Residential Group Care Accountability System

ANNUAL REPORT

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Attachment:Report: Development and Validation of the Group Care Quality Assessment: Fiscal Year 2017-2018

Purpose

The Quality Standards for Group Care was established to set core quality standards for the Department of Children and Families (department) licensed group homes to ensure that each residential program is managed equally to provide high quality services to the children in their care. Section 409.996(22), Florida Statutes, requires the department to provide an annual report to the Governor, President of the Senate and Speaker of the House of Representatives as an update on the development of a statewide accountability system for residential group care providers, a plan for department oversight, and implementation of the statewide accountability system.

Section 409.996(22), Florida Statutes, requires the department, in collaboration with the Florida Institute of Child Welfare (institute), to develop a statewide accountability system for residential group care providers based on measurable quality standards. The accountability system is required to include the following:

1. Promote high quality in services and accommodations, differentiating between shift and family-style models, and programs and services for children with specialized or extraordinary needs such as pregnant teens and children with Department of Juvenile Justice involvement.

2. Include a quality measurement system with domains and clearly defined levels of quality. The system must measure the level of quality for each domain, using criteria that residential group care providers must meet to achieve each level of quality. Domains may include, but are not limited to, admissions, service planning, treatment planning, living environment, and program and service requirements. The system may also consider outcomes six months and 12 months after a child leaves the provider's care. However, the system may not assign a single summary rating to residential group care providers.

3. Consider the level of availability of trauma-informed care and mental health and physical health services, providers' engagement with the schools that children in their care attend, and opportunities for children's involvement in extracurricular activities.

Background

The Group Care Quality Standards Workgroup was established in 2015 by the department and the Florida Coalition for Children with a goal to develop core quality standards for residential child-caring agencies (group homes) licensed by the department. In addition, the Group Care Quality Standards Workgroup created the Quality Standards for Group Care to aid children in receiving high-quality services that surpass the minimum thresholds currently assessed through licensing. The workgroup was comprised of 26 stakeholders including The Florida Institute for Child Welfare, group care providers, Community-Based Care Lead Agency staff, and other stakeholders. From the workgroup a draft set of standards was developed and approved by the department. The approved quality standards are broken into the following eight domains:

Quality Practice in Residential Group Care – Eight Domains

1. Assessment, Admission, and Service/Treatment Planning
2. Positive, Safe Living Environment
3. Monitor and Report Problems
4. Family, Culture, and Spirituality
5. Professional and Competent Staff
6. Program Elements
7. Education, Skills, and Positive Outcomes
8. Pre-Discharge/Post-Discharge Processes

The institute developed a project plan that consisted of six phases including:

1. Development of core quality performance standards
2. Development of a quality assessment tool
3. Feasibility pilot
4. Implementation pilot
5. Statewide implementation
6. Full validation study and evaluation

Oversight Activities

Quality Standards Assessment Tool

Following the approval of the quality standards and development of the project plan, the institute took the lead on the development and validation of an assessment tool designed to measure residential group providers within the eight domains.

As a part of this effort, the institute completed an extensive report entitled the *Development and Validation of the Group Care Quality Assessment: Fiscal Year 2017-2018 (Boel-Studt, 2017).* This report provides a detailed description as to:

- Implementation and evaluation of field test results;
- Recommendations for measurement revisions and successful integration across the state; and
- Initiating the statewide pilot; and
- Identification of core outcomes for residential group homes.

For the full report, please see attachment from the Florida Institute for Child Welfare entitled: *Development and Validation of the Group Care Quality Assessment: Fiscal Year 2017-2018* (Boel-Studt, 2017).

Accountability System

The Quality Standards Workgroup reconvened in January 2018 to begin work on defining the statewide accountability system for group care. The research team has completed an extensive review of the research literature to identify and define the outcomes used in prior group care studies to generate recommendations to guide the workgroup in selecting a set of outcomes. The workgroup anticipates a preliminary list of outcomes and recommendations will be ready for internal review in the Fall of 2018 in addition to engaging the workgroup in next steps.

Conclusion

The department has worked toward implementation of the statutory requirements and goals associated with the Quality Standards for Residential Group Homes contained in section 409.996, Florida Statutes. The department has completed the field test of the Quality Standards Assessment tool and has established evidence of scale score reliability and validity of the Florida Group Care Quality Standards Assessment. The project team and contributors have made great progress with further developing and refining implementation procedures. In preparation for the statewide pilot, trainings were conducted in all six regions followed by the start of the year-long period of data collection. The aim of the pilot is to evaluate the assessment for accuracy, efficiency, and fidelity to facilitate greater uptake of the quality standards at the program and state levels. The completion of the statewide pilot and selections of outcomes in the upcoming year will mark critical progress toward fully validating the assessment and finalizing procedures.

FLORIDA INSTITUTE
for CHILD WELFARE

FINAL REPORT

PROJECT TITLE: Development and Validation of the Florida Group Care Quality Standards Assessment: Fiscal Year 2017-2018

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Executive Summary

This project is part of an ongoing initiative to enhance the quality of care provided in residential group homes licensed by the Florida Department of Children and Families (Department). In 2015, The Group Care Quality Standards Workgroup established a set of quality practice standards for residential group homes drawing upon published literature and the expertise of the workgroup members. Following the Department's approval of the standards, the Florida Institute for Child Welfare (FICW) developed an assessment, the Florida Group Care Quality Standards Assessment (FGCQSA), designed to measure the extent to which practices and conditions within group homes are consistent with the standards defined by the work group. The assessment was designed to be implemented as part of the state's re-licensing process. A feasibility study was conducted using a sample of 10 group homes in one service region. The results supported the feasibility of implementing the assessment as part of the annual re-licensure process and provided initial evidence of scale score reliability. This was followed by a larger field test of a revised assessment including two service regions and a larger sample of group homes (n = 37). In this report, we present results from the field test and recommendations based on the culmination of findings from the feasibility study and field test. In addition, we provide a progress update from the ongoing statewide pilot and efforts to identify a preliminary set of outcomes to use to establish construct validity and consider for inclusion in statewide accountability system for residential group homes.

The aims of the field test were to evaluate and refine the assessment tool and implementation protocol and inform the development of a comprehensive training to guide statewide implementation. The study sample included 31 group homes and six shelters located in the Central or Northeast regions of Florida. In addition to assessment data, we collected process data from both regions from technical support/adherence calls with the licensing teams, site observations, and post-field test participant debriefing sessions.

Consistent with the feasibility study, response rates among various respondents (i.e., youth, Group Home Directors, Direct Care Workers, lead agencies, Licensing Specialists) remained high (79-100%), while the percent of programs with completed assessments submitted by all respondents was 69 percent. Rates of missing due to non-response were remained low (<5%). The selection of 'not applicable' (NA) responses was higher for certain items (i.e., standards). We flagged items with a higher percentage of NA ratings ($\geq$25%) and low variance ($\geq$90%) for follow-up during the participant debriefing sessions. The purpose was to ascertain reasons underlying respondent ratings that may reflect a need to clarify the meaning of the items or standards, divergent views on the applicability or practicability of certain standards, or, in some cases, a tendency toward positive response biases.

Results of a confirmatory factor analysis for the Service Provider Form A (SPFA) [1] and Licensing Form (LF) supported the *feasibility* of an eight-factor model and a seven-factor model for the Youth Form (YF) and Service Provider Form B (SPFB).[2] For most of the scales, reliability coefficients were in the acceptable to excellent range.

[1] SPFA is completed by group home directors and staff.

[2] SPFB is completed by case managers, placement coordinators, supervisors or contract managers from the lead agencies.

Thematic analyses of text responses from the assessment, documented triage calls, debriefing sessions and field notes organized around three focal areas: the implementation process, the assessment forms and items, and training needs and recommendations. Common themes related to implementation indicated participants perceived the process as manageable, few issues with participation across the various respondents, and a need to further adapt the sampling methods to increase fit with the practice context. Participants provided feedback on item language and terms needing clarification. Participants shared mixed views on the applicability and practicability of some of the standards. In some instances, the standards reflected practices that are not currently the normative practice across group homes that require a substantial shift in perspectives and practices in the field (e.g., family and youth involvement during admissions). In other instances, there were mixed views among providers where some felt the standards reflected areas that were the responsibility of the case manager (e.g., working with psychiatrists to manage medications) while others reported they were engaging in these practices. These discussions pointed to areas where the standards may have potential to positively affect practice through facilitating incremental changes and provided guidance for revising items to more precisely capture aspects of care that are within the group home provider's range of influence. Assessment data and participant feedback also pointed to standards that may be less applicable for shelters. This resulted in the creation of a version of the assessment adapted for shelters. Finally, participants identified the need for training focused on assessing informal and/or undocumented practices and education on the use of multiple assessment methods and content areas including evidence-based/informed practice and trauma-informed approaches. The combined results from the feasibility study and implementation pilot yielded eight recommendations to guide the next phases of the project.

In preparation for the statewide pilot, we conducted trainings in all six regions followed by the start of the yearlong period of data collection. With the statewide pilot, the project team achieved an important milestone in that the FGCQSA is now being implemented in all six regions. The pilot will include the full population of Department licensed group homes and will conclude in March 2019. Process data collected during technical support calls shows emerging evidence of positive impacts of the FGCQSA, with several providers reporting that they are using the assessment as an opportunity to review their models to guide quality improvements.

Project Description

Purpose

The purpose of this project is to develop, validate, and evaluate a quality assessment for residential care programs licensed by the Florida Department of Children and Families (Department). To date, a feasibility study and implementation pilot (i.e., field test) have been completed with a statewide pilot in progress at the time of this report. This report provides a brief review of the project phases completed prior to the current fiscal year and a detailed summary of project activities and milestones achieved in 2017-2018.

Background

Ensuring that children in residential group care (RGC) receive the services and supports needed to achieve safety, permanency, and well-being is an ongoing concern among child welfare stakeholders nationally. Research findings highlight the heightened vulnerability that characterizes the subset of children likely to be placed in RGC. Compared to children receiving community-based care or placed in non-residential settings, children in RGC often have more complex abuse/trauma histories and more extensive mental/behavioral health problems.[1,2,3,4,5,6] Characteristics common to children admitted to RGC (including severe mental/behavioral health problems and experiencing multiple placement changes, often prior to placement in RGC) negatively impact child well-being and are associated with poorer permanency outcomes.[7,8,9,10]

Research on the effectiveness of RGC overall supports that youth experience improvements following placement,[11,12,13] and that quality of care affects service outcomes.[14,15] With the increased emphasis on accountability at the federal and state levels,[16,17] efforts to identify and address issues impacting the quality of care and effectiveness of RGC are needed. The Association of Children's Residential Centers (2009),[18] and the Child Welfare League of America (2007),[19] along with a number of other stakeholders, recommend licensing, accreditation, and the development of core practice standards as a starting place for initiatives focused on improving the quality of residential programs.

The development of core practice indicators and performance standards is a valuable means for assessing quality. Quality standards build upon the frameworks of licensing and accreditation to identify critical values and practice foundations for achieving a broader service mission.[20] Establishing and measuring desired performance standards and outcome indicators can be used to assess the degree to which residential programs are providing quality care and inform a process of continuous quality improvement.[21]

Quality Standards for Florida's Residential Group Homes

Work on the development of quality standards for Florida's residential group care programs began in 2015. The project plan consists of six key phases including:

1) Development of core quality performance standards
2) Development of a quality assessment tool

3) Feasibility study
4) Implementation pilot
5) Statewide pilot
6) Full validation study and ongoing evaluation.

Phases 1-3 were completed in FY 2016-2017. During the FY 2017-2018, work on Phase 4 was completed and Phase 5 was initiated.

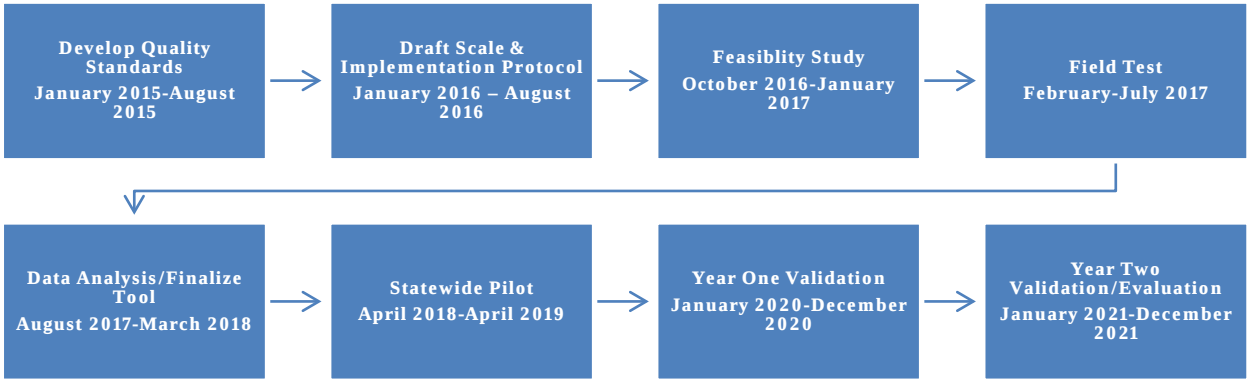

Figure 1: Quality Standards Project Timeline

Phase 1: Development of the Core Quality Standards for Residential Group Care

The Group Care Quality Standards Workgroup was established by the Florida Department of Children and Families and the Florida Coalition for Children (FCC) in April of 2015. The aim of the workgroup was to develop a set of quality standards for Department licensed residential group homes to ensure children receive high quality, needed services that surpass the minimum thresholds being assessed through licensing. A set of standards derived from published literature and the expertise of the workgroup was completed and approved by the Department in August of 2015. Practice standards were organized into the eight quality domains below (see Group Care Quality Standards Workgroup, 2015):[22]

1. Assessment, Admission, and Service/Treatment Planning
2. Positive, Safe Living Environment
3. Monitor & Report Problems
4. Family, Culture, & Spirituality
5. Professional & Competent Staff
6. Program Elements
7. Education, Skills, & Positive Outcomes
8. Pre-Discharge/Post-Discharge Processes

Phase 2: Development of the Florida Group Care Quality Standards Assessment

Following approval of the standards, the Department engaged the FICW to develop an assessment designed to measure, document, and facilitate quality services in Florida's

Department licensed RGCs. The objectives entailed designing and validating an assessment to quantify the core quality standards as defined by the Group Care Quality Standards Workgroup and developing a process for implementing the assessment as part of the Department's re-licensure process.

Steps in the development of the FGCQSA included distilling the standards, conducting a crosswalk of the standards with state licensing code (C65-14), selecting priority standards for inclusion in the assessment, and developing a draft assessment tool.

The draft assessment tool and implementation plan were completed in September 2016. Following review by the Department, the team received approval to move forward with the feasibility study. For details on content validation and project planning see: *Development and Validation of the Group Care Quality Assessment Fiscal Year 2016-2017 Phases II/III*.[23]

Phase 3: Feasibility Study

The purpose of the feasibility study was to evaluate the feasibility of the embedding the assessment into the state licensing system and to collect field data to conduct an initial examination of instrument psychometrics.

The final sample included 10 group homes in the Central region. Drawing upon the combined qualitative and quantitative data and our experiences with the pilot study, areas of strengths and challenges were identified. Overall, participants expressed support for the assessment with a number of them expressing views on the value of the assessment and its potential to have positive impacts on group care. The preliminary findings supported the feasibility of implementing a quality assessment within the state's licensing system as part of the annual re-licensure requirements. Results of the reliability analysis of the youth and provider forms were promising, with the overall scale and most of the subscales demonstrating acceptable to excellent reliability. The results demonstrated that a promising foundation for the assessment had been established and provided critical insights to guide the next phase of development. For detailed results from the feasibility study, see: *Development and Validation of the Group Care Quality Assessment Fiscal Year 2016-2017 Phases II/III*.[23]

Fiscal Year 2017-2018: Phases 4-5

Phase 4: Field Test

The process of measurement development traditionally involves two to three phases of data collection, stakeholder reviews, and multiple revisions.[24] Field testing involves administering a draft form of an instrument using a sample of target respondents.[25] The purpose is to refine the draft form in preparation for a validation study. Given that the intent is to embed the group care quality standards assessment in the state's re-licensure process, the pilot studies also focused on implementation. To that end, the purpose of the field test was to evaluate the implementation of the assessment using two samples of group homes located in two different service regions. The aims of the field test were to evaluate

and refine the assessment tool and implementation procedures and inform the development of a comprehensive training to guide statewide implementation.

To evaluate the assessment, we focused on the following:

- Item responses patterns (e.g., evaluating patterns of missing and response variability)
- Scale dimensionality - Testing how well the data fit the hypothesized structure (i.e., an assessment comprised of eight quality domains [subscales])
- Internal consistency reliability - Examining how well the items within the subscales hold together such that they appear to measure a common construct or set of constructs (i.e., scalability)

In addition, qualitative data including text responses from the assessment, participant feedback from documented technical support calls with the licensing teams, two participant debriefing sessions, and field notes, were used to examine the following:

- The applicability and practicability (elements of ecological validity) of the standards as measured by the assessment when applied to the 'real world' of group care practice
- Implementation procedures (e.g., fit with re-licensure procedures, manageability of the assessment, attitudes and experiences of participants, etc.)
- Participant views on resources and training needs in preparation for statewide implementation

Methods

This study was approved by the Florida State University Institutional Review Board and the Florida Department of Children and Families Human Protections Review Committee. We utilized purposive sampling and mixed methodologies to collect assessment data and participant feedback. Group homes located in the Central (CR) or Northeast (NER) regions that were due for re-licensure during the study period were selected for inclusion. Group home directors, direct care workers, and personnel employed by the lead placement agencies in the region were invited to participate. Additionally, youths receiving care in the selected group homes were invited to participate. Licensing specialists used a combination of convenience sampling (i.e., selecting youth based on availability) and selecting youth randomly from a roster.

To begin, a half day orientation and training was held in each region. The orientation was open to licensing staff, group home providers, and lead agencies in the region. During the orientation, participants were provided with background information on the project, an overview of the assessment and its intended use, and information on the study and what participation would entail. A training with all members of the regional licensing teams was held following the orientation and focused on assessment procedures and study protocol.

The study consisted of three primary data collection components. First, data were collected using a revised version of the FGCQGA following the feasibility study. Second, we documented technical support calls and site visits with the licensing teams. Third, two

separate debriefing sessions were held in each region to collect participant feedback. Each of these components is described below. In addition, we maintained records of all meeting minutes, email correspondences between project team members and participants, and field notes recording significant events and ongoing reflections which served as supplementary data sources.

Component 1: Group Care Quality Standards Assessment

Sample and Setting

The final sample included 37 group homes located in either the CR or the NER. Table 1 shows the total number of each form completed by different respondent types. Eight homes were single sites that were part of a 'parent' program comprised of multiple sites. The revised sampling plan for the field test specified that each group home site complete a separate assessment (i.e., sampling by site/campus). There were some differences in understanding among participants concerning whether an assessment should be completed for each site/campus or if one assessment should be completed for a program (which may encompass multiple sites). Respondents associated with multiple sites were required to complete multiple assessments. Based on respondent feedback, we found that many program directors and lead agency personnel tend to view the group homes as one program versus as individual sites. Due to this issue resulting in inconsistencies in sampling, response rates were computed for assessments completed for each program (versus site). This includes programs with multiple group homes located at different physical addresses, bringing the sample to 29 programs. Table 2 shows response rates by each respondent type for the 29 group homes. Consistent with the feasibility study, response rates among the various respondents remained high, indicating the majority of respondents who were asked to complete an assessment followed through. Sixty-nine percent of programs had completed assessments submitted by all respondents.

Table 1. Form Completion by Respondent Type

Forms Completed	Respondent Type	Percent Completion
LF (*n* = 37)	Licensing specialist	37 (100%)
SPFA (*n* = 116)	Group home director	35 (30.2%)
	Direct care worker	47 (40.5%)
	Other staff[a]	34 (29.4%)
SPFB (*n* = 72)	Case manager	32 (44.4%)
	Placement coordinator	40 (55.6%)
YF (*n* = 78)	Youth	78 (100%)

Note. [a]Other staff includes a combination of supervisors, group home case managers, youth care workers, assistant directors, program managers, cottage parents and a CEO.

Table 2. Response Rates by Respondent Type

Form	Respondent	Requested/Completed	Percent Completed
LF	Licensing specialist	29/28	96.6%
SPFA	Director	29/29	100%
SPFA	Direct care worker	29/29	100%
SPFB	Case manager	29/23	79.3%
SPFB	Placement coordinator	29/28	96.6%
YF	Youth	29/27	93.1%
Total	All	29/20	69.0%

Procedures

With the exception of revisions to the sampling plan, implementation procedures for the field test were consistent with the feasibility study including oversight provided by the licensing teams. The field test was initiated in early March 2017 and data collection was finalized in July 2017.

Measures

Section one of the assessment is designed to collect information about respondents and group homes and includes multiple choice and text response items. Section two is comprised of eight scales for each of the practice domains and the standards. Respondents are instructed to rate items based on how well they represent practice in the group home using a 5-point Lickert-type scale (1 = Not at all, 5 = Completely). This section also includes text response items in which respondents are prompted to provide additional information related to certain standards and general comments pertaining to their ratings.

With the exception of a few changes and additions, the structure and content of the revised FGCQSA used in the field test was the same as the pilot version. Items were revised based on analyses of pilot data and stakeholder feedback. An additional change included the creation of a separate form (i.e., Service Provider Form B) designed to be completed by external providers (i.e., case managers and placement coordinators). For the feasibility pilot, all providers (i.e., group home directors, direct care workers, case managers, and placement coordinators) completed the same form. Another change was excluding the fifth subscale (Domain 5: Professional and Competent Staff) from the Service Provider B and Youth Forms due to the items being focused on training and supervision of staff; areas of practice of which external providers and youth were found to lack first-hand knowledge.

A final addition was the creation of two new checklists that were added to the licensing specialist form. The Trauma-Informed Care Checklist (TICC) is designed to assess the extent to which a program is using a trauma-informed approach. The TICC is comprised of five dichotomous (0 = no, 1 = yes) items. Example items include *"All program staff are trained in trauma-informed care", "The program screens and/or assesses for trauma in all youth"* and *"The program provides trauma-focused individual or group therapy"*. Scores are summed and can range from 0-5. The summed score is used to rate the corresponding item on the quality standards assessment (Domain 6. Item: *The program uses a trauma-informed*

approach). A similarly constructed and scored checklist, the Evidence-Informed Model of Care Checklist (EIMCC), includes five dichotomous items including *"The program has a clearly described model that is documented in a handbook or manual", "The program model is informed by published research on evidence-based practices"* and *"Within the past five years, the program had its own quality assurance specialist or other staff members evaluate the model finding evidence to support its effectiveness in helping youth achieve positive outcomes"*. The summed score is used to rate the corresponding item on the quality standards assessment (Domain 6. Item: *The program uses an evidence-informed model of care*).

Component 2: Triage Calls and Site Visits

Throughout the field test, regularly scheduled triage calls were held between the project team and the licensing teams in each region. In addition, the project team conducted a site visit in each region that involved observing the licensing specialists during a site inspection of a group home and completing the FGCQSA. The purpose of the triage calls and site inspections were to provide/receive progress updates and to identify and discuss implementation challenges and questions. Detailed notes were taken by at least one member of the project team during each call. In total, three triage calls were held with the licensing team in the NER. In the CR, two calls were held, and one took place in person prior to the site visit.

Component 3: Participant Debriefing Sessions

A debriefing session was held in each region with field test participants in August 2017, following the completion of data collection. Participants included members of the licensing teams, group home providers, case managers and placement coordinators. A total of 24 participants attended the NER session and eight participants attended the CR session. The NER session was held at the Department of Children and Families in Jacksonville and the CR session was held at the Kids Central CBC.

The debriefing sessions were each approximately two to three hours and structured so that all participants attended the first half and the second half was limited to the licensing teams. Participants were asked to provide input on item ratings, especially focusing on items that 25 percent or more respondents rated as 'not applicable'. In addition, participants were asked about their experiences with taking part in the assessment process. Finally, participants were asked to provide suggestions for training, including what content they would like to see more coverage of, and what additional training formats (e.g., web-based) and resources would be beneficial to facilitating learning and successful implementation.

Analysis

Quantitative analyses were performed in SPSS version 23 and Mplus 7. Descriptive analyses were used to describe the sample and summarize responses on the assessment. A reliability analysis was performed to examine internal consistency reliability. A confirmatory factor analysis was performed as a *preliminary* examination of scale dimensionality. Documented notes from triage calls and the debriefing sessions along with

meeting minutes, emails, and field notes were sorted and analyzed. A thematic analysis[26,27] was used to identify themes related to three focal areas: 1) the assessment items; 2) implementation; and 3) training needs. Two trained members of the project team independently reviewed and coded content related to the three focal areas (level 1 coding). Initial codes were reviewed and discussed among three members of the project team. This was followed by a second review to identify sub-themes within the larger themes (level 2 coding). These themes were again reviewed, and the salient themes agreed upon by the team were selected and interpreted.

Results

Descriptive Analysis

A descriptive summary of group home characteristics is presented in Appendix A. The sample of homes was split about evenly between the regions. The majority (62%) use a shift-care model with fewer than half of all homes having been accredited (38%). The most common types of services included recreation (97%), life skills development (87%), and education/educational supports (73%) followed by behavioral health (67%) and family support services (62%). The service population is diverse, encompassing youth of all ages and genders who are referred from various systems and voluntarily.

Item Analysis

Descriptive analyses were used to examine item response patterns and preliminary scores. *The scores are not intended to be interpreted as group homes' performance on the standards.* Rather, the focus of these analyses was to examine response variability, missingness, and skewness; issues that are relevant to the performance of the assessment and interpretation of ratings.

Frequencies were run for items from all four assessment forms. Here, we focused on issues with missing and response variability. Missing due to nonresponse (i.e., respondent left item blank) was minimal across forms (<5%). Items in which ≥25% of respondents rated it as 'not applicable' were flagged as this may reflect areas where there is a lack of clarity on the meaning of an item or the applicability of a standard.

Items with minimal response variability were also flagged. That is, items that 90 percent or more of the respondents rated as 5 (5 = statement is completely consistent with practices or conditions in the group home) were flagged. This may reflect various possibilities including positive response bias, highlighting areas where group homes are already performing exceptionally well[3], or a tendency among respondents to interpret the application of the standards from a dichotomous viewpoint (i.e., yes the standard is met or no the standard is not met) where, in reality, this likely to be more nuanced.

Table 3 summarizes items meeting these criteria for all four forms (see Appendix B for table listing the actual items by form). Some level of missing due to NA was observed for all

[3] None of the items received a majority rating of 1.

forms. However, issues with low variability in ratings was only observed among group home providers' responses (SPFA) and, to a lesser extent, the licensing specialists. A more salient tendency toward positive ratings was observed on the forms completed by group home providers, in particular, among respondents in administrative positions (e.g., directors). A subset of these items was selected for follow-up during the debriefing session with participants to try to ascertain reasons for the NA ratings and/or lack of variability in ratings.

Table 3. Items Flagged Due to Not Applicable Ratings or Low Response Variability

Form	Not applicable (≥25%)	Item response variability (≤10%)
SPFA (total items 74)	8 items (10.8%)	18 items (24.3%)
SPFB (total items 66)	10 items (6.6%)	0
YF[4] (total items 69)	9 items (13.0%)	0
LF (total items 78)	6 items (7.7%)	6 items (7.7%)

Data Preparation – Missing Data and Skewness

Missing and overly skewed data can bias results of analyses leading to inaccurate interpretations. To address issues with missing data, we applied listwise deletion and imputation. Multiple imputation (i.e., predictive mean matching) was performed for items with 25 percent or less missing. Items with >25 percent were excluded from analyses (listwise). Items meeting the above criteria for low variability were excluded from subsequent analyses.

Descriptive Summary of Scores

Across forms mean scores for domains 2, 3, 4, 5, 6, and 7 ranged from 3-5, indicating the overall practices and conditions in the group homes were rated as somewhat to completely consistent with the collective standards in a given domain. Mean scores across respondents varied more for domains 1 and 8. Comparing these results to the scores obtained from the sample of 10 group homes included in the feasibility study showed increased variability in ratings during the field test, particularly on the licensing form.

[4] The majority (98%) of items rated as NA on the Youth Form were related to family involvement.

Table 4. Average Domain Scores by Respondent Type (Form)

	LF		SPFA		SPFB		YF	
Domain	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Assessment, Admission & Service Planning	2.88	1.19	4.38	.55	3.76	.92	3.88	.93
Positive, Safe Living Environment	4.57	.40	4.78	.29	4.20	.75	4.17	.74
Monitor & Report Problems	4.46	.56	4.77	.37	4.15	.70	4.29	.91
Family, Culture, & Spirituality	3.90	.72	4.81	.31	4.31	.70	4.41	.77
Professional & Competent Staff	4.14	.75	4.74	.46	--	--	--	--
Program Elements	3.99	.67	4.78	.29	4.14	.75	4.48	.62
Education, Skills, & Positive Outcomes	4.25	.72	4.70	.42	3.99	.93	4.25	.89
Pre-Discharge/Post Discharge Processes	2.57	1.21	4.42	.86	3.84	.93	3.71	1.11

Note. SD = standard deviation for the sample mean.

Confirmatory Factor Analysis

A *preliminary* confirmatory factor analysis was performed to evaluate scale dimensionality. The analyses tested the fit of the data with the assessment modeled with the eight hypothesized subscales for the SPFA and seven subscales for the YF and SPFB. The results are viewed as providing *preliminary* evidence of scale structure. CFA is a conventional method for determining which items to retain or exclude from a scale to increase fit and parsimony. In the process of improving model fit, items were temporarily removed from the model. These items may be candidates for future reduction based on a combination of results and substantive reasoning. However, given the small sample and potential issues with insufficient power to detect inter-item correlations, no items were permanently dropped at this time. A combination of model fit indices and removing items (temporarily) with factor loadings <.60 was applied.[28,29] In sum, the results of the CFA for the SPFA supported the *feasibility* of an eight-factor model and a seven-factor model for the YF and SPFB. Fit statistics are shown for the final best fitting model for each form after removing items. These analyses could not be performed on the LF due to the small number of completed forms (n = 37).

Table 5. Fit Statistics for the Final Models for Three out of Four Scales

Fit Model (items retained)	X^2	df	X^2/df	RMSEA	CFI	TLI
SPFA (37 items)	667.626	601	1.11	.031	.963	.995
SPFB (34 items)	746.30	515	1.44	.080	.975	.973
YF (48 items)	1246.83	1065	1.17	.047	.973	.972

Note. Cut-off values indicating good fit for each index are as follows: Chi-square Goodness-of-Fit Ratio (X^2/df) < 2, Root Mean Square Error of Approximation (RMSEA) < .08, Comparative Fit Index (CFI) < .90, Tucker Lewis Index (TLI) < .90.

Internal Consistency Reliability (Scalability)

Internal consistency reliability reflects whether items that make up a scale measure a common construct and is calculated from pairwise correlations between items. In general,

reliability coefficients that are ≥.90 are excellent, ≥ .80 are good, and ≥ .70 are acceptable. For most of the subscales, reliability coefficients were in the acceptable to excellent range. Cronbach's alpha for the third subscale (Monitor & Report Problems) fell below the cutoff for the LF, SPFA, and YF. One other subscale (Professional & Competent Staff), which is only included in the LF and SPFA forms, fell below the cutoff. This indicates potential issues with inter-item correlations for these subscales which may be addressed through item revisions, deletion, or additions. Of note, the TICC and EIMCC exceeded the minimum cutoff.

Table 6. Internal Consistency Reliability for All Four Forms

	LF	**SPFA**	**SPFB**	**YF**
Subscale	α	α	α	α
Assessment, Admission, & Service Planning	.90	.76	.90	.84
Positive, Safe Living Environment	.80	.81	.94	.89
Monitor & Report Problems	.64	.46	.73	.60
Family, Culture, & Spirituality	.86	.76	.93	.86
Professional & Competent Staff	.32	.59	--	--
Program Elements	.86	.78	.94	.90
Education, Skills, & Positive Outcomes	.80	.76	.90	.87
Pre-Discharge/Post-Discharge Processes	.83	.70	.74	.69
TICC	.77	--	--	--
EIMCC	.84	--	--	--

Note. The Kuder-Richardson method for evaluating scale score reliability for scales with binary (yes/no) items was used with the TICC and EIMCC. The value and interpretation is equivalent to Cronbach's alpha.

Participant Feedback

Thematic analyses of text responses from the assessment, documented triage calls, debriefing sessions and field notes organized around three focal areas: the implementation process, the assessment forms and items, and training needs and recommendations. Sub-themes based on recurring comments related to each are discussed below.

Implementation Process

The analysis of the implementation process focused largely on participants' experiences and participation in the assessment and the fit of the assessment procedures within the existing re-licensing process. Commonly identified themes were related to manageability of the process, youth participation, and sampling methods.

Manageability of the process. Overall, there were minimal issues with implementation. Participants expressed support and a willingness to participate, and were able to access and complete forms upon request with few problems. Although the overall feedback from the licensing teams reflected that participants perceived the implementation process to be manageable, it was noted that the more involved process for completing the licensing forms and providing oversight in the completion of other forms resulted in a slightly longer

process for licensing specialists. It was suggested that adding a feature so that licensing specialists can receive notification of forms that are in-progress or incomplete which would trigger automatic follow-up notifications to complete surveys could help minimize time spent tracking form completion and engaging in follow-up activities.

Youth participation. Similar to the feasibility study, feedback during the field test supported that there were few issues with youth participation. It was noted that the youth were completing the forms quickly (10-15 minutes on average). Whenever possible, licensing specialists were present while youths completed their forms, assisting as needed and interjecting to inquire whether they had any questions. This was viewed as helpful to the process. Some youth were also noted as commenting on the length. In response, it was suggested that a feature that would allow youth to track their progress be added to the form.

Sampling method. Further clarity regarding sampling methods continued to surface as a need. Two themes related to sampling methods emerged. First, there were different views regarding the relevancy of having individual homes (sites) each complete a survey or whether to include multiple homes that were part of the same program in one assessment. A further concern was related to certain providers (e.g., group home directors who were responsible for multiple site/homes, case managers, placement coordinators) having to complete multiple assessment forms. In their feedback, these providers shared feeling that this was a duplicative effort and that they tend not to view the homes on an individual basis but as part of a unified program, reflecting a need to adapt the sampling methods to more adequately fit the practice context.

Assessment Forms and Items

Analyses of the assessment focused on participant's perceptions of the applicability, clarity, and relevancy of the items. Identified sub-themes related to the assessment forms and items included defining terms/adding criteria to guide ratings, practicability of the standards, applicability for different types of homes, and assessing informal/undocumented practices.

Defining terms/adding criteria to guide ratings. Differences in understanding or lack of clarity regarding the meaning of certain terms emerged in our discussions with participants. As an example, participants requested clarification concerning the time frame and practices intended to be encompassed by items asking about the admission process. During the debriefing, participants discussed whether admissions should include pre-admission and post-admission intake. In other instances, participants identified terms that needed to be rephrased or further defined (e.g. Level of care, service/treatment/care plan, evidence-based practice).

Other items reflect standards that overlap with requirements in the licensing code, but the standard exceeds licensing requirements. For example, an item from Domain 1 stating that service plans are reviewed every 90 days was rated as 'not applicable' by several respondents with some providing the rationale that service plans are only required to be

reviewed every six months according to current policy. While this is correct, it suggests that participants may need further education on the purpose of the standards and their relation to current licensing requirements which serve as the minimum quality thresholds with the standards being designed to expand upon these requirements. Therefore, it is possible to meet the licensing requirement of six-month reviews while not meeting the *quality enhancement* standard of 90 days.

Practicability of the standards. Participants shared mixed views on applicability and/or practicability of some of the standards. In some instances, these views may reflect standards that represent practices that may not be the current normative. For instance, feedback from multiple sources indicated that youth and family involvement in admissions decisions and family involvement in service planning and provision are presently not routine practice across the field. However, some providers shared examples of efforts to involve youth and families in the admissions process and engaging family. For example, multiple providers reported asking youth about their views on being on be admitted to the program as part of the intake interview. As an example of family engagement, some providers noted encouraging family involvement through visitation and inviting family to participate in group home activities. One provider gave an example of a parent who comes to the group home to cook for the youth on certain days. Engaging family in their child's care, however, was understandably viewed as challenging as many families are not involved, difficult to engage, or could create liability issues for the group home.

Discussions about the practicability of standards to group home providers also focused on whether a given practice was the responsibility of the case manager or the group home provider. The extent to which family involvement was a realistic expectation was discussed with some providers, indicating that it is not within the provider's control and that family involvement was dictated by case managers and the courts. Whether some practices reflected in the standards were the role of the provider or case manager was discussed in relation to other standards as well, including working with a psychiatrist to manage psychiatric medications. Some providers indicated that this was the role of the case manager while others reported more direct involvement including setting appointments, taking youth to appointments, and talking with psychiatrists.

Other comments were about the practicability of standards for following up with youth and caregivers post-discharge and monitoring post-discharge outcomes. Most providers indicated not formally engaging in follow-up and expressed that this would be challenging due to time constraints and difficulty with keeping track of youth. Provider's ability to engage in discharge and transition planning was noted as being limited due to the frequently limited time between being notified that a youth is being discharged and the actual discharge. Not being informed of impending discharges in advance allows providers little time to prepare youth for the transition.

Applicability of standards for different types of homes. Concerns regarding the applicability of certain standards to emergency shelters were highlighted initially during the feasibility study and were echoed during the field test. For instance, emergency shelters are not required to develop service plans and, due to the limited time in which youth are in care,

the educational and some family-involvement standards were considered inapplicable. Some shelter providers reported engaging in efforts to involve families and support youth's cultural and spiritual identity through providing access to religious services and other activities.[5]

Assessing informal/undocumented practices. Another point of feedback concerned the ability to assess the practices that occur on a more informal basis for which there is little supporting documentation. As an example, programs' proper use of formal grievances was mentioned as difficult to rate unless a grievance had been filed and, for many programs, this is a rare occasion according to licensing specialists and providers. In these cases, licensing specialists or other respondents would need to rely on documented policies and forms and to discuss the process with providers and youth. Other examples included supervision meetings that were regular but less formal and not documented and programs' quality improvement efforts. Few programs, particularly smaller ones, were reported to have a formal quality assurance department or designated specialist, but there may have been quality assurance activities occurring. In addition, ascertaining whether certain training standards were met was challenging due to limited detail in the documentation on staff trainings. In the future, group care providers may want to focus on documenting activities related to the standards to ensure they are reflected in sufficient detail.

Participant Feedback on Training Needs. Participants provided suggestions on resources and content to include or spend more time focusing on during trainings to help them feel more prepared to complete the assessment. One participant felt that there was a need to reiterate/emphasize that respondents, particularly case managers, should assess programs as a whole, not based on one or a few cases. Others agreed with this suggestion. Other suggestions included spending time during the training to further discuss certain topics such as trauma-informed care and evidence-based and evidence-informed practices and, specifically, how to assess whether programs are meeting standards related to these areas. In addition, respondents requested further guidance on how to rate certain items including the use of examples and scenarios to demonstrate. Some participants felt that the use of web-based training as boosters or for new employees could be useful. Finally, some participants indicated that a condensed, more concise manual may facilitate greater utilization.

Summary of Key Findings and Recommendations

The challenge of translating practice and policy generated standards into clearly defined domains and measurable standards that can be meaningfully applied in a practice context comprised of a heterogeneous population of group homes and stakeholders with widely varying perspectives while accounting for multiple system-related influences cannot be understated. Recognizing and accounting for these complexities is critical to bridge the gap between good intentions, politically driven mandates, research-informed practice and,

[5] Sub-analyses were performed on a sample of six shelters that were included in the field test to identify standards that were viewed as inapplicable. The results were discussed with respondents during the debriefing and used to select standards from which shelters would be exempt. A report of these analyses is available upon request.

ultimately, achieving what is in best interest of children in care. Since the development of the quality standards for residential group care, substantial progress has been achieved in the development and piloting of the FGCQSA. *Specifically, the aim of the assessment is to provide a reliable and valid measure with potential to facilitate the uptake and integration of an ecologically valid set of quality practice standards among group homes throughout Florida.*

The combined results from the feasibility study and field test have yielded many insights and recommendations for measurement revisions and successful integration across the state using a research-informed, data-driven process. Below, we summarize key findings and offer recommendations related to continued development and refining the assessment and implementation procedures and developing the statewide FGCQSA training.

Implementation Process

The combined findings from the feasibility study and field test support that integrating the FGCQSA into the state's re-licensure process is feasible and that a promising framework has been established for statewide implementation. The pilot studies shed light on areas to target for further development. During the pilot studies response rates among different stakeholder groups were evaluated as one indicter of participation. While each stakeholder group included in the pilots, and some that were not (e.g., parents), were considered important contributors in a multi-informant assessment of group care quality, we needed to determine which groups can serve as reliable data sources for a mandatory annual assessment. We found response rates among all stakeholders to be quite high during both studies but noted that the number of programs with assessments completed by all respondents dropped somewhat during the field test. We also used the pilots to test different sampling strategies. Challenges with the sampling methods were encountered in both pilot studies. Based on these results, we offer several recommendations for adapting the sampling methods to increase the fit within the service context.

Assessment completed at the level of programs within a regional boundary

We recommend adapting the sampling strategy so that a single assessment is completed for *each group care program*. That is, each group care program, whether the program consists of a single group home or multiple homes located on one campus or with different physical addresses within a region, is represented by one assessment (versus separate ratings for each site or campus as was done in the earlier pilots). Group homes that are part of a larger parent program often follow the same operating procedures and policies. Oftentimes, we found that the site directors, supervisors, and even staff may oversea or work in multiple sites that are part of the same program, particularly if those sites were located within relatively close proximity to one another. However, facilities operating under different models (e.g., shelter care vs. group home) that are part of the same parent agency should continue to complete separate assessments.

Fit sampling to respondent roles

Moving forward, we recommend that licensing specialists, directors, case managers, and placement coordinators complete one form for each program encompassing all sites within

the region. Such a change may minimize duplicative efforts and increase the fit between the assessment and the perspective of the professionals who more often view the group homes as one unified program versus as individual sites/campuses. Additionally, one service provider form B, currently completed separately by one case manager and one placement coordinator, could be completed at the level of the Lead Agency that contracts with the group home. This may include case managers, placement coordinators, contract managers, or others who are most familiar with the given group home being assessed. This may alleviate issues with identifying a single person to complete the form, allowing for multiple perspectives to inform the assessment and minimize the tendency to base ratings on individual cases (i.e., the assessment may be more representative of external providers' experiences with group homes). For direct care workers and youth, we applied an approach where a minimum of 2 or 10 percent, from each facility complete a separate form. We recommend continuing to apply this strategy and adding two options: group homes may opt to have all youth complete the assessment, and to request that all direct care workers complete an assessment. Implementing these strategies could reduce some of the burden on the licensing specialists, increase the representativeness of the assessment by increasing the sample of youth and direct care workers, and may help ensure higher response rates.

Assessment Forms and Items

A key purpose of the pilots was to test the applicability and practicability of the proposed set of standards in the actual practice context. We also conducted preliminary analyses of the measurement characteristics with promising results, showing reliability estimates for most scales to be in the good to excellent range. From these analyses, we identified areas to target for revisions that will improve the capacity of the measure to tap into the intended and relevant practices and to do so consistently across respondents.

Quality enhancement orientation

Analyses of the practicability and applicability of the standards extends to finding the proper, most relevant, and beneficial role of the standards within the practice context considering existing criteria (particularly licensing code) and policies. Given the intent of the standards is to expand upon licensing criteria, it may be most appropriate to view them from the standpoint of *quality enhancement*. This is fitting with the intended use and criteria that a group home must first be licensed in order to participate in the quality standards assessment. *From this perspective, the licensing criteria represent the minimum criteria that must be in place to ensure quality care while the quality standards represent practices and procedures that surpass minimum quality requirements*.

Revise items to increase targeted assessment and improved performance

The pilot data has also been useful in narrowing in on the aspects and scope of practices that are within the group care providers' range of influence. That is, the group home provider and their staff influence quality of care in a given domain or practice area versus external policies or providers (e.g., case managers, lead agencies, courts). Discerning the influences is oftentimes challenging, if not impossible, given the multiplexity of influences comprising the child welfare system and practices within it. Given the interconnectedness

of the providers and professionals who are part of the child welfare system, often there are multiple factors that impact service quality. Therefore, parsing out those elements that group care providers can reasonably be considered accountable for is essential. Based on the pilot findings, item language has been revised to more narrowly (or sometimes broadly) target those specific aspects. This is essential to developing an equitable accountability measure that can inform continuous quality improvement. At the same time, we are collecting, through qualitative methods, data to inform greater understanding of the various factors influencing quality practice both internal and external to the group care setting. This too can be used to inform systems changes that may facilitate higher quality services.

Revisions focused on clearly defining terms, increasing parsimony to promote greater ease and consistency in interpretation across respondents, and revising language to encourage greater response variability where needed. Related to the later point, we rephrased language to discourage dichotomous interpretations leading to ratings that are stacked on one end of the scale. Although the use of checklists (dichotomous scaling) has an appeal because of perceived ease, there is almost always a reduction of information when creating scales that are designed to encompass a wide range of constructs resulting a less accurate reflection of a more nuanced reality. Effectively expanding respondents' perspectives may take some time and training, however, it is essential to understanding the *extent* to which practices are being implemented versus whether or not group care programs have the capacity to provide quality. The later approach is purely structural and may be appropriate for an assessment of minimum thresholds, such as licensing, but provides limited information about the extent to which such practices are being put into place, how to precisely target practice enhancement initiatives, and, more importantly, the full extent to which given practices are associated with benefits to youth. Finally, some items were separated into two and a limited number of new items were added to Domains 3 and 5 in an effort to improve scale score reliability.

Training and Next Steps

Finally, we offer recommendations aimed at facilitating successful statewide implementation. These recommendations are specific to training and continued evaluation of implementation procedures and the assessment.

Developing a comprehensive training incorporating participant feedback

The suggestions previously mentioned were considered in the development of the statewide quality standards assessment training. Training content also focuses on educating participants on the use of documentation, observation, interviewing, and subjective experiences and judgment to inform item ratings.

Add features and processes to help licensing teams directly track survey completion

This is a simple addition that may include adding a feature to Qualtrics or other options to aid licensing teams' ability to track form completion and follow-up. We also recommend issuing regular status reports for each region.

Continue providing technical support

Regular triage calls and technical support was provided on an ongoing basis throughout both pilots. This greatly enhanced the project team's ability to monitor implementation and facilitates greater accountability. Another consideration might include conducting regional site observations and a mid-year booster session either in-person or via webinar. The assessment currently includes open-ended items that allow participants to provide feedback on their ratings. These have proven to be a useful source of information. We recommend retaining these items and adding open-ended item(s) requesting that respondents provide feedback on their experiences with participating in the assessment. This may provide another source of data to guide further implementation developments.

Large sample and selecting outcome measures for validation

Having a sufficiently large sample is *essential* to conducting rigorous analyses of scale dimensionality, reliability, and validity. The combined results of these analyses based on a larger sample along with substantive reasoning and continued input from key stakeholders will allow for selecting items to retain and to eliminate those that that are less relevant from the assessment. The *Group Care Quality Standards* (2015) proposed 59 standards with 248 sub-standards.[30] Substantial effort was made in the development of the measures to reduce the standards while not detracting from the efforts of the workgroup and the core meanings of the proposed standards. This has yielded a relatively lengthy assessment, which creates some burden in terms of time to complete the assessment. However, being inclusive of all potential practices that manifest quality care allows for a thorough examination of which practices are directly and indirectly associated with positive program and youth outcomes. A critical element of this will include identifying, selecting, and measuring a set of outcomes. We recommend collaborating with key stakeholders in the process of selecting a core set of outcomes that can be applied to most group homes and that are relevant to safety, permanency, and well-being.

Phase 5: Statewide Pilot

Purpose

The purpose of the statewide pilot is begin implementing the FGCQSA in all six regions, giving each region an opportunity to become familiar with the assessment and the procedures. The statewide pilot will include all DCF licensed group homes and shelters throughout the state representing more than 300 providers. Applying similar methods as in the two previous pilots, we are collecting assessment data that will be used to finalize the assessment in preparation for full validation. We are also collecting process data via technical support calls and survey data to evaluate implementation that will inform final adjustments to facilitate accuracy, efficiency, and fidelity to the process.

Statewide Pilot Training

With assistance from the DCF regional licensing managers, we conducted trainings in all six regions throughout February and March 2018. The trainings were well attended with representation from DCF licensing, Community-Based Care agencies, and group care

providers. A webinar of can be accessed using the following link: http://centervideo.forest.usf.edu/video/center/groupcaretool/cmmuntyprtnr/start.html.

Data Collection

Data collection for the statewide pilot officially began on April 2, 2018 and will continue through March 31, 2019. Based on the most recent verified counts, a total of 524 FGCQSA forms have been completed representing 83 group homes and shelters. Approximately 30.7% of the forms were completed by respondents in the Suncoast region, followed by 28.2% Central, 15.1% Southeast, 10.3% Northeast, 8.9% Northwest, and 6.6% Southern.

Table 7. Verified Regional Counts by Group Homes/Shelter & Respondent Type

	Central	Northeast	Northwest	Southeast	Southern	Suncoast	Total
Group homes/Shelters	24	13	5	12	7	22	83
Group home Director/Supervisor	31	14	4	20	7	31	107
Direct Care Worker	40	19	18	19	8	59	163
Youth	42	17	19	28	6	46	158
Lead Agency	15	0	4	6	7	8	40
Licensing Specialist	20	4	2	6	7	17	56
Total	148	54	47	79	35	161	524

Notes. Counts based on data reviews for each region were taken on the date of the most recent triage call (Central 8/15/18; Northeast 8/24/18; Northwest 8/21/18; Southeast 8/17/18; Southern 8/21/18; Suncoast 8/27/18).

Technical Support

Throughout the statewide pilot, the project team is providing on-going technical support to the regional licensing teams and providers. During the statewide pilot training, we provided participants with lead team members' contact information where they could direct questions or comments they encountered when completing the assessment. Similar to the previous pilots, we are also conducting regularly scheduled triage calls with each regional licensing team. Separate calls are held with each region in order to address specific questions and concerns. Biweekly calls were held with the four regions that were new to the assessment (Northwest, Southern, Southeast, Suncoast) and monthly calls were held with the two regions that participated in the initial pilots (Central, Northeast). Each call begins with a review of the data followed by discussing any questions and updates. Since the start of the pilot, 26 triage calls with the regional licensing teams have occurred.

Table 8. Summary of Technical Support Calls with Regional Licensing Teams

Central	Northwest	Northeast	Southern	Suncoast	Southeast
5/7/2018	5/15/2018*	5/25/2018*	5/15/2018	4/30/2018	5/11/2018
6/4/2018	5/29/2018*	6/22/2018	5/29/2018*	5/28/2018*	6/8/2018*
7/2/2018	6/12/2018	7/27/2018*	6/12/2018	5/14/2018	6/22/2018
8/6/2018	6/26/2018	8/24/2018	6/26/2018	6/11/2018*	7/6/2018
	7/10/2018		7/10/2018	7/9/2018	7/20/2018
	7/24/2018		7/24/2018	7/23/2018	8/17/2018
	8/20/2018*		8/21/2018	8/27/2018	

Note. Dates with an asterisks indicate calls that were cancelled due scheduling conflicts.

As the pilot has progressed the licensing teams have consistently reported that they are adapting to the process and finding it worthwhile. During the calls licensing specialists requested clarification on interpreting items (e.g., Does it count as a comprehensive assessment if the Community-Base Care agency provides the assessment?), how to handle issues with inconsistencies or limited documentation, or situations where the evidence was ambiguous (e.g., If the service plan only addresses strengths or needs but not both, how should that be rated? What if the group home uses a contracted therapist, does this still count as trauma-informed therapy? Can an IEP count as the educational assessment?). One frequently asked question concerned identifying a lead agency to compete forms for homes that do not or rarely serve dependency youth or where youths are referred from lead agencies outside of the region. The team responded to these questions on a case-by-case basis. However, although all homes licensed by the Department should take the FGCQSA, a lead agency form is not required for homes for which there is no identified lead agency.

The calls also provide an opportunity for the licensing teams to share feedback and to communicate questions they have received from the lead agencies and providers. Across regions, the licensing specialists reported that they are not encountering many questions or issues from providers. Providers have noted that the assessment feels lengthy and the licensing specialists have had to follow-up with providers and lead agencies to prompt completion. However, the follow-up efforts have been largely effective in increasing rates of form completion. Overall, feedback from providers has been supportive with views that the assessment has potential to yield positive results. Evidence of early impacts are beginning to emerge. The licensing teams have communicated that providers are using the assessment to review their program models and to make changes to improve quality where needed. One licensing specialist described her experience with assessing two group homes that used the same model and are part of the same program. After completing the site visit

at the first homes, she observed some differences from the first home including better quality and more organized documentation – improvements that were reportedly prompted by the initial site at the first group home.

Identifying Core Outcomes for Residential Group Homes

The Quality Standards Workgroup was reconvened in January 2018 to begin work on defining the statewide accountability system for group care. The workgroup was tasked with selecting a set of outcomes indicators for group homes. The selection of a research informed set of outcomes measures a required element of fully validating the GCQSA. Specifically, this will allow the research team to examine the extent to which the quality measures correlate with a set of youth and program outcomes generally organized in the areas of safety, permanency, and well-being. To date, the research team has completed an extensive review of the research literature to identify and define outcomes used in prior group care studies and to generate recommendations to guide the workgroup in selecting a set of outcomes. The research team is compiling the information and anticipates that a list of preliminary outcomes and recommendations will be ready for internal review this fall followed by engaging the workgroup in next steps.

Conclusion

Substantial progress was achieved in during the 2017-2018 fiscal year. With the completion of the field test, we established preliminary evidence of scale score reliability and validity of the FGCQSA. The project team and contributors made great progress with further developing and refining implementation procedures. Efforts to scale up the FGCQSA have begun with the statewide pilot. The aim of the pilot is to fit the assessment to the state – maximizing accuracy, efficiency, and fidelity in order to facilitate greater uptake of the quality standards at the program and state levels. The completion of the statewide pilot and selection of outcomes in the coming year will mark critical progress toward fully validating the assessment and finalizing procedures.

Appendix A

Group Home Characteristics (*N* = 37)

Item	*n*	%
Region		
Northeast	19	51.4
Central	18	48.6
# Homes on Campus		
One	31	83.8
Two	4	10.8
Three	--	--
Four	1	2.7
Five	1	2.7
Facility type		
Group home	31	83.8
Shelter	6	16.2
Model		
Shift care	23	62.2
Family style	14	37.8
Accredited	12	32.4
CARF	3	25.0
COA	6	50.0
Joint Commission	3	25.0
Services provided		
Education	27	73.0
Vocation	8	21.6
Recreation	35	97.2
Family support	23	62.2
Medical	18	50.0
Behavioral health	25	67.6

Case management	13	36.1
Life skills/IL	32	86.5

Note. IL = Independent living. Other services provided = coordinating visit, transport, equine, psychiatric, psychoeducational trauma recovery groups, moral/spiritual services

Service Population Characteristics (*N* = 37)

Item	n	%
Referral source		
Child welfare	37	100.0
Juvenile justice	6	16.2
Mental health	4	10.8
Voluntary	11	29.7
Age Range		
0-5 years	4	10.8
6-10 years	22	59.5
11-14 years	37	100.0
15-17 years	37	100.0
18-21 years	10	27.0
Sex of youth served		
Girls	8	21.6
Boys	11	29.7
Both	18	48.6

Note. n = number of programs.

Appendix B

Items Flagged for Missing (Not Applicable) or Minimal Response Variability

Form	Missing (>25%)	Item response variability (≤10%)
SPFA	1.2. When possible, families or significant others are involved in the admissions process (e.g., asked about their preference or how they feel about their child being admitted to the group home, present and involved during the decision-making process). 1.10. Service/treatment plans are reviewed with the youth and, when relevant, family, and updated at least every 90 days. 5.5. The treatment team meets with clinical supervisors on a weekly basis. 6.17. Staff work with a psychiatrist to manage youth medications. 8.4. Before a youth is discharged to a new placement, he or she is given a period of transitional time to become familiar and comfortable with the new placement. 8.5. Prior to discharge, the program helps connect youth and their caregivers with community resources and aftercare services. 8.6. Within 30 days after discharge, the program follows up with youth and their caregivers to check whether they are connected with aftercare services and other supports. 8.7. The program follows-up with youth and their caregivers to monitor post-discharge outcomes (e.g., permanency, educational, family, and functional outcomes).	2.2. All staff follow policies and procedures prohibiting the use of corporal punishment and the use of any practices that could constitute verbal or physical abuse or bullying. 2.3. The program has documented policies clearly stating the rights of the youth that are reviewed with youth. 2.4. All staff protect the rights of the youth in accordance with program policies. 2.5. The program provides for youths' basic needs (e.g., shelter, food, clothing, personal hygiene…etc.). 2.10. All staff closely supervise youth and respond quickly when a youth's actions threaten the safety of others in accordance with program policies. 2.11. All staff follow written policies and procedures to protect youth from self-harm, including the use of risk assessments and safety plans. 3.2. All staff report serious problems immediately during/following an incident to supervisors and report to external agencies and file incident reports as needed (e.g., crisis management, abusive practices, youth-to-youth incidents, suicidal behavior). 3.4. Youth may contact an advocate (e.g., GAL, case manager, child advocate) outside of the program to share concerns about their care. 3.5. All allegations of unsafe, inappropriate, abusive practices or medication errors within

Form	Missing (>25%)	Item response variability (≤10%)
		the program are reported to external oversight agencies. 4.1. The program allows youth to have contact, including phone calls and visits, with family whenever possible. 4.3. Staff understand the importance of family involvement and support family preservation and reunification. 4.8. Program staff respect youths' cultural identities (e.g., race/ethnicity, sexual orientation, gender identification). 6.2. The program provides a family-like environment to the extent possible based on the youths' needs (e.g., eating meals together, sharing in household chores and responsibilities, doing recreational activities together, etc.). 6.13. Regular staff meetings occur that are focused on youth progress, teamwork, and addressing program issues. 6.16. Staff are aware of medication adjustments, watch out for any adverse side effects, and report any concerns. 7.6. Staff teach pro-social skills, values, and behaviors to youth in the program.
SPFB	1.2. When possible, families or significant others are involved in the admissions process (e.g., asked about their preference or how they feel about their child being admitted to the group home, are present and involved during the decision-making process). 1.6. When possible, families are involved in creating service/treatment plans (e.g., help determine the goals, are present or consulted with as part of the service planning meetings). 3.3. All staff document steps taken to respond to grievances filed by youth and families. 3.6. The program uses surveys to assess consumer satisfaction with services (e.g., youth, parent/guardian, partner agencies). 7.2. For youth who stayed in this group home for a full school year, the majority (over 60%) of them progressed into a higher grade. 7.4. The program ensures that qualified youth have a current 504 Plan or Individualized Educational Plan (IEP). 8.1. Transition planning starts soon after admission and includes a focus on education and/or employment and other supportive services to help youth successfully transition from care. Transition plans include a focus on the continuity of family relationships.	None

Form	Missing (>25%)	Item response variability (≤10%)
	8.5. Prior to discharge, the program helps connect youth and their caregivers with community resources and aftercare services.	
YF	1.2. My family was involved in the decision to have me come to this group home. 1.5. My family helped set the goals in my current service plan. 1.8. My service plan includes goals and expectations for my family. 2.16. Staff use restraints or time out rooms only when there is no other way to keep us from getting hurt. 4.2. In this group home I have been allowed to have home visits on a regular basis. 4.3. Staff help make sure that I get to see or talk to my family on a regular basis. 6.5. Staff teach us about doing the right thing and caring about how our actions affect others. 7.3. I have a discharge plan that focuses on helping me find a permanent place to live, either on my own, or with others.	None
LF	1.4. Youth are involved in the admission process (e.g., asked about their preference or how they feel about being admitted to the group home, are present and involved during the decision-making process). 1.6. Effort is made to collaborate with other professionals who have worked with the youth in making admissions decisions (e.g., case managers, behavioral health providers, GAL, school staff). 3.6. Staff document steps taken to respond to grievances filed by youth and families. 5.1. Staff receive regular, documented supervision from program supervisors to ensure compliance with training and program policies and procedures. Please indicate the frequency (e.g., daily, weekly, biweekly, monthly...etc.) in which supervision occurs in the space below. 5.2. Staff receive training and demonstrate competency in teaching prosocial skills to youth. 6.16. Staff in this program appear to be actively involved with the youth during the daily routine.	2.3. The program has documented policies clearly stating the rights of the youth. 2.4. The program adequately provides for youths' basic needs (e.g., shelter, food, clothing, health care, personal hygiene). 2.9. The program has clear procedures for supervising youth and for how to respond when a youth's actions threaten the safety of others. 2.10. Physical restraints and seclusions are either not used or are used at the bare minimum in emergencies involving imminent safety risks. 3.2. The program has established policies and procedures for youth and families to file a grievance. 6.16. Staff in this program appear to be actively involved with the youth during the daily routine.

References

[1] Bettman, J. E., & Jasperson, R. A. (2009). Adolescents in residential and inpatient treatment: A review of the outcomes literature. *Child and Youth Care Forum, 38*, 161-183.

[2] Jaycox, L. H., Ebener, P., Damesek, L., & Becker, K. (2004). Trauma exposure and retention in adolescent substance abuse treatment. *Journal of Traumatic Stress, 17*, 113-121.

[3] Warner, L. A., & Pottick, K. J. (2003). Nearly 66,000 youth live in U.S. mental health programs. *Latest findings in children's mental health: Policy report submitted to Annie E. Casey Foundation, 2*, 1-2.

[4] Baker, A. J. L., Kurland, D., Curtis, P., Alexander, G., & Papa-Letini, C. (2007). Mental health and behavioral problems of youth in the child welfare system: Residential centers compared to therapeutic foster care in the Odyssey Project population. *Child Welfare, 86*, 363-386.

[5] U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau (2015). A National Look at the Use of Congregate Care in Child Welfare. Retrieved May 23, 2015 from http?//www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.phd

[6] James, S., Roesch, S. & Zhang, J. J. (2012). Characteristics and behavioral outcomes for youth in group care and family-based care: A propensity score matching approach using national data. *Journal of Emotional and Behavioral Disorders, 20*, 1-21.

[7] Havlicek, J. R., Garcia, A. R., & Smith, D. C. (2013). Mental health and substance use disorders among foster youth transitioning to adulthood: Past research and future directions. Children and Youth Services Review, 35, 194–203.

[8] Oosterman, M., Schuengel, C., Wim Slot, N., Bullens, R. A. R., & Doreleijers, T. A. H. (2007). Disruptions in foster care: A review and meta-analysis. Children and Youth Services Review, 29, 53–76.

[9] Strijker, J., Knorth, E. J., & Knot-Dickscheit, J. (2008). Placement history of foster children: A study of placement history and outcomes in long-term family foster care. Child Welfare, 87, 107–124.

[10] Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. Child Welfare, 79, 614–632.

[11] Bettman, J. E., & Jasperson, R. A. (2009). Adolescents in residential and inpatient treatment: A review of the outcomes literature. *Child and Youth Care Forum, 38*, 161-183.

[12] Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies, 14*, 551-575.

[13] Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth are. *Children and Youth Services Review, 30*, 123-140.

[14] Barth, R. P. (2005). Residential care: From here to eternity. *International Journal of Social Welfare, 14*, 158-162.

[15] Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2010). Outcomes of group care for

youth: A review of comparative studies. *Research on Social Work Practice, 21*, 177-189.

[16] James, S., Roesch, S. & Zhang, J. J. (2012). Characteristics and behavioral outcomes for youth in group care and family-based care: A propensity score matching approach using national data. *Journal of Emotional and Behavioral Disorders, 20*, 1-21.

[17] Lee, B. R., & McMillen, C. (2008). Measuring quality in residential treatment for children and youth. *Residential Treatment for Children & Youth, 24*, 1-17.

[18] Association of Children's Residential Centers. (2009). Redefining residential: Ensuring the pre-conditions for transformation through licensing, regulation, accreditation, and standards. *Residential Treatment for Children & Youth, 26*, 237-240.

[19] Child Welfare League of America. (2007). CWLA's position on residential care. *Residential Group Care Quarterly, 7*, 1-9.

[20] Association of Children's Residential Centers. (2009). Redefining residential: Ensuring the pre-conditions for transformation through licensing, regulation, accreditation, and standards. *Residential Treatment for Children & Youth, 26*, 237-240.

[21] Lee, B. R., & McMillen, C. (2008). Measuring quality in residential treatment for children and youth. *Residential Treatment for Children & Youth, 24*, 1-17.

[22] Group Care Quality Standards Workgroup (2015). *Quality Standards for Group Care.* Father Flanagan's Boy's Home.

[23] Boel-Studt, S., Huang, H., & Harris, R. (2017). Development and validation of the group care quality assessment: Fiscal year 2016-2017 Phases II/III. Retrieved from https://ficw.fsu.edu/sites/g/files/upcbnu1106/files/pdf-files/Report-%20Development%20and%20Validation%20of%20the%20Group%20Care%20Quality%20Assessment%20082517.pdf

[24] Wolfe, E. W., & Smith, J. E. (2007). Instrument development tools and activities for measure validation using Rasch models: part II--validation activities. *Journal of applied measurement*, *8*(2), 204-234.

[25] Dimitrov, D. M. (2012). *Statistical methods for validation of assessment scale data in counseling and related fields.* American Counseling Association. Alexandra, VA.

[26] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*, 77-101.

[27] Yin, R. K. (2011). *Qualitative Research from Start to Finish.* New York, NY: Guildford Press.

[28] Abell, N., Springer, D. W., & Kamata, A. (2009). *Developing and validating rapid assessment instruments*. Oxford University Press. Chicago.

[29] Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical assessment, research & evaluation*, *10*(7), 1-9.

[30] Group Care Quality Standards Workgroup (2015). *Quality Standards for Group Care.* Father Flanagan's Boy's Home.

NOTICE OF FILING

Reporting Agency:	Department of Children and Families
Recipient Agency:	Governor Speaker of the House of Representatives President of the Senate
Subject:	Annual Report regarding Residential Group Care Accountability System
Report Due Date:	October 1, 2018
Statutory Requirement:	s. 409.996(22)(c), F.S.

Abstract: A legislatively mandated report must be submitted to the Governor and Legislature each year, providing details about the Department's provision on the development of a statewide accountability system for residential group care providers and a plan for department oversight and implementation of the statewide accountability system.

The 2018 report addresses requirements in Section 409.996(22)(c), F.S. as follows:

(22)(c)The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1 of each year, with the first report due October 1, 2017. The report must, at a minimum, include an update on the development of a statewide accountability system for residential group care providers and a plan for department oversight and implementation of the statewide accountability system. After implementation of the statewide accountability system, the report must also include a description of the system, including measures and any tools developed, a description of how the information is being used by the department and lead agencies, an assessment of placement of children in residential group care using data from the accountability system measures, and recommendations to further improve quality in residential group care.

Copies of this report may be obtained by contacting Traci Leavine at 850.717-4760 or via email at Traci.Leavine@myflfamilies.com. Lawful recipients will not be charged for copies. Charges for copies requested by others will conform to requirements of Department of Children and Families CFOP 15-9, Requests for Public Records.

CF 1610, Oct 96

LEGISLATIVELY MANDATED REPORT – STATUTORY REQUIREMENT

REPORT TITLE	STATUTORY REFERENCE	SPECIFICATIONS
The Department shall submit a report October 1 of each year including an update on the development of a statewide accountability system for residential group care providers and a plan for department oversight and implementation of the statewide accountability system.	s.409.996(22)(c), F.S.	By October 1, the Department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives that addresses requirements in Section 409.966(22)(c), F.S. as follows: (22)(c)The department shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1 of each year. The report must, at a minimum, include an update on the development of a statewide accountability system for residential group care providers and a plan for department oversight and implementation of the statewide accountability system. After implementation of the statewide accountability system, the report must also include a description of the system, including measures and any tools developed, a description of how the information is being used by the department and lead agencies, an assessment of placement of children in residential group care using data from the accountability system measures, and recommendations to further improve quality in residential group care.