State Oversight of Children's Residential Care

Evaluation Report
June 2025

Office of Performance Evaluations
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Idaho Legislature

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From the director

June 2025

Members
Joint Legislative Oversight Committee
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This report comes during a time of transformation for the Department of Health and Welfare (department). As Director Adams highlighted last session, the department has made some significant improvements by ending the use of short-term rentals and improving the ratio of foster parents to kids. This report focused on one specific part of how Idaho keeps children safe: the oversight of children's residential care facilities.

Our evaluation identified critical coordination, policy, and enforcement gaps that undermine child safety. The state lacks a formal process for investigating abuse in facilities, unlike the clear process that exists for investigating abuse in homes. When abuse of a child in a facility in foster care is reported, case workers are not required to respond as quickly as for other children in foster care.

When Licensing adopted clear criteria for determining enforcement actions, the number of actions significantly increased. We estimate Licensing would have taken 29 enforcement actions over a 4-year period using these criteria instead of the 8 taken. Licensing could take several steps to improve the quality of information it gathers from facilities and the amount of information it offers to the public.

The items identified by the department and the Health and Human Services Ombudsman in the response letters, once fully implemented, will address many of our concerns and contribute to the promising changes that seek to make the lives of Idaho's children better. As the governor writes in his response, "we have more work to do, but these improvements and current momentum have us on the right track."

Sincerely,

Ryan Langrill, Director
Office of Performance Evaluations

Acknowledgments

Mackenzie Moss, Lauren Bailey, and Tasha Schreiter conducted this evaluation with assistance from Ryan Langrill and Alex Welker.

Casey Petti and Christopher Shank provided quality control review. Leslie Baker copyedited the report.

OPE extends a special thanks to Disability Rights Idaho for providing information during this evaluation and to the children's residential facilities who responded to a questionnaire and were helpful during site visits.

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Executive Summary

Children's residential care facilities serve some of Idaho's most vulnerable children and youth. Children live full time with other children in the care of staff. In March 2025, Idaho had 30 residential care facilities and one therapeutic outdoor program. Two facilities were certified to provide psychiatric care. Some children are placed by their parents. The Idaho Department of Health and Welfare (department) also places some children who are in foster care in residential care facilities. Children in residential care are almost three times as likely to be diagnosed with mental health disorders, behavioral challenges, or other disabilities.

In March 2024, following concerns from community members and policymakers, the Joint Legislative Oversight Committee directed our office to evaluate Idaho's role in ensuring the safety of children living in residential care facilities.

What we did.

We evaluated the state's oversight of children in residential care facilities. We provide recommendations for entities that have oversight roles in the system including various divisions within the department and the Health and Human Services Ombudsman. We present considerations for the Legislature.

What we found.

We present findings about gaps in Idaho's children's residential care system. Each chapter in the report provides additional findings, recommendations for the department, and considerations for the Legislature.

One of the department's primary goals is to strengthen child welfare. The department was transitioning many of its practices to align with this goal during our evaluation. Some of those transitions are highlighted in our report. We identify additional areas for improvement of the oversight of children in residential care facilities.

The many entities with responsibility to keep children safe in facilities face coordination and process challenges that impede safety.

We evaluated how well entities with oversight responsibilities in the children's residential care system work together. We identified several gaps. For example, the department has a clear process for investigating abuse and neglect in homes. An equivalent process does not exist for investigating abuse and neglect in facilities. As a result, there is no formal process to include staff at facilities on Idaho's Child Protection Central Registry. The Legislature should consider assigning an entity responsible for investigating abuse in facilities.

The Legislature should consider assigning an entity responsible for investigating abuse in facilities.

There is also no department-wide protocol for communication or issue escalation across divisions. Several department divisions play a role in overseeing children's residential care. Some entities within those divisions have formal communication protocols. We found that others lack formal protocols to define when an issue, such as a complaint or safety concern, warrants investigation and which other entities should be informed. The department should develop a department-wide protocol to define communication and issues escalation across divisions.

Licensing took minimal enforcement actions.

The department's Division of Licensing and Certification (Licensing) is responsible for licensing children's residential care facilities in Idaho. Licensing can issue enforcement actions against facilities when they are not in compliance with administrative rule. We found that of the 271 surveys (or inspections) that Licensing conducted from 2016 to 2024, 225 required the facility to create correction plans, but only 10 led to enforcement actions. In 2024, Licensing developed and began testing a risk assessment matrix to help staff make decisions about when to issue enforcement actions. We found that Licensing took more enforcement actions since the introduction of the matrix.

Licensing's scope of enforcement is limited.

Although administrative rule includes some requirements to promote child safety, Licensing's scope of enforcement is limited. For example, we found that children's rights in facilities are not enumerated and communicated in administrative rule. The department should create a bill of rights for children in facilities. The Legislature should consider amending statute to require that facilities follow, post, distribute, and interpret the rights for children and families.

Children's rights in facilities are not enumerated or communicated.

Licensing also does not assess treatment quality. Unless the entity paying for treatment assesses its quality, or a facility is nationally accredited, no entity oversees treatment. Licensing also does not know how frequently high-risk strategies like restraint are used. The department should amend administrative rule to require facilities to report restraint and seclusion use to the department. The Legislature should consider amending statute to require the department to report restraint and seclusion use to the Legislature.

We also found that Licensing's processes limit knowledge of what is happening in facilities. Licensing staff are rarely on-site and rely heavily on facility documentation. For example, we found that scheduled surveys allow facilities to curate what Licensing staff see. The department should amend administrative rule to require at least one annual unannounced survey.

No entity oversees treatment in all facilities.

Some administrative rules are difficult for Licensing staff to assess using documentation alone. We found that the information Licensing staff receive about what is going on in a facility may be limited by their decision to allow facility administrators to choose interviewees. The department should revise the child and staff interview process.

The department faces challenges in overseeing children in foster care who are placed in facilities.

The department contracts with facilities to place children in foster care in residential care facilities. We found that the department has no internal policy regarding how to conduct monitoring of placement contracts for children's residential care facilities. The department should standardize its monitoring procedures for children's residential care facilities, including formalizing their role in ensuring child safety. The department is developing a monitoring tool to standardize their monitoring of children's residential care facilities.

Case workers are not required to respond to abuse allegations of children in facilities as quickly as for other children in foster care.

Case workers manage the cases of individual children placed in facilities. We found that case workers are not required to respond to abuse allegations of children in facilities as quickly as for other children in foster care. The department should apply existing response priority requirements to safety-related issues involving children in foster care who are placed in facilities.

In fiscal year 2024, the department opened a facility called the Payette Assessment and Care Center. We found that the facility faces some oversight concerns. The department should closely monitor its use of the facility.

The department's new facility faces some oversight concerns.

National best practice, as well as federal and state policy, agree that children in foster care should only be placed in facilities when a foster home placement cannot meet their needs. The department does not currently track 1) the ideal setting for a child based on their needs and 2) whether placement is due to limited access or because it is the ideal fit. While this information may be captured in case notes, it is not tracked in a way that can be used to assess placement trends. The department should track the ideal placement type for children in care.

1 Introduction

Children's residential care facilities serve some of Idaho's most vulnerable children and youth. Children live full time with other children in the care of staff. In March 2024, following concerns from community members and policymakers, the Joint Legislative Oversight Committee directed our office to evaluate Idaho's role in ensuring the safety of children living in residential care facilities. Our report follows this outline:

1

INTRODUCTION

We define what children's residential care is, who the system serves, and what entities are responsible for keeping children safe.

2

SYSTEM

We identify current gaps in the system's oversight and recommend solutions.

3

LICENSING

We explore findings related to facility licensure.

4

CHILDREN IN FOSTER CARE

We evaluate the current oversight of children in foster care placed in residential care facilities.

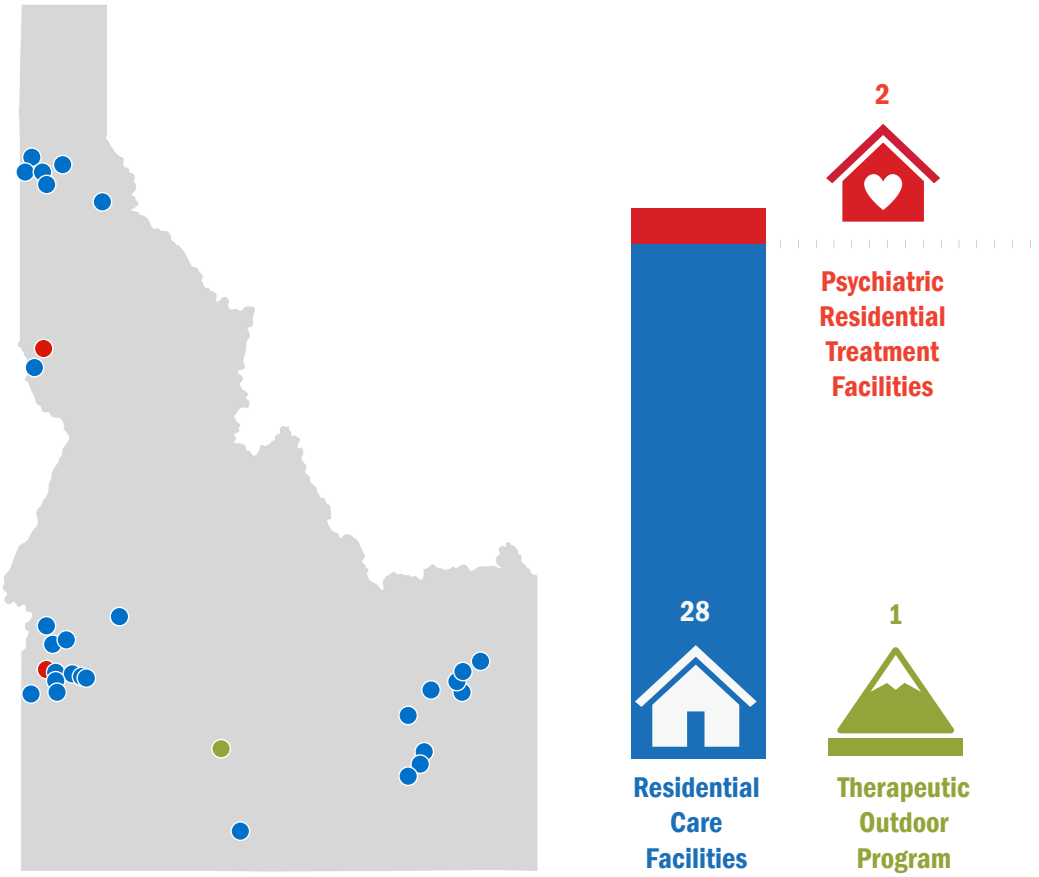
What is children's residential care?

Children's residential care facilities provide children with 24-hour overnight care. Children eat, sleep, play, and may even go to school at a facility. Facilities sometimes provide specialized treatment. We were asked to evaluate the state's role in the oversight of three types of facilities (see exhibit 1). Throughout our report, we refer to these three types as children's residential care facilities. If we have findings that pertain to just one of these facility types, we state that explicitly.

Exhibit 1

Idaho has 31 residential care facilities.

In March 2025, Idaho had 30 residential care facilities, two of which were certified to provide psychiatric care, and one therapeutic outdoor program.



Children's Residential Care Facilities provide 24-hour childcare. Some facilities provide treatment, therapy, or rehabilitation for children.

Psychiatric Residential Treatment Facilities provide specialized treatment for children. These facilities are certified using federal standards and undergo additional inspections.

Children's Therapeutic Outdoor Programs are outdoor children's agencies that specialize in some form of behavioral, substance use, or mental health service. Outdoor programs are regulated like children's residential care facilities with a few additional requirements because children are living outdoors.

Who does the children's residential care system serve?

Children's residential care is an important part of the continuum of care for Idaho's most vulnerable children. There are many pathways that may lead to a child's placement in a residential care facility. Some children are placed by their parents, who have made the difficult decision that a facility is the best fit for their child. Some are placed by the Idaho Department of Health and Welfare (department) after they have been removed from their home because of abuse or neglect concerns. Others are referred to residential care by the department because they qualify for specialized services, like treatment for a behavioral or developmental need. A 2015 study found that children in residential care are almost three times as likely to be diagnosed with mental health disorders, behavioral challenges, or other disabilities.[1] (See appendix F for some information on identified disabilities of children in foster care in facilities.)

Children in residential care facilities are almost three times as likely to be diagnosed with mental health disorders, behavioral challenges, or other disabilities.

1. U.S. Dep't. of Health and Hum. Serv., Admin. for Child. and Families, A National Look at the Use of Congregate Care in Child Welfare, at 11, (2015)

Residential care is one option on a continuum of care for children in Idaho depending on their pathway to placement (see exhibit 2). Facilities serve a wide range of ages, from toddlers to young adults. Generally, children living in facilities are below the age of 18.[2] In December 2024, most children in foster care that were placed by the department in Idaho facilities were above the age of 12. We refer to children in residential care facilities as either children or youth throughout this report.

Exhibit 2

Residential care facilities are one option on a continuum of care for children in Idaho.

This exhibit does not represent all the placement options for children in Idaho.

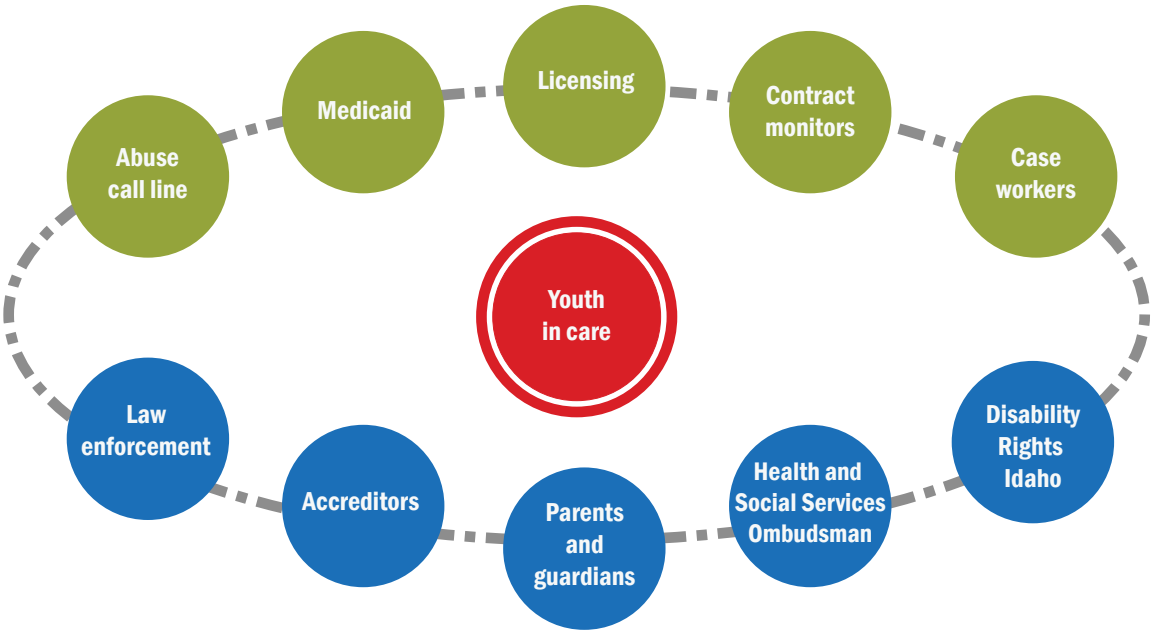
2. Children placed in therapeutic outdoor programs must be at least 11 years old.

Who is responsible for keeping children safe?

Idaho does not have an explicit definition of safety in children's residential care facilities. Generally, safety is about avoiding physical and emotional harm, including freedom from abuse and access to appropriate and effective care. Many entities at the federal, state, and private levels have oversight roles in the children's residential care system (see exhibit 3).

Exhibit 3

The department and other entities are responsible for keeping children in facilities safe.



Federal regulations

Federal frameworks like the Child Abuse Prevention and Treatment Act and the Code of Federal Regulations outline requirements that states must enforce for facilities receiving federal funding.[3,4] Federal guidelines seek to prevent, prosecute, and treat child abuse and ensure that children receive adequate care.

3. 42 U.S.C. § 5101 (2023)
4. 45 C.F.R. § 1355-1357 (2023)

The federal government also requires states to designate a Protection and Advocacy Agency.[5] Idaho designated Disability Rights Idaho, which receives federal funding to work at the state level to protect individuals with disabilities.[6] When Disability Rights Idaho identifies abuse, neglect, or exploitation in a facility, they may submit a formal complaint to the department.

Idaho Department of Health and Welfare

We discuss three department divisions with oversight roles in the children's residential care system: Licensing and Certification; Children, Youth, and Family Services; and Medicaid.

Licensing and Certification

Statute establishes the department's responsibility for licensing facilities.[7] Administrative rule establishes the requirements for licensing, maintaining, and operating children's residential care facilities and therapeutic outdoor programs.[8] The department's division of Licensing and Certification enforces those requirements. We provide findings and recommendations about facility licensure in chapter 3.

Children, Youth, and Family Services

The department's Division of Children, Youth, and Family Services (CYFS) manages the state's child abuse call line, which receives calls about abuse and neglect in facilities. We provide findings and recommendations about the abuse call line in chapter 2.

Administrative rule outlines requirements for the department to place children in foster care in residential care facilities. CYFS has placement contracts with in- and out-of-state facilities. Contract monitors ensure that facilities meet contract requirements. Case workers manage the individual cases of children in facilities. The department also operates one facility that serves children in foster care. As of February 2025, the facility is operated by the Division of State Care Facilities. We provide findings and recommendations about the oversight of children in foster care placed in facilities in chapter 4.

5. Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, § 101, 114 Stat. 1680.
6. Disability Rights Idaho, Monitoring, (2025), https://www.disabilityrightsidaho.org/services/#monitoring.
7. Idaho Code § 39-12.
8. Idaho Admin. Code r. 16.04.18

Medicaid

In July 2024, the department's Division of Medicaid (Medicaid) began a contract with Magellan Healthcare Incorporated (Magellan) to oversee behavioral health services, including children's residential care. The contract covers treatment specific to behavioral health services that some children receive in facilities. In the case of Psychiatric Residential Treatment Facilities, the contract may cover the entire cost of a child's placement. In addition, Medicaid also pays for other services through fee for service when not covered in the Magellan contract.

These payments come with some additional oversight. For example, Magellan monitors the services that children receive at facilities through provider agreements and a complaint process. Medicaid monitors the contract with Magellan, including assessing how Magellan responds to quality of care concerns and processing complaints received directly to Medicaid. At the time of this evaluation, Medicaid was in the beginning stages of its contract with Magellan. We did not assess the quality of each oversight function performed by Medicaid or Magellan. We provide some findings about Medicaid's role in chapter 2.

Other entities

Local law enforcement plays a role when potential criminal issues arise within facilities. The newly created Health and Social Services Ombudsman will also "receive and respond to complaints related to services provided to Idaho children in foster care, protective supervision, or residential treatment facilities."[9]

Some private entities have the responsibility to keep children safe in facilities. For example, parents and guardians play a crucial role in assessing the safety of their child in a facility. We provide findings about information available to parents in chapter 2. Residential care facilities themselves also have an immense responsibility to ensure the children in their care are safe. Facilities that choose to become accredited through a national accreditation entity have additional oversight (see appendix D for more on accreditation).

9. Idaho Health and Social Services Ombudsman, (2025), https://hsso.idaho.gov/.

2 System

Both Idaho and national policymakers are looking for ways to ensure that residential care settings are safe for children. In 2022, staff of the US Senate Committee on Finance published a report detailing the bleak reality of children wrongly placed and treated in residential care.[10] In 2024, Congress passed the Stop Institutional Child Abuse Act, which requires the federal Department of Health and Human Services to oversee a contract to study and make recommendations about youth residential programs.[11]

In this chapter, we present findings about how effective Idaho's residential care system is at keeping children safe in facilities. We found that the entities responsible for keeping children safe in facilities face coordination and process challenges that impede safety. Having multiple entities responsible for similar roles can make it difficult for any entity to be responsible and accountable.

Having multiple entities responsible for similar roles can make it difficult for any entity to be responsible and accountable.

10. U.S. Senate Comm. on Fin. Staff, Warehouses of Neglect (2022).
11. Stop Institutional Child Abuse Act, Pub. L. No. 118-194, § 138 Stat. 2664, (2024).

The department does not investigate abuse in facilities the same way it does in homes.

The Idaho Department of Health and Welfare's (department) Division of Children, Youth, and Family Services (CYFS) has a clearly defined process for investigating abuse and neglect in homes. An equivalent process does not exist for investigating abuse and neglect in facilities. Most statute and department protocol surrounding abuse and neglect were crafted to protect children in home environments by legal caregivers. These laws and protocols do not translate effectively to the abuse or neglect of children in facilities by staff.

CYFS receives calls about abuse and neglect allegations in facilities.[12] The information is transferred to the Division of Licensing and Certification (Licensing) which may investigate whether the facility violated administrative rule. Law enforcement may conduct a criminal investigation (see exhibit 4).

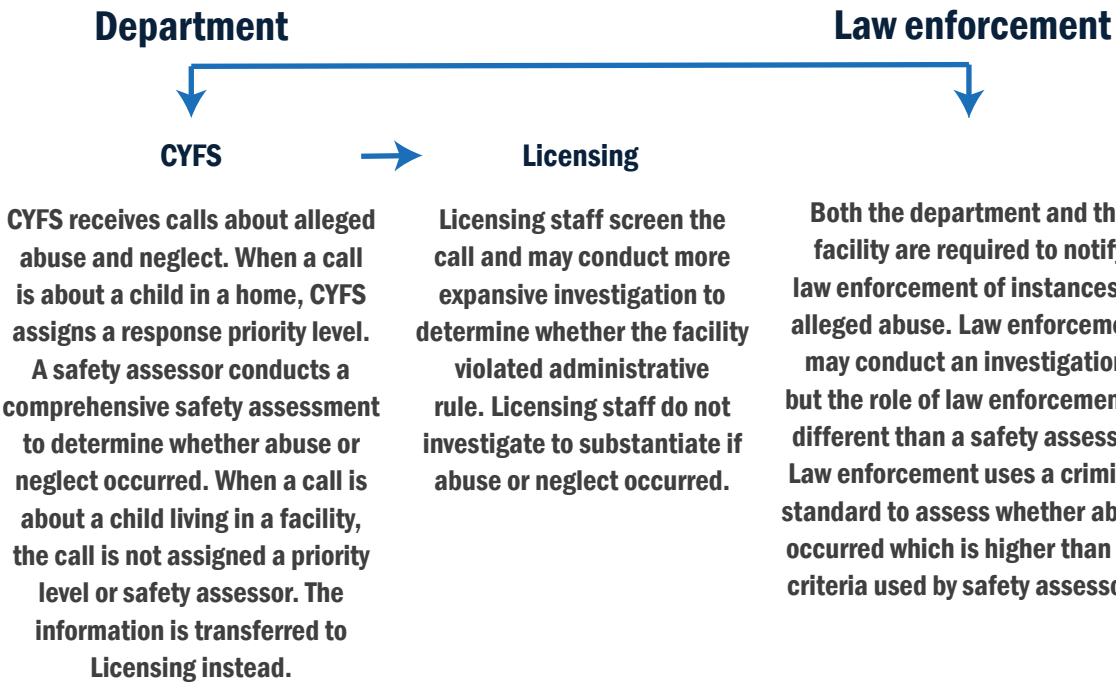
What is abuse in children's residential care facilities?

While statute defines abuse and neglect, Idaho does not have a specific definition of either in facilities.[13] The Government Accountability Office found in 2022 that "differing interpretations of what constitutes maltreatment by residential facility administrators, staff, and state agencies may result in facilities over- or under- reporting issues."[14] We found that without a specific definition of abuse, facility and state employees have discretion in how to interpret an issue. Some states have established specific definitions for child abuse in facilities. For example, Ohio includes specific descriptions like sexual contact with children and improper use of restraints in its definition of out-of-home child abuse.[15]

12. Other entities within the department can also receive information about concerns at facilities. This finding relates specifically to the CYFS child abuse call line.
IDAHO DEP'T. OF HEALTH AND WELFARE, *Reporting Neglect Abuse and Abandonment*, (2025), https://healthandwelfare.idaho.gov/services-programs/children-families-older-adults/child-and-family-services-and-foster-care-3.
13. IDAHO CODE § 16-1602 (2025).
14. U.S. GOV'T. ACCOUNTABILITY OFF., GAO-22-104670, CHILD WELFARE: HHS SHOULD FACILITATE INFORMATION SHARING BETWEEN STATES TO HELP PREVENT AND ADDRESS MALTREATMENT IN RESIDENTIAL FACILITIES 23 (2022).
15. OHIO ADMIN. CODE 5180:2-1-01 (2024).

Exhibit 4

The department and law enforcement play different investigation roles.



Disability Rights Idaho may also investigate if they suspect abuse or neglect after a facility visit or receive a complaint from the public. Their investigation could result in a referral to the department or law enforcement.

Licensing's findings are about policies like staffing ratios, improper training, or staff discipline, and often result in staff being retrained or terminated. Here's how this might play out in Idaho:

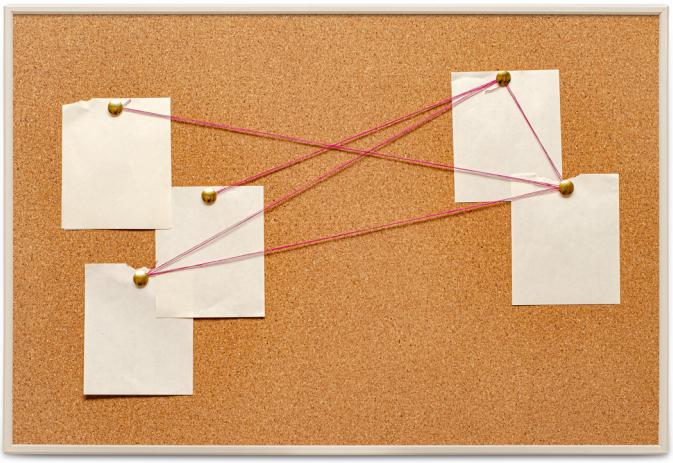
Law enforcement received a report that a child in a facility harmed themselves. Law enforcement reported the event to Licensing. Licensing opened an investigation and found no rule violations. Licensing closed the report, noting the police report number and confirming law enforcement involvement. Staff were not investigated.

Someone reported suspected abuse of a child in foster care in a facility to CYFS's abuse call line. Licensing, law enforcement, and the child's case worker were notified. Licensing investigated and found no rule violations. Law enforcement also investigated. According to police reports, department staff told law enforcement it would request assistance if needed.

The Legislature should consider assigning an entity responsible for investigating abuse in facilities.

Idaho could use department safety assessors to complete assessments in facilities like those completed in homes. However, CYFS staff reported that investigating abuse in facilities may require a different process and authority than in homes. They reported that the current process focuses on substantiation of a child's caregiver, which does not apply to facility staff.[16]

The US Government Accountability Office found that "states could minimize oversight gaps by making one state agency responsible for responding to abuse and neglect in facilities."[17] Minnesota assigns licensing staff to investigate abuse and determine if maltreatment occurred.[18] Some states have clearly defined an entity outside of their Department of Health and Welfare equivalent to investigate abuse in facilities. New Jersey investigates allegations of child abuse and maltreatment through an Institutional Abuse Investigation Unit.[19] Oregon's Office of Training, Investigations, and Safety investigates abuse in all residential care facilities, including those that serve adults.[20]



16. Statute defines caregiver as "a foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed." Idaho Code § 16-1602 (2025).
17. U.S. Gov't. Accountability Off., GAO-24-107625, Abuse of Youth Placed in Residential Facilities 10 (2024).
18. Minn Dep't. of Hum. Serv., *Maltreatment Investigations in DHW-licensed programs: frequently asked questions*, (2025), https://mn.gov/dhs/general-public/licensing/maltreatment-investigations/descriptions/.
19. N.J. Dep't. of Child. and Families, Manual of Requirements for Residential Child Care Facilities, (2023).
20. OR. Dep't. of Hum. Serv., Office of Training Investigations and Safety Overview, (2021).

There is no process to include facility staff on Idaho's child protection registry.

The department has the statutory responsibility to maintain a registry "for the reporting of child neglect, abuse, and abandonment."[21] We found that there is not a formal process for staff at residential care facilities to be included on Idaho's Child Protection Central Registry. If a safety assessor determines that abuse or neglect occurred in a home, the perpetrator is added to Idaho's Child Protection Central Registry. Since Licensing does not conduct safety assessments, there is no process for perpetrators of abuse or neglect in facilities to be included on Idaho's Child Protection Central Registry.

Facilities are required to screen new employees for both criminal charges and inclusion on Idaho's Child Protection Central Registry.[22,23] Since facility staff are not investigated by the department the same way caregivers are, perpetrators of abuse in facilities who did not receive criminal charges for their behavior may still be eligible to work at other residential care facilities.

> **"Staff can facility-hop and their bad behaviors are not reported and might not be tracked or known to the other facility.**
>
> **— Community Stakeholder**

Perpetrators of abuse who did not receive criminal charges may still be eligible to work in facilities.

21. Idaho Code § 16-1629(3) (2024).
22. Idaho Admin. Code r. 16.04.18.009 (2024).
23. Idaho Admin. Code r. 16.05.06.001 (2023).

What else could Idaho do with information about perpetrators of abuse in facilities?

The Office of the Administration for Children and Families 2022 report on Child Maltreatment identified Idaho as one of only 17 states that does not report residential facility staff as perpetrators of maltreatment.[24] Although group home and residential facility staff account for only 0.2 percent of reported perpetrators in the 2022 maltreatment report, they are an important perpetrator type to track in the oversight of children's residential care.

The department should develop a process to include perpetrators of abuse in children's residential care facilities on Idaho's Child Protection Central Registry.

This recommendation aligns with past OPE findings about abuse in all residential facilities, including those that serve adults. We found in our 2019 report Southwest Idaho Treatment Center that unlicensed caregivers with a history of abuse are not excluded from caregiving employment in Idaho. In 2019, we presented a consideration for the Legislature to establish a registry of perpetrators of abuse of vulnerable adults, including the designation of an entity responsible for conducting investigations of abuse.[25]

24. U.S. Dep't. of Health and Hum. Serv., Admin. for Child. and Families, Child Maltreatment 2022, at 63, (2022)
25. Office of Performance Evaluations, Southwest Idaho Treatment Center, at 7, (2019) https://legislature.idaho.gov/ope/reports/r1901/.

There is no department-wide protocol for communication or issue escalation.

The US Government Accountability Office found in 2022 that "state oversight of residential facilities is often fragmented."[26] We found that while the department shared oversight responsibilities of children in facilities, it lacks protocol to define communication or issue escalation across divisions. As a result, safety-related information may be passed from one staff member to another without timely action or clear accountability.

CYFS, Licensing, and Medicaid all play a role in overseeing children's residential care in Idaho. Some entities within those divisions have formal communication protocols for their roles. We found that others lack formal protocols to define when an issue, such as a complaint or safety concern, warrants investigation and which other entities should be informed. It was difficult to assess where one division's responsibility ended and another's began (see exhibit 5).

It was difficult to assess where one division's responsibility ended and another's began.

26. U.S. Gov't. Accountability Off., GAO-22-104670, Child Welfare: HHS Should Facilitate Information Sharing Between States to Help prevent and Address Maltreatment in Residential Facilities 28 (2022).

Exhibit 5

Some department divisions have formal complaint and communication protocols.

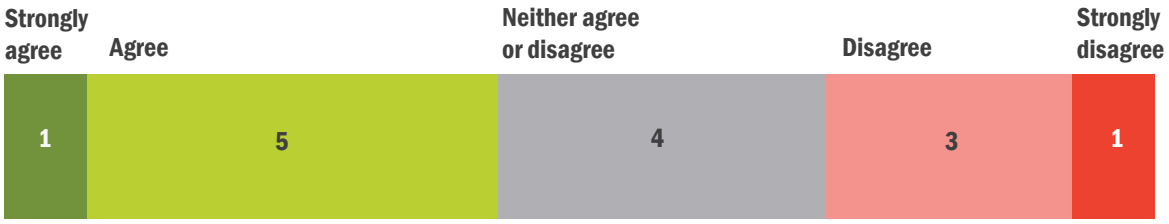
	Licensing	Case workers (CYFS)	Contract monitors (CYFS)	Magellan	Medicaid	Child abuse call line (CYFS)
Role	Conducts annual surveys to assess compliance with administrative rule	Oversees placement and treatment of individual children	Ensures compliance with placement contracts	Oversees contracts that pay for care in facilities for some children	Oversees department's contract with Magellan	Receives calls about potential abuse in facilities
Complaint protocol	Receives complaints via, phone, email, or a form Screens each complaint and may conduct more expansive investigation	No formal process to receive or follow up, but case workers are in regular contact with children	No formal process to receive or follow up, but monitors are in regular contact with children	Receives complaints via email or a form Has a formal process to follow up on complaints	Oversees Magellan's complaint follow up Receives complaints through email and has a formal process to follow up	Receives complaints through a public call line Plays no follow up role on calls about children in facilities
Cross division communication protocol	Licensing staff will reach out to a facility's monitor when any enforcement actions are issued	Required to notify the monitor or Licensing staff about concerns, minimal specificity about what information should go to which division	No formal documentation of how or when to escalate a concern Licensing's manual defines that monitors should reach out to Licensing with concerns	No formal process to communicate concerns with other divisions	Has a process to send information to internal partners, minimal specificity about what information should go to which division	Transfers information about children in facilities to Licensing Informs a child's case worker if a call involves a child in foster care

With so many entities involved, we found that department staff will often assume that the responsibility to follow up on an issue lies within another division. Some department staff reported that clear separation of responsibilities was lacking between divisions. Facility administrators also reported that sometimes the department did not demonstrate clear separation of roles and responsibilities (see exhibit 6).

Exhibit 6

Facility administrators reported mixed opinions on whether the department's divisions had clear roles and responsibilities.

Facility administrator agreement with the statement: Each division has clear roles and responsibilities.



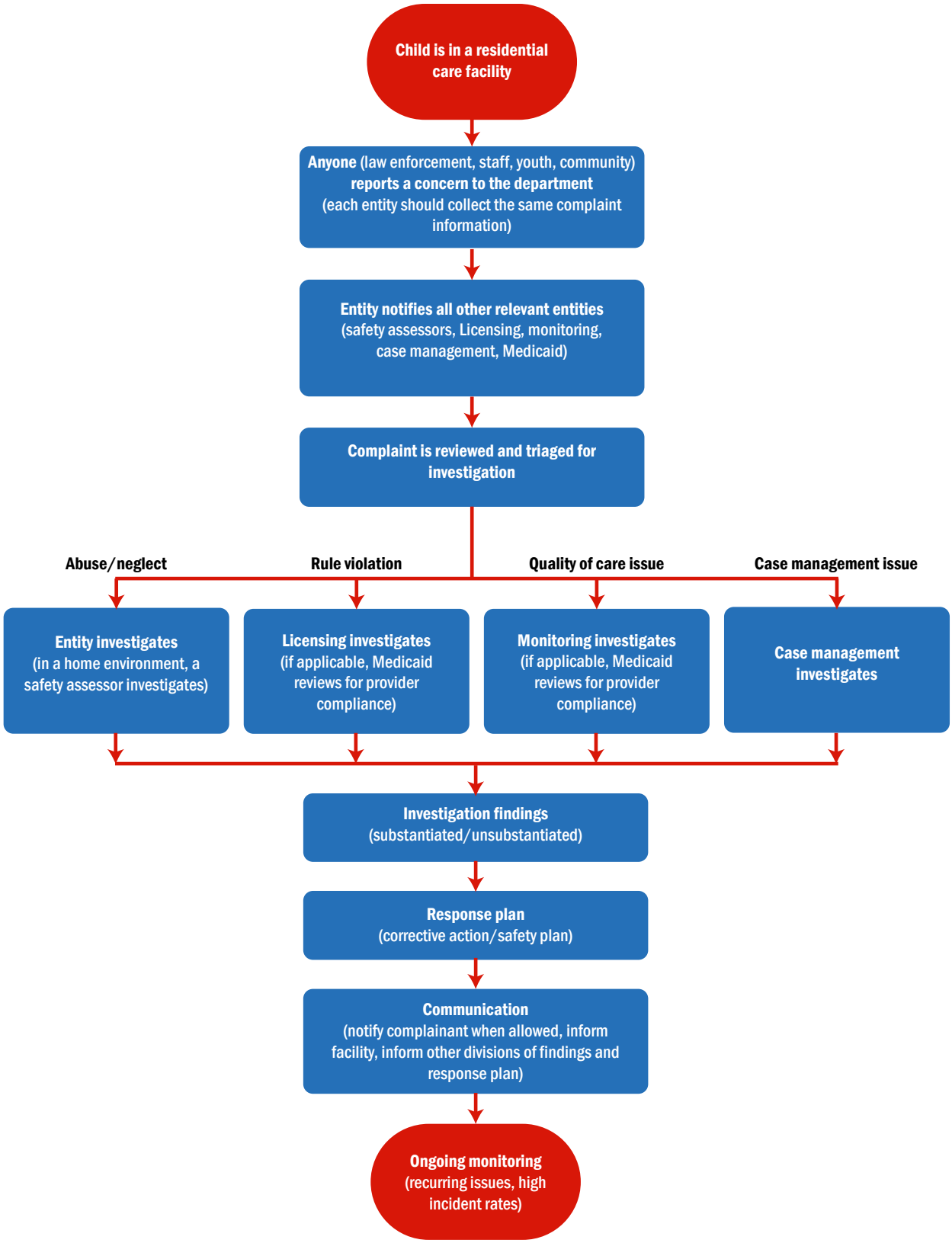
The department should develop a department-wide protocol to define communication and issue escalation across divisions.

While department employees communicate across divisions, a formal protocol would help the department consistently identify and act when an issue warrants follow up. A protocol would ensure that all relevant parties are informed and assign appropriate separation of responsibilities. We created a sample protocol for cross-division complaint coordination based on an example from the Administration for Children and Families (see exhibit 7).[27] In 2024, the department created a Continuum of Care Bureau within CYFS. The bureau's goal is to help make placement decisions for children in foster care. The bureau should be included in a department-wide protocol.

27. U.S. Dep't. of Health and Hum. Serv., Admin. for Child. and Families, Children's Bureau, How the Child Welfare System Works, at 8, (2020), https://www.childwelfare.gov/resources/how-child-welfare-system-works/.

Exhibit 7

Complaints could be routed across divisions.



Federal funding sources carry different requirements for facilities, which may affect access to care for children.

The department can fund children's residential care by using state or federal dollars to place children who are in foster care in facilities. The department can also use federal Medicaid dollars to pay for services that children receive in facilities. We found that complicated federal guidelines can be challenging for facilities to navigate and may inhibit children's access to care.

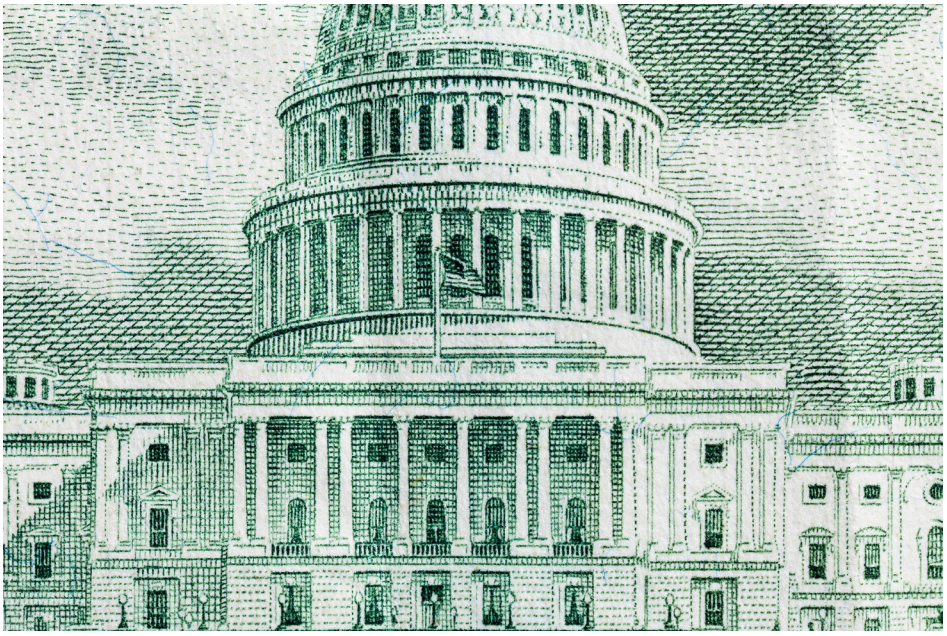
There are four sets of requirements that may apply to a facility depending on the payment source of the children in their care:

1) State licensing requirements to operate

2) Federal Medicaid requirements to receive payment for treatment

3) Federal Qualified Residential Treatment Program requirements to receive Child Protection Act funds for serving children in foster care (see appendix D for more on qualification requirements)

4) Federal Medicaid Psychiatric Residential Treatment Facility requirements to receive payment for housing and treatment



Many facility administrators reported frustration with their interactions with the department, particularly about meeting federal requirements. For example, some administrators reported that the forms they were required to submit across multiple divisions were repetitive and confusing. When asked why they had chosen not to become Qualified Residential Treatment Programs, some administrators responded that the reimbursement was not worth the effort. We compared the average daily rates of contracts for facilities that are Qualified Residential Treatment Programs versus those that are not. We found that Qualified Residential Treatment Programs generally have higher daily rates (see appendix D for more on daily rates). Many administrators also reported frustration about receiving adequate payment from the department. These frustrations may affect the level of care and services that facilities choose to provide to children.

> **"It takes a long time to get paid. We have had hundreds of thousands of dollars owed to us at some points. We have had to take out loans. We went through a lot of trouble to become a QRTP and Medicaid enrolled just for it to still be a mess.**
>
> **— Facility administrator**

The department should explore opportunities to streamline and consolidate the requirements for funding across federal regulations.

Since November 2024, the department has hosted bi-monthly provider partnership forums to engage facility administrators in discussions about serving Idaho youth. The meetings include representatives from CYFS, Licensing, and Medicaid.

> **"I have appreciated that the last several months there have been calls with [CYFS] leadership and the children's residential facilities to work together and problem solve.**
>
> **— Facility administrator**

The Health and Social Services Ombudsman should establish processes to fulfill its oversight role.

During the 2024 session, the Legislature created the Health and Social Services Ombudsman to "monitor and evaluate the compliance of public agencies and private entities with relevant statutes, rules, and policies pertaining to the provision of health and social services" for children in residential care facilities.[28] According to the ombudsman's website, the ombudsman will receive and respond to complaints, compile and analyze trend data to recommend changes to Idaho laws, and report annually to the Governor, Legislature, and department. The website states that the ombudsman began receiving complaints in February 2025.[29] Findings in this report may be valuable in establishing the explicit roles and processes of the ombudsman.

The ombudsman should establish processes to fulfill its oversight role that address some of the oversight gaps identified in our report.

Potential roles of the ombudsman could be to

- assist the department in establishing a set of rights for children in residential care facilities (see chapter 3 for more on our recommendation to the department for a bill of rights);
- assist the department in compiling and sharing information about safety in residential care facilities to the Legislature and public (see chapter 3 for examples of this information);
- establish as part of its complaint response process that complaint final reports be shared with the department and that the department must provide a written response; and
- formalize an evaluation function to regularly assess department compliance with statute, rules and policies.[30]

28. Idaho Code § 56-1901(3) (2025).
29. Idaho Health and Social Services Ombudsman, (2025), https://hsso.idaho.gov/.
30. This role could include requirements for Licensing survey and monitoring processes (see chapter 3) or case worker and contract monitor visits (see chapter 4).

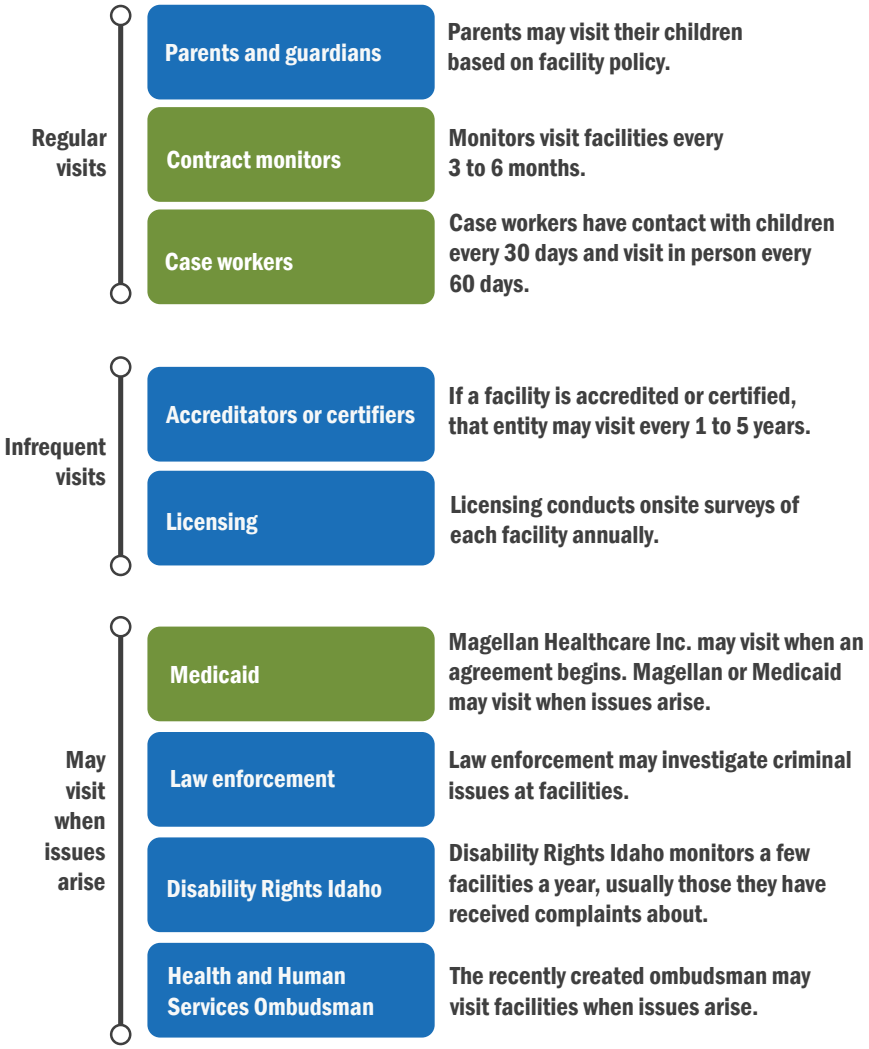
Children placed privately in facilities have less oversight.

We found that children who are placed in facilities by their parents have the least amount of oversight. When a parent places and pays for their child's stay in a facility, less entities are invested in the oversight of their care (see exhibit 8).

Exhibit 8

Children who are placed privately in residential care are required to be visited less often by oversight entities.

Some entities have oversight only when children who receive their services are placed.



Entities that visit regularly or infrequently may also visit when issues arise.

When the department places a child or funds services that a child receives, the facility must undergo additional assessment to ensure it is a good fit for the child. When a parent places their child, they have the responsibility of deciding whether the facility is a good fit. This leaves parents with an immense responsibility to assess the quality of the facility they choose. We found that information about facilities may be limited for parents, especially when children are placed out of state. Some facilities have websites with descriptions of the services they offer, including types of treatment. Other facilities have no website or social media presence. Some facilities are nationally accredited, which gives parents some information about the facility (see appendix D for more on facility accreditation).

> **"In some states, little information can be found about these facilities, leaving Idaho families unaware of the conditions their youth are subject to.**
>
> **— Disability Rights Idaho[31]**

The department licenses residential care facilities in Idaho, including children's residential care facilities. One source of information a parent may use when making a placement decision is a facility's licensure results. Although Licensing posts children's residential care facility survey results publicly on its website, we found that the information may be difficult to find and interpret.

The department should institute an online dashboard for children's residential care licensure.

Licensing maintains an online portal with detailed information about assisted living facility licensure.[32] The portal reports key information like the facility's contact information, license status, survey results, and history of complaints. A dashboard would provide the public, including parents, with better access to information about survey results. The dashboard should include facility survey results and risk levels, as well as complaint histories (see chapter 3 for more on facility risk levels).

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31. This quotation refers to out-of-state facilities, and to all placement types, including those made by the department.
DISABILITY RIGHTS IDAHO, WRITTEN TESTIMONY SUBMITTED FOR INCLUSION IN THE RECORD IN THE U.S SENATE FINANCE COMMITTEE HEARING HELD ON JUNE 12, 2024, 8, (2024), https://www.disabilityrightsidaho.org/youth-residential-treatment-facilities-examining-failures-and-evaluating-solutions/.

32. IDAHO DEP'T OF HEALTH AND WELFARE, *Facility Licensure and Regulatory Enforcement System*, https://www.flareslive.com/portal/searchfacility.aspx.

3 Licensing

The Idaho Department of Health and Welfare's (department) Division of Licensing and Certification (Licensing) is responsible for licensing children's residential care facilities in Idaho. Licensure requirements are set in statute and administrative rule. Surveys, or inspections, are completed annually and involve review of facility documents to assess compliance, an onsite visit of a facility, and interviews with children and staff. Licensure serves as a baseline assurance that a facility is compliant with state regulations and is safe for children.

Our study requesters were concerned that Licensing was not doing enough to keep children safe. In this chapter, we review the scope of Licensing's current authority. We found that although administrative rule sets some requirements to promote child safety, Licensing's scope of enforcement is limited by what is and is not included in administrative rule. We also assess how well Licensing holds facilities accountable. We found that Licensing staff are rarely on-site and rely heavily on facility documentation to understand what is happening at a facility. We present considerations for the Legislature to improve child safety and recommendations for the department to improve Licensing's processes.

Licensing does not know how frequently high-risk strategies like restraint are used.

In March 2025, five residential care facilities in Idaho reported in their licensure application that they use seclusion and 23 reported that they use restraint. However, we know little about how often these strategies are used across the state. In June 2024, Disability Rights Idaho submitted testimony to the US Senate Finance Committee that the Idaho facilities they monitored used restraints inappropriately.[33] We found that although administrative rule places some regulations on the use of restraints and seclusion, Licensing does not collect information about how often facilities use these high-risk strategies.

Risk of harm

Restraint and seclusion can result in harm to children when implemented or monitored inappropriately. A nationwide study discovered 79 youth fatalities related to restraint from 1993 to 2018. Fatalities result from staff incompetence, improper techniques, and a lack of procedures to reduce risk.[34]

What can happen during a restraint?

We reviewed Licensing's documentation and compiled a composite case study based on several real occurrences in Idaho. This fictional example highlights some ways harm may occur—such as when staff lack proper training, the experience causes psychological trauma, or injuries go without medical follow up.

A 13-year-old living in a facility became upset after they couldn't play video games. They began yelling and threatening staff. To prevent disruption and potential harm to other children, a staff member who was not fully trained restrained the child without attempting other strategies. The child later reported shoulder pain but was not taken to a doctor. A complaint was filed with Licensing citing lack of staff training, unnecessary restraint, emotional harm, and neglect due to lack of medical care.

33. *Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions: Hearing Before the S. Fin. Comm., 118th Cong.*, 5 (2024) (statement of Disability Rights Idaho), https://www.disabilityrightsidaho.org/youth-residential-treatment-facilities-examining-failures-and-evaluating-solutions/.
34. Michael A. Nunno, Lisa A. McCabe, Charles V. Izzo, Elliot G. Smith, Deborah E. Sellers, & Martha J. Holden, *A 26-Year Study of Restraint Fatalities Among Children and Adolescents in the United States*, 51, Child & Youth Care Forum, 661–680, (2022).

Limited oversight

Current state and federal regulations set guidelines for restraint and seclusion use.[35] Seclusion is allowed only when a child's behavior presents a high risk of physical or emotional harm to themselves or others and less restrictive strategies have not worked.[36,37] Restraint is allowed only with processes that follow a nationally recognized program.[38] Facilities inform Licensing that they plan to use these strategies as part of their annual application. Administrative rule requires facilities to document use, including what staff attempted to avoid the strategy.[39]

Licensing reviews facility documentation to determine if facilities are using behavior management strategies properly. By relying on facility documentation, Licensing has a limited view of actual restraint use. A report by staff of the US Senate Committee on Finance details that relying on facility documentation to review the use of seclusion and restraint can limit the ability of entities like Licensing to effectively monitor.[40]

Relying on facility documentation means Licensing has a limited view of actual restraint use.

We found that when facilities had cameras on site, Licensing staff were better able to investigate behavior management strategies. For example, in one complaint about improper staff supervision and training, Licensing was able to substantiate that staff "stood watching without intervening" and "were not trained on physical intervention" because of the footage. The report by staff of the US Senate Committee on Finance suggested that facilities should be required to have cameras everywhere other than bathrooms and bedrooms.[41] Other national entities have expressed concerns about the use of cameras in institutional settings. For example, the Centers for Medicare and Medicaid Services requires that the use of video cameras in intermediate care facilities be reviewed by a special committee to protect client rights.[42]

35. 45 C.F.R. § 410.1304 (2025).
36. Idaho Admin. Code r. 16.04.18 (2023).
37. There is a restriction on the use of isolation for people with developmental disabilities in a different section of statute.
Idaho Code § 66-412 (2025).
38. Idaho Admin. Code r. 16.04.18.460 (2023).
39. Idaho Admin. Code r. 16.04.18.231 (2023).
40. Staff of S. Comm. on Finance, 118th Cong., Warehouses of Neglect, 4, (2024).
41. Staff of S. Comm. on Finance, 118th Cong., Warehouses of Neglect, 7, (2024).
42. Ctrs. for Medicare & Medicaid Serv., *The Use of Video Cameras in Common Areas in Intermediate Care Facilities For*, (2011), https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions-items/cms1250531 .

Do facilities use other high-risk strategies?

Facilities may use physical exercise and physical work assignments as punishment or part of their programming, as long as neither are cruel, unusual, or produce unreasonable discomfort.[43] Some stakeholders reported concerns with facilities use of exercise and work as punishment. Facilities are not required to document their use of these behavior management strategies. Licensing may ask children about them during site visits.

The department should amend administrative rule to require facilities to report restraint and seclusion use to the department.

The Legislature should consider amending statute to require the department to report restraint and seclusion use to the Legislature.

National organizations and other states have explored ways to increase transparency about restraint and seclusion use. For example, Oregon requires that facilities report seclusion and restraint to its licensing entity. The state also passed legislation in 2021 that requires the Oregon Department of Human Services to produce quarterly reports detailing the use of restraints and seclusion.[44] All reports are available on the department's website and one of the reports is produced quarterly for legislative use.[45]

43. Idaho Admin. Code r. 16.04.18 (2023).
44. OR. Dep't. of Hum. Serv., *Restraint and Involuntary Seclusion Report Instruction Guide*, (2023), https://www.oregon.gov/odhs/licensing/childrens-care-agencies/Documents/ris-quarterly-report-instructions.pdf.
45. OR. Dep't. of Hum. Serv., *Restraint and Involuntary Seclusion Reports*, https://www.oregon.gov/odhs/licensing/childrens-care-agencies/pages/sb710.aspx.

Scheduled surveys allow facilities to curate what Licensing staff see.

Study requesters and stakeholders were concerned that Idaho does not require Licensing to conduct unannounced visits of facilities. Stakeholders reported that while scheduled notice gives facilities time to prepare their documents and staff for an interruption to their workflow, it may also prevent Licensing from seeing what the actual day-to-day at a facility looks like.

The department reported a goal to conduct one unannounced visit a year at each facility.

Licensing can conduct unannounced visits. The department reported a goal to conduct one unannounced visit a year at each facility. However, neither statute nor administrative rule require visits beyond a facility's annual scheduled survey. From 2016 to 2024, Licensing documented 11 unannounced visits.[46]

> **I worry about the larger facilities and if a once a year [survey] is enough to ensure the children are safe and thriving.**
>
> **— Facility administrator**

The department should amend administrative rule to require at least one annual unannounced survey.

Some states have implemented requirements for unannounced surveys. Of the 13 states we reviewed, California, Oregon, and Texas required an unannounced site visit as part of the licensing process (see appendix C for more on our review of other states licensure practices). The National Association of Regulatory Administrators also recommends a minimum of two annual surveys, with at least one being unannounced.[47]

46. Licensing began using its current data system in November 2021. Our analysis is an estimate because some information from before that transition was lost or improperly saved.
47. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation, at 46, (2020).

Licensing relies on facility administrators to choose child and staff interviewees which may limit the information they receive.

Licensing staff use interviews to assess compliance with administrative rules that are difficult to assess using documentation alone.

Some administrative rules are difficult for Licensing staff to assess using documentation alone. During surveys, Licensing staff interview children and facility staff to assess how well a facility is in compliance with these rules. We found that the information Licensing staff receive about what is going on in a facility may be limited by their decision to allow facility administrators to choose interviewees.

Licensing staff interview children to understand their experience at a facility. They ask questions about food, sleeping arrangements, and the behavior management strategies the facility uses. Licensing began interviewing facility staff in 2024 after discovering that a facility had misrepresented the duration of staff training in its documentation.

It is the practice of Licensing staff to ask the facility administrator to select which children and facility staff are interviewed. Licensing staff reported that facility administrators are best equipped to know which children are physically at the facility, as some may be at school, and which children would be most willing to speak with an unknown adult. We observed six child and six staff interviews and found that no information was revealed that insinuated a facility was out of compliance with administrative rule. Allowing facility administrators to select interviewees may limit the information that Licensing staff receive about what is actually going on at facilities because certain children and staff may be more aware of or willing to share information.

It is the practice of Licensing staff to ask the facility administrator to select which children and staff are interviewed.

The department should revise the child and staff interview process.

Licensing should establish criteria, such as recent critical incident reports, complaint submissions, or other risk indicators to guide the selection of children and staff to be interviewed (see chapter 3 for more on how Licensing staff can use the information from these reports). In its guidelines for surveys of Intermediate Care Facilities, the Centers for Medicare and Medicaid Services recommends that facility staff not be permitted to select residents to be interviewed or observed and instead criteria should be used to select interviewees.[48]

48. Ctrs. for Medicare & Medicaid Serv., State Operations Manual Appendix J, at 17, (2018), https://www.cms.gov/files/document/surveyor-guidelines.

Licensing does not assess treatment quality.

Study requesters asked us whether the department consistently monitors facility treatment plans. We found that while the department plays a role in monitoring treatment for children in foster care placed in facilities, Licensing has no authority to assess the treatment that children receive in facilities (see more on the department's oversight of children in foster care in chapter 4).

Licensing staff review facility documents to ensure that facilities properly document a child's service plan, including any needed treatment.[49] They do not review whether treatment is being administered in line with that plan, is appropriate for a child's needs, or if children are making adequate progress. While not all facilities provide treatment to children, many do. Unless the entity paying for treatment assesses its quality, or a facility is nationally accredited, no entity assess treatment quality (see appendix D for more on how some facilities have additional treatment oversight).

No entity assesses treatment quality at all facilities.

> **In many cases, facilities are not providing children the care they describe in the children's treatment plans.**
>
> **— Staff of the US Senate Committee on Finance**

The Legislature should consider extending Licensing's authority to include treatment oversight.

The Legislature could create a separate licensure designation for facilities that provide treatment. Some states have separate licensure designations for facilities that provide treatment. For example, Wisconsin licensure distinguishes between group homes and residential care centers. Group homes offer 24-hour care, while residential care centers offer both care and treatment. Wisconsin's administrative rules include specific requirements for facilities that provide treatment. One requirement is that staff must develop a treatment plan within 30 days of a child's admission. The plan must focus on treatment goals and long-term stability.[50]

49. Idaho Admin. Code r. 16.04.18.309 (2023).
50. Wis. Admin. Code § 52.21.9.b.1 (2024).

Children's rights are not enumerated and communicated.

In other facilities in Idaho and in other states, residents are given an enumerated set of rights that must be communicated to them and publicly posted. This informs residents of the minimum standard for how they should be treated, lets them understand when their rights are being violated, and tells them who to contact if their rights are violated. While administrative rule specifies ways that children cannot be treated in facilities, we found that Idaho lacks a set of rights for children in facilities.

Children and parents may be not know how children should be treated.

A set of rights may include the child's right to be free from unwarranted restraint, to participate in their case planning, and to file a complaint or grievance. While these allowances are codified in administrative rule, a set of rights would condense information about how a child must be treated in a facility into one easily accessible and understandable document. Without a specifically enumerated set of rights, children in facilities and their parents may not know how children should be treated.

> "Some children are **not being adequately oriented to facilities and their rights** .
>
> — Staff of the US Senate Committee on Finance

We do not know how many complaints Licensing receives from children and parents each year because Licensing does not collect information about the role of each person who submits a complaint. Licensing staff reported that they rarely receive complaints from children in care.

Can children communicate with people outside of facilities?

Some stakeholders reported concerns that children do not have access to communicating with their families about what is happening within facilities. Administrative rule allows facilities to restrict the contact a child has with outside entities, but requires that parents and guardians be made aware of the restriction. Facility staff cannot read a child's correspondence except with a legitimate and documented reason.[51]

51. Idaho Admin. Code r. 16.04.18.403 (2023).

The department should create a bill of rights for children in residential care and amend administrative rule to require that facilities follow, post, distribute, and interpret the rights for children and their families.

The Legislature should consider amending statute to require that facilities follow, post, distribute, and interpret the rights for children and their families.

The National Association of Regulatory Administrators recommends that statute "clearly define the protective intent" of licensing entities.[52] Many states have instituted a set of rights for children in facilities. For example, New Jersey requires a minimum set of rights and that the rights are posted in prominent locations. New Jersey also requires that facilities give the list of children's rights to parents and staff.[53]

Statute outlines a set of rights for residents in Idaho's assisted living facilities and requires that they be shared with residents and posted publicly.[54] The department also has a set of rights for foster youth that is not codified in state law or administrative rule. The rights apply only to foster youth and do not extend to youth placed in facilities by parents or guardians. Facilities are also not required to post, distribute, or interpret the rights for children.

A bill of rights for children in facilities would not create additional administrative burden, as facilities are already required to share their grievance policies with parents and children.[55] A few facility administrators reported that their facility already shares information about rights with the children in their care.

Facilities are required to share their grievance policies with parents and children.

52. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation, at 42, (2020).
53. N. J. Dep't. of Children and Families, *Manual of Requirements for Residential Care Facilities*, (2023), https://www.nj.gov/dcf/providers/licensing/laws/3A.55.pdf .
54. Idaho Code § 39-3316 (2025).
55. Idaho Admin. Code r. 16.04.18.233 (2021).

Licensing took minimal enforcement actions.

Licensing can issue enforcement actions against facilities when they are not in compliance with administrative rule. We found that Licensing has taken few enforcement actions against facilities.

Licensing conducts annual surveys of facilities to assess compliance with administrative rule. Based on a facility's survey results, Licensing may create a statement of deficiencies that outlines rule violations the facility must address through a plan of corrections. Licensing may also take an enforcement action to ensure the facility takes the necessary steps towards compliance. Licensing's enforcement action options include issuing a

six-month license, which indicates that Licensing will reassess sooner than usual whether deficiencies have been addressed;

provisional license, which indicates that Licensing may take additional enforcement action if deficiencies are not addressed;

ban on admissions, which prohibits admission of children until deficiencies have been addressed;

license suspension, which indicates that a license may be revoked if deficiencies are not addressed; and a

license revocation, which is the equivalent of closing the facility.

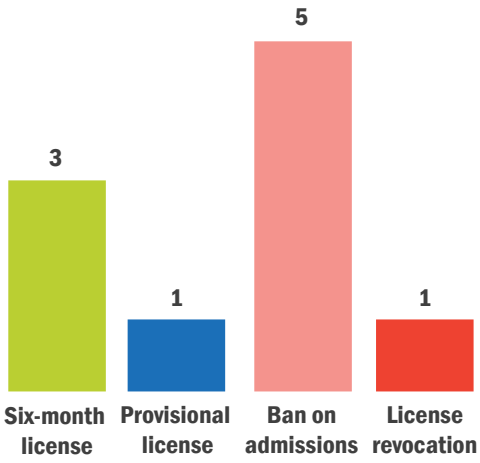
Of the 271 surveys that Licensing conducted from 2016 to 2024, 225 required plans of correction. Only 10 led to enforcement actions (see exhibit 9).[56]

Exhibit 9

Licensing has taken ten enforcement actions in the last nine years.

Licensing enforcement actions from 2016 to 2024.

The one license revocation was repealed during an administrative review process.



We reviewed the violations that each facility received during surveys from 2021 to 2024. The five most common were related to staff training, documentation of medication management, personnel records, compliance with background check requirements for staff, and documentation of medication changes.

Developing criteria to improve enforcement action decisions

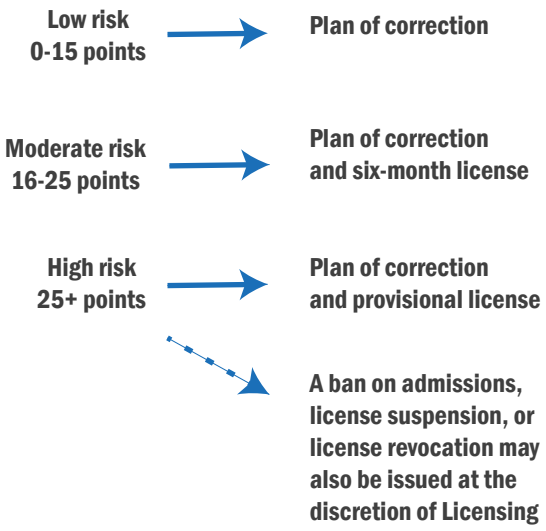
In 2024, Licensing developed and began testing a risk assessment matrix to help staff decide when to issue enforcement actions. Licensing staff described the matrix as a weighted approach that recognizes violations of certain rules place children at greater risk of harm than others. The matrix assigns each rule a risk category based on its likelihood to occur and potential consequences.

56. If Licensing determines there is a health and safety risk to a child, it may issue an expeditious correction which gives the provider 24 hours to implement a correction. Five facilities had expeditious corrections from 2016 to 2024.

For example, failing to record an employee's hire date is considered low risk, while improperly storing medications is considered high-risk. Low-risk deficiencies are worth one point, moderate-risk deficiencies are worth two points, and high-risk deficiencies are worth three points. The matrix assigns each facility a total score based on the sum of each deficiency they receive during a survey. A facility's total points are used to assess its overall risk level and advise Licensing staff on the recommended enforcement action to take (see exhibit 10).

Exhibit 10

The matrix recommends enforcement actions based on risk.



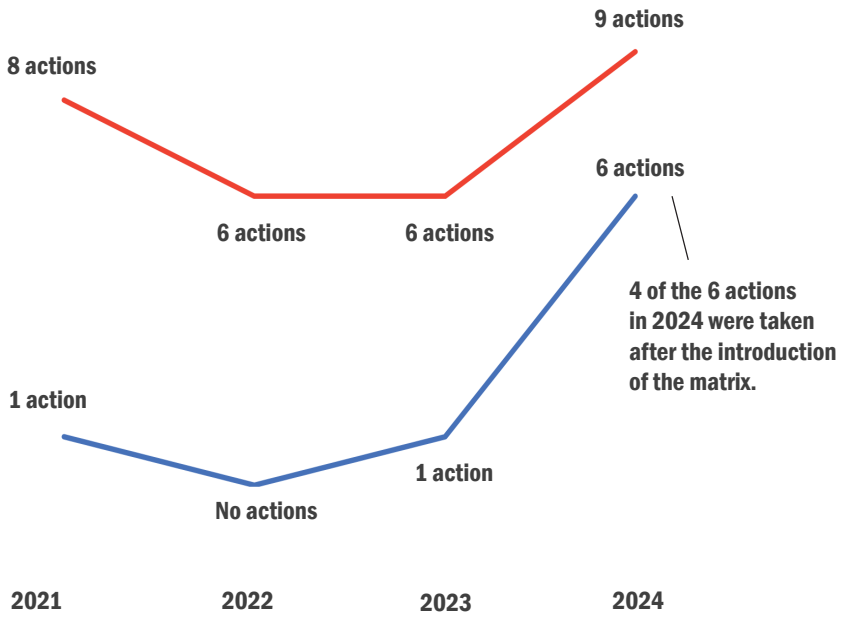
While Licensing staff are not required to follow the recommended action, the matrix helps them make consistent and informed decisions. It also creates an opportunity for them to document why they make a decision that varies from the recommended action. In our interviews, Licensing staff described the matrix as helpful in making more objective decisions.

Licensing has taken more enforcement actions since the introduction of the matrix in August 2024.

Licensing began using the matrix in August 2024. We found that Licensing has taken more enforcement actions since the introduction of the matrix. Licensing retroactively scored a sample of facility surveys as part of its matrix testing process.[57] Out of 74 surveys, they found 24 instances when a facility's survey score would have recommended an enforcement action that was not taken. We furthered Licensing's analysis by retroactively scoring all surveys that resulted in plans of correction from 2021 to 2024. Out of 141 surveys, we found 21 instances where a facility's score would have recommended an enforcement action that was not taken (see exhibit 11).[58]

Exhibit 11

If Licensing had been following its matrix recommendations from 2021 to 2024, it would have taken 29 enforcement actions instead of 8.



OPE application of Licensing's risk matrix to surveys from 2021 to 2024.

57. Licensing staff scored all surveys from 2023 and 2024, all past surveys that had an enforcement action, and a few other randomly selected surveys.
58. Our analysis varied from Licensing's in that we did not have information about when a deficiency resulted in a child needing medical treatment. We also may have considered a deficiency to be repeating more often than Licensing staff would. Licensing staff may also be better equipped to use their professional judgement to retroactively apply the matrix to past facilities and variations of administrative rule.

What do facility administrators think about the matrix?

We had the opportunity to attend multiple meetings between the department and facility administrators. A few administrators expressed concerns over the matrix's point calculations. A few others were concerned about whether a facility's risk score would be made public alongside its survey results. Officials with Licensing explained the matrix and made a few adjustments based on administrator feedback.

The department should make the risk assessment matrix available to the public and facility administrators.

Licensing should make the risk assessment matrix publicly available to facility administrators who can use the matrix to better understand regulations. Licensing could also consider conducting training for facility staff on how to interpret the matrix, understand how Licensing staff use it, and apply it in their compliance efforts.

The National Association of Regulatory Administrators recommends that licensing entities develop guides for use in applying regulations consistently.[59] We agree that the matrix will serve as a tool to help Licensing make objective decisions. The association further describes that enforcement guides allow providers to better understand regulations. Public risk scores (low to high risk) may also help parents and other stakeholders interpret survey results.

59. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation, at 52, (2020).

Licensing does not have a systematic way to respond to information it receives outside of the survey process.

Licensing receives and screens information outside of the survey process. We found that Licensing lacks criteria for when to conduct more expansive investigation on information received in critical incident reports, child abuse calls, and complaints.

Beyond its annual survey of each facility, Licensing receives additional information about what is happening at a facility through

critical incident reports submitted by a facility to Licensing when there is a fire, a child is hospitalized, law enforcement is called, a child attempts suicide, a child is missing or runs away, a child dies, or if an employee is investigated for child abuse or neglect;[60]

child abuse calls made to the CYFS's abuse call line about potential abuse within a facility; and

complaints submitted by anyone to Licensing via phone, email, or an online form.

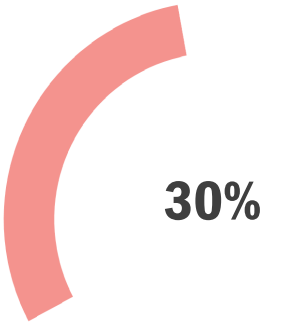
60. Idaho Admin. Code r. 16.04.18.202 (2023).

Licensing staff screen this information and may conduct more expansive investigation if they suspect an administrative rule violation. Licensing staff may review facility documentation, police reports, and video; communicate with the facility administrator or complainant; and interview children and staff.

We reviewed a few examples of child abuse calls. One involved an allegation of sexual abuse by a staff member. Licensing confirmed that the facility placed the staff member on administrative leave while law enforcement conducted an investigation. Another involved an allegation of sexual assault between two children. Licensing found administrative rule violations that resulted in enforcement action against the facility. In March 2022, Licensing began tracking whether complaints received through their online portal were substantiated or not. We found that Licensing substantiated a third of the complaints it received from March 2022 to December 2024 (see exhibit 12).

Exhibit 12

A third of complaints were substantiated.



Of the 70 complaints submitted from March 2022 to December 2024, 21 or 30% were not substantiated.

Our analysis was limited because Licensing was updating its data tracking systems throughout these time periods.

Not every critical incident report, child abuse call, or complaint warrants more expansive investigation by Licensing, as many may not relate to compliance with administrative rule. We found that Licensing does not use criteria to guide when to conduct more expansive investigation and relies on staff discretion. Discretion is important for staff to be able to make case-by-case decisions based on their experience, the specific issue, and the facility. However, criteria may help staff make more informed and consistent decisions about when to conduct more expansive investigation.

The department should develop criteria to guide responses to critical incident reports, child abuse calls, and complaints.

The National Association of Regulatory Administrators recommends that regulatory agencies use information from reports to guide their actions.[61] Similar to Licensing's new risk assessment matrix, criteria could recommend but not require actions. While Licensing staff may be best equipped to develop criteria, we identified two considerations: patterns of reporting and timelines.

Patterns of reporting

Licensing staff may investigate patterns of critical incident reports, like many of the same type in a row. Formal criteria could recommend that Licensing staff investigate when certain patterns arise in critical incident reports, child abuse calls, and complaints. Licensing could investigate facilities:

With no critical incident reports to ensure that proper reporting procedures are being followed. We found that from 2022 to 2024, 9 to 17 facilities submitted no critical incident reports each year.[62] For example, Disability Rights Idaho compared one facility's reports between law enforcement and Licensing and found the facility often did not report required incidents to Licensing.[63]

61. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation, at 39, (2020).
62. At the end of 2021, Licensing started tracking critical incident reports. The first complete calendar year of incident report data was 2022.
63. Disability Rights Idaho reported this incident to Licensing in early 2023 and reported to the Senate Finance Committee in June 2024.
Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions: Hearing Before the S. Fin. Comm., 118th Cong., 5 (2024) (statement of Disability Rights Idaho), https://www.disabilityrightsidaho.org/youth-residential-treatment-facilities-examining-failures-and-evaluating-solutions/.

That fail to submit critical incident reports within the required timeframe of one business day. From 2022 to 2024, we found 32 instances of a facility reporting an incident after one business day.

With repeated critical incident reports, child abuse calls, or complaints. For example, we found that over half of all complaints received from March 2022 to December 2024 only involved four facilities.

The US Government Accountability Office found that licensing agencies will sometimes consider firing a staff member a sufficient resolution while failing to take action against a facility that may have a larger organizational issue.[64] Criteria that takes patterns of reporting into consideration may better help Licensing determine when a facility is facing a systemic issue.

Timelines

Criteria could also recommend timelines for prioritizing and conducting investigations. The National Association of Regulatory Administrators recommends that licensing entities have written guidelines that include timelines for conducting complaint investigations based on severity that ranges from immediate to five days.[65]

Data system limitations

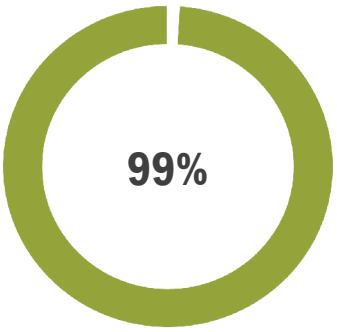
To implement this recommendation, we found that Licensing may need to make improvements to its data system. The National Association of Regulatory Administrators recommends that Licensing agencies maintain an efficient data repository that supports research to strengthen program management, consistency, and quality.[66] We found that Licensing may be limited in its ability to analyze the data it collects. As of March 2024, Licensing is only able to query information from within the last 365 days from its data tracking system. An inability to query data further than one year limits the department's ability to make data driven decisions.

64. U.S. Gov't. Accountability Off., GAO-22-104670, Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities 29 (2022).
65. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation, at 58, (2020).
66. Nat'l. Ass'n. of Regul. Administrators, Best Practices for Human Care Regulation at 55, (2020).

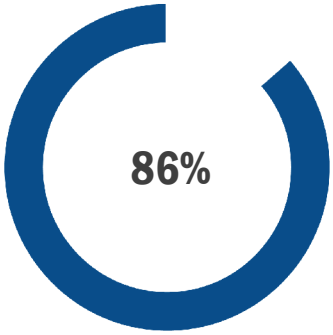
We also found that Licensing's tracking of critical incident reports and child abuse calls may limit their ability to query information about trends at facilities. We analyzed information based on Licensing's current data system and found that most critical incident reports and child abuse calls were labeled as reviewed with no further action taken (see exhibit 13).

Exhibit 13

Most critical incident reports and child abuse calls were labeled as reviewed with no further action taken.



Of the 476 critical incident reports from 2022 to 2024, 471 or 99% were labeled reviewed with no further action taken.



Of the 59 child abuse calls from December 22, 2023 to September 23, 2024, 51 or 86% were labeled reviewed with no further action taken.

Our analysis is limited because Licensing was updating its data tracking systems throughout these time periods.

Licensing staff also reviewed each of the calls we referenced, and reported that 44 involved additional investigation work and only 15 did not warrant additional follow up. This means that Licensing's current data system may be unable to provide information to accurately quantify Licensing's responses to information in critical incident reports and child abuse calls. Accurate quantitative data may be helpful in developing criteria to guide responses to information received outside of the survey process.

4 Children in foster care

In December 2024, 216 Idaho children in foster care in lived in residential care facilities in or out of state. The state spent almost $30 million in 2024 on facility placements. The Idaho Department of Health and Welfare's (department) Division of Children, Youth, and Family Services (CYFS) is responsible for making and overseeing placements. The department's goal is to place children based on their needs. Placement also depends on the availability of settings like foster homes and facilities that provide specific services or treatment. In appendix F, we provide additional data on the department's use of facilities, including state spending, number of children in foster care placed in facilities over time, and demographic information about children placed in facilities.

One of the department's primary goals is to strengthen child welfare. CYFS was transitioning many of its practices to align with this goal during our evaluation. In this chapter, we evaluate the department's oversight of children in foster care placed in facilities and identify areas for oversight improvement. We first discuss three oversight roles:

Contract monitors ensure that facilities meet contract requirements

Case workers manage individual cases of children placed in facilities

The department operates the Payette Assessment and Care Center

We then review concepts related to the department's placement of children in facilities: the use of facilities with open enforcement actions and the way the department tracks the ideal placement for children.

What do contract monitors and case workers do?

Contract monitors

ensure compliance with placement contract terms;

produce quarterly monitoring documents;

assess compliance through site visits, communication with stakeholders, and report reviews; and

receive reports from facilities on safety-related issues for individual children.

Case workers

manage the cases of individual children placed in facilities;

notify contract monitors or Licensing staff when there are safety concerns at a facility;

produce contact and progress notes for children in care;

make contact every 30 days (at school or video call) and visit in-person at facility at least every 60 days; and

receive reports from facilities on safety-related issues for individual children.

The role of contract monitors is unclear.

The department contracts with facilities to place children in foster care in facilities. Administrative rule requires the department to monitor contracts to ensure children's safety, permanency, health, and well-being.[67] Statute and administrative rule also require state agencies to develop and document monitoring tools, communication and escalation plans, and the responsibilities of monitors.[68] We found that CYFS has no internal policy for how to conduct monitoring of placement contracts for children's residential care facilities.

> **One thing [the department] does not do is regulate contract monitoring... There is no policy written down that says monitors have to do anything specific.**
>
> **— Department employee**

We reviewed 409 performance monitoring reports from 2019 to 2024, shadowed 2 contract monitoring visits, and interviewed CYFS staff (see appendix E for more on our document review). We identified the following oversight gaps in the contract monitoring process:

- no defined frequency or scope of communication between monitors and case workers
- no documented procedure for handling issues discovered through monitoring, such as missed health exams
- no communication procedures between monitors and Licensing staff for when to report facility issues
- no documented procedure for responding to serious issues, such as allegations of abuse of a child in foster care
- no minimum requirement for monitors to visit facilities (visits range from every 90 days to over 200 days)
- no requirement for in-person visits (contract monitoring documentation often does not indicate whether visits were on site or virtual)
- no documented corrective action procedure and inconsistent documentation on how issues are resolved

67. Idaho Admin. Code r. 16.06.01.030.11.d (2022)
68. Idaho Admin. Code r. 38.05.01.113.02 (2023)

What is contract monitoring?

Monitors are meant to ensure contract accountability by monitoring compliance with contract terms. In 2013, our office evaluated the state's contract management and recommended formalizing contract monitoring.[69] Idaho now requires regular oversight of contracts. Each agency conducts monitoring and develops internal tools based on contract value and risk.[70]

Contract monitors have no documented corrective action procedure for facilities that are out of compliance with contracts. From 2019 to 2024, we found little evidence of formal, documented corrective action, such as management letters or holds on placement. Instead, verbal corrections and technical assistance were the most used form of corrective action. We did find evidence that monitors follow up on Licensing enforcement actions with facilities.

Although contract monitors do not have a defined role in ensuring child safety, we found that they follow up on safety concerns. For example, after an issue involving two youths, a monitor asked about the facility's safety plan and confirmed that the youth's case worker followed up. In another case, a monitor coordinated with both the facility and the case worker to ensure a youth's needs were met. Monitors may even play a quasi-case management role. For example, division staff reported that they may send a monitor in the case of a safety issue as a first line of response—especially for issues that happen out of state. Monitors often arranged video calls between case workers and children during facility visits, making the monitor the only CYFS employee to actually see the child in person for months at a time.

Unclear roles for contract monitors may create risks in ensuring that every issue receives an adequate response.

While these examples demonstrate the positive contributions that monitors can make to child safety, unclear roles for contract monitors may create risks in ensuring that every issue receives an adequate response. A lack of standard operating procedures means that CYFS relies on the hope that a monitor or case worker will hear about an issue and escalate it to the appropriate entity to respond. While we found examples of effective responses on a case-by-case basis, we were not able to assess the overall effectiveness of monitors as a form of oversight.

69. Office of Performance Evaluations, Strengthening Contract Management in Idaho, (2013), https://legislature.idaho.gov/wp-content/uploads/OPE/Reports/r1302.pdf.
70. Idaho Admin. Code r. 38.05.01.113 (2023)

We also found that monitors' undefined role led to a wide variation in the quality of their documentation. It is CYFS practice that monitors assess each facility on a quarterly basis. We found missing information and inconsistencies in our review of contract monitoring documentation. For example, reports often missed key details, such as the date of the site visit, whether the visit was virtual or onsite, or the monitor's name. Some monitors also reused language from earlier reports without updates, or gave a facility a rating (only used by some monitors) that did not match their written findings. These gaps make it hard to verify whether monitoring occurred, assess the level of oversight, or hold monitors accountable (see appendix E for examples of variation across the documents).

The department should standardize monitoring procedures for children's residential care facilities, including formalizing their role in ensuring child safety.

CYFS should standardize monitoring practices through formal requirements for regular onsite visits, consistent documentation, and the recording of key details, such as the date of each visit and the monitor's name. These steps will ensure timely and consistent oversight, support comparisons across facilities, identify patterns of noncompliance, and improve accountability. CYFS should also develop a formal complaint process and procedures for when and how contract monitors should communicate with case workers. At the time this report was released, the department was developing a tool to standardize monitoring of children's residential care facility contracts.

Case workers are not required to respond to abuse allegations of children in facilities as quickly as for other children in foster care.

Despite having a formal process for case workers to respond when a call is about a child in a foster home, CYFS does not apply this process to calls about children in facilities. CYFS assigns a priority level to each report and follows a specific timeline for case worker responses. We found that when these requirements are not applied to children in facilities, there is a risk that youth do not receive timely support from their case worker when they need it most.

CYFS's practice is to refer calls that come into the child abuse call line about children in facilities to Licensing. This means that when a call is about a child in foster care who is placed in a facility, their case worker is not required to follow response timeline protocols and the call is not assigned a priority level or safety assessor. Based on administrative rule, the response timeline for case workers to respond to calls about children in foster care ranges from immediately to five working days depending on the severity of the issue (see exhibit 14). CYFS policy details that increased contact with children in facilities may be necessary when safety concerns arise but does not provide a specific response timeline.

Exhibit 14

Response priorities are applied to most calls about children in foster care.

The response timeline for case workers ranges from immediately (priority 1) to five working days (priority 3).

Level	Conditions	Case worker response
Priority 1	When a child is in immediate danger involving a life-threatening or emergency situation	Immediately unless directed otherwise
Priority 2	When a child is not in immediate danger, but the referral includes clear allegations of abuse or neglect	Within 48 hours
Priority 3	When a child is vulnerable and could experience harm, like lack of supervision or a hazardous environment	Within three calendar days and must see the child within five calendar days

We found that facility contracts also require facilities to notify case workers immediately when safety-related issues involve a child in foster care, such as a significant medical issue, allegation of abuse, or death. Despite the requirement for notification, there is no requirement for how case workers respond to information from facilities. A facility administrator shared the impact on youth:

> **"The state often seems content to place a child and then let the care facility bear the burden of health and safety. The Department of Health and Welfare should take a more active interest in helping facilities meet the challenges caused by mental health, disabilities or other behavioral and cognitive challenges of the children.**
>
> **— Facility administrator**

While other entities may play a role in responding to safety issues, case workers are ultimately responsible for addressing the needs of the children in their care. Department staff reported that responses to serious issues depend on the situation. This lack of follow-up requirement does not align with CYFS's model which links frequent, high-quality case worker contact to improved outcomes in safety, permanency, and well-being.

We reviewed three time periods across different facilities and found that case workers did not consistently visit children immediately following serious issues, nor did they consistently document issues in case files. The delay between a serious issue and a case worker visit was regularly over a week. It is unclear from the documentation whether other department staff visited. Some of the cases involved youth with increased needs and disabilities.

Case workers did not consistently visit children immediately following issues.

In one case, a child experienced physical harm from a staff member. Although the case worker had visited earlier that month, they didn't visit the child until several weeks later. This visit was via video call.

In a second case, a facility reported inappropriate contact between staff and two children. One child's case worker visited within a few days. The other case worker waited a month to visit the child.

In a third case, someone reported that one child abused another at a facility. A case worker visited one of the children a week later. The other child didn't receive a visit from the case worker for more than two weeks. This visit was via video call.

The department should apply existing response priority requirements to safety-related issues involving children in foster care who are placed in facilities.

Were facility administrators concerned about case worker visits?

Facility administrators reported that case workers were stretched thin, lacked consistency, and had a lot of turnover. Some added that working with case workers to get required documents and signatures sometimes hindered their ability to serve children. One administrator reported that it can be difficult to get timely consent from the case worker when medical care is needed.[71] We recommended in our 2017 report Child Welfare System that the department develop a plan for ensuring staffing levels are sufficient to manage workloads.[72]

> "It can be **difficult to get department staff to respond in a crisis** in a way that is productive."
>
> — Facility administrator

> "Case workers have too many cases on their case load leading them to **not being able to be responsive in emergencies**."
>
> — Facility administrator

Contract monitors also noted communication issues and delays in communication between case workers and facilities.

71. Department staff reported that Senate Bill 1329, passed during the 2024 legislative session, made it more difficult to obtain timely medical care for children in foster care. Idaho S. 1329, 67th Leg., 2d Reg. Sess. (2024).
72. Office of Performance Evaluations, Child Welfare System, at 10, (2017), https://legislature.idaho.gov/wp-content/uploads/OPE/Reports/r1701.pdf.

Children placed out of state have less oversight.

We found that Idaho children who are placed in out-of-state facilities receive less oversight than those placed in state. While out-of-state facilities serve an important role in meeting the needs of children with complex or specialized conditions, CYFS faces challenges in monitoring out-of-state placements. We found the following oversight issues:

- Case workers and contract monitors visit children and the facility in person less frequently
- CYFS has no formal procedure to discover licensing violations of out-of-state facilities
- Less Idaho staff are notified of out-of-state issues as only the case worker and contract monitor are notified

Less frequent visits

We found that case workers visit children in out-of-state facilities less frequently than in-state facilities. For residential placements that occurred partially or entirely during fiscal year 2024, children out of state were one-and-a-half times more likely to experience gaps of more than 60 days between case worker visits.[73]

Until recently CYFS used monitors to visit children in foster care who were placed in out-of-state facilities while case workers joined those visits via video call. Monitors also visit out-of-state facilities less frequently. It is CYFS practice for monitors to visit facilities in person every six months, which is less frequent than the quarterly visits conducted for in-state facilities.

Lower quality visits

CYFS staff reported that out-of-state placements can be traumatic for children who are removed from their communities and placed in unfamiliar environments. The quality of case worker interaction matters to ensure that children feel safe. Community stakeholders and CYFS staff expressed concerns that children placed out of state receive less in-person visits. When visits happen via video call instead of in person, case workers may struggle to assess a child's well-being—especially if the child does not speak or has trouble expressing how they feel.

73. We use the term visit to include all case worker contact including in-person visits, video, telephone, and written.

These challenges are not unique to Idaho. The US Government Accountability Office recently reported that states struggle to monitor youth in out-of-state facilities.[74] Limited resources can make it difficult for staff to conduct in-person visits across state lines. Instead, they must rely on information and reports from the state where the facility is located.

No knowledge of licensing violations or enforcement actions

We found that CYFS lacks access to information about licensing violations of out-of-state facilities. While all facilities must report issues related to youth to case workers and contract monitors, facilities are not required to report licensing violations to either. In Idaho, Licensing staff share deficiency information with CYFS staff, and in-state data is available on Licensing's website. Some out-of-state information may be online, but we heard from CYFS staff that access is limited in some states. Monitors sometimes find deficiencies through searches or by directly reaching out to other state's licensing entities.

> **According to the [out-of-state licensing agency's] website, there have been 11 infractions that are being investigated. I got a hold of the [state's] worker and [they] would not give me any information about the investigations other than [they] will be returning in January to continue [their] assessment.**
>
> **— Monitor report**

Study requesters specifically asked whether the department places kids in facilities that are undergoing investigation for neglect, abuse, and sexual assault. Without reporting requirements for out-of state facilities, case workers and contract monitors may not learn about concerns or investigations of out-of state licensing agencies. This makes it hard to ensure children in out-of-state placements receive safe, high-quality care.

74. U.S. Gov't. Accountability Off., GAO-22-104670, Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities, 16 (2022).

The department should revise the contracts used to place children in out-of-state facilities to require facilities to report licensing information to the department.

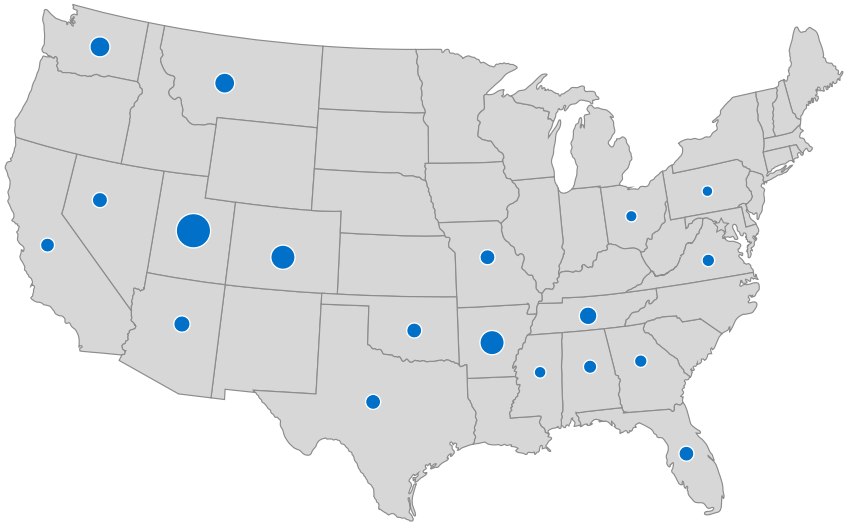
How many contracts are out of state?

From fiscal year 2017 to 2024, the department placed Idaho children in facilities across 19 states. The majority of out-of-state placements were in Utah (see exhibit 15). As of December 2024, the department held open contracts with 18 in-state facilities and 31 out-of-state facilities. Statute allows the department to place children out of state when in-state options cannot meet their needs. In a presentation to the Legislature, department staff explained that many children placed out of state had complex needs, including medical conditions, mental health issues, and substance use. Until recently, Idaho did not have a Psychiatric Residential Treatment Facility, further limiting in-state placement options for children with significant mental health needs (see appendix F for more on the number of children with identified disabilities placed in facilities).

Exhibit 15

Since fiscal year 2017, the department placed children in 19 states.

Utah accounted for 58 percent of out-of-state placements from fiscal years 2017 to 2024.



Some youth have multiple placements in facilities. This map represents the number of placements, not the number of children placed at each facility.

The department should closely monitor its use of a new state-run facility.

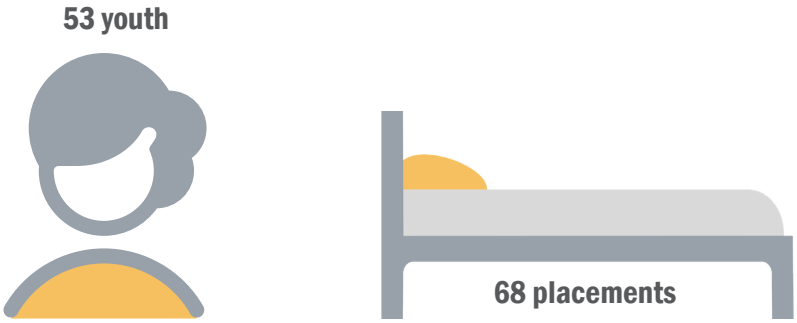
In fiscal year 2024, the department opened a facility called the Payette Assessment and Care Center. While national entities have encouraged the deinstitutionalization of care, Idaho is pursuing a state-run facility to address capacity challenges.

Intent versus use

The department began placing youth in foster care at the Payette Assessment and Care Center in May 2024. By the end of December 2024, 53 youth had a total of 68 placements at the facility (see exhibit 16). The department intended to use the Payette Assessment and Care Center to assess children and identify the best placement to fit a child's needs. CYFS staff reported that it can be difficult to understand the needs of children when they first enter the system. They described the facility as temporary housing for children transitioning into care from other settings like out-of-state placements or juvenile corrections.

Exhibit 16

A total of 53 youth had 68 placements at the Payette Assessment and Care Center from May 2024 to December 2024.



Some youth had multiple placements at the facility because they were placed in a different settings and then returned to the Payette Assessment and Care Center.

Some CYFS staff reported issues in aligning the use of the facility with its intent as a short-term assessment center. Some children who are difficult to find placement for may end up at the facility long-term, even though the facility is not equipped to provide treatment for children with higher needs. From May 2024 to December 2024, the longest placement at the facility was 109 days. The median length of stay was 18 days.

Oversight concerns

We found that the facility faces some oversight concerns. For example, because the facility is operated by the department, it does not have a placement contract. No contract monitors are assigned to visit the facility. While contract monitors may not have a formal role in ensuring the safety of children, we found that monitors often receive and follow up on safety-related information.

The facility was also issued a provisional license in November 2024 following a high-risk survey score. The facility's violations included three staff who did not have background checks on file, two staff administering medications who were not trained to do so, and one staff who worked alone with children without CPR and First Aid training.

The department confirmed in its fiscal year 2026 budget request that the facility did "not have sufficient capacity to meet the growing demand for services offered" at the facility.[75] We also heard from a few community stakeholders that facility staff were not properly trained to administer restraints or work with children with developmental needs. The Governor did not recommend the appropriation of additional staff for the facility, citing a need to evaluate "the effectiveness of operating a state-run facility".[76]

In February 2025, operation of the facility was moved from CYFS to the Division of State Care Facilities. Department staff reported that the change in management structure may help address oversight concerns.

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75. Idaho Legis. Serv. Off., 2025 Legislative Budget Book, at 216, (2025), https://legislature.idaho.gov/wp-content/uploads/budget/publications/Legislative-Budget-Book/2025/Legislative%20Budget%20Book.pdf?ts=1736550793

76. The department also requested $1,750,000 for fiscal year 2026 to purchase the facility. The Governor did not recommend the purchase of the facility.
Idaho Legis. Serv. Off., 2025 Legislative Budget Book, at 216, (2025), https://legislature.idaho.gov/wp-content/uploads/budget/publications/Legislative-Budget-Book/2025/Legislative%20Budget%20Book.pdf?ts=1736550793

The department kept children in facilities with open enforcement actions.

As discussed in chapter 3, when Licensing takes an enforcement action against a facility, it may mean that the facility poses risks to child safety. We reviewed Licensing's enforcement actions and placement data we received from CYFS. We found that children in foster care continued to reside in facilities with active enforcement actions. Of the 10 enforcement actions taken by Licensing from calendar years 2016 to 2025, eight of the actions applied to facilities that housed children in foster care (see exhibit 17).

Exhibit 17

The department used facilities that had open Licensing actions from 2016 to 2025.

Facility	Enforcement action	Date range	Youth at the facility	Youth who exited the facility	Youth who entered the facility
Northwest Children's Home	Ban on admissions	12/7/16 - 5/23/17	7	5	0
Cornerstone Cottage	Ban on admissions	3/19/21 - 6/22/21	8	3	0
East Idaho Youth Homes	Ban on admissions	7/25/24 - 8/14/24	26	1	0
Payette Assessment and Care Center	Provisional license	11/9/24 - 5/9/25	14	11	5
GuidePost Children's Residential Services	6 month license	11/15/24 - 5/14/25	3	0	0
	Ban on admissions	11/18/24 - 2/17/25	3	0	0
Hinge Point Youth Homes	Ban on admissions	7/23/24 - 8/8/24	11	0	0
Mountaintop Behavioral Health	6 month license	9/21/24 - 3/20/25	10	2	3

This table represents the number of youth in foster care at each facility during the enforcement date ranges. It excludes youth who temporarily left and returned to a facility for home visits or hospital stays. More children may have exited a facility after the date range of an enforcement action.

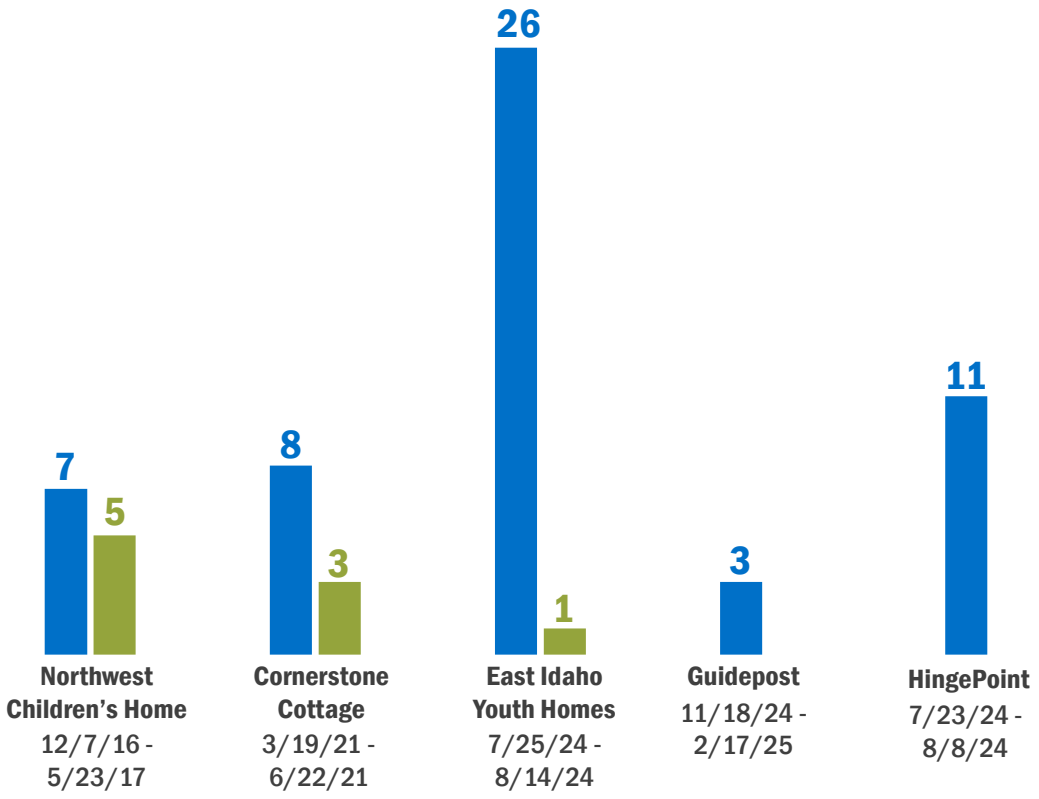
An enforcement action does not automatically mean a facility is unsafe.

While an active enforcement action does not automatically mean that a facility is unsafe, it is one source of information the department can use when deciding whether to keep or place children in foster care in facilities. CYFS staff reported that it is the department's practice not to place children in foster in facilities that have bans on admission. They will also review the children who are already placed at a facility during a ban and decide if a move is necessary. Five of the enforcement actions that applied to facilities that housed children in foster care were bans on admission. We found that no children were placed in a facility during a ban (see exhibit 18).

Exhibit 18

No children were placed in facilities that had a ban on admission.

While youth remained at or exited facilities with a ban on admission, no youth were placed during a ban.



More children may have exited a facility after the date range of a ban.

In chapter 3 we discussed the risk assessment matrix that Licensing staff now use to make enforcement action decisions. We found that when we applied the risk assessment matrix retroactively to calendar years 2021 to 2024, an additional 21 enforcement actions would have been recommended. We reviewed placement records and found that children in foster care resided in 9 facilities that would have had recommended enforcement actions (see exhibit 19).

Exhibit 19

The department used facilities that would have had recommended enforcement actions if Licensing had been following its risk matrix | from 2021 to 2024.

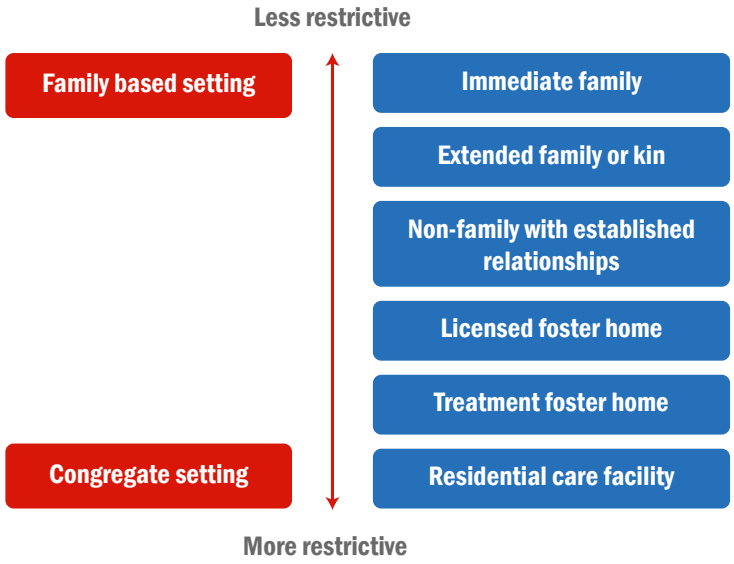
Facility	Date of survey that would have recommended an enforcement action	Youth at the facility
East Idaho Youth Homes	8/27/21	18
East Idaho Youth Homes	8/3/22	20
East Idaho Youth Homes	9/1/23	18
Gustafson House	6/24/21	6
Gustafson House	5/17/22	3
Hinge Point Youth Homes	2/28/23	5
Northwest Children's Home	8/12/21	4
Stewards of Recovery	3/2/23	6
Stewards of Recovery	3/27/24	4

The department does not track placement based on children's needs.

National best practice, as well as federal and state policy, agree that children in foster care should only be placed in facilities when a foster home placement cannot meet their needs.[77,78] The department prioritizes placing children in the least restrictive setting possible (see exhibit 20).[79] The department must also consider access, which means children may be placed in settings that are more restrictive than ideal. The department does not currently track 1) the ideal setting for a child based on their needs and 2) whether placement is due to limited access or because it is the ideal setting. While this information may be captured in case notes, it is not tracked in a way that can be used to assess placement trends. As such, we were not able to quantify how many children placed in facilities may be better served in foster homes.

Exhibit 20

The department's goal is to prioritize the least restrictive placement option.



77. Staff of S. Comm. on Finance, 118th Cong., Warehouses of Neglect, at 9 (2024); Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50741, 132 Stat. 64, 253 (2018).
78. Idaho Admin. Code r. 16.06.01.050.04 (2025).
79. Idaho Admin. Code r. 16.06.01.001.03 (2022).

The department reported in a 2025 legislative committee meeting that it had placed youth in facilities who didn't need that level of care. The department director emphasized the need to move children into foster homes.

Use of short-term rentals

Although we were unable to assess how often children were placed in residential care facilities without a documented need, we do know of one placement type that was not ideal for any child. Beginning in calendar year 2021, the department used short-term rentals to temporarily house children in foster care. The department reported that short-term rentals were a last resort due to a shortage of foster homes. From March 2021 to December 2024, a total of 307 children were placed in short-term rentals. The department maintained an average monthly count of 22 placements in short-term rentals (see exhibit 21).

What was the oversight of children in short-term rentals?

While case workers were assigned to the children placed in short-term rentals and department staff lived at the rentals with children, we found that the short-term rentals had less oversight than a children's residential care facility. For example, short-term rentals were not required to be licensed by the department as either a foster home or residential care facility. The rentals were also not subject to monitoring by contract monitors. In 2024, Senate Bill 1379 limited the department's ability to place children in short-term rentals.[80] The bill also created a requirement for the department to review residential care and short-term rental placements every two weeks. By December 2024, no children in foster care in Idaho were living in short-term rental placements. In 2025, Senate Bill 1035 amended that requirement, allowing the department to review congregate care placements every 90 days.[81] In November 2024, the department announced that they had ended the practice of using short-term rentals.[82]

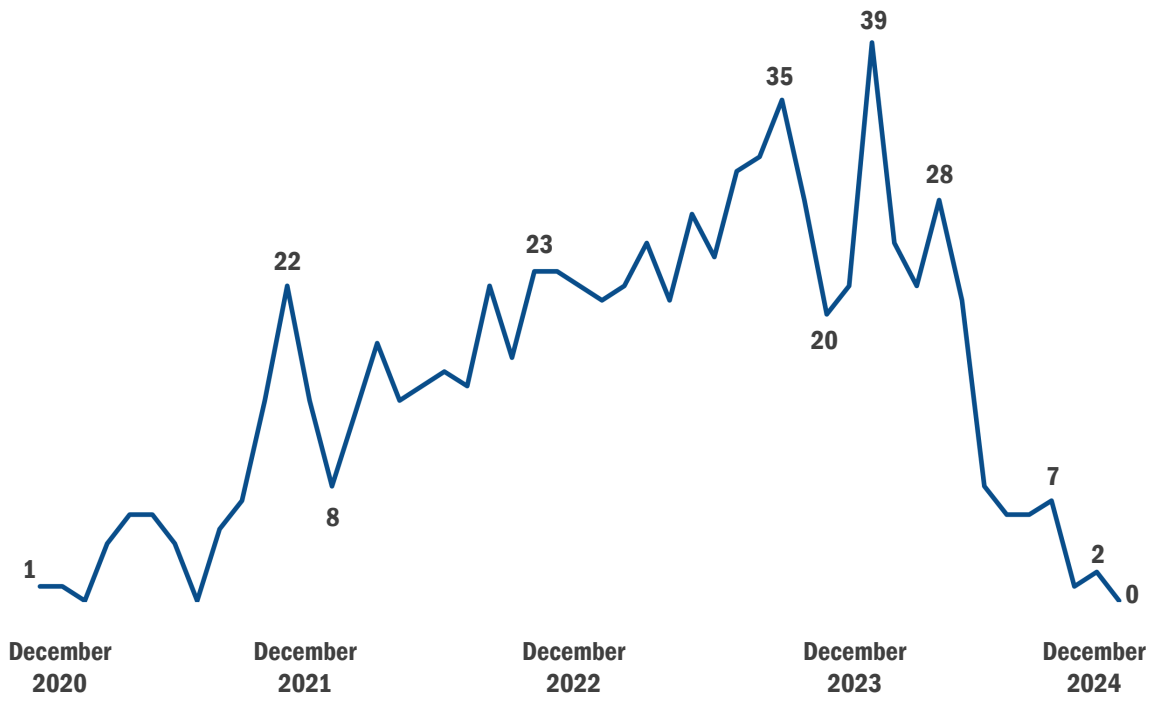
80. Idaho S. 1379, 67th Leg., 2d Reg. Sess. (2024).
81. Idaho S. 1035, 67th Leg., 3d Reg. Sess. (2025).
82. Idaho Dep't of Health and Welfare, *DHW successfully ends temporary housing program for youth in foster care*, (November 2024), https://healthandwelfare.idaho.gov/news/dhw-successfully-ends-temporary-housing-program-youth-foster-care.

> **CYFS has experienced a shortage in foster homes.** When foster homes cannot be found, short-term rental housing and rotating staffing have been implemented to supervise children.
>
> — Fiscal Year 2021 Annual Legislative Foster Care Report

Exhibit 21

During the peak period of use from October 2021 to May 2024, there was an average of 22 placements a month in short-term rentals.

Monthly count of total placements in short-term rentals from December 2020 to December 2024.



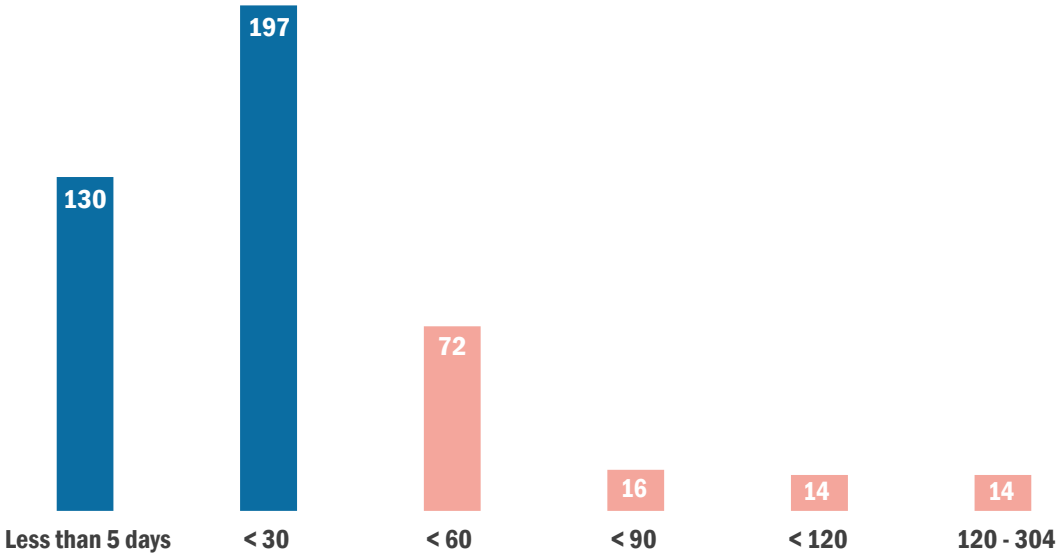
Some youth may have had multiple placements in short-term rentals. This chart represents the number of placements, not the number of youth placed.

Although short-term rentals were intended to be a temporary solution, we found that more than 100 placements lasted longer than 30 days (see exhibit 22).

Exhibit 22

More than 100 short-term rental placements lasted longer than 30 days.

From December 2020 to December 2024, count of short-term rental placements grouped by length of stay in days.



Some youth may have had multiple placements in short-term rentals. This chart represents the number of placements, not the number of youth placed.

While we do not know what the ideal placement would have been for children placed in short-term rentals, we found that when the department ended the use of short-term rentals most of those children were moved to facilities (see exhibit 23). The department reported that part of the reason they were able to end the use of short-term rentals was the creation of the Payette Assessment and Care Center. We analyzed short-term rental exits from April 2024 to December 2024 and found that twelve children that exited short-term rentals were moved directly to the department's new assessment center. An additional six children who exited short-term rentals to other placements ended up at the Payette Assessment and Care Center at some point prior to December 31, 2024.

Exhibit 23

Of the 57 placements that exited short-term rentals from April 2024 to December 2024, 74 percent were moved to residential care facilities.

Subsequent placement	Count of placements	Percent of total placements
Residential care facility	42	73.68%
Non-relative foster care	6	10.53%
Detention	4	7.02%
Hospital	2	3.51%
Supervised independent living	1	1.75%
Aged out	1	1.75%
None	1	1.75%

The department should track the ideal placement type for children in care.

Without better tracking of a child's needs and required level of care, the department cannot assess the quantity of children being improperly placed in facilities or the level of need for certain types of care settings. Some states have taken steps to ensure that children only enter residential care when it is necessary. For example, under Minnesota's 3rd Path program, a formal assessment determines both the level of care a child needs and whether residential care is medically necessary. Federal guidance also recommends using a formal process to review assessments and placement decisions to ensure children receive the right level of care.

In 2024, the department created a Continuum of Care Bureau to improve assessments of children entering facilities and match children with the care setting. The department should consider assigning the responsibility of formally documenting the need for residential care placements to the Continuum of Care Bureau in a way that would allow the department to assess placement trends. The department should also consider including all staff who work with children, like the contract monitors and case workers, in that assessment process.

A Study request

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Idaho State Senate

SENATOR ALI RABE

OPE Request

Idaho's Residential Care Programs for Children and Youth

The reason for this request stems from reported concerns about the safety and welfare of children and youth living in Idaho's residential programs.

Recent news articles by InvestigateWest, a nonprofit investigative journalism organization, detailed years of concerning reports at a facility for girls, where most of the clients were in Idaho's foster care system. The reports revealed the state's lack of oversight at this facility and disturbing incidents of girls being raped, assaulted, physically and/or medically restrained against protocol, or harassed by untrained staff. The news organization also released state investigation records that suggested the state's lack of oversight at this facility was not out of the ordinary. State regulators had found serious concerns with several similar facilities in the last decade, yet regulators continued to let them operate. Further investigation indicates that Idaho has no record of suspending or shutting down a youth residential program, despite repeatedly finding children in danger.

Finally, the report reveals investigations into complaints over the past decade have shown that the state's lack of oversight at the facility described above is typical. State regulators identified significant issues at several similar residential facilities in the last decade. In spite of this, the Department allowed these facilities to continue operating.

Idaho's laws for monitoring these programs do not mandate that the Department of Health and Welfare have a comprehensive understanding of the conditions inside, as the state only requires one announced licensing inspection per year, which is scheduled in advance. In contrast, other states require multiple unannounced inspections. As an example, the Idaho Department of Juvenile Corrections (IDJC) has chosen not to contract with specific facilities due to increased safety risks while the Department continues to send youth in their custody or youth with behavioral health issues to these same facilities. Insufficient monitoring of facilities under contractor monitoring by the Division of Licensing and Certification under the Department of Health and Welfare does little to ensure that Idaho's residential

care programs for children and youth are delivering safe, quality care for their residents, positive outcomes for families or using taxpayer funds responsibly.

We are seeking examination of how well the Department of Health and Welfare investigates complaints, conducts on-site surveys, and takes appropriate licensure action to protect the health and safety of vulnerable children receiving residential services. We hope the evaluation will shed light into:

1. Incident Reports: How well does the Department handle incident reports involving harm, sexual assault, and mistreatment? Do the actions taken by the Department actually reduce the risk of harm?

2. Placement Decisions: Does the Department send Idaho's vulnerable youth to residential facilities that are undergoing open investigations for neglect, abuse, and sexual assault?

3. Inconsistencies in Practices: Does the Department consistently monitor facility treatment plans, training records, policies and procedures, standards of care, and other requirements found in rule for licensing? Or, does the Department's practices allow substantial and ongoing discrepancies between records and what is actually happening in the facility?

We are looking to the Office of Performance Evaluations to develop recommendations to ensure the Department of Health and Welfare's Division of Licensing and Certification is functioning effectively as applied to Children Residential Care Facilities, Children's Therapeutic Outdoor Programs, and Psychiatric Residential Treatment Facilities (PRTFs).

Thank you for your consideration,

Senator Alison Rabe

Senator Julie VanOrden

Senator Melissa Wintrow

Representative Marco Erickson

B Scope

This evaluation will

define Idaho's current regulatory framework for children's residential care facilities;

assess the department's handling of incident reports, monitoring of facilities, and placement of children;

identify and consider best practices for regulation of children's residential care from other national and state entities;

assess the distribution of responsibilities across department divisions;

assess the department's approach to making policy and practice changes;

develop findings and recommendations to promote continuous improvement.

C Methods

Our evaluation involved a literature review, stakeholder engagement, and data analysis. This mixed methods approach allowed us to triangulate findings across varied sources.

Literature review

We reviewed national literature, licensing practices in other states, and documents from the Idaho Department of Health and Welfare (department).

National documents

We gathered data and information from a variety of sources, including articles, annual reports, press releases, congressional hearings, and materials from federal organizations like the Department of Health and Human Services and the US Government Accountability Office. We focused on publications related to youth in residential care, child welfare, and Medicaid.

Licensing best practices

The US Government Accountability Office has made recommendations for the Department of Health and Human Services to provide more technical assistance and facility information sharing among states to prevent and address maltreatment in residential care. One impact of this recommendation is to find and promote best practices within the oversight of children's residential care. In the absence of information sharing, states have developed distinct systems and regulations for overseeing children's residential care, with each system varying greatly from the next. We conducted a multiple state review of licensing practices for children's residential care facilities. There is a significant difference between states in practice.

We reviewed the following state's licensure practices. We selected these states based on geographic location, unique oversight models, national attention or reforms in residential care, and the availability of online information.

California	Ohio
Idaho	Oregon
Maine	Texas
Minnesota	Utah
Montana	Washington
Nevada	Wisconsin
New Jersey	Wyoming

Department documents

Alongside statute and administrative rule, we reviewed documents from the department including standard operating procedures and other process documents. From the Division of Licensing and Certification, we requested and analyzed

- all annual licensure applications (43), letters of no deficiency (43), technical assistance forms (42), critical incident report summaries (499), complaint summaries (23), licenses (296), and plans of correction (225) from July 2016 to December 2024;
- an Excel file with complaint information from July 2016 to March 2022 and a custom report with summary complaint information about complaints from December 2023 to December 2024;
- a sample of 4 child abuse call summary reports from 2021 to 2024 and a custom report with summary information about abuse calls from December 2023 to September 2024.

In chapter 3 we discuss a risk assessment matrix used by Licensing staff. The matrix assigns each administrative rule a risk category based on its likelihood to occur and potential consequences. We retroactively scored all plans of correction from 2021 to 2024 using the matrix. Our application varied from Licensing's in that we did not have information about when a deficiency may have resulted in a child needing medical treatment. We also may have considered a deficiency to be repeating more often than Licensing staff would. Licensing staff may be better equipped to use their professional judgement to retroactively apply the matrix to past facilities and variations of administrative rule.

Our review was limited by the division's data retention practices. In November 2021, the division began using their current data system. Some information from before that transition was lost or improperly saved.

From the Division of Children, Youth and Family Services, we requested and analyzed

- all contract monitoring documents (409) from 2019 to 2024 (see appendix E for more on our review of contract monitoring documentation);
- a sample of 7 case files for specific children in care.

Our review was limited by the retention schedule for children's residential care contracts. The retention schedule for children's residential care contracts allows for documents to be destroyed three years from the final date of the invoice from the contract and most data available is limited from 2021 to 2024. We identified several contracts we did not have from placement-level data.

From the Division of Medicaid, we requested and analyzed

- monitoring reports, complaint trackers, and funding trackers from July 2024 to November 2024;
- the contract with Magellan, including documents that Magellan uses to interface with facilities.

Our review was limited because the department was in the beginning stages of its contract with Magellan at the time of our evaluation.

Stakeholder engagement

Interviews

We interviewed 66 individuals including department employees, legislators, community stakeholders, families who experienced children's residential care in Idaho, and facility administrators. Interviews were our primary method of learning about community stakeholder experiences with the children's residential care system. We also used interviews to learn about the department's processes, which we corroborated with other sources of information.

Facility site visits

We visited six residential care facilities. We shadowed four Licensing surveys. We witnessed Licensing staff touring facilities, reviewing facility documentation, and interviewing children and staff. We also shadowed two contract monitoring visits. We witnessed contract monitors interacting with facility administrators about contract requirements and the care of children.

Facility administrator questionnaire

In February 2025, we sent a questionnaire to the administrators of the 31 active children's residential care facilities at that time to learn about their experiences as providers. We included both open-ended and multiple-choice questions about their facility's relationship with the department, outlook on child safety, and specific services. By the end of March, we received 21 responses.

Data analysis

We requested individual, case-level data from the department's Division of Child, Youth, and Family Services to better understand the department's use of residential care. Our request included placement and demographic data for all children in foster care who experienced at least one residential care placement from July 1, 2016, to December 31, 2024. The request allowed us to analyze data for the entire population of children with residential placements across eight state fiscal years and the first half of fiscal year 2025.

Children in residential care facilities

From the initial data received, we refined our study population to focus specifically on children who experienced the following types of residential care placements:

Group Home
Children's Treatment Facility
Alcohol/Drug Treatment Facility

We included children in our data set who had experienced at least one placement in a residential care facility each fiscal year (see exhibit 26).

Exhibit 26

Our data set included children who had experienced at least one residential care placement.

FY	Count of children
2017	216
2018	238
2019	258
2020	275
2021	371
2022	302
2023	372
2024	447
First half of 2025	302

Children in short-term rentals

We also analyzed the department's use of short-term rentals. We did not include short-term rentals in our analysis of residential care placements because the rentals did not fall under Licensing and Certification's definition of children's residential care. In the data provided by the department, we found 307 children had placements in short-term rentals from March 2021 through November 2024.

Data limitations

We chose to focus our analysis on children who experienced residential care at least once during their time in foster care. However, because of this choice, we were unable to draw any comparisons to the population of children in foster care without residential placements. Quantitative analysis of system data is also limited by human error that can occur during data entry, querying, cleaning, and rejoining of data sets.

D Qualification and accreditation

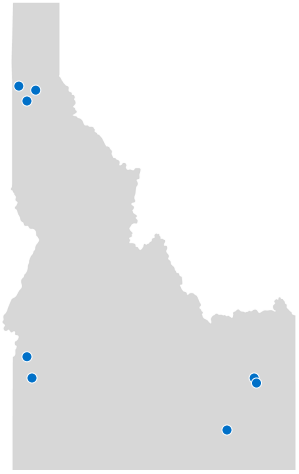
Some facilities pursue qualification by the Idaho Department of Health and Welfare (department) as a Qualified Residential Treatment Program. Some pursue accreditation from a national entity. These facilities must comply with additional standards.

Qualification

In 2018, the Family First Prevention Services Act specified that federal funds may only be used to place children in Qualified Residential Treatment Programs that use a trauma-informed treatment model, have registered nursing staff, facilitate participation of family members, and are accredited by a national accreditation entity.[83] In March 2025, Idaho had eight Qualified Residential Treatment Programs (see exhibit 27).

Exhibit 27

Idaho had eight Qualified Residential Treatment Programs.



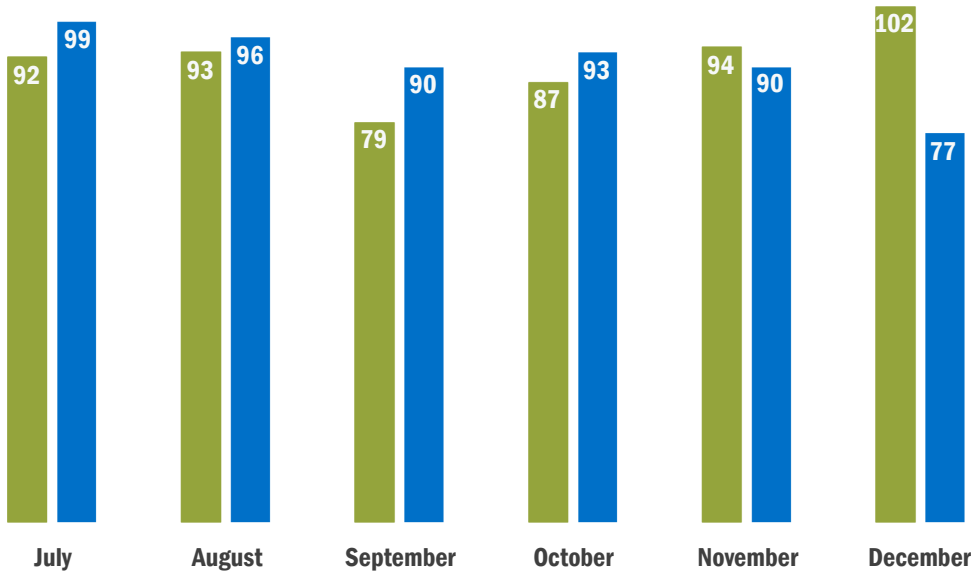
83. Cong. Rsch. Serv., Family First Prevention Services Act, (2018), https://www.congress.gov/crs-product/IN10858.

We found that 50 percent of the in-state residential care placements made by the department in the first half of fiscal year 2025 were in Qualified Residential Treatment Programs (see exhibit 28).

Exhibit 28

In the first half of fiscal year 2025, 50 percent of all in-state placements made by the department were in Qualified Residential Treatment Programs.

Monthly count of Idaho residential care placements in Qualified Residential Treatment Programs and non-Qualified Residential Treatment Programs.



Accreditation

There are several accrediting organizations for children's residential care. The most common are the Commission on Accreditation Facilities, the Joint Commission on Accreditation of Healthcare Organizations, and the Council on Accreditation. Accreditation provides an additional level of oversight of facilities by requiring adherence to additional standards (see exhibit 29).

Exhibit 29

Each accrediting organization has a set of standards that a facility must meet.

Entity	Purpose	Example of standard
Commission on Accreditation Facilities	"A review to determine if the programs and services offered meet defined international standards of quality in health and human services."[84]	A risk assessment for each child served is conducted at the time of admission. It identifies suicide risk, risk of self-harm, risk of harm to others, and trauma. It results in a personal safety plan when risks are identified.
The Joint Commission on Accreditation of Healthcare Organizations	"The objective evaluation process of organizational compliance to performance standards designed to inspire and improve quality and safety."[85]	The organization performs screenings and assessments. Examples include risk assessments of the individual served and of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and threats from another person.
Council on Accreditation	"An independent, objective, and reliable verification that organizations and programs qualify for the confidence and support of their stakeholders. It involves a detailed review and analysis of an organization or program's administrative functions and service delivery practices. All are measured against international standards of best practice."[86]	The comprehensive assessment includes an evaluation for risk of suicide, self-injury, neglect, exploitation, and violence towards others.

In Idaho, at least 13 facilities are currently accredited by one of these entities. While accreditation does require additional work for facilities, many facility administrators reported that accreditation helped their facility develop and maintain standards.

84. Commission on Accreditation Facilities, *Accreditation,* (2025), https://carf.org/accreditation.
85. The Joint Commission, *Accreditation*, (2025), https://www.jointcommission.org/what-we-offer/accreditation/.
86. Social Current, *COA Accreditation*, (2025), https://www.social-current.org/impact-areas/coa-accreditation/#:~:text=COA%20Accreditation%20is%20a%20powerful,practices%2C%20and%20incorporating%20community%20voice.&text=Accreditation%20promotes%20trust%20and%20reassures,%2C%20government%20agencies%2C%20and%20clients.

E Contract monitoring documentation

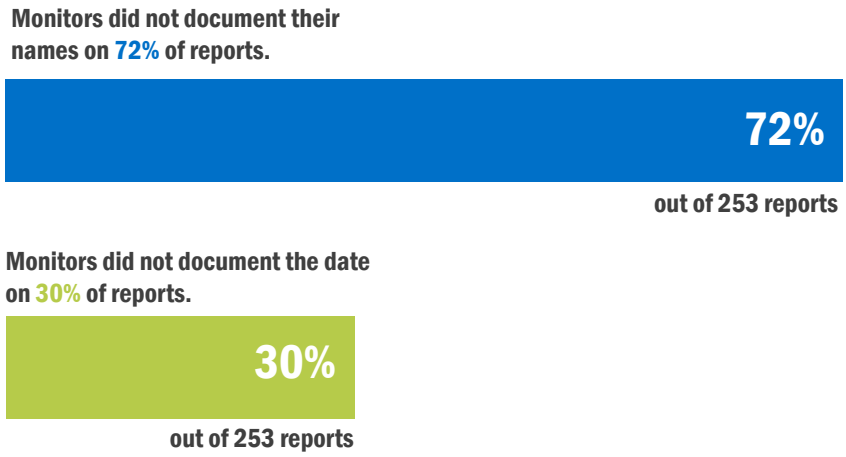
We reviewed 409 performance monitoring reports from calendar years 2019 to 2024. We found information was often missing or incomplete, documentation was inconsistent among monitors, and some reports appeared to be duplicates of previous reports.

Missing information

Thirty percent of in-state reports lacked site visit dates or had unclear date ranges, making it hard to verify if monitoring actually happened every quarter like department practice aims for (see exhibit 30). We also found documents, including those for out-of-state monitoring, that didn't say whether the site visit was virtual or on-site, making it hard to understand the level of oversight for each visit. Additionally, 72 percent of in-state reports did not include the monitor's name (see exhibit 30). While each contract is assigned a specific monitor, staff changes or absences may mean different people conduct monitoring visits. It was also unclear when multiple monitors visited together.

Exhibit 30

Monitoring documentation did not always have monitor names and dates.



Inconsistent documentation

We also found that monitors tracked compliance and recorded performance in different ways, leading to inconsistent levels of documented oversight. For example, some of the reports had ratings like "Met/Not Met Expectations" with explanations, while other reports only included written narratives. In some cases, the ratings did not match the explanations, making it unclear whether the facility actually met expectations (see exhibit 31).

Exhibit 31

Ratings do not always match the narrative of findings.

Example monitoring report indicating that the facility did not meet expectations, despite a positive narrative of findings.

Performance metric	Met required level of expectation?	Narrative of findings
Quarterly Progress Reports	No	Progress Reports are being completed with good detail. [Facility] is providing very good independent living assistance.

We found that monitors do not consistently document how non-compliance issues and complaints were resolved. For example, we found that monitors recorded complaints in monitoring reports but failed to include resolution details in subsequent reports.

F State use trends

In this appendix, we provide data on the state's use of residential care facilities for children in foster care. We include information on the following trends:

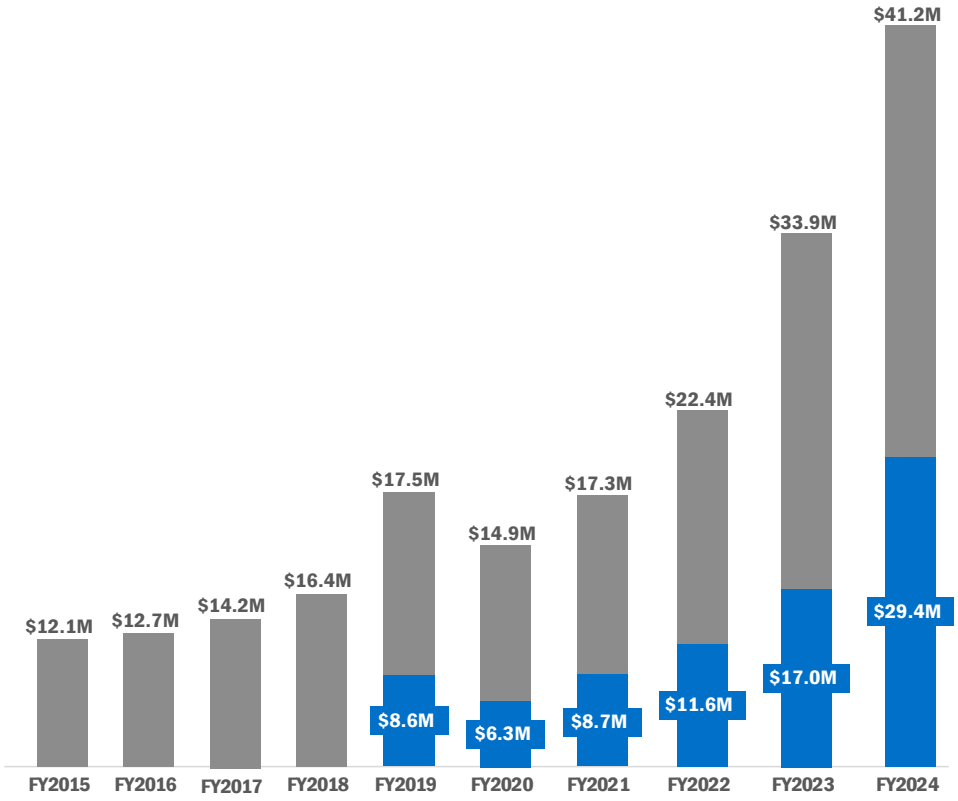
1) More spending on residential care
2) More children in residential care
3) More total placements
4) More children with identified disabilities
5) Improved final dispositions

1) More spending on residential care

Foster care and residential care expenditures have steadily risen since fiscal year 2021 (see exhibit 32). Average annual spending increased 78 percent, from $14.6 million (from fiscal years 2015 to 2019) to $25.9 million (from fiscal years 2020 to 2024).

Exhibit 32

Foster care and residential care spending rose significantly from fiscal years 2015 to 2024.



This chart uses data presented by the department. It may include some placement types that are not residential care facilities.

The cost of placing a child in foster care may come from general fund dollars, federal Child Protection Act dollars when a facility is a Qualified Residential Treatment Program, or federal Medicaid dollars depending on the services the child is receiving. We found that the department has a policy goal of using Medicaid dollars to support children who are in foster care in residential care placements more often. At the end of December 2024, Medicaid dollars were at least partially covering services for 42 children in foster care.

The average daily rate for in-state contracts in Qualified Residential Treatment Programs was lower in 2021 and 2022 but increased to $50 higher than non-qualified programs in 2023 and 2024 (see exhibit 33).

Exhibit 33

The average daily rate for contracts to place children in Qualified Residential Treatment Programs (QRTP) in state was higher in 2023 and 2024.

Year	Non-QRTP	QRTP	Rate difference
2021	$284	$270	-$14
2022	$314	$321	$7
2023	$333	$391	$58
2024	$330	$385	$55

The daily rate at each facility covers essentials like food, clothing, hygiene, transportation, and some therapy for the child in care. In Idaho, daily rates for children's residential care range from $225 at a facility that does not provide treatment to close to $696 at a Psychiatric Residential Treatment Facility. Higher costs may be due to more complex treatment needs and additional therapy services. Out-of-state facilities are more expensive, with daily rates ranging from $333 to close to $798.

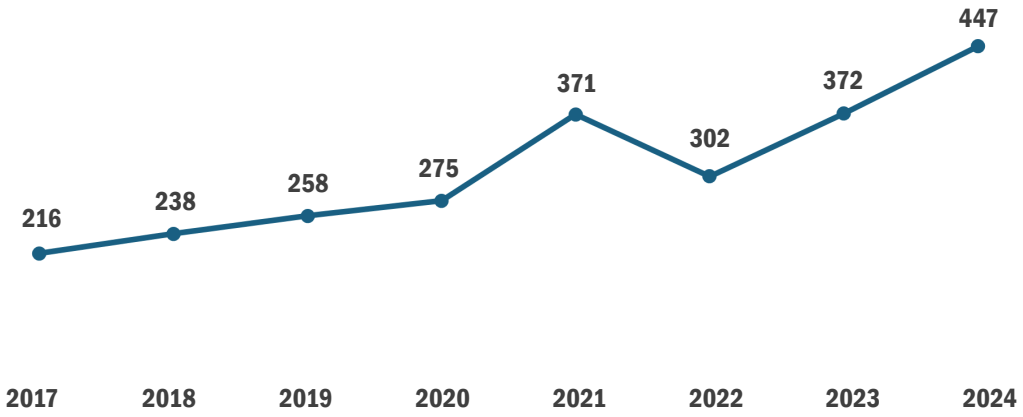
2) More children in residential care

We analyzed data from Children, Youth, and Family Services to understand how many children in the foster care system were placed in residential care since fiscal year 2017 (see appendix C for a detailed explanation of our data request and methods). A total of 1,493 children experienced at least one residential care placement from July 1, 2016 to December 31, 2024 (see exhibit 34).

Exhibit 34

The total number of children with at least one residential care placement more than doubled.

Count of youth in foster care with at least one residential care placement for each fiscal year from fiscal years 2017 to 2024.

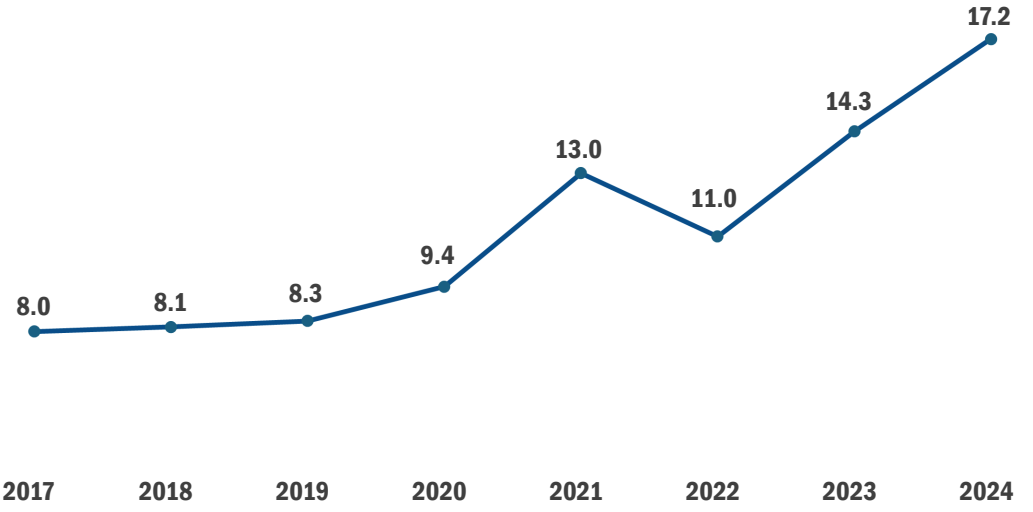


The proportion of youth in foster care who experienced residential care has also more than doubled (see exhibit 35).

Exhibit 35

The proportion of youth in foster care who experienced residential care increased from 8 to 17 percent.

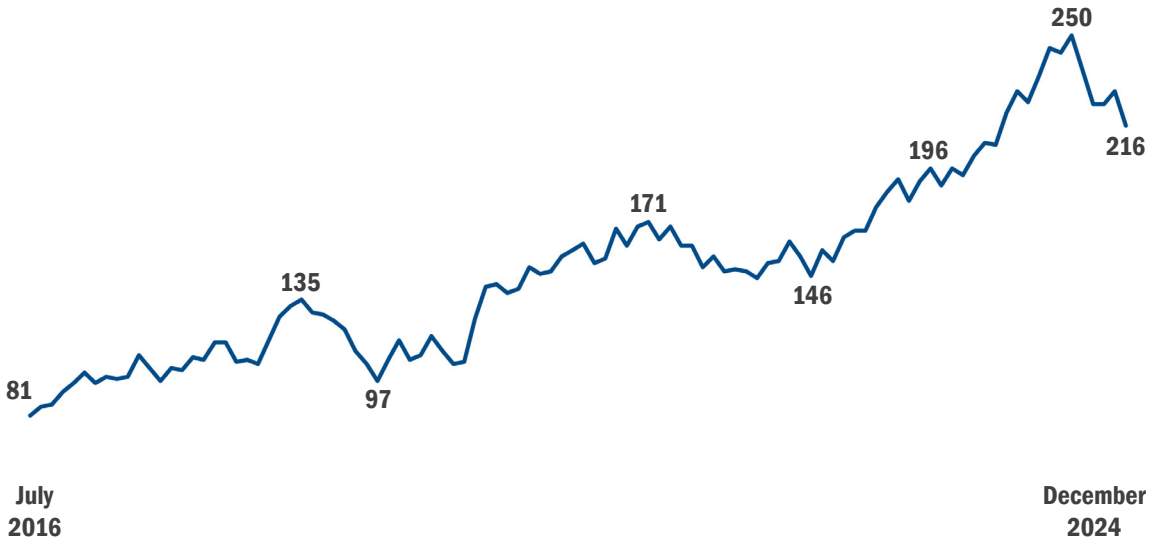
Percentage of youth in foster care with at least one residential care placement per fiscal year from fiscal years 2017 to 2024.



The monthly count of youth in residential care steadily increased since July 2016 with some dips in the first year of the COVID-19 pandemic and again in late 2021 and early 2022 (see exhibit 36).

Exhibit 36

The monthly count of youth in residential care steadily increased from July 2016 to December 2024.



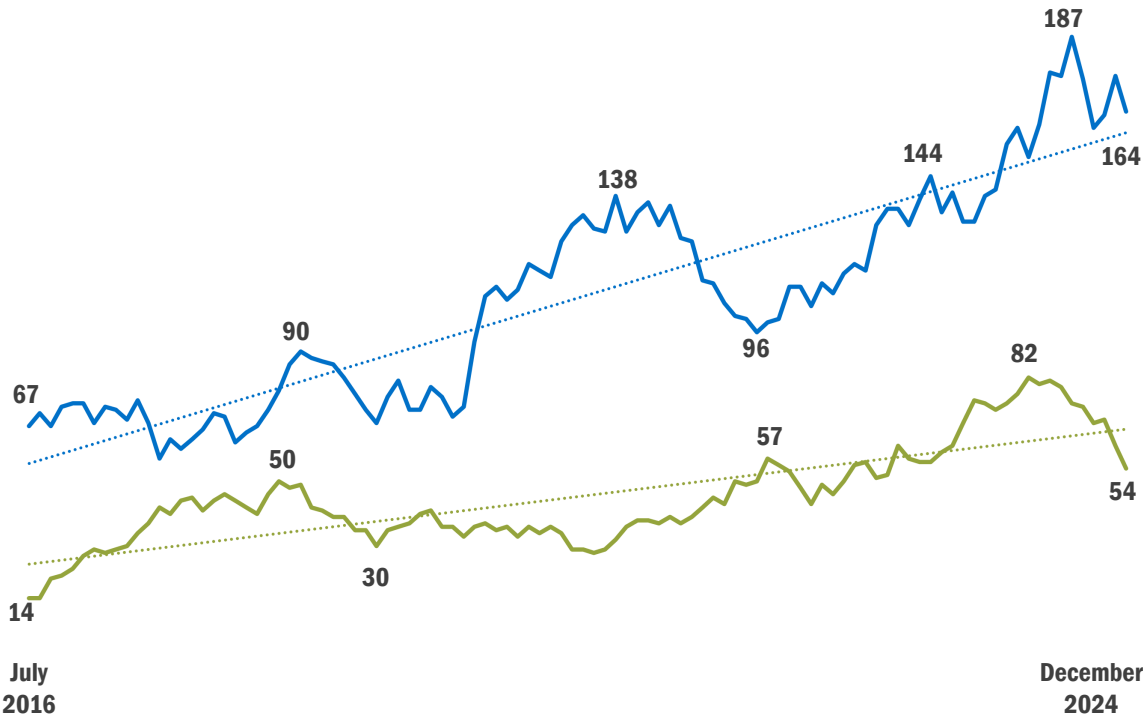
The majority of children experience residential care in state. However, the use of out-of-state facilities has increased over time. In December 2024, 54 youth were placed in out-of-state facilities (see exhibit 37).

The use of out-of-state facilities has increased over time.

Exhibit 37

The count of youth placed in state has increased by 145 percent and out of state has increased by 293 percent.

Monthly count of youth in foster care with at least one residential care placement from July 2016 to December 2024.



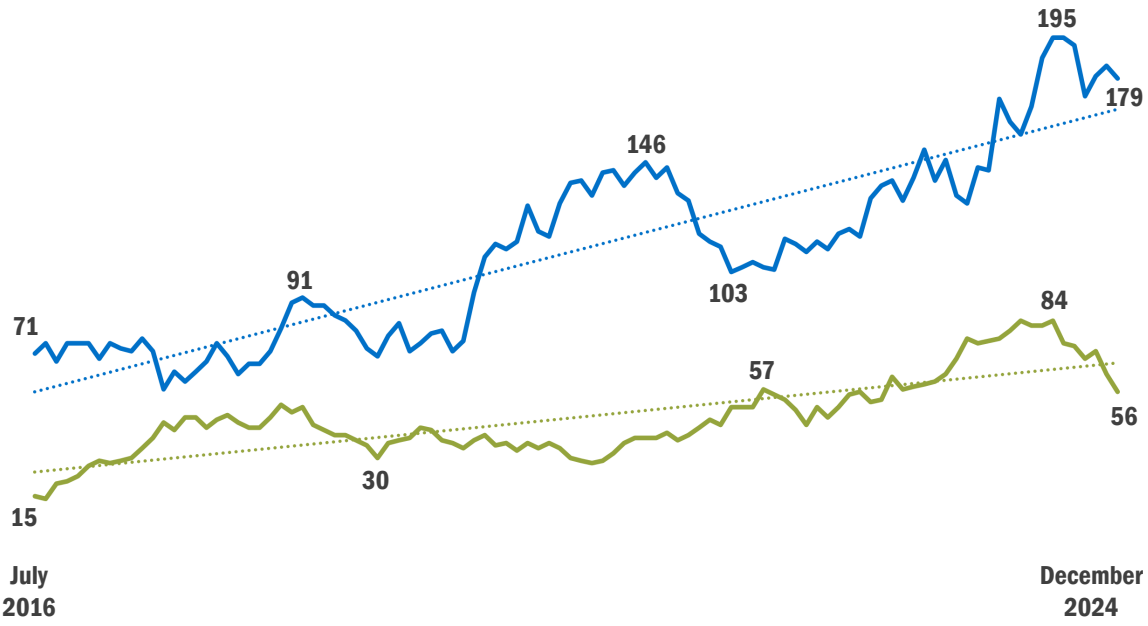
3) More total placements

In addition to more children experiencing residential care, we also found the total number of monthly placements rose. Some children experienced more than one residential care placement each month. They may have had an unsuccessful foster care or other residential placement because their behaviors could not be managed (see exhibit 38).

Exhibit 38

In-state placements have increased by 152 percent and out-of-state placements have increased by 273 percent.

Monthly count of residential care placements for youth in foster care from July 2016 to December 2024.



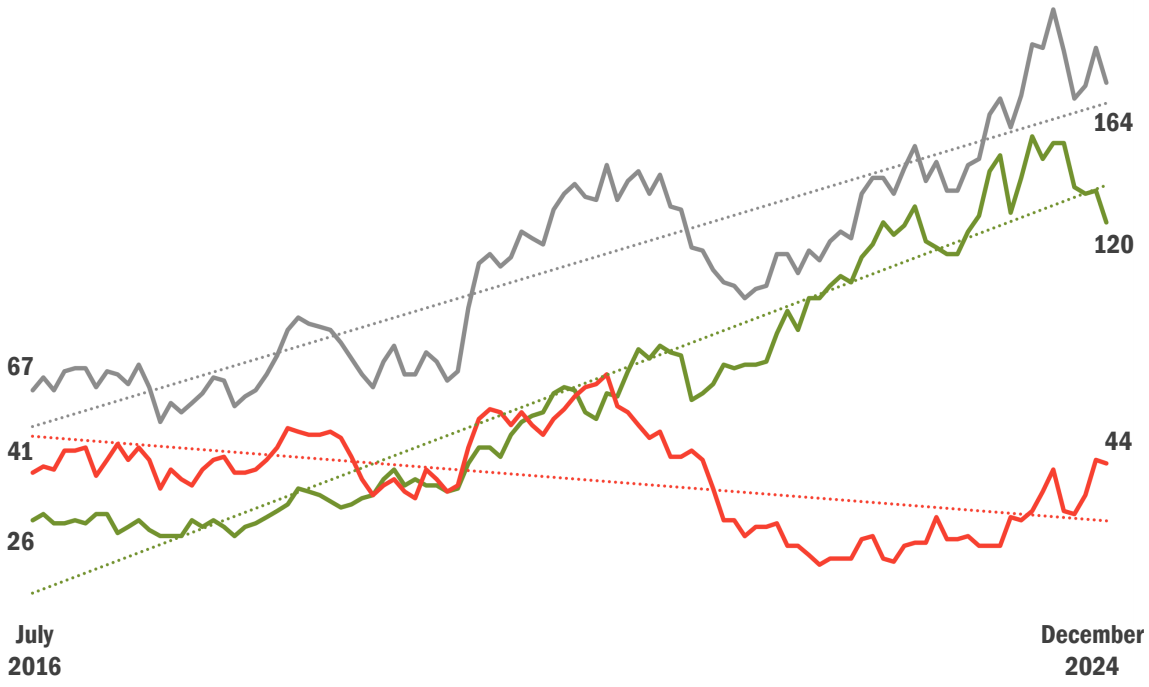
4) More children with identified disabilities

We found that over time, the proportion of children placed in Idaho facilities with identified disabilities increased (see exhibit 39). This may reflect an increase in the actual number of children with disabilities. It may also be explained by the department's data system improvements and more consistent identification of disabilities by case workers.

Exhibit 39

The proportion of children with an identified disability has increased in Idaho residential care.

Monthly count of all children in Idaho residential care, children with identified disabilities, and children with no identified disabilities from July 2016 to December 2024.

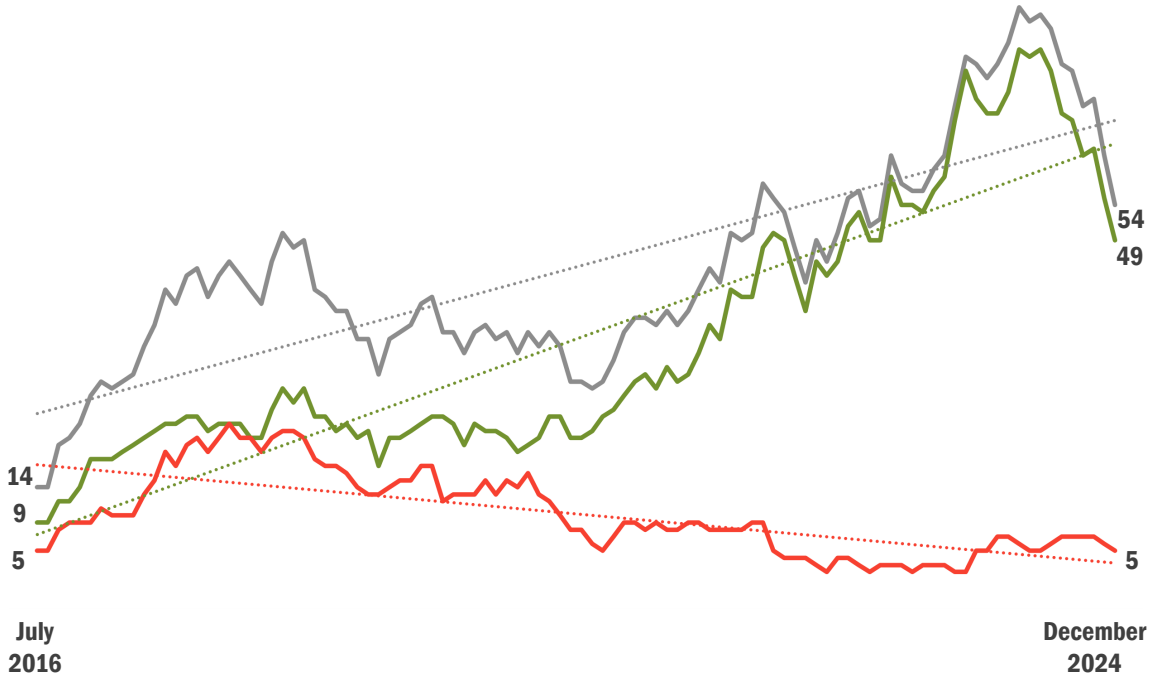


We found a similar but more dramatic shift in the share of children with identified disabilities placed out of state (see exhibit 40).

Exhibit 40

In December 2024, a greater proportion of children had an identified disability in out-of-state residential care.

Monthly count of all children in out-of-state residential care, children with identified disabilities, and children with no identified disabilities from July 2016 to December 2024.



We found that the largest increases were with the identification of mental/emotional disorders, Attention Deficit Hyperactivity Disorder, and serious mental disorders. The department tracks the following disabilities:

Attention Deficit Hyperactivity Disorder
Autism Spectrum Disorder
Developmental Delay
Developmental Disability
Hearing Impairment and Deafness
Intellectual Disability
Mental/Emotional Disorders
Orthopedic Impairment or Other Physical Conditions
Other Diagnosed Conditions
Serious Mental Disorders
Visual Impairment and Blindness

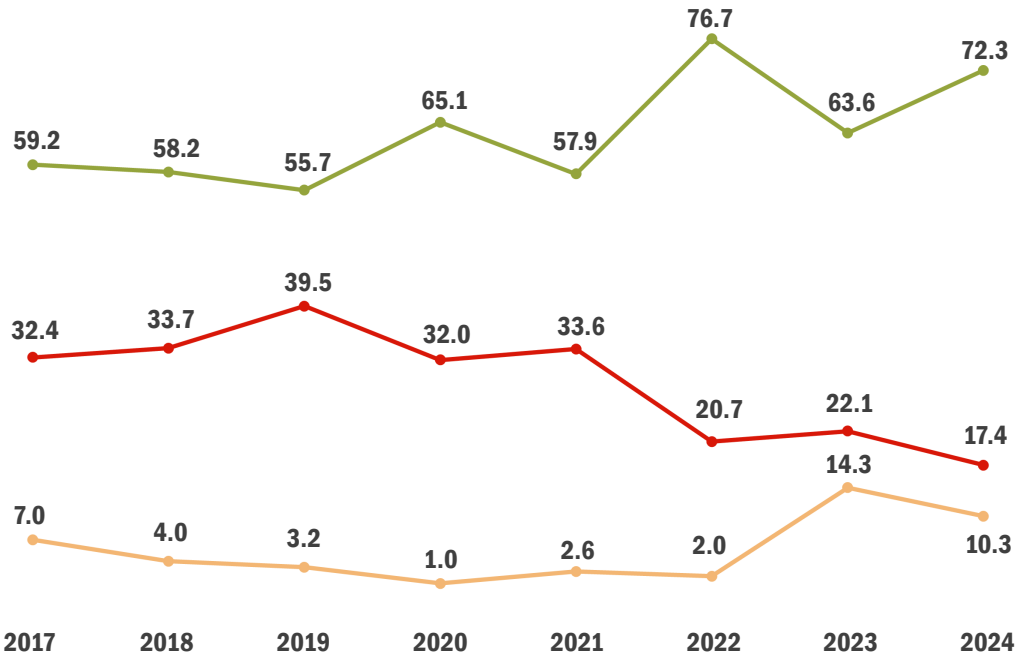
5) Improved final dispositions

We analyzed final disposition data for 993 children who exited foster care from fiscal years 2017 through 2024. We found that annual positive outcome rates improved over time for children who had experienced residential care (see exhibit 41). Over the eight-year period, approximately 64 percent of children were reunified with parents or caregivers, adopted, or placed in a guardianship. Approximately 27 percent aged out of foster care—a less desirable outcome.

Exhibit 41

Positive outcomes such as reunification, adoption, and guardianship placement increased by 13 percentage points while negative outcomes like aging out decreased by almost 15 percentage points.

Percent of youth with residential care experience who had positive, negative, and neutral outcomes at the time they exited foster care by from fiscal years 2017 to 2024.



G Responses to the evaluation

Governor Brad Little
State Capitol :: Boise, Idaho 83720
(208) 334-2100 :: gov.idaho.gov

June 5, 2025

Ryan Langrill, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Via e-mail: rlangrill@ope.idaho.gov

Dear Director Langrill,

Thank you for your office's work related to the important topic of the State's Oversight of Children in Residential Care.

Idaho's children are our greatest asset. Their education, health, and safety have been a top priority of mine throughout my time in public office. The Idaho Department of Health and Welfare (IDHW) is tasked with a difficult job in keeping some of our most vulnerable and at-risk children safe. I am pleased with the improvements IDHW has made in serving these children over the past year. I am encouraged the number of children in congregate care has been reduced by 30%, including a 50% reduction in out-of-state placements. Additionally, under my "Keeping Promises Initiative," I recommended and the Legislature funded 63 new positions that will be dedicated to prevention and further strengthening our child welfare system. We have more work to do, but these improvements and current momentum have us on the right track. The IDHW team and I are committed to continuing this work and meeting the needs to best serve Idaho's children and families.

Again, thank you for work on this important issue. I stand ready to work with IDHW, legislators, and stakeholders to further improve our system.

Sincerely,

Brad Little
Governor of Idaho

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
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May 21, 2025

Office of Performance Evaluations
Attn: Ryan Langrill
954 W. Jefferson St., Ste. 202
Boise, ID 83702

Dear Director Langrill:

Thank you to you and your staff for your thoughtful review of the state's role in ensuring the safety of children living in Idaho's residential care facilities. Department of Health and Welfare (DHW) leadership agrees that keeping all of Idaho's children safe is of the utmost importance, and that children living in residential care settings are particularly vulnerable and at risk. In 2024, largely due to the Office of Performance Evaluation's (OPE's) work detailing the challenges in Idaho's child welfare system and opportunities for improvement, DHW established an agency-wide single unifying goal to improve child welfare outcomes.

Since focusing agency-wide on child welfare, the department has implemented many interventions intended to eliminate abuse and neglect of children. Many of these interventions specific to children's residential care facilities are under way, while some will begin soon. All are responsive to OPE's findings.

In Process

Division of Licensing and Certification

- In May 2024, the division of Licensing and Certification (L&C) began conducting one unannounced survey per year in addition to the annual announced survey.
- The division has and will continue to use its existing risk score matrix to determine the most appropriate enforcement action.

Children, Youth, and Family Services (CYFS)

- The contracts team has introduced a robust residential contract monitoring tool. This tool increases inner-rater reliability among monitors, mandates corrective action when necessary, and comprehensively assesses all contractual requirements.
- Case workers now directly visit children placed in residential facilities; these visits are no longer coordinated by the Contracts Team during their monitoring appointments.
- In 2024, the Division of Youth Safety and Permanency (YSP) established the Continuum of Care bureau to ensure that only children requiring heightened support are placed in residential care facilities, to better monitor the treatment and therapy children receive to ensure they are progressing towards stabilization and discharge, and to improve transition into home settings upon discharge.

Continuum of Care Bureau

- Case workers or clinicians now visit children in out-of-state facilities every 60 days.
- Clinicians conduct expanded reviews to ensure that youth are in the most appropriate placement, work with treatment facilities to ensure a solid treatment plan is built with concrete measures defined to monitor, on-going, the youth's treatment progress.
- The bureau added additional layer of oversight to re-review placements of youth who could have been placed in a less-restrictive option, but none were available.

Division of State Care Facilities (DSCF)

This division, newly established on February 1, 2025, combined State Hospital West (SHW), Southwest Idaho Treatment Center (SWITC), the Payette Assessment and Care Center (PACC), and Crisis Prevention and Court Services (CPCS) under one umbrella.

- This structure allows stronger support from SHW, SWITC and CPCS, including enhanced training on crisis prevention, behavior management and working with children with developmental disabilities.
- The PACC now has an onsite administrator.
- DSCF has a Quality Improvement Team, made up of experienced employees from the other facilities, which will evaluate and guide the PACC.

Division of Medicaid

- The Division of Medicaid has worked to streamline processes with CYFS to place youth in residential or psychiatric residential treatment facilities when medical necessity is established.
- The division has worked to identify additional qualifying residential providers to enroll as Medicaid providers. This has supported increased access to this level of care across the state and providers enrolled in other states.

Cross-Division Initiatives

- A series of regular meetings to address facility concerns and review corrective actions now occurs and includes representatives from YSP's contracts team, L&C, and the Continuum of Care bureau.
- The YSP and L&C divisions have enhanced their collaboration on facility investigations to ensure that all identified gaps are effectively closed.

Beginning Soon

Licensing and Certification

- Randomized staff and children will be interviewed during survey.
- Internal policies/procedures to standardize screening and triaging of incident reports and CPS calls are being developed.
- Cross-division policies and procedures to standardize responses to safety concerns are being developed. Policies will include communication pathways, timelines and define division roles and responsibilities.

Children, Youth, and Family Services

- Create an internal, written protocol to clearly delineate the role of the contract monitor.
- Implement a requirement for out-of-state children's residential facilities to report any licensing violations and survey results directly to the contract monitor.

Cross-Division Initiatives

- Formalize a clear definition of "abuse" within the context of children's residential facilities.
- Develop a comprehensive, written protocol for investigating incidents at residential facilities, which will incorporate the responsibilities of multiple divisions within IDHW.

While these improvements have been occurring over the past year, we recognize that there is much work to do to improve child welfare in Idaho, and particularly to support Idaho youth living in residential care facilities. Over the past year, we have reduced the department's use of congregate care facilities for children in foster care, with 260 children in congregate care in May 2024 now reduced to 180 just one year later. Ultimately, it takes strong public policy, cooperation from the courts, support of law enforcement, assistance of guardians ad litem, and collaboration with the Health and Social Services Ombudsman to ensure the safety of Idaho's children. DHW looks forward to working with OPE and these key stakeholders in this effort.

Thanks again to you and your team for your work on this important topic. DHW values OPE and our continued collaboration. We thank you for these recommendations, which validate the importance of our ongoing focus on child safety.

Sincerely,

Brad Little-Governor
Trevor Sparrow- Ombudsman

OFFICE OF THE OMBUDSMAN
Boise, ID 83720

June 2, 2025

Mr. Ryan Langrill, Director
Office of Performance Evaluations
Sent via Email

Dear Mr. Langrill,

Thank you for the opportunity to review and respond to the report on the *State's Oversight of Children's Residential Care*. I value the work of your office in this report and feel that residential care for our youth is an area where the state and its stakeholders must get it right. As a system charged with protecting some of our most vulnerable population, accountability and positive progression are important.

In reviewing this report, I have concerns that as a state, we are not properly adapting to the needs of our youth in care, indicating a clear need for further progress. Nonetheless, I am encouraged, however, by the positive direction and laser focus that leadership in the Governor's office, Department of Health and Welfare, and Legislature have shown within the last 12 to 18 months. I look forward to seeing this focus continue as we address the issues identified in this report.

The Office of Health and Social Services Ombudsman (HSSO) received several recommendations in the OPE report and I find these recommendations are on target. These recommendations outlined the potential roles of the HSSO as our office continues to establish oversight processes.

As an office, the Ombudsman role was not filled until mid-December. During the last 5 months, our office has worked diligently to fill the couple of FTEs allotted, train staff, and collaborate with the United States Ombudsman Association (USOA) and other Ombudsman and Child Advocacy Offices. I am pleased to report that we are nearing the finalization of our review policies and procedures as well as our office's charter. This report will assist in finalizing the initial adoption of our policies and procedures.

Brad Little-Governor
Trevor Sparrow- Ombudsman

OFFICE OF THE OMBUDSMAN
Boise, ID 83720

Suggested Roles of the Ombudsman listed in the report:

1. Assist the Department of Health and Welfare (DHW) in establishing a Set of Rights for Children in Residential Care Facilities.

The HSSO fully supports this recommendation and is eager to assist however it can help to establish a bill of rights for children in care. This, along with the bill of rights for foster children, should be distributed to every child in care, accompanied by contact information for the HSSO The HSSO hopes to establish these bill of rights as a standard against which it conducts reviews complaints and or grievances received by our office.

2. Assist DHW in compiling and sharing information about safety in residential facilities to the Legislature and public.

The HSSO is prepared to assist the department in compiling and disseminating safety information. Recently, with the help of Idaho Technology Services (ITS), we have procured and implemented a case management database that will allow us to track issues and trends in real time. We recommend that all critical incidents reported by facilities to licensing and/or contract monitors also be forwarded to the HSSO . One of the issues identified in this report includes several entities receiving reports but all having separate roles. Our tracking system can help consolidate data, identify trends across facilities, and facilitate broader discussions with the department, legislature, and the Governor's office.

Additionally, another recommendation the report made to the legislature was to consider assigning an entity responsible for investigating abuse in facilities. Current statute for the HSSO includes responsibility to "receive, examine, and resolve complaints submitted…alleging an agency's or department's behavior or action was (i) contrary to law, rule, or policy (ii) imposed without an adequate statement of reason; or (iii) based on irrelevant, immaterial, or erroneous grounds" I.C. 56-1902 & 3. The HSSO could be assigned this responsibility to review complaints of abuse or neglect in facilities as a means of having an impartial review. When cases warrant law enforcement involvement, HSSO is obligated by statute to make this referral.

Brad Little-Governor
Trevor Sparrow- Ombudsman

OFFICE OF THE OMBUDSMAN
Boise, ID 83720

3. Establish as part of its complaint response process that complaint final reports be shared with the department and that the department must provide a written response.

This has been written into our process for complaints that require a response. Not all complaints will be substantiated, however, and will not require a report from the department. In addition, a fundamental part of Ombudsman work, is confidentiality. In all aspects possible, every effort will be made to inform the department of issues while safeguarding the anonymity of the reporting party.

4. Formalize an evaluation function to regularly assess department compliance with statute, rules and policies.

This evaluation will come into focus as we continue to move forward as an office. We intend to do regular visits of facilities, both announced and unannounced. We also intend to work with facilities in other states to check on the safety and progress of our youth placed out of state. I look forward to working with department leadership to develop a system and process that allows HSSO to have consistent feedback on its compliance as well as residential treatment providers.

In conclusion, the HSSO stands ready to assist with implementing effective and safer practices in providing residential care to the youth of our state. We will work with DHW, the Governor's office, and the Legislature to evaluate the recommendations in this report and apply them along with additional best practices in order to provide the best quality care for such an important and vulnerable population of Idaho's youth.

Respectfully,

Trevor Sparrow, Ombudsman
Office of Health and Social Services

Find the report at legislature.idaho.gov/ope

Office of Performance Evaluations
ope
Idaho Legislature

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