Brad Little
Governor

Sara Omundson
Jared Larsen
Co-Chairs

IBHC Meeting Minutes

June 20, 2025
9 a.m. – 11 a.m.

Location: Idaho Supreme Court, Lincoln Room (basement level)

Meeting Recording:
https://idcourts.zoom.us/rec/play/MWNFhT8IVYCICYe8YpX4TXpl_wWDONM2k7IAKYVyOSTU1ujBN56Wj4y9KPw7wEj03cgj0TFHCfC4JrnU.H6HhR14IABEG15sh

Slide Deck: https://behavioralhealthcouncil.idaho.gov/wp-content/uploads/2025/06/IBHC-6-20-25-PPT.pdf

Members in Attendance: Jared Larsen (DHW), Judge Gene Petty, Bree Derrick (IDOC), Christine Starr (COPP), Dave Jeppesen, Sen. Ali Rabe, Jeff Agenbroad (SDE), Leahann Romero for Ashley Dowell (IDJC), Jason Spillman for Sara Omundson (AOC),

Staff in Attendance: Brandi Hawkins (AOC), Rosie Andueza (DHW), Tiffany Prochaska (DHW), Cheryl Foster (IBHC),

Presenters: Thomas Stopka (Tufts University School of Medicine), Shikhar Shrestha (Tufts University School of Medicine), Olivia Lewis (Tufts University School of Medicine), Jackie Yarbrough (Blue Cross of Idaho Foundation for Health), Rachel Blanton

Agenda Items

Actions taken in red

Welcome
Co-Chair Jared Larsen opened the meeting by acknowledging the recent passing of Carl Crabtree. He is a former state senator and recently represented the State Department of Education on the Council. The SDE will host a memorial for him on Monday, June 24, at noon on the lawn outside the L.B.J. building.

Co-Chair Larsen also welcomed back to the Council Jeff Agenbroad. He is a former state senator and is now the permanent substitute for the state superintendent on the IBHC.

Approval of Meeting Minutes

After acknowledging a quorum, Co-Chair Larsen asked for a motion to approve the April 25, meeting minutes. Judge Petty motioned, Dave Jeppesen seconded, and the motion passed without discussion.

Review of IBHC Vision, Guiding Principles, and Framework

Co-Chair Larsen asked Jeff Agenbroad to read the council's vision statement, as it was his first meeting back with the council. Co-Chair Larsen then read Guiding Principle #6 on Financial Sustainability, in noting recent budget news. Cheryl Foster briefly described the behavioral health continuum and partners that make up the framework.

Tufts University Vulnerability Assessment Reports for Idaho

Rosie Andueza from the Department of Health and Welfare's Division of Behavioral Health introduced the Tufts University speakers: Dr. Tom Stopka, Dr. Shikhar, and Ms. Olivia Lewis.

Dr. Tom Stopka, professor at the Tufts University School of Medicine in the Department of Public Health and Community Medicine, explained that their opioid, alcohol, and stimulant vulnerability assessments are epidemiological and geospatial assessments conducted in collaboration with a number of individuals in Idaho. They've conducted studies in several other states across the U.S. Their mixed-method research includes qualitative, statistical analysis, secondary analysis of existing Shrestha data, and mapping.

He provided QR codes with links to the reports:

Opioid-Related Overdose Vulnerability in Idaho
Alcohol-Related Vulnerability in Idaho
Stimulant-Related Vulnerability in Idaho

In general, concurrent use of opioids and stimulants is on the rise and exacerbating the risk of fatal overdose in the past decade. Alcohol-related harms have declined, but problems remain.

Their methodology uses data from 2020-2022 and looks at outcome measures, core indicators of vulnerability, and co-variates. They use statistical analysis to help calculate the vulnerability scores. Maps are created for each measure and indicator, significant covariates, access to treatment, and vulnerability scores. Counties with non-zero counts are suppressed on the maps.

Opioid Vulnerability

Olivia Lewis shared a series of maps showing opioid-related overdose death rates, chronic HCV infection rates, and drug-related crimes. She showed that large swaths of rural central Idaho were more than two hours driving round-trip to harm reduction or treatment services (MOUD).

Dr. Shrestha shared the results of his bivariate regressions which determined the significant covariates, followed by a map of the counties with the highest opioid-related vulnerability from 2016-2018 and 2020-2022 and an overlay map showing tribal lands. The counties with the highest scores were Kootenai, Benewah, Nez Perce, Clearwater, Boise, Ada, Bannock, and Bear Lake.

Dr. Stopka shared that both urban and rural areas were vulnerable to opioid-related overdose. The county overdose rate for Idaho increased by 22.8% from the previous assessment. The fatal overdose rate among American Indian and Alaska Native populations was nearly double the statewide rate in 2020. He noted that the syringe services programs can no longer operate in Idaho as of 2024, which could increase the risk of opioid-related harm. He also shared that opioid overdoses were starting to level off before the COVID-19 pandemic, increased in fatality during the pandemic in Idaho and nationwide, and we are now starting to see a leveling off and maybe a decrease in overdoses nationally.

Ms. Foster asked if naloxone availability was included as part of the opioid assessment. Dr. Stopka answered that it was not included in the report, though it typically overlaps with syringe service programs. Ms. Andueza said that naloxone distribution was halted for months, though it is operating now. Ms. Lewis clarified that centers requesting naloxone between 2020-2022 are mapped in the report, but they are not included in the vulnerability scores.

Dave Jeppesen asked if the inverse of the correlates would indicate a low overdose risk. Dr. Shrestha answered that they could look at some of the beta coefficients of the individual factors to see what could be considered low or high risk, or an association. If the beta coefficient is negative and the p-value is significant, with caveats, it might be considered protective. Dr. Stopka added that we know some of the protective factors from literature, such as naloxone distribution, methadone, and buprenorphine. Perhaps in a future analysis, they could do more sophisticated modeling for a deep dive into the potential impact of protective factors.

Jeff Agenbroad asked about the improvement in Canyon County's vulnerability score from 2018 to 2022. Dr. Shrestha did not think we can specify from individual factors from the aggregated vulnerability score, but we could look at individual indicators and covariates. He also noted that the rankings are relative to the other counties. Dr. Stopka said that for rural counties, where the denominator is small, a slight change in the numerator could impact the rate. Mr. Agenbroad noted that the county has had some of the largest growth in the state, so the population numbers could be impacting it or the type of people moving in could impact it. However, the first responders in Canyon County have made a real push to distribute naloxone, which could be making a difference. Dr. Stopka reviewed a few of the positive indicators for Canyon County, but said more data, particularly qualitative, from Canyon County could help inform their impact on risk.

Ms. Foster asked if the researchers would be willing to share the absolute values of the vulnerability scores. The researchers had determined not to share them due to difficulties in interpretation.

Co-Chair Larsen asked Bree Derrick to share her thoughts, as Director of the Department of Correction, about the supervised population in rural communities accessing MOUD. Director Derrick responded that they are doing the best they can with the dearth of providers in the rural areas. Their supervision staff carry Narcan, but the reality is that they've seen an increase in overdose deaths probably in the same timeframe as this report. They are using opioid settlement dollars to connect people on reentry to services. As the data in the report indicate, it's a struggle.

Ms. Andueza noted that daily trips for treatment are for methadone clinics, but buprenorphine is much easier. Those can be prescriptions and more effective in certain situations.

Dr. Stopka noted that he is a co-investigator on an NIH-funded study in Massachusetts. The state mandated medications for opioid use disorder be provided for incarcerated individuals: buprenorphine, methadone and naltrexone. He is happy to connect Ms. Derrick to the individuals implementing those programs. Ms. Derrick said that she would be open to that, and that she is also working with the Rhode Island team, who leads in that area.

Alcohol Vulnerability

Ms. Lewis shared descriptive county maps of alcohol-related death rates (using alcohol as an underlying cause), alcohol-related crashes, median age, and one-way driving time to alcohol use disorder treatment programs.

Dr. Shrestha shared the significant variables used in the bivariate and multivariable regressions, which include rates of alcohol-related visits to emergency departments, retail alcohol outlets, and gallons of alcohol sold. Next, he shared maps of the aggregated alcohol-related vulnerability scores by county with the tribal lands map overlaid. The highest vulnerabilities were in rural counties in northern and central Idaho and include tribal lands.

Dr Stopka noted that aspects of rural life contribute to the risk, such as drinking and driving, so the most vulnerable counties for alcohol don't include the urban counties like the opioid ones. The risk is also higher for older populations. Sales of alcohol (and drinking) increased during the pandemic but have since declined.

Co-Chair Larsen asked how they controlled for very rural counties, such as Clark County, which has a population of 900 and a heavily traveled freeway. Dr. Stopka complimented the question and said that they had lots of discussions with their Idaho counterparts about recreational areas. Dr. Shrestha said they debated creating changes to the model to address these but decided to leave it as it was. Dr. Stopka added that even if the risk is tied to people coming to town for recreation, it just means the interventions need to be different for preventing risk. The risk is still tied to the geographic area, even if not to the people who live there.

Director Christine Starr asked how they capture DRE cases (Drug Recognition Evaluators). Dr. Stopka said that the data they used focused on alcohol-related accidents that didn't rule out other substances. Ms. Lewis added that the alcohol-related crime rates encompassed DUIs, but they do not believe they captured DRE data.

Stimulant Vulnerability

Ms. Lewis shared indicator maps of stimulant-related overdose death rates, rates of stimulant-related emergency department visits, the social vulnerability index scores, and one-way driving time to cognitive behavioral therapy and contingency management programs. The social vulnerability scores were highest in Benewah, Shoshone, Lewis, Washington, Elmore, Owyhee, Gooding, and Power.

Mr. Stopka noted that drive time considers street network data, such as speed limits. However, the limitation is that it assumes people have a car or can get a ride.

Dr. Shrestha shared the variables used in the bivariate and multivariable regressions, which include drug-related crime and chronic HCV infections, in addition to the mapped indicators. The counties with the highest stimulant-related vulnerability scores were Shoshone, Clearwater, Lewis, Idaho, Owyhee, Gooding, Lincoln, and Bannock. Three Indian reservations intersect with high-vulnerability counties: Nez Perce, Duck Valley, and Fort Hall.

Dr. Stopka noted that rural counties are in the top quintile rank for vulnerability and that stimulant co-use with opioids is more prevalent in rural areas. The social vulnerability index was a significant predictor of fatal stimulant-related overdose rates. Although stimulant-related emergency department visits have been decreasing, the fatal overdose rates have been increasing. Cognitive behavioral therapy and contingency management and motivation incentives are evidence-based interventions for stimulant use disorder. However, stigma in rural areas can impede access to treatment.

Overall Recommendations

The researchers recommend targeting initiatives and funding to high-vulnerability counties and using evidence-based strategies to increase access to treatment, especially in rural areas. There are evidence-based strategies to reduce stigma in rural areas, and telemedicine is effective in increasing access to treatment. They have reduced barriers to getting access to buprenorphine, so they can get access to a new prescription once every 30 days in some states, instead of a new prescription once a week.

Harm reduction resources are worth considering, based on the scientific literature and the impact of these programs in reducing risk and increasing access to referrals.

Dave Jeppesen said that he is chairing a subcommittee working on reduction or stigma and that they quickly identified rural stigma as an area of focus. I'd like to follow-up to see if you have suggestions on how we can actually reduce stigma. Dr. Stopka said that he's a principal investigator on the rural opiate initiative in New England, which has a few items focused on stigma. He's happy to provide those resources and chat offline to provide potential thoughts and suggestions.

Ms. Andueza expressed gratitude to the researchers and said that their research has been invaluable in helping them target resources to specific areas as needed instead of just statewide.

IBHC Website Update

Cheryl announced that they would not be providing any updates today but wanted to make everyone aware that the IBHC website now has a page for the strategic plan implementation: https://behavioralhealthcouncil.idaho.gov/2024-sap/. Each recommendation is linked to its own page, which currently includes the project charter and scope of work developed by its implementation team.

Report – Investing in Idaho Youth Mental Health: Our Current Broken Systems and Direct Strategies to Improve

Ms. Jackie Yarbrough, senior program officer at Blue Cross of Idaho Foundation for Health, emphasized her experience in working with Idaho's youth and the background of the foundation's work leading to this report. Their Healthy Minds Partnership program works to connect clinicians to schools to provide direct access to kids and families needing behavioral health support. However, this proved exceedingly difficult, and they began investigating the complex problem. She introduced Rachel Blanton to present on the report.

Ms. Blanton thanked the co-authors of the report and the team of biostatisticians and public health experts in this work. She explained that they did a deep dive and interviewed parents, teachers, reviewed raw data sets and performed financial modeling. The report describes five recommendations to address the Idaho's system of youth behavioral health treatment.

She explained that there is a behavioral health crisis at the national level, but the diagnosis data show that Idaho's crisis is more severe. Beyond well-being, there is an issue with the utilization of services. The state also lost a critical resource in terms of youth assessment, where they can identify issues in advance. [Youth Risk Behavioral Survey] She gave an example of knowing about suicidal ideation trends in advance of emergency room visits.

The first finding is to *Enhance reimbursement for master-level clinicians with an emphasis on Medicaid*. Ms. Blanton noted that Medicaid is a high-stakes issue now, but this is a big issue as there is low access to services. In interviewing the clinicians, one of the big reasons for lack of providers is low reimbursement rates. Many admitted that they lose money providing mental health services to youth on Medicaid. Existing providers are dropping out of the Medicaid network. She noted that Medicaid rates increased around 12 months ago, so they updated their financial models. The margins are still very, very tight.

The next finding is to *Decrease burden of paperwork for Medicaid clients and providers*. They discovered that at the different points of data collection, families and children are dropping out of services. From the initial referral, it often takes two visits to a provider before they can receive therapeutic services. Administrators, case managers, and providers told them that they spend as much time clicking through data entry systems for Medicaid as they do for their provider appointments because it takes four seconds per click. This takes providers away from clinical time, when there is already a four-month-long wait list. Ms. Blanton said that she knew DBH is currently working on this; however, there is still a high burden in the CANS assessment compared to neighboring states.

The third finding is to *Bolster capacity for care in rural communities across the state*. Ms. Blanton said that even the paperwork burden hits the rural communities the hardest. She had spent so much time in rural communities looking for providers, as it takes a long time to find someone willing to drive or even willing to provide telehealth. The rural areas have wait lists, and national data show that rural communities struggle more with youth mental health. She highlighted North Idaho and the Magic Valley. In North Idaho, they lack higher level services and patient care. In the Magic Valley, they lack access to care in general. Some communities

have gone from three to five years waiting to be paired with a clinician (with the Healthy Minds partnership).

Finding four is to *Significantly increase the funding for schools to implement evidence-based prevention resources and support coordination of services for students*. Ms. Blanton explained that school counselors and administrators are spending a lot of time navigating services for kids. She described school principals spending 20 hours a week navigating mental health services for the students. She said they need to receive training to do that work or have the resources in place.

The last finding is to *Facilitate enhanced coordination and communication*. There needs to be an information flow pathway to create an efficient youth, mental health system.

Ms. Yarbrough said they will keep trying to ensure kids have access to the care they need, but she also believes that prevention work is necessary. They need to create systems and environments where fewer kids need help at that level. She highlighted Project Echo's work in upskilling school personnel in behavioral health. The foundation is funding evidence-based frameworks like PBIS (Positive Behavioral Interventions and Supports) and pilots mirroring the federally funded Idaho Aware Project. In the school districts she works with (Parma, Notus), she pairs the Healthy Minds Partnership with the PBIS programs to create a better culture.

The foundation is also working to expand the Community Schools strategy across the state, where they can bring more wraparound services and supports into the schools. They also support the Idaho Youth Well-being Assessment, and Superintendent Critchfield created a Youth Mental Health Workgroup to address the lack of data in this area.

Director Starr asked Ms. Yarbrough her opinion on the massive increase in diagnoses, whether that could be attributed to removing the stigma of mental health. She agrees that there has been a reduction in stigma and that kids are more willing to talk about their struggles. However, the survey specifically looked into that, and we found isolation, phone addiction, and negative social media as issues. If the kids aren't able to express their feelings and turn inward, they end up in the hospital or emergency room.

She elaborated on the Youth Well-being Assessment, where the schools own their data. She said that Marsing school district went from a 68% rate of anxiety down to 24%. The survey revealed that students lacked connection to a caring adult at school. So, the school targeted interventions to high-risk groups based on the survey data (e.g., grade, gender).

Upcoming IBHC Announcements

Co-Chair Larsen described the council's statutory responsibilities in the upcoming announcements. The first is the state-directed Opioid Settlement Fund. Each year the IBHC makes recommendations to the Legislature and the Governor on how to spend the opioid settlement funds. The press release requesting public comments will go out on Monday, and the council will vote to prioritize recommendations at the August 22nd meeting. The Governor will incorporate our suggestions into his budget, and the legislature may do so as well. The memo from DFM shows sources for behavioral health priorities, including the Opioid Settlement Fund and Millennium Fund.

The Legislature also tasked the council in SB1215 with making recommendations on funding the youth assessment centers from the Millennium Fund. Co-Chair Larsen shared the IBHC's history in creating the assessment centers, with IDJC providing grants to start-up youth assessment centers around the state. The centers have proven successful, but not all of them have become financially sustainable yet. To comply with the statute, the centers will submit to the council a description of their financial needs and a sustainability plan. This information will be provided back to the legislature.

Adjourn

Co-Chair Larsen reminded the council of their next meeting on August 22 and adjourned the meeting.