

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 25, 2026

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chair VanOrden, Senators Harris, Zuiderveld, Shippy, Blaylock, and Wintrow

ABSENT/ EXCUSED: Vice Chair Bjerke, Senators Lenney and Keyser

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chair VanOrden** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

H 639 **MIDWIFERY - Amends and adds to existing law to provide for a licensed midwife to obtain and administer medication indicated for maternal care or neonatal care if a midwife possesses requisite education, training, and experience.** **Senator Toews** explained this legislation removed unnecessary barriers to maternal and neonatal care by striking obsolete statutory language regarding the specific formulary for licensed midwives. The bill would allow the profession to operate under an adaptable protocol-driven framework that reflected current education, training, and standards of care. He went on to explain the bill accomplished the following:

- Revised the Board of Midwifery's (Board) rulemaking authority, removed the highly specific static list of allowable medications, and replaced the list with a directive for the Board to define a formulary and protocol for drugs indicated for maternal or neonatal care.
- Established that licensed midwives may obtain and administer any medication indicated for maternal or neonatal care defined by the formulary.
- Updated existing code references related to client disclosure and record keeping.
- Declared the administrative rules, IDAPA 24.26.01 rule 200.01, related to protocols for the use of the formulary drugs shall be null and void on and after July 1, 2026.

(See Attachment #1)

DISCUSSION: **Senator Wintrow** asked how this legislation originated. **Senator Toews** explained he worked with the Idaho Midwifery Council on the legislation and they were supportive.

TESTIMONY: **Charity Catlin**, Licensed Midwife, testified in support of the legislation. She stated this bill would allow licensed midwives to treat postpartum hemorrhage quickly and effectively without exceeding statutory limits. This change would eliminate unnecessary hospital transfers for patients who were stable following blood loss after birth. This legislation protected public safety by requiring transport for bleeding that did not respond to the administration of anti-hemorrhagic agents and provided for appropriate and timely transfer of mothers needing management beyond the scope of licensed midwives.

Valerie Hall, Licensed Midwife, testified in support of **H 639**. **Ms. Hall** noted this bill directly benefited the State by minimizing costly and unnecessary hospital transports. She explained many clients lived far from the nearest hospital and in underserved areas for maternity care. This bill would allow midwives to provide more complete care at a much lower cost.

DISCUSSION: In closing, **Senator Toews** explained this legislation modernized Idaho Code and aligned with standards in surrounding states. He stated the bill would provide midwives the flexibility to better serve their patients.

MOTION: **Senator Shippy** moved to send **H 639** to the floor with a **do pass** recommendation. **Senator Blaylock** seconded the motion. The motion carried by **voice vote**.

PRESENTATION: State Oversight of Children's Residential Care. **Lauren Bailey**, Principle Evaluator, Office of Performance Evaluations (OPE), presented the following information and recommendations for State Oversight of Children's Residential Care (See Attachment #2, #3, and #4):

- Defined residential care and identified who had regulatory authority over child safety in residential care facilities.
- Highlighted the limited scope of enforcement licensing had over residential care facilities including:
 - a. Licensing did not assess treatment quality.
 - b. Children's rights were not enumerated or communicated.
 - c. Licensing did not know how often high-risk strategies were used in residential care facilities.
- Provided considerations for the Legislature and recommendations for Idaho Department of Health and Welfare (IDHW) including:
 - a. One annual unannounced survey in addition to scheduled surveys to prevent facility administrators from curating what licensing staff observed.
 - b. Revise the child and staff interview process.
- Reviewed the minimal enforcement actions taken by licensing.
- Explained the matrix OPE created to address the lack of enforcement actions and how the matrix provided guidance to licensing staff.
 - a. Demonstrated when retroactively applied, the matrix indicated 21 additional enforcement actions from 2021 to 2024.

In relation to children in foster care, **Ms. Bailey** reviewed the following information:

- Privately-placed foster children had the least oversight.
- Since FY 2017 the proportion of youth in foster care who experienced residential care increased from 8 percent to 17 percent.
 - a. Since July 2016 in-state placements increased by 152 percent while out-of-state placements increased by 273 percent. She noted there was less oversight for out-of-state facilities and violations were not tracked.
- Presented findings that IDHW had not tracked placements based on children's needs (the most appropriate and least restrictive setting).
- Recommended IDHW track the ideal placement type for children in care.

Tasha Schreiter, Evaluator, OPE, presented the following information on the Payette Assessment and Care Center opened by IDHW in May 2024:

- The median length of stay was 18 days while some foster children stayed as long as 109 days.
- The state-run facility faced oversight concerns including:
 - a. It did not operate under a contract monitor.
 - b. Untrained staff and missing background checks.
- The role of contract monitors was unclear and there was no formal guidance regarding:
 - a. Documentation.
 - b. Visitation frequency.
 - c. How to respond to safety issues.
 - d. When to coordinate with licensing and case workers.
 - e. When and how to require corrective action.
- Caseworkers were not obligated to respond to abuse allegations involving children in facilities with the same urgency required for children in foster care.
 - a. Most abuse calls related to children in foster care required an immediate to five-day response.
 - b. Children in facilities were excluded from response timeline requirements.
 - c. Some children waited days or weeks for a visit after serious incidents.
- Recommended IDHW apply existing response requirements to residential care facilities.
- IDHW did not investigate abuse in facilities with the same investigation process used in homes.
 - a. In facilities no investigation was done to substantiate abuse.
 - b. Staff in facilities were not included on Idaho's Child Protection Central Registry.
- Recommended IDHW create a process to include perpetrators of abuse in facilities on Idaho's Child Protection Central Registry.
- Recommended the Legislature consider assigning an entity responsible for investigating abuse in facilities.

DISCUSSION: **Senator Blaylock** asked how many children were placed in residential care. **Ms. Bailey** stated when the evaluation was conducted there were 164 foster care youth placed in residential care. There was no entity that collected information for private placements. Therefore, it was impossible to definitively know how many privately-placed youth were in residential care facilities. OPE surveyed Idaho facilities and of the approximately 20 that responded, it was estimated there were 250-260 children privately-placed in residential care.

Senator Blaylock inquired about children in residential care going missing. She explained she requested information from the Director of IDHW regarding missing children brought to her attention by constituents. She stated the Director confirmed missing child cases occurred and there were two active missing cases being investigated by IDHW. She asked if OPE encountered any missing child cases during the investigation of residential care facilities. **Ms. Bailey** stated OPE was aware of instances of runaways. In the case of foster youth, that was something IDHW was aware of and investigated. Facilities were required to report youth runaways to licensing; however, the data was not consistently tracked statewide for all private and foster youth.

Senator Wintrow stated there were findings that potentially required legislation and asked for recommendations on how to address policy concerns. She noted children privately placed, not in state custody, deserved the same oversight as foster youth. She asked IDHW to provide a plan on how to resolve this problem that ensured all children were safe and accounted for regardless of private pay or state custody. She requested IDHW address some of the major recommendations and progress made on changes that had been implemented. **Ms. Bailey** stated there was legislation proposed that would address some concerns raised by the OPE report. A central oversight for private and foster care youth was recommended and the report highlighted a few different options other states had implemented. She stated one option was to assign oversight to the Health and Human Services Ombudsman as a central authority for collecting complaints regarding children and facilities.

Monty Prow, Deputy Director of Child, Youth, and Family Services, IDHW, thanked the Joint Legislative Oversight Committee and OPE for their work on this critical issue. He stated since mid 2024 the number of kids in congregate care was reduced by almost one third and the out-of-state number was reduced by two-thirds of all kids in IDHW care. IDHW established a Continuum of Care Bureau within Children's and Family Services. He addressed the recommendation to ensure a child's needs were met with the appropriate treatment and placement. He stated IDHW knew every day, where each child in state custody was across the spectrum of six different placements. He explained IDHW continually asked the following questions: Was each child placed appropriately, how many children were waiting for the next placement, was the child ready to come home, or had IDHW found the most appropriate community placement. **Senator Wintrow** asked how IDHW was ensuring the oversight of all children, and the urgency to respond to allegations of abuse, was addressed by IDHW. **Mr. Prow** explained the responses to out-of-state reports looked different than local responses and it was difficult to investigate out-of-state allegations immediately. He assured the Committee the urgency of visiting with that child, making sure their needs were met and determining next steps, was the same regardless of where the child was located. However, the entity that did the initial investigation work may be different.

Laura Stute, Licensing and Certification Administrator, IDHW, stated one of the discoveries in the OPE report was that licensing had the opportunity to refine and standardize response times. She explained IDHW created a response timeline that paralleled what was used for allegation responses within a home. There was priority one, two, and three. IDHW felt this was a comprehensive way to address the safety of the child, and usually involved removing the alleged perpetrator. The role of IDHW was to ensure the administrator was promptly responding. She added IDHW did not have a legal mechanism to place an individual, working in a residential facility, with substantiated abuse allegation on a registry. The registry only applied to parents or legal guardians. She added that IDHW was working with Representative Marco Erickson on a bill that enhanced children's rights, and required posting information about how to reach out for help should there be a concern. This was an important mechanism to inform IDHW when to investigate.

Senator Wintrow stated work needed to be done on the registry to list residential facility staff with substantiated abuse allegation on the registry. She stated it was just a matter of doing work in the interim to accomplish that.

In closing, **Mr. Prow** assured the Committee the focus of IDHW was right kid and right place for the right amount of time.

ADJOURNED: There being no further business at this time, **Chair VanOrden** adjourned the meeting at 3:50 p.m.

Senator VanOrden
Chair

Madyson Crea
Secretary