State Oversight of Children's Residential Care

Follow-up Review
August 2026

Office of Performance Evaluations
ope
Idaho Legislature

Promoting confidence and accountability in state government.

Office of Performance Evaluations

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Joint Legislative Oversight Committee (2025-2026)

The eight-member, equally bipartisan Joint Legislative Oversight Committee selects our evaluation topics. OPE staff conduct the evaluations. Reports are released in a public meeting of the committee. The findings, conclusions, and recommendations in OPE reports are not intended to reflect the views of the committee or its individual members. Senator Melissa Wintrow and Representative Jordan Redman co-chair the committee.

Senators

Melissa Wintrow
Co-Chair

C. Scott Grow

Dave Lent

James D. Ruchti

Representatives

Jordan Redman
Co-Chair

Douglas T. Pickett

Ilana Rubel

Steve Berch

Contents

Report staff

Tasha Schreiter conducted this follow-up review. Christopher Shank provided quality control review, and Leslie Baker copy edited the report.

Overview of evaluation

Children's residential care facilities provide lodging, care, and sometimes mental or behavioral health services to children under the age of 18. These facilities are licensed by the Division of Licensing and Certification (Licensing) within the Department of Health and Welfare.

In June 2025, we released the report *State Oversight of Children's Residential Care* in response to concerns with the Department of Health and Welfare's oversight of children living in residential care facilities in Idaho, including:

1. Insufficient handling of incidents
2. Inconsistent practices in monitoring facilities
3. Placement of children in unsafe facilities

This follow-up review evaluates the implementation status of the original report's 19 recommendations: 14 directed to the department, with additional recommendations for the Legislature and the Health and Social Services Ombudsman (Ombudsman). Of those, 13 are complete, 2 are in progress, and 4 reflect no change. We rate each recommendation's completion status using the following categories:

- **Complete:** Measurable steps have been taken to meet the recommendation's intent, or an approach that diverged from the recommendation has been taken to meet the intent.
- **In progress:** Measurable steps have been taken that begin to meet the recommendation's intent.
- **No change:** No measurable steps have been taken to meet recommendation's the intent.

The status of each recommendation is listed in exhibit 1 in the order they appear in this review.

Exhibit 1

Implementation has progressed since the report's release, with most recommendations complete and four requiring legislative action.

Recommendation	Status	Page #
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.	Complete	9
The Legislature should consider amending statute to require that facilities follow, post, distribute, and interpret the rights for children and their families.	Complete	9
The department should amend administrative rule to require at least one annual unannounced survey.	Complete	11
The department should revise the child and staff interview process.	Complete	12
The department should amend administrative rule to require facilities to report restraint and seclusion use to the department.	Complete	12
The Legislature should consider assigning an entity responsible for investigating abuse in facilities.	No change	13
The department should develop a process to include perpetrators of abuse in children's residential care facilities on Idaho's Child Protection Central Registry.	No change	13
The Legislature should consider extending Licensing's authority to include treatment oversight.	No change	15
The Legislature should consider amending statute to require the department to report restraint and seclusion use to the Legislature.	No change	15
The department should standardize how it monitors contracts with children's residential care facilities and formalize contract monitoring as a tool for overseeing foster child safety.	Complete	16
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.	Complete	17
The department should apply existing response priority requirements to safety-related issues involving children in foster care who are placed in facilities.	Complete	18
The department should develop criteria to guide responses to critical incident reports, child abuse calls, and complaints.	Complete	18

Recommendation	Status	Page #
The department should develop a department-wide protocol to define communication and issue escalation across divisions.	Complete	18
The department should track the ideal placement type for children in care.	Complete	20
The department should explore opportunities to streamline and consolidate the requirements for funding across federal regulations.	Complete	21
The department should institute an online dashboard for children's residential care licensure.	In progress	22
The department should make its risk assessment matrix available to the public and facility administrators.	In progress	22
The Ombudsman should establish processes to fulfill its oversight role that address some of the oversight gaps identified in our report.	Complete	24

For this follow-up, we requested implementation and status updates from the Department of Health and Welfare and the Health and Social Services Ombudsman, who provided documentation and updates in September 2025 and May 2026 through June 2026. Within the Department of Health and Welfare, we interviewed the Division of Licensing and Certification, the Division of Medicaid (Medicaid), and Children, Youth, and Family Services. We reviewed documentation from each. We also tracked relevant legislation from the 2026 session.

Implementation of these recommendations has happened in distinct phases. First, the department took administrative action beginning in September 2025, revising monitoring procedures, establishing cross-team protocols, and amending out-of-state placement contracts. Next, the Legislature passed House Bill 723 in the 2026 session, effective July 1, 2026, codifying several of these changes in statute and adding new requirements. Exhibit 2 illustrates this timeline of activity.

Exhibit 2

Implementation activity has occurred over the past year since the report's release.

June 2025	Joint Legislative Oversight Committee releases *Oversight of Children's Residential Care* report. Department responds with changes made and implementation plans.
Sept. 2025	Department submits formal update to Joint Legislative Oversight Committee. Department implements new cross-division policy for responding to incidents. Licensing implements revised staff and child interview process. Children, Youth, and Family Services implements new contract monitoring tool.
Jan. 2026	Payette Assessment Care Center, renamed Birch Children's Residential Facility, relocates to Nampa campus with the Southwest Idaho Treatment Center.
May 2026	OPE begins follow-up review. Department and Health and Social Services Ombudsman provides updated status report and documentation to OPE.
July 2026	House Bill 723 takes effect, codifying several recommendations and department processes.
Aug. 2026	OPE releases follow-up review. Licensing transitions to new publicly accessible data management system.

1 Status of recommendations for the Legislature

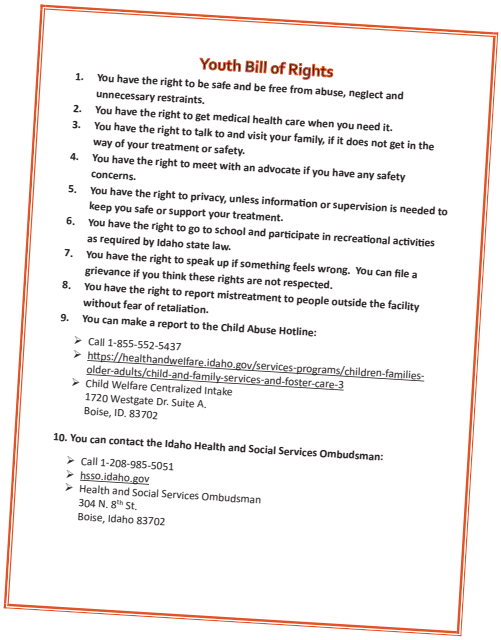
The passage of House Bill 723 strengthens oversight of children's residential care facilities.

The Legislature passed House Bill 723 in the 2026 legislative session. This legislation meets the intent of five of our recommendations and went into effect on July 1, 2026.

COMPLETE

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

House Bill 723, effective July 1, 2026, satisfies both recommendations regarding a bill of rights for children in residential care facilities. The bill requires children's residential care facilities to post, distribute, and interpret a children's bill of rights to children and their parents or guardians. This ensures children and their families know their rights and have a clear path to report concerns. Requiring facilities to post and explain these rights strengthens accountability by making protections visible to children, families, Licensing staff, and advocacy groups.



Youth Bill of Rights

1. You have the right to be safe and be free from abuse, neglect and unnecessary restraints.
2. You have the right to get medical health care when you need it.
3. You have the right to talk to and visit your family, if it does not get in the way of your treatment or safety.
4. You have the right to meet with an advocate if you have any safety concerns.
5. You have the right to privacy, unless information or supervision is needed to keep you safe or support your treatment.
6. You have the right to go to school and participate in recreational activities as required by Idaho state law.
7. You have the right to speak up if something feels wrong. You can file a grievance if you think these rights are not respected.
8. You have the right to report mistreatment to people outside the facility without fear of retaliation.
9. You can make a report to the Child Abuse Hotline:
   - Call 1-855-552-5437
   - https://healthandwelfare.idaho.gov/services-programs/children-families-older-adults/child-and-family-services-and-foster-care-3
   - Child Welfare Centralized Intake
     1720 Westgate Dr. Suite A.
     Boise, ID. 83702
10. You can contact the Idaho Health and Social Services Ombudsman:
    - Call 1-208-985-5051
    - hsso.idaho.gov
    - Health and Social Services Ombudsman
      304 N. 8th St.
      Boise, Idaho 83702

The department developed the bill of rights in collaboration with the Ombudsman to distribute to facilities. It contains ten rights:

1. *You have the right to be safe and be free from abuse, neglect and unnecessary restraints.*
2. *You have the right to get medical health care when you need it.*
3. *You have the right to talk to and visit your family, if it does not get in the way of your treatment or safety.*
4. *You have the right to meet with an advocate if you have any safety concerns.*
5. *You have the right to privacy, unless information or supervision is needed to keep you safe or support your treatment.*
6. *You have the right to go to school and participate in recreational activities as required by Idaho state law.*
7. *You have the right to speak up if something feels wrong. You can file a grievance if you think these rights are not respected.*
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    hsso.idaho.gov
    Health and Social Services Ombudsman
    304 N. 8th St.
    Boise, Idaho 83702

COMPLETE

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

Prior to our report, Licensing staff typically visited facilities once a year through announced, scheduled surveys. While Licensing could conduct unannounced visits, it was not required in statute or administrative rule and it was rare in practice. House Bill 723, effective July 1, 2026, now requires children's residential care facilities to have at least one annual unannounced survey. This codifies the existing practice into statute rather than an administrative rule change. This still meets the intent of the recommendation by preventing facilities from curating what Licensing sees. The department reports that unannounced visits have been going well.

COMPLETE

The department should revise the child and staff interview process.

Effective July 1, 2026, an interview selection process led by the department is codified in statute. Licensing changed this process in September 2025. Prior to a survey, Licensing now uses a systematic approach to select interviewees. They review critical incident, restraint/seclusion, and child protective services reports, and select children with varying lengths of stay. This new process removes facilities' ability to select their own interviewees, and makes sure that Licensing staff hears from children and staff in high-risk situations, rather than those hand-picked by the facility.

COMPLETE

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

House Bill 723, effective July 1, 2026, requires children's residential care facilities to include restraint and seclusion as critical incident reports. This was accomplished through statute rather than administrative rule but still meets the intent of the recommendation. These reports join other incidents Licensing already tracks, such as fires, hospitalizations, law enforcement calls, suicide attempts, missing children, deaths, and abuse or neglect investigations of facility staff. Licensing acknowledged this will increase workload due to higher report volume for these types of incidents. Licensing also reported that after July 1, 2026, it will incorporate restraint and seclusion data into its monthly trend reviews of incident reports.

Gaps in current law limit oversight of children's residential care facilities.

Four recommendations remain unaddressed that, if acted on, would strengthen oversight of abuse, restraint, and treatment in children's residential care facilities.

No Change

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

Although Licensing, law enforcement, and facilities each conduct investigations within their respective roles, no state entity is specifically responsible for investigating and substantiating abuse allegations in children's residential facilities. Each entity investigates according to its own statutory mandate and evidentiary standards. Based on previous recommendations from OPE, the department now uses a priority system with an escalation path for all abuse reports to ensure children's immediate safety. However, the department's authority remains protective and regulatory rather than adjudicative. The department's oversight does not result in placement on the Idaho Child Protection Central Registry, and only law enforcement can take action against staff when criminal conduct is found. Other states have addressed this gap by designating a single agency for these investigations, either within Licensing or as a separate entity. The Legislature took no action on this recommendation during the 2026 legislative session.

No Change

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

In our report State Oversight of Children's Residential Care, we identified that there is no formal process to include staff at facilities on the Idaho Child Protection Central Registry. The department has indicated that legislative action

would be required to accomplish this as recommended. The Legislature could consider two approaches to close this gap, outlined in exhibit 3.

Exhibit 3

Two legislative approaches to make sure children's residential care facility staff are eligible for placement on the child protection registry

1 Expand who can be placed on the Idaho Child Protection Central Registry

An approach taken by Texas has expanded the list of eligible persons to be found by the department to have abused or neglected a child to include "an employee, volunteer, or other person working under the supervision of a licensed or unlicensed child-care facility, including a family home, residential child-care facility, employer-based day-care facility, or shelter day-care facility". This approach would require amending Idaho Code § 16-1602(31) to expand the definition from beyond just parents, guardians, or other custodians to include similar language that includes children's residential care facility staff as defined by Idaho Code § 39-1202 and Idaho Administrative Rule 16.04.18.

2 Create a definition of institutional abuse or neglect

Delaware defines and separately addresses that the state may investigate any allegation of institutional child abuse or neglect in any facility licensed by the state, and against any person who has assumed control of or responsibility for the child. This approach would require adding and integrating this category into Idaho Code § 16-1629(3).

Note: This analysis was informed by the Office of the Attorney General. It may not be all-encompassing, and the specific statutory changes required would depend on the scope of the approach ultimately taken.

Checking staff against the Idaho Central Child Protection Registry would make sure that individuals with a substantiated history of abuse or neglect, even without a criminal conviction, cannot simply move between facilities. This underscores the importance of also designating an entity responsible for investigating and substantiating abuse allegations, as noted earlier.

No Change

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

House Bill 723 strengthened Licensing's oversight to ensure facilities provide safe, high-quality care and supervision. However, Licensing does not have the authority to oversee treatment. While Licensing ensures facilities deliver all elements of a child's service plan, including prescribed safety measures and daily support, Licensing is not responsible for assessing if treatment is happening or whether a treatment meets a child's individual needs. Licensing reported that even if authorized to do so, assessing treatment would be challenging given the range of approaches used across facilities. The Legislature took no action on this recommendation during the 2026 legislative session.

No Change

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

While House Bill 723 now requires facilities to report restraint and seclusion use to Licensing, that information goes no further. Neither the Legislature nor the public has visibility into how often these high-risk practices are used on children in care. Without this data, the Legislature cannot track whether use of restraint or seclusion is increasing or decreasing over time in facilities, nor evaluate the impact of any future statutory changes to these practices. Requiring the department to report aggregate data to the Legislature would enable trend tracking and provide an additional layer of accountability. Some states, including Oregon, require public reporting for this purpose, adding a layer of transparency that Idaho currently lacks.

2 Status of recommendations for the Department of Health and Welfare

Children, Youth, and Family Services has improved monitoring of foster children placed in residential care facilities.

The Idaho Department of Health and Welfare's Children, Youth, and Family Services is responsible for making and overseeing placements of foster children in residential care facilities. Children, Youth, and Family Services holds placement contracts with both in-state and out-of-state facilities, and a contract monitoring team ensures those facilities meet contract requirements.

COMPLETE

The department should standardize how it monitors contracts with children's residential care facilities and formalize contract monitoring as a tool for overseeing foster child safety.

Effective July 2025, the contract monitoring team implemented a new monitoring tool and process for placement of foster children in children's residential care facilities. The updated process includes a pre-site visit form that documents policies reviewed, licensing status, and facility and treatment information, as well as revamped site visit documentation that tracks contract requirements, compliance status, guidance for monitors, and corrective action. This change clearly defines a contract monitor's role and standardizes monitoring procedures across facilities and meets the intent of the recommendation.

COMPLETE

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.

In June 2025, Children, Youth, and Family Services began amending existing contracts with out-of-state facilities to require reporting of licensing status changes. As of July 2026, 6 of the 13 contracts governing out-of-state placement of foster children require facilities to report licensing information to the department. Children, Youth, and Family Services continues working to amend the remaining contracts, though progress has been slow due to administrative delays. In the meantime, children's residential care facilities have voluntarily reported licensing status changes while the amendment process continues. This step, along with the department's ongoing work to update contracts, shows that measurable steps have been taken to meet the intent of the recommendation. This requirement already existed for children placed through Medicaid, but now extends to Children, Youth, and Family Services placement contracts. If the facility follows this requirement, it gives the department visibility into licensing concerns at out-of-state facilities.

Clearer roles and response protocols now guide how the department handles incidents in residential facilities.

When an incident involves a child in a residential facility, multiple teams within the department play a role. Licensing, Medicaid, and Children, Youth, and Family Services operate as three separate divisions. Caseworkers and contract monitors are both within Children, Youth, and Family Services. Our report found gaps in how the department handled incidents involving foster children in residential facilities.

COMPLETE

The department should apply response priorities, criteria, and a cross-team protocol for responding to incidents involving foster children in residential facilities.

Effective September 2025, the department established a cross-team policy and response priority timelines for incidents involving foster children in residential facilities. These changes address three of our recommendations to apply response priorities, develop criteria for responding to critical incident reports and complaints, and define communication and escalation across divisions.

When an incident is reported to the department about an Idaho facility, Licensing now assigns a priority level to each incident and coordinates the initial response (exhibit 4). The cross-team policy now defines distinct roles across Licensing, contract monitors, caseworkers, and Medicaid for investigating allegations and monitoring child safety. Findings and corrective actions are now tracked through trend analysis meetings occurring every other month.

Exhibit 4

Licensing assigns priority levels to guide response timelines for incidents in residential facilities.

Priority level	Timeline	Definition
Priority 1 – Immediate response	Investigate immediately, on-site within 2 business days, unless contradicted by law enforcement	Allegations that have caused, or are likely to cause, serious physical or psychosocial harm, injury, or death
Priority 2 – Medium	Investigate immediately, on-site within 5 business days or conducted via records/video review	Allegations that may have caused physical or psychosocial harm, but immediacy is removed
Priority 3 – Low	Investigation completed at next survey or within 90 days via records/video review	Allegations caused no actual harm or appear isolated or resolved

The department also created seven facility case manager positions to oversee all foster children placements within residential facilities. This gives each foster child a dual-caseworker structure—one caseworker manages the child's case while the facility case manager conducts visits, coordinates with the facility, and ensures timely response to incidents. The department reported positive feedback from facilities on these positions.

The department reported no compliance issues with response timelines and that the cross-team process is working well. It should be noted that Licensing responds to incidents for all children in Idaho residential facilities, including privately placed children. The same priorities and response timelines are used for foster children at out-of-state facilities for facility case managers and contract monitors. Response timelines were not independently audited as part of this follow-up.

The department has improved its ability to track and match foster children to appropriate residential care placements.

COMPLETE

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

The department has implemented a tracking system to identify and match foster children with an appropriate residential care placement. The Congregate Care Unit collects case complexity information including diagnoses (developmental disability, mental health) and relevant histories (juvenile justice involvement, family history), alongside placement outcomes such as treatment completion and placement disruptions. Using a framework, the unit analyzes which populations of children perform well in which programs to improve placement matching.

Placements are categorized by treatment status and discharge readiness, among other factors. This includes cases where treatment is complete, but no suitable home is available for discharge, and cases where no treatment is needed but no appropriate home is available. Current data reflects this tracking in practice. For example, of the 190 foster children living in children's residential care, about 89% were in an appropriate placement type as of May 20, 2026. The remaining children had varying needs and circumstances, including lack of an available home, being nearly ready for discharge, or having no permanency plan. Children will move between categories as their needs and treatment progress change. Without this tracking, the department could not assess how many children are improperly placed or identify gaps in the availability of appropriate care settings.

This recommendation was intended to produce usable system-level data within the department's case management software rather than that information being buried in case notes. Due to current limitations, tracking is maintained in a separate spreadsheet; however, the data can be matched to case-level records for future analysis of placement trends.

The department is actively working to address billing and payment challenges for children's residential care facilities.

COMPLETE

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

The department has taken meaningful steps to address the billing and payment frustrations that children's residential care facilities reported. To improve payment timeliness, the Division of Purchasing, on behalf of the Department of Health and Welfare, formally notified the Managed Care Organization in January 2025 that claims payment rates had fallen below contractual thresholds and required corrective action. Claims payment rates were resolved and have been at or above 99.9% since March 2025. The department also reports that the Managed Care Organization provided direct technical assistance to children's residential care facility staff to improve claims submission accuracy.

Additionally, Children, Youth and Family Services hosts provider partnership meetings every other month that bring together facility administrators, Managed Care Organization representatives, and Licensing staff. These forums give facility administrators a consistent venue to ask questions about claims and denials, access technical assistance, and receive updates from the department. Together, these efforts reflect active departmental engagement with the funding complexity faced by facilities and represent sufficient progress to consider this recommendation complete. Our assessment of progress is based on departmental reporting. We did not conduct a follow-up survey of facility administrators to independently verify their experience with these changes. It should be noted that the survey in the original report was conducted after a period when claims payment issues were actively being addressed, which may have shaped responses related to billing difficulties.

Licensing is making facility information more accessible to the public, increasing facility accountability.

In Progress

The department should institute an online dashboard for children's residential care licensure and make its risk assessment matrix available to the public and facility administrators.

In August 2026, Licensing will transition to a new data management system specifically for oversight entities like Licensing. This is the same system used by the department's residential assisted living program. Although some Licensing information for children's residential care has been available online, it is in a hard-to-navigate website, limiting accessibility for parents and the public. The new system will improve public accessibility of facility information, including documented deficiencies found during surveys and the corrective actions required to address them. Licensing reported the new system will also make internal processes more efficient.

The new system will also make Licensing's risk assessment matrix ratings easier to find. The matrix assigns facilities a rating of Gold, Silver, or Bronze based on compliance with licensing standards:

- **Gold:** Demonstrates full compliance with licensing standards, with minimal to no corrective action.
- **Silver:** Demonstrates substantial compliance with licensing standards, with limited corrective actions necessary.
- **Bronze:** Demonstrates areas of non-compliance with licensing standards, requiring heightened monitoring or corrective action.

Although ratings have been included in plans of correction and available online since December 2025, they appear on the last page of a document that is hard to navigate to. Once the new system goes live, ratings will be prominently viewable to the public and facility administrators. Licensing reported the matrix has

already increased accountability on facilities and prompted more staff discussions about issuing enforcement actions—greater visibility is expected to strengthen this effect. Because this system is already in use by the department's residential assisted living program, we expect that both recommendations will be satisfied upon its August 2026 launch. Exhibit 5 shows a screenshot of the licensing system used for residential assisted living facilities and illustrates how the system might look for children's residential care once it goes live. One feature of note is that the new system consolidates documentation and risk ratings in one place, making it easier to navigate.

Exhibit 5

The new system for licensing documentation and risk assessment ratings will be easier to navigate.

This screenshot illustrates how licensing documentation and risk ratings could appear in the new system.

★ - Gold Excellence in Care Award - No deficiencies were cited during the survey
☆ - Silver Excellence in Care Award - No core deficiencies were found and there were three or fewer non-core deficiencies cited during the survey

Award	Provider Name	Address	City
	Ashley Manor - Arlington	3123 South Arlington Avenue	Caldwell
☆	Ashley Manor - Cloverdale	3749 North Cloverdale Road	Boise
	Ashley Manor - Crescent	421 Crescent Drive	Caldwell
★	Ashley Manor - Harmony	2703 Harmony Avenue	Boise
☆	Ashley Manor - Hill Road	3424 West Hill Road	Boise
★	Ashley Manor - Hyde Park	1908 North 13th Street	Boise
☆	Ashley Manor - Iowa	2604 Iowa Avenue	Caldwell
	Ashley Manor - Midland	67 South Midland Boulevard	Nampa
☆	Ashley Manor - Mountain Home	940 West 8th South	Mountain Home

Note: This is not a screenshot of the children's residential care documentation system. It shows an existing program's rating display, which uses stars rather than gold, silver, and bronze. This exhibit is used to illustrate what the system might look like when it launches in August 2026.

3 Status of recommendations for the Health and Social Services Ombudsman

The Health and Social Services Ombudsman has begun developing oversight processes.

COMPLETE

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

The Legislature created the Health and Social Services Ombudsman during the 2024 legislative session. Because the office was newly established, we recommended that it develop processes to fulfill its oversight role. The Idaho Health and Social Services Ombudsman has taken measurable steps toward meeting this recommendation. Oversight activities established include:

Bill of rights: Effective July 1, 2026, licensed facilities must post, distribute, and explain the youth bill of rights to children and their families. The ombudsman collaborated with the department on its development and is listed as an independent complaint resource, with reported calls handled through its standard investigation process.

Site visits: The ombudsman visited 12 in-state residential care facilities in the spring of 2026 to observe operations and identify strengths and challenges. Findings were reported to the Governor's office and the department. While most facilities appeared clean, organized, and appropriately supervised, the

ombudsman identified a limited number of operational concerns related to transport coordination, intake practices, and overly institutional or detention-like environments. The ombudsman reported the goal to do site visits annually as an added layer of oversight.

Trend and critical incident report monitoring: The ombudsman and department meet regularly to discuss trends and cases. The ombudsman reviews critical incident reports daily and Licensing notifies the ombudsman of enforcement actions, such as license suspensions.

Evaluation and reporting: In FY2025, the ombudsman reviewed over 82 complaints and reported to the Legislature and department findings and recommendations. The ombudsman has also conducted independent reviews to determine whether agencies acted in accordance with current law, policy, and procedure.

While the ombudsman has established these processes, they have not yet been formally documented in a policy handbook or procedure manual. We encourage the ombudsman to prioritize documenting its processes, including how investigations are conducted, to support continuity and accountability. We also encourage the ombudsman to continue to work collaboratively with the department to establish oversight roles.

A Responses to the follow-up

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
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July 14, 2026

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 follow-up 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 it's critical to provide a safe, secure environment for all of Idaho's children living in residential care settings, where they are particularly vulnerable.

We are pleased by the progress we've made to complete the recommendations outlined in the report. Even so, we recognize that innovation in child welfare never stops. It's critical to support Idaho youth living in residential care facilities. This is a race that does not have a finish line. We will continue to work hard to ensure Idaho youth are receiving the right care, in the right place, and at the right time.

Significantly, we have reduced the department's use of congregate care facilities for children in foster care over the past two years. Most notably, the number of children placed in out-of-state facilities was reduced by 67%, and now only 25 children are placed out of state to best meet their needs.

Ultimately, ensuring the safety of Idaho's children is a system-wide effort. It takes strong public policy, cooperation from the courts and law enforcement, assistance of guardians ad litem, and collaboration with the Health and Social Services Ombudsman. DHW looks forward to continuing to work with OPE and these key stakeholders in this important effort.

Sincerely,

Juliet Charron

Juliet Charron, Director

IDAHO HEALTH AND SOCIAL SERVICES
OMBDUSMAN OFFICE

Brad Little-Governor
Trevor Sparrow- Ombudsman

OFFICE OF THE OMBUDSMAN
Boise, ID 83720

July 17, 2026

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

Dear Director Langrill:

The Health and Social Service Ombudsman Office (HSSO) would like to extend our gratitude to you and your staff for your thoughtful and deliberate examination of the children's residential treatment systems in the state. How we take care of our most precious resource, our children, tells us a great deal about the kind of stewards we are as administrators, caretakers, legislators, and providers. OPE's examination and findings have already played a huge role in aiding to enhance our capabilities and be better stewards.

We are excited about the progress that has already been made to help facilities, state, and local entities improve the care of our children. Legislation has been passed to improve reporting and investigation of incidents as well as informing residents and their loved ones about their rights while in care. Our office traveled around the state and visited nearly all the youth residential treatment facilities early this spring. Our overall assessment is that the care of the youth is improving in the state, treatment providers are doing their best to take care of our youth, and the legislation and improvements made in response to the OPE report will continue to enhance that care.

HSSO has established a great working relationship with the licensing division of the Department of Health and Welfare, and they are keeping our office apprised of trends and issues. In addition, after a year of data collection in our reporting systems, we are very much on track to solidify our policies and procedures as it relates to receiving, investigating, and acting on the complaints and concerns we receive. Thanks are extended again to OPE for your excellent report and follow through.

Respectfully,

Trevor Sparrow

Trevor Sparrow
Health and Social Services Ombudsman

Find the report at legislature.idaho.gov/ope

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