



## IBHC Meeting Minutes - Approved April 24, 2026

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

[Meeting Recording](#)

[Slide Deck](#)

**Members in Attendance:** Sara Omundson (AOC), Judge Gene Petty, Bree Derrick (IDOC), Christine Starr (COPP), Ross Edmunds (DHW), Jeff Agenbroad (SDE), Leahann Romero for Ashley Dowell (IDJC), Sen. Ali Rabe, Sen. Camille Blaylock

**Guests and Staff in Attendance:** Miren Unsworth (DHW), Wally Campbell (IDOC), Eric Call (DHW), Scott Rasmussen (DHW), Nicole Cleaveland (DHW), Shannon Fox (DHW), Brandi Ellis (AOC), Brandi Hawkins (AOC), Scott Ronan (AOC), Sandy Jones (AOC) Cheryl Foster (IBHC),

### Agenda Items

#### Welcome

Co-Chair Sara Omundson opened the meeting by sharing a physical copy of the current Strategic Action Plan. She explained that the implementation teams will provide updates to the council so they can help break down barriers. She said the true role of the council is to bring people together and coordinate the work going around the state.

Today the council will also receive an update on CCBHCs, which was a goal from the prior strategic plan, and DHW will provide an update on the recently received rural healthcare grant,

#### Approve Minutes

For the August 24, 2025 meeting minutes, Judge Petty moved to approve, and Director Derrick seconded. The motion passed. Ross Edmunds abstained because he was not in attendance at the meeting. Judge Petty also moved to approve the October 24 meeting minutes, and Director Derrick seconded. The motion passed.

#### Review of IBHC Vision, Guiding Principles, and Framework

Co-Chair Omundson read the IBHC vision statement, and Cheryl Foster shared that the council's behavioral health framework.

#### CCBHC Update

Co-Chair Omundson introduced her co-chair Ross Edmunds to give an update on CCBHCs. Co-Chair Edmunds said that Certified Community Behavioral Health Clinics are a model going around the country and was included in the first IBHC strategic action plan.

The recommendation was to explore piloting CCBHCs. Due to COVID funding, the Governor recommended, and the legislature approved funding for an initial startup for four CCBHCs. There were also federal CCBHC grants, which led to five locations around the state. However, full implementation of the model was never realized due to a required Prospective Payment System or PPS for Medicaid. Other states have found that this is very expensive. Simultaneously, the legislature asked to move to a full comprehensive managed care model.

Each of the proposed CCBHCs is also a federally qualified health center, and they still offer behavioral health services, just not under the PPS payment structure.

Judge Petty asked what it means for the patient if the services are not funded under that model. Co-Chair Edmunds said that they can still access the care, but they are funded through a fee-for-service model or the FQHC PPS. He said the benefit of the CCBHC was the required level of services provides an infrastructure of full coverage compared to the existing patchwork of providers.

In the chat, a link to more information was shared: [Idaho Community Health Center Association](#). (Note the webpage is not active anymore.)

Co-Chair Omundson asked whether the managed care model provides the same level of coordination of services as was expected for the CCBHCs. Co-Chair Edmunds said that the contract with Magellan requires coordination of services.

### **Idaho Rural Health Transformation Grant**

Former IBHC Co-Chair Miren Unsworth provided an overview of the state's Rural Health Transformation Plan. The background is the OBB established a \$50 billion rural health program to help rural communities reimagine healthcare delivery systems and improve outcomes. Funding is awarded over a 5-year period and is a cooperative agreement with the Centers for Medicare and Medicaid Services.

There are five strategic goals: Make rural America healthy again, Sustainable access, Workforce development, Innovative care, and Tech innovation. The 50 states were eligible to apply. They must invest in at least three permissible uses, and funding is not allowed for new construction or supplant existing or planned funding. It must also include a sustainability plan. No more than 10% is allowed for administrative expenses (indirect and direct).

Deputy Director Unsworth said that the Notice of Funding Opportunity came out in September and applications were due to CMS on November 4<sup>th</sup>. They received the first year of funding on December 29<sup>th</sup> for just under \$186 million. The funds must be obligated by October 30<sup>th</sup> and spent by the end of the next federal fiscal year. The application was a very heavy lift in a short amount of time. The entire application is available on the DHW website. CMS will monitor states' use of funds and outcomes and can potentially adjust a state's award up or down in future funding cycles.

They received over 500 responses to a public survey to help inform the initiatives: workforce, access and chronic disease prevention. The Governor appointed a rural health task force to advise the application, including legislators and agency heads, and tribal representatives.

The first initiative *Improving rural access to care through technology* involves procuring mobile apps and online portals that integrate HER systems, including creating digital education campaigns tailored for rural populations.

The second initiative *Ensuring accessible, quality care through innovative models* involves new technologies such as pharmacy kiosks and remote patient monitoring programs. They will also complete

rural community needs assessments to determine gaps in care that can be filled by health extenders. She clarified that health extenders are community health workers, like Community Health EMS or CHEMS. They serve a more preventative role in performing home assessments, as opposed to reactive like traditional EMS. To support this workforce, they would like to increase the number of allied and health-centered certificate programs.

This relates to the third initiative *Sustaining rural workforce with training, recruitment, and retention*. They want to leverage financial incentives and training pathways to build and sustain a skilled rural health workforce. Notably, any incentive payment to a provider comes with a requirement that they must serve or practice in a rural community for a five-year period.

The fourth initiative *Implementing population specific, evidence-based projects to Make America Healthy Again* is focused on chronic disease prevention, treatment and management. It also includes behavioral health prevention and treatment and expanding those services to primary care and school-based settings. They are looking at enhancing mobile and telehealth-enabled crisis response. It also includes startup costs for a pediatric psychiatry access line, as Idaho is the only state without one. (Note: this proposal was developed by Project ECHO for the IBHC Prevention implementation team.) There is also a focus on maternal and child health efforts. There is also a 3.5% set aside for the tribes, and they can apply for any of the other solicitations.

The fifth initiative *Investing in a rural health infrastructure and partnerships* primarily invests in healthcare facility renovations tied to the other initiatives in the plan. Co-Chair Omundson asked about the kiosk locations, whether they would be in locations such as libraries. Deputy Director Unsworth said yes, community spaces. They will see who responds to the opportunities, but they've had inquiries about non-traditional medical spaces. Co-Chair Omundson suggested they have a conversation on how they could leverage that for other purposes (such as court appearances). Director Starr asked how some of these items could be implemented with the limitations on construction costs. Deputy Director Unsworth clarified that only new construction is prohibited, but renovations are allowable. They are waiting on CMS to provide guidance on defining minor renovations.

Judge Petty asked about the definition of rural. The Federal Rural Health Policy Office designates census tracts as rural, and Ada County is the only county that does not have a rural census tract. About 36% of Idaho's population resides in one of the rural census tracts.

DHW are preparing the procurement and subgrant opportunities and working with the rural health transformation legislative committee. That committee will review the draft solicitations and help guide implementation activities. Under SB 1453, they are authorized to hire 12 limited-service positions to run the program under the Idaho Rural Health Transformation Office within the office of the Director of Health and Welfare. They hope to begin posting request for proposals and subgrant solicitations in May.

### **Criminal Justice – Continuum of Care Recommendation Update**

Co-Chair Omundson read the recommendation for the Criminal Justice – Continuum of Care: *Ensure continuity of care for those entering and leaving the criminal justice system by providing treatment and ensuring links to services for those coming out of incarceration* and introduced the team co-chair “Dr. Wally” Campbell, the head psychologist at the Idaho Department of Correction and team co-chair.

Dr. Wally introduced himself and co-chair Sandy Jones and provided his background as a juvenile probation officer seeing the impacts from parents returning from incarceration. He said that leaving

incarceration and getting back to the community is a very vulnerable, challenging time, as well as a public safety aspect.

The first project the team is working on is peer recovery services for folks coming out of incarceration who have either significant mental health problems and/or substance abuse problems. These peers and recovery coaches have similar lived experiences but have certification and training. The peers had lost their funding in the fall, which put the team on hold for a while, but it has been reinstated. The team's goals are 1) to expand access and ensure they have good quality supervision and continuing education, for which they are still seeking funding opportunities; 2) develop oversight for the nine recovery centers, which is complete; 3) create a network for those peer recovery specialists to share their professional experiences, which resulted in monthly meetings; and 4) advocate for the development of a forensic endorsement, for which they are researching curricula.

The second initiative is funding for assessments and services for those releasing from adult or juvenile prison systems. This one has been difficult. The first goal was to explore using a Medicaid 1115 waiver to fund services, but it was explored and dropped. The second goal was to monitor the federal law that required incarcerated youth to be enrolled in Medicaid 30 days prior to release, but they have not moved that forward due to lack of legislative authority. The third goal was to review potential providers for Medicaid to increase the services available to juveniles in the community. They couldn't find any additional providers willing to take Medicaid to provide these services. The last one was to find resources for juveniles needing behavioral health services in either congregate or foster care. They explored Medicaid health home and behavioral health coverage but didn't find resources. They recently connected with the Continuum of Care group and Health and Welfare and will continue to look for solutions.

The third initiative is expanding the use of MOUD/MAT. Dr. Wally said that there has been a shift since he started practicing in the 90s to treating substance use with medication instead of using will power approach. Although it still faces resistance, it is very effective. Their first goal was to develop awareness around the processes serving clients, and they developed a list of all available services in Idaho. Their second goal was to enhance community partnerships, and they are doing that by connecting service providers and referrals. They are also reviewing different types of supervision systems for individuals with these services.

The last initiative was a cross-agency collaboration around processes impacting IDOC, the courts, and parole commissioners. They completed their objectives, which included presentations to parole commissioners and district judges about clinical assessments and improved IDOC reports to the courts on rider outcomes for individuals with significant mental health concerns. The reports now clarify whether an individual failed to complete programming due to capacity rather than noncompliance.

Co-chair Omundson asked Judge Petty if he had seen the new forms in practice yet. This led to a discussion on about sharing protected health information and diagnoses. Director Starr noted that there is a gap in the law about who can receive protected health information, as they are not sure who is qualified to view it (i.e., licensed provider). Co-chair Omundson asked why we don't have something like electronic health records for individuals in the system with permissions that can be shared. Director Derrick thought the Health Data Exchange attempted to do that, but didn't know what happened to it. Co-chair Omundson asked if that group could find out what happened with the health exchange or find out the possibilities for exchanging that information. Scott Ronan suggested a legal analysis to determine what is allowable.

**Break**

The council took a 15-minute break.

### **Workforce Development Recommendation Update**

Co-chair Omundson introduced team leader Scott Rasmussen, who introduced the other team lead Eric Call to give the presentation.

Subteam one is working on expanding behavioral health training programs by conducting a statewide analysis of existing behavioral health degree programs. They sent a survey to Idaho's educational institutions and identified the initial barrier as limited clinical supervision capacity due to the inadequate number of internship and practicum sites around the state. There are financial barriers to putting those in. They completed their report yesterday and are working on a gap analysis. They are creating partnerships with training programs to see how they can expand training statewide.

Subteam two's main goal was the peer workforce, and they had begun collaborating with the Criminal Justice – Continuum of Care peer team. This team paused their work when the funding was eliminated, but they are reinitiating now. They are collecting data regarding the peer workforce and preparing to do an analysis. This team's next objective was to help transition the certification of peers to the Idaho Division of Occupational and Professional Licenses, but another internal team at DBH is currently working on that process. Scott Rasmussen added that they have contracts for peer certification through March 2027. If a solution isn't in place, there may be a gap for certification next March because the DHW doesn't have statutory authority to certify. Cheryl added that the Criminal Justice – Continuum of Care peer team had the exact objective around certification and professionalism, as it was very important to them. Part of the two teams' collaboration was to give that objective to the Workforce team. Director Derrick asked if certification allows the peers to be reimbursed for those services. Scott Rasmussen said that they must be certified as a peer to practice as a peer. The team's last objective is to conduct focus groups of peers, so they are putting together a list of questions for these groups.

Subteam three is addressing rural and frontier workforce gaps. They are using national and state data to obtain information about rural clinics. They conducted an inventory of existing workforce strategies and have developed five different proposals. They expect to provide formal recommendations in June on supervision voucher programs for rural areas, rural differential pay, CEUs and certifications offered through the Behavioral Health Authority, an insurance consortium, as well as rural recruitment and retention payments. Cheryl asked if there was collaboration between the Rural Health Transformation Grant and the workforce initiatives. Nicole Cleveland said that they are first building out the proposals and then will collaborate with the DHW public health staff or RHTP staff to have those proposals inform future work.

Judge Petty asked if it is appropriate for the full council to support a recommendation or authority to certify peers. Co-chair Omundson said that the implementation team would need to make a request and then the council could vote, and the co-chairs could write a letter of support.

### **IBHC Strategic Action Plan Implementation Status**

Cheryl shared how council members or the public can check the status of the implementation projects on the IBHC website. She shared a [dashboard](#) that lists the high-level status for the action items and objectives for each recommendation. She also shared that each recommendation has its own web page with a project charter, project scope of work, and links to any deliverables developed by the implementation team. There is also a narrative status update on each team's implementation process if anyone would like a more in-depth understanding of the work done.

The project charter has the names of the team leaders and members, although it does not contain their contact information.

### **Upcoming Opioid Settlement Fund Public Comment**

Co-Chair Omundson said that the council's only statutory task is to make recommendations to the Governor and JFAC on how opioid settlement funds should be spent. Annually, the council makes high-level recommendations for areas of investment, following a public comment period announced via press release. All information submitted by the public, as well as the IBHC's recommendations will be sent to the Governor and JFAC.

The next meeting on June 26<sup>th</sup> will be to vote on those recommendation. Co-Chair Omundson asked that everyone come in person to voting; snacks will be provided.