how policymakers could identify areas of greatest need and allocate funding accordingly—for example, increasing investment in substance-use programs if alcohol-related incidents continued to rise. Leah discussed survey results showing that some DHHS employees felt unable to perform certain duties because they lacked full access to the APCD. The auditors suggested that internal access protocols and statutory constraints were limiting effective use of data even within state government. The team also presented an example of linking APCD data with Salt Lake County Jail records, comparing recidivism rates between individuals who had received behavioral health services and those who had not. Surprisingly, the analysis initially appeared to show that those who had received treatment had higher rates of re-arrest. Leah clarified that this did not mean treatment was ineffective, but rather

			that individuals receiving treatment likely had more severe underlying conditions or higher baseline risk factors. The example illustrated how combining data could raise valuable questions—but also underscored the need for nuanced interpretation and additional context, such as housing or employment status. When a member asked what the audit defined as "treated," Nick explained that it encompassed any behavioral health-related billing codes, ranging from emergency interventions to ongoing therapy. The definition was intentionally broad to illustrate potential analyses but could be narrowed for more precise evaluations. Leah reiterated that the example was not a conclusion about program success or failure, but a demonstration of the importance of integrating multiple data sources to understand real-world outcomes. Nick added that most research users were interested in aggregate, de-identified data, not personally identifiable information. Commission members raised broader governance questions. One asked whether defining a statutory "purpose" for the APCD might unintentionally limit its use. Leah responded that the audit's recommendation was not to constrain the database but to articulate a guiding purpose—such as using the data to inform public health decisions—so that DHHS had clearer authority to balance privacy and utility. Another member asked whether DHHS had sufficient analytical staff to make full use of the data. Leah and Nick acknowledged that staffing shortages and turnover had been challenges, but DHHS leadership was already exploring process automation and reallocation of analytical resources. The auditors concluded that, while staffing was currently limited, the department recognized these gaps and had begun implementing improvements.

			Tammer asked which entity should ultimately be responsible for managing, connecting, and analyzing interagency data. Nick explained that Utah currently has multiple data warehouses and integration efforts (e.g., the Utah Data Research Center housed at the University of Utah) but no single authority over all sources. Under current statute, only the Legislative Auditor General's Office had unrestricted authority to review all datasets for audit purposes. Leah suggested the Legislature may wish to consider designating a central data authority through statute to oversee integration and privacy compliance. Tracy added context, noting that a 2023 gubernatorial executive order had initiated the creation of an enterprise data system for the state and that the Utah Data Research Center was one potential hub. DHHS, she said, treaded carefully with data sharing due to federal and state privacy laws but remained committed to finding solutions.
Workstream 2: Budget and policy recommendations			
3	**1:30 - 2:00 pm:** Kyle Snow	Rural Health Transformation Program: Recommendations from the Commission *(Action required: Vote)*	Kyle presented recommendations for projects that could be submitted under the Rural Health Transformation Program (RHTP). He explained that the Commission's Strategic Plan identified several priorities that aligned with the goals of the RHTP, which provides substantial federal funding to improve health care systems in rural areas. Kyle described four project concepts for Commission approval: ● Rural Behavioral Receiving Centers (BRCs): ○ Proposed establishment of two centers in rural areas, potentially through remodeling existing facilities in Central Utah and Tooele. ○ Funds would cover renovations and limited operational support, rather

			than new construction, given federal restrictions. ● Crisis Transportation Pilot Program: ○ Would test new models for transporting individuals in a behavioral health crisis between facilities. ○ Kyle explained that currently, sheriff departments are the primary transporters, which can be traumatic for individuals and burdensome for law enforcement. ○ The pilot would fund up to five rural areas to design regionally appropriate, humane, and legally compliant alternatives—potentially incorporating specialized vehicles and trained personnel. ● Behavioral Health Workforce Scholarships: ○ Scholarships targeted to behavioral health professionals in rural communities to improve recruitment and retention. ● Support for the Live On Suicide Prevention Campaign: ○ Though a statewide effort, Kyle noted that Live On had demonstrated significant reach in rural populations and could be partially funded through the transformation grant. He also mentioned that the Acute Recovery Treatment Center (ARTC) at the State Hospital had been considered for reopening but was not included in the final list due to the short-term nature of the funding. Mia clarified the process, explaining that the DHHS Transformation Team had established several public-private workgroups to vet project proposals against grant criteria. The Commission's recommendations would be formally

			transmitted to those workgroups for consideration. Nate Checketts noted that the RHTP funding—part of a national $25 billion allocation over five years—would provide Utah approximately $100 million per year for five years. Continued funding beyond the first year would depend on performance metrics and accountability formulas set by CMS. Nate encouraged the Commission to send forward their recommendations, assuring that DHHS workgroups would review each for eligibility and alignment with federal requirements (such as prohibitions on new construction). Kyle made a motion that the Commission advance the four recommendations—Rural Behavioral Receiving Centers, Crisis Transportation Pilot, Workforce Scholarships, and Live On Campaign—to DHHS for inclusion in the Rural Health Transformation proposal. Jordan Sorenson seconded.The motion passed unanimously.
Workstream 5: County-based behavioral health services			
4	**2:00 - 2:05 pm:** Kyle Snow	Develop workgroup to combine county mental health and substance use statute *(Action required: Vote)*	Kyle explained that several counties were currently reviewing their behavioral health statutes. During that review, inconsistencies between mental health and substance use disorder provisions had surfaced. He recommended that the Commission form a workgroup to examine and harmonize these statutes to promote clarity and consistency statewide. Ally agreed that this work fit naturally under the Commission's purview and suggested that the matter be referred to the Executive Leadership Team for the appointment of members to the workgroup. There was consensus that no formal vote was necessary at this stage.
Workstream 3: Engage with the private sector			
		No items to discuss	

Workstream 4: Consolidate committees			
5	**2:05 - 2:35 pm:** Mia Nafziger	Present initial structure to Commission ● Membership *(Action required: Vote)*	Mia began by explaining that this work had been in progress for several months and was aimed at consolidating existing committees and clarifying membership in line with the Strategic Plan and legislative expectations for improved efficiency. Ally reminded members that at earlier meetings, the Commission had approved the new four-committee structure conceptually. The September discussion focused on refining membership, representation, and governance details, including whether committee composition should be established in statute or administrative rule. The new structure would include: ● Prevention and Early Intervention Committee ● Crisis Response Committee ● Treatment and Recovery Committee ● Policy Review Committee (formerly USAAV+) Mia described this design as a way to ensure the Commission could cover the full behavioral health continuum—from early prevention through crisis, treatment, and policy oversight—without unnecessary duplication. Tammer observed that the Legislature had been explicit about wanting consolidation to reduce overlap among existing groups, and he asked whether this structure indeed reduced the total number of committees compared to the prior configuration. Mia confirmed that while the number of committees would be similar, the scope and structure were far more unified and intentionally interconnected. Mia reviewed the proposed membership of the Prevention and Early Intervention Committee, which included representatives from mental illness prevention, the Utah Prevention Advisory Coalition, the State Board of Education, the Utah Suicide Prevention Committee, and members from

			the Youth and Young Adults Advisory Subcommittee. Mike asked whether local behavioral health authorities were adequately represented. He emphasized that local authorities and health departments are the entities statutorily responsible for implementing prevention services. Several Commissioners agreed that local representation—both from mental health and public health sides—was essential. Mia acknowledged the omission and agreed to add seats for representatives appointed through the Utah Behavioral Health Committee and local health departments. Ally raised a concern that the membership list skewed toward youth and adolescents and risked overlooking early childhood and perinatal mental health. She emphasized the importance of capturing the earliest prevention window, including infants, toddlers, and new parents. Other members agreed, citing research linking early childhood resilience with later behavioral health outcomes. The group agreed to add two new seats: one for a subject matter expert in early childhood or infant mental health and one for a parent representative of a young child. The Commission also discussed the Youth and Young Adult Advisory Subcommittee, which would sit under this committee. Mia and staff explained that this subcommittee would involve youth ages 14–26, with adult mentors (age 30+) providing guidance and ensuring safe participation. Tracy and Tammer both expressed caution about potential risks of re-traumatization for youth participants sharing personal experiences. Staff responded that participation would be voluntary, trauma-informed protocols would be in place, and best practices from similar youth councils in child welfare and juvenile justice would be adopted.

			Mia then turned to the second committee, noting that this group already existed in statute and had been instrumental in launching Utah's 988 Crisis Response System. With that implementation complete, the committee's ongoing focus would shift toward evaluating performance and guiding continuous improvement of the crisis system statewide. The Commission discussed whether to retain the committee in statute or move it to administrative rule for flexibility. Tammer questioned why some committees were statutory while others were not, expressing concern about inconsistency. Ally agreed, stating that uniform treatment across committees was preferable for clarity and fairness. Mia clarified that the current inconsistency resulted from historical factors—Crisis and USAAV+ had been in statute prior to the Commission's formation—while the Prevention and Treatment groups were newer. After discussion, members agreed that consistency in governance was desirable and that a final recommendation on statutory placement would be made at the October meeting, after the Crisis Committee itself completed its own review and vote. Mia noted broad support within the Crisis Committee for several changes: ● Adding a representative with lived experience in substance use disorder recovery; ● Removing obsolete seats for rural telecommunications and VOIP providers; ● Considering the addition of a rural sheriff representative, given law enforcement's role in crisis response and transportation Mike again emphasized the importance of clarifying whether the county seat represented an elected commissioner or the local behavioral health authority executive, suggesting it should explicitly name the local authority to ensure relevant expertise.

			Mia described the Treatment and Recovery Committee as “newly formalized,” though it replaced a previously inactive treatment workgroup under USAAV+. The initial draft membership list was extensive—19 membership slots including state agencies, local authorities, private providers, payers, peers, and parents. Ally and Tammer both noted that a committee of that size could be unwieldy and counterproductive. Tammer suggested developing a core working group supported by ad hoc participants who could be invited when relevant to specific agenda items (for example, Insurance Department staff for parity discussions or private insurers during payment policy reviews). Several members agreed this approach would strike a balance between inclusivity and efficiency. Mia explained that the School-Based Behavioral Health Subcommittee was designed to ensure strong collaboration between the State Board of Education, local education agencies, and behavioral health providers serving students. Commissioners supported the membership but recommended two clarifications: ● Replace “local education agency” terminology with plainer “school district” language for public clarity, while keeping LEA as the formal term in documents. ● Consider including private schools that receive public prevention or mental health funds, if legally permissible. Eric Tadehara (OSUMH) confirmed that some funds are distributed to private schools but that most oversight flows through public education channels. Tammer asked about the State Board of Education’s feedback. Mia responded that Board staff had reviewed the proposal positively but preferred that the subcommittee be housed under Prevention and Early Intervention rather than Treatment, to align with their Multi-Tiered

			System of Supports (MTSS) model where Tier 1 and 2 efforts emphasize prevention. The Commission agreed to note that the subcommittee could report to both Prevention and Treatment to maintain continuity across the prevention-treatment continuum. Mia presented the final major change: reducing the membership of USAAV+ as the Policy Review Committee. USAAV+ currently had 41 statutory members, but attendance averaged 21–25 per meeting, and many statutory seats were outdated or duplicative. The proposed streamlined committee would include approximately 19 seats, ensuring representation from across all Commission committees, key agencies, the judiciary, local authorities, and lived experience members. New composition highlights included: ● Representatives from each of the other Commission committees (Prevention, Crisis, and Treatment). ● A seat for the Commission on Criminal and Juvenile Justice, Department of Corrections, and Juvenile Justice and Youth Services. ● A judge presiding over either a mental health, drug, or juvenile court. ● Two individuals with lived experience (one with mental illness, one with substance use disorder). ● A citizen representative, intended to provide a neutral perspective and serve as chair if appropriate. ● Continued representation from the Utah State Hospital, private providers, and advocacy organizations. Commissioners discussed attendance and accountability. Tammer noted that when attendance drops, the intended diversity of voices is lost, leaving decisions to a small core group. Mia explained that USAAV+ bylaws already specify that members missing three consecutive meetings would be contacted and possibly replaced, but statutory members are harder to enforce.

			The Commission agreed that future revisions should strengthen participation expectations and require appointing organizations to ensure active involvement. Mike and Tracy both supported these refinements, emphasizing the importance of meaningful engagement, not just nominal membership. Mia summarized that staff would: ● Incorporate all feedback into updated committee drafts; ● Identify which committees should remain in statute or move to administrative rule; ● Highlight final decision points for Commission action in October; and ● Continue soliciting input from external partners before the final vote.
Workstream 6: Communications			
		No items to discuss	Ally briefly revisited ongoing discussions about the Commission's communications strategy, emphasizing the need for a designated communications liaison or spokesperson to ensure consistent messaging and public engagement. Mia and staff were asked to follow up with interested members and present options at a future meeting.
Workstream 7: Legislative report			
6	**2:35 - 2:55 pm:** Mia Nafziger	Discuss and approve legislative report *(Action required: Vote)*	Mia presented the draft legislative report, summarizing the Commission's progress over the past year. The report provided updates on the Strategic Plan, stakeholder engagement, and legislative recommendations. It also included a section describing the Commission's committee restructuring efforts. Tammer recommended keeping some information on the committee's restructuring in the final report to clearly communicate progress to the Legislature. Mia requested guidance on how much detail to include about statutory changes

			still under discussion. Ally proposed removing the specific language on pages 20–21, which enumerated draft statutory revisions, and replacing it with a general statement of intent: that the Commission would work with the Legislative Policy Committee to finalize and submit a comprehensive package during the 2026 session. Tamara made a motion to approve the 2025 Legislative Report as amended (removing pages 20–21 and adding the intent statement). Mike seconded. The vote was unanimous. Ally thanked Mia and the staff team for their detailed and professional work on the report and asked that it be submitted to legislative leadership and included in materials for the upcoming meeting with the Speaker of the House.
Project management			
8	**2:55 - 3:00 pm:** Ally Isom	Review priorities for next meeting *(Action required: None*)	<u>Decisions</u> ● Voted to approve recommendations for the Rural Health Transformation Program. ● Agreed to postpone vote on the committee membership and structure until October meeting. ● Approved the 2025 legislative report, as amended during the meeting. <u>Action items</u> ● Staff will share recommendations for the Rural Health Transformation Program with the appropriate workgroup. ● Executive committee will discuss next steps for creating a workgroup to combine county mental health and substance use statute. ● Staff will update the committee structure proposal. ○ **Commissioners will review the proposal and provide any additional feedback by COB**

			Thursday, October 9, particularly considering ways to reduce membership for the Treatment and Recovery Committee. ● Staff will adjust the legislative report based on feedback discussed during the meeting and submit to the Legislature.
Next Meeting: October 16, 2025 1 PM - 3 PM			