REPORT

Development and Validation of the Group Care Quality Assessment: Fiscal Year 2016-2017 Phases II/III

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Principal Investigator:
Shamra M. Boel-Studt, PhD, MSW
Assistant Professor
Florida State University, College of Social Work

Co-Principal Investigator:
Hui Haung, PhD, MSW
Assistant Professor
Florida International University

Project Team:
Zandra Odum, M.Ed.
Project Management Consultant
Office of Child Welfare, Florida Department of Children and Families

Xiomara Turner, MSW
State Foster Care Licensing Specialist
Office of Child Welfare, Florida Department of Children and Families

Neil Abell, PhD, MSW
Professor
Florida State University, College of Social Work

Rachel Harris, MSW
Research Assistant
Florida State University, College of Social Work

Helen Osborn, MSW
Assistant Researcher
Florida Institute for Child Welfare

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Executive Summary

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, DCF). The Group Care Quality Standards Workgroup was established by the Department and the Florida Coalition for Children (FCC) in April of 2015. The aim of the workgroup was to develop a set of core quality standards for DCF licensed residential group homes to ensure children receive high quality, needed services that surpass the minimum thresholds assessed through licensing. Following approval of the standards, the Department engaged the Florida Institute for Child Welfare to develop an assessment designed to measure quality services in Florida's licensed residential group care facilities (RGC). In this report, we describe milestones achieved in the development and validation of the group care quality assessment during 2016-2017. Milestones included completing a draft of the assessment tool and implementation plan, a content validity review, and a feasibility pilot study.

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The group care quality assessment was piloted as a multi-dimensional, multi-informant assessment. It includes subscales measuring eight quality domains and items representing the standards within each domain. The pilot version included three on-line forms completed by different groups of stakeholders including service providers, youth, and Department licensing specialists. The assessment was designed to be implemented as part of the Department's annual re-licensing inspection.

Overall, the results of the content validity review supported that the assessment items were viewed by subject matter experts as representative of the standards they were designed to measure. A pilot study was also completed to evaluate the feasibility of the implementation plan and to collect field data to conduct preliminary psychometric analyses of the assessment tool. The pilot included a sample of 10 group homes located in the Central region of Florida. The preliminary findings supported that the total scale and six of the subscales of the youth form demonstrated acceptable to excellent internal consistency. The total scale and half of the subscales of the provider form were in the acceptable to excellent range. The results of the pilot study support the feasibility of integrating the assessment into the state's re-licensure process and provided insights to guide the next phases of development. Overall, participants were supportive of the assessment and reported that the assessment was manageable to complete. Following the pilot, revisions were made to the sampling methods and select items. Additionally, an abbreviated form for case managers and placement specialists was created.

A second, larger implementation pilot (i.e., field test) is currently underway. The purpose of the field test is to evaluate the assessment in two DCF service regions using a larger sample of approximately 40 group homes. Data from the field test will guide further item selection/reduction and will be used to perform additional tests of reliability and validity.

Project Contributors

- Florida Coalition for Children
- Group Care Quality Standards Workgroup
- Ken Bender, *Vice President of Youth Care Programs*, Boys Town
- Brad Gregory, *Chief Executive Officer*, A Kids' Place
- Candace Cox, *Licensing Specialist*, Florida Department of Children and Families
- Carlos Colon, *Licensing Specialist*, Florida Department of Children and Families
- Carmen James, *Licensing Specialist*, Florida Department of Children and Families
- Connie Bryd, *Attorney*, Byrd & Byrd, LLP
- Desmond Taylor, *Executive Director*, Friends of Children and Families, Inc.
- Don Labrecque, *Director of Quality Improvement*, Florida Sheriffs Youth Ranches
- Edwin Castro, *Student*, Florida State University
- Evan Leach, *Regional Licensing Manager-SunCoast*, Florida Department of Children and Families
- Fawn Moore, *Regional Program Manager-Central*, Florida Department of Children and Families
- Heather Rosenberg, *Florida Children's Ombudsman*, Florida Department of Children and Families
- Heather Thompson, *Assistant Professor*, Florida Atlantic University
- Jonathan Huefner, *Research Scientist*, Boys Town National Research Institute
- Lisa Schelbe, *Assistant Professor*, Florida State University
- Rebecca Robinson, *Northeast Regional Program Administrator*, Florida Department of Children and Families
- Katie Ropes, *PhD candidate*, Florida State University
- Kendra Bradley, *Licensing Specialist*, Florida Department of Children and Families
- Rusty Kline, *Director of Quality/Data Management*, Deveroux Community-Based Care
- Schuyler Siefker, *Executive Director*, St. Augustine Youth Services
- Shatavia Brown, *Student*, Florida State University
- Vanessa Snoddy, *Operations Management Consultant II*, Florida Department of Children and Families
- Yanin Hernandez, *Licensing Specialist*, Florida Department of Children and Families

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. During the 2016-2017 fiscal year, a draft version of the group care quality assessment was completed. The assessment has undergone a feasibility pilot with a broader implementation pilot in progress at the time of this report.

Background

Ensuring that children in residential group care (RGC) receive the services and supports needed to achieve safety, permanency and well-being is an on-going 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[1,2,3] and more extensive mental/behavioral health problems.[4,5,6] Characteristics common to children admitted to RGC, including severe mental/behavioral health problems and experiencing multiple placement changes, negatively impact child well-being and are associated with poorer permanency outcomes.[7,8,9,10] Children in RGC experience over twice as many placement changes as those in non-RGC settings[a] are at greater risk for re-entry into care following discharge[11,12] and of aging out of care without physical permanency.[13]

Research on the effectiveness of RGC overall supports that some youth experience improvements following placement[14,15,16] and that quality of care affects service outcomes.[17,18] With the increased emphasis on accountability at the federal and state levels,[19,20] efforts to identify and address issues impacting the quality of care and effectiveness of RGC are needed. The Association of Children's Residential Centers, and the Child Welfare League of America, 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.[21,22]

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.[23] Establishing and measuring desired performance and outcome indicators can be used to assess the degree to which residential programs are meeting quality standards and inform a process of continuous quality improvement.[24]

Quality Standards for Florida's Residential Group Homes

Work on the development of quality standards for Florida's residential group care programs was initiated in 2015. The project plan consists of six distinct 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.

Prior to the FY 2016-2017 report, Phase 1 was completed and substantial progress was made toward the completion of Phase 2.

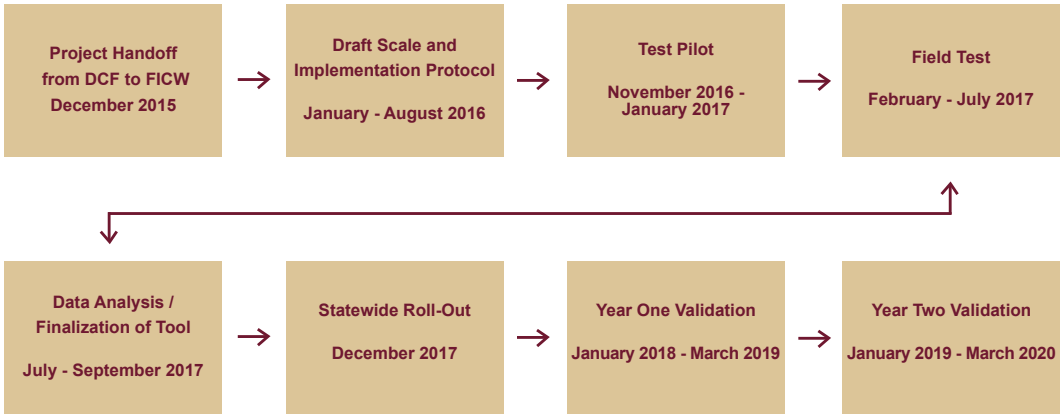

FIGURE 1: Quality Standards Project Timeline

[a] Many youths enter residential care already having experienced multiple placement disruptions. Polices in some states require youth to have 'failed out' of less restrictive settings to become eligible for placement in residential care.

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

In response to state-level concerns about the quality and effectiveness of RGC that echoed national concerns, the Group Care Quality Standards Workgroup was established by the Department and the Florida Coalition for Children (FCC) in April of 2015. The aim of the workgroup was to develop a set of core 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. The workgroup was comprised of 26 stakeholders throughout the state including RGC providers, the Department, the FCC, and the Florida Institute for Child Welfare (FICW). The standards were derived from published literature delineating proposed standards for RGC and the combined expertise of the workgroup members. A set of standards was completed and approved by the Department in August of 2015 that included eight quality domains comprised of 59 practice standards and 248 sub-standards.[25]

Eight Domains of Quality Practice in Residential Group Care

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 Group Care Quality 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 specific 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 system for implementing the assessment as part of the Department's re-licensure process.

Importantly, a collaborative approach was adopted early on and has continued throughout this initiative. A subcommittee comprised of members of the Group Care Quality Standards Workgroup, members of the FCC Residential Committee, and Boys Town National Research Institute provided consultation and project support. Additionally, child welfare scholars, former foster youth, RGC providers, and child advocates participated in reviews and provided feedback on various iterations of the assessment tool.

Pre-planning work began in October 2015. Activities completed included forming a project team, submitting a grant proposal, and conducting an exhaustive review of both published and unpublished quality measures (or related types of measures) across a wide range of practice areas including child welfare, juvenile justice, health, mental health, and education.

Formal work on phase 2 began in March 2015 following the award of a FICW Planning Grant to support the development of a draft quality assessment tool and designing the feasibility pilot and implementation pilot (i.e., field test) studies. Steps in the development of the assessment 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 of assessment tool and item pool.

The research team employed a distillation process that involved extracting and refining information from the source document, *Quality Standards for Group Care* (Group Care Quality Standards Workgroup, 2015) to obtain a set of measurable standards. The process involved multiple document reviews, identifying and removing redundancies, and coding information to identify the core elements of each of the eight quality domains and the standards comprising the domains. We then drew upon content from the source document to create definitions for each domain and operational definitions for each of the core standards.

The principal investigator (PI) and a regional licensing manager for the Department, who served as a key project consultant, conducted a crosswalk review of the distilled standards with the state's licensing code (C65-14) to identify areas of duplication and to ensure the standards met the intended goal of expanding upon the minimum thresholds assessed through licensing. Through this review process we found 25 percent duplication between the quality standards and licensing criteria and that 75 percent of the standards either expanded upon licensing criteria or represented areas of practice that were not being assessed. These results provided guidance in selecting standards to include in the assessment and affirmed that that distilled standards were well aligned with their intended purpose. The research team also surveyed stakeholders to help further prioritize which of the standards to include in the assessment. A total of 16 surveys were completed in which respondents rated each standard based on their perception of its importance in assessing quality of care.

Following the completion of these steps, the research team drafted a pool of items to operationalize the distilled standards within each of the eight practice domains. The pilot version of the assessment is multi-dimensional and multi-informant. It includes subscales measuring the eight quality domains and items representing the standards within each domain. The pilot version includes three on-line surveys completed by different groups of stakeholders including service providers, youth, and Department licensing specialists. The assessment is designed to be implemented as part of the Department's annual re-licensing inspection. For a detailed description of the steps in the development process see: *The Development and Validation of an Assessment of Quality Standards for Residential Group Care* (Boel-Studt, 2016).

Fiscal Year 2016-2017: Project Phases 2-4

Major milestones achieved during the 2016-2017 reporting period include completion of the draft assessment tool (Phase 2) and a feasibility pilot study (Phase 3). A second, larger implementation pilot (Phase 4) is underway at the time of this report.

Phase 2: Completion of the Draft Assessment Tool

Steps involved in completing the draft assessment included planning meetings with the project's lead FICW and DCF team, content validation, and stakeholder feedback reviews. A series of planning meetings between the Department and FICW occurred between May through September of 2016 to further develop a project plan including the major phases, timeline, and logistics (see Figure 1).

Content Validity Review

An essential step in the development of assessment instruments following initial item specification and development, is evaluating content validity.[26,27] Content validity is a reflection of the extent to which an item is viewed as providing an adequate operational definition of the construct it is designed to measure. Content validity is evaluated by panels of three to ten professionals and lay subject matter experts (SME).[28,29]

Selected subject matter experts for this review included group care providers, quality assurance specialists, Department licensing specialists, former foster youth, and child welfare scholars from two Florida universities. SMEs received a combination of verbal and email invitations to participate in the review. A link to a Qualtrics survey was emailed with an introduction stating the purpose of the review, the reason the SMEs were selected, a description of the measure and its scoring, and an explanation of the response form. SMEs were instructed to read the definition of a quality domain followed by reading the items reflecting the operationalized standards within each domain. The following instructions were provided to guide the review:

As a member of our expert panel, we are asking you to help us learn how well these items fit the definitions of the constructs they're meant to represent. Please read each item carefully, then check the number showing how well you think each item fits the target definition, where:

1 = not at all ***2 = a little bit*** ***3 = somewhat*** ***4 = quite a bit*** ***5 = very well***

In total, 16 SMEs participated in the review. All three forms were evaluated separately for content validity. The survey data were analyzed using the Scale Content Validity Index (S-CVI; also referred to a S-CVI/Ave).[31] To compute the S-CVI, the ratings were collapsed into a dichotomous variable where 1, 2, 3 = Not relevant and 4, 5 = relevant. The S-CVI is computed based on the average proportion of items rated as relevant across SMEs.[32] A S-CVI score of .80 or higher is considered acceptable.[33] In addition to the S-CVI scores for each form, the minimum and maximum ratings across items in a subscale using the original 5-point scale are reported in Table 1.

TABLE 1: Results of Content Validity Review of Items on the Three Forms of the Group Care Quality Assessment

	Youth Form (SME = 5)		Provider Form (SME = 7)		Licensing Form (SME = 4)	
Subscale	**Min/Max**	**S-CVI**	**Min/Max**	**S-CVI**	**Min/Max**	**S-CVI**
Assessment, Admission, & Service Planning	3/5	.90	2/5	.84	3/5	.80
Positive, Safe Living Environment	3/5	.95	1/5	.77	3/5	.80
Monitor & Report Problems	5/5	1.00	3/5	.88	4/5	1.00
Family, Culture, & Spirituality	3/5	.92	2/5	.84	4/5	1.00
Professional & Competent Staff	4/5	1.00	2/5	.86	1/4	.60
Program Elements	4/5	1.00	1/5	.81	3/5	.80
Education, Skills, & Positive Outcomes	4/5	1.00	2/5	.78	3/4	.70
Pre-Discharge/Post-Discharge Processes	4/5	1.00	3/5	.86	4/5	1.00
Total Scale	3/5	.97	1/5	.83	2/5	.84

The results show that the total S-CVI was above .80 for all three forms. Examining each form separately, all eight subscales in the youth form had high S-CVI scores; six out of eight subscales in the provider and licensing forms had high S-CVI scores. The survey also included open-ended items where SMEs were asked to provide comments on items and offer recommendations for revisions. Reasons for lower item ratings that were provided included SMEs feeling an item was redundant of another, the item language was viewed as inconsistent with the standard, or the item needed clarity. SME's comments and recommendations were used to guide item revisions. The revised items were sent out for review by a subset of consultants and reviewers who were invited to provide further feedback.[b]

In August 2016, a meeting with the FICW and Department was held at the Florida State University College of Social Work to review the draft implementation plan for embedding the assessment into the existing re-licensure process. Additionally, the draft items from the licensing specialist form of the assessment were reviewed to determine which of the items could be assessed as part of the licensing process and how evidence could be gathered to rate an item. The draft assessment tool and implementation plan were completed in September 2016. Following reviews by the Department, the team received approval of the project plan and to move forward with the initial pilot study.

Phase 3: Feasibility Pilot

The purpose of the pilot test was to evaluate the feasibility of the implementation plan and to collect field data to conduct preliminary psychometric analyses of assessment tool. Analyses were generally aimed at understanding participant's experiences with completing the assessment and evaluating the applicability, response patterns, and initial reliability of the assessment.

Methods

Sample/Setting The Department's Central service region was selected as the pilot site. The Central region covers Hardee, Highlands, Polk, Brevard, Seminole, Citrus, Hernando, Lake, Marion, Sumter, Orange, and Osceola Counties. The pilot sample included 11 group homes with licenses due for renewal between November 2nd and December 8th of 2016.

Procedures The pilot study procedures were approved by the Florida State University Institutional Review Board and the Florida Department of Children and Families Human Protections Review Committee. To introduce the study to participants, members of the project team co-facilitated a two-day orientation and training with service providers and the regional licensing team.

Orientation The orientation took place on October 31, 2016 at Kids Central Inc., the Community-based Care lead agency in Orlando from 9:00 a.m. - 12:00 p.m. and included two separate sessions. The first session was one hour long and was open to licensing staff, group home providers, placement coordinators, and case managers in the region. In total there were 39 attendees. During the orientation, attendees were provided with background information on the project, including an overview of the development of the quality standards and the assessment, and a conceptual overview of the assessment and its intended use.

The second, approximately two-hour, session was limited to group home providers who were selected for inclusion in the pilot. All of the 11 homes had representatives in attendance. In this session, we reviewed the assessment forms with attendees, discussed the pilot study, and what participation would entail. The final 20-minutes were reserved for questions from the attendees.

Training A three-hour training with the Central region licensing team took place on November 1, 2016. There were six licensing staff in attendance. The training was also held at the Kids Central's office. During the training, we reviewed the assessment forms and the implementation manual with the licensing team and walked through the procedures for the pilot. In addition, project monitoring and assistance (i.e., triage calls) calls were scheduled.

[b] Due to time constraints another full expert review was not completed to re-assess content validity of the revised items. The revised items were provided to a selected group of consultants and reviewers who provided additional feedback that was incorporated into the items included in the piloted version of the assessment.

Data Collection Methods Both quantitative and qualitative data were collected in this study. To conduct a preliminary study of the psychometric features of the Group Care Quality Assessment, quantitative data were collected by inviting participants to answer the draft version of the assessment. To evaluate the feasibility of the implementation plan, qualitative data was collected from triage calls with the licensing teams and a pilot debriefing/feedback session with participants. Data collection officially began on November 2, 2016 and ended on January 23, 2017 following a debriefing session with participants.

Regional licensing specialists facilitated data collection and provided oversight. They sent emails to participants asking them to complete the online survey through the Qualtrics survey platform licensed through the Florida State University. Each group home was rated by four types of participants: youth, group care providers, case managers, placement specialists, and licensing specialists. The sampling methods are depicted in Table 2. Participants included group home on-site directors, direct care workers, and licensing specialists responsible for inspecting the selected group homes. A convenience sampling approach was used to invite youth who were available and willing to volunteer to complete the youth form of the assessment. Additionally, case managers and placement specialists who were managing the case of a child or coordinated a placement of a child, respectively, in the group home being assessed were eligible to participate. Throughout the pilot, researchers exported data from Qualtrics weekly and updated the licensing team on the numbers and names of completed and uncompleted forms.

TABLE 2: Sampling Method

For each licensed group home, the following respondents complete an assessment form	Name of form to be completed
1 on-site director	Service Provider Form
1 unit supervisor/direct care worker	Service Provider Form
1 case manager	Service Provider Form
1 placement specialist	Service Provider Form
1 licensing specialist	Licensing Specialist Form
A minimum of 2 or 10% of youth currently receiving services	Youth Form

Triage Calls Triage calls were held with members of the FICW/DCF project team and the Central licensing team to monitor implementation and provide technical support. A total of four triage calls were held on the following dates: 11/9/16, 11/18/16, 11/30/16, and 12/9/16. All calls were documented by research assistants who took notes during the calls.

Pilot Debriefing Session The pilot debriefing was held in Orlando at Kids Central on January 23, 2017. In total, there were 13 participants in attendance (note some participants did not sign the sign-in sheet). During the debriefing, participants were asked to share their experiences with participating in the assessment. Participants were asked open-ended questions: “What went well?” “What challenges did you encounter?” “Were there any issues with the youth completing the forms?” “Did you experience any issues with finding time to complete the forms?” “Were the items on the assessment clear?” “Did you feel that the items were relevant?” “Did you find the manual useful?”

Data Analysis

Quantitative analyses were performed in SPSS version 23. Descriptive analyses were used to describe the sample and response patterns on the assessment. A reliability analysis was performed to assess internal consistency reliability of the subscales and global scores. Finally, a thematic analysis was used to analyze qualitative data collected during triage calls and the debriefing session. Documentation from the triage calls and debriefing were manually coded independently for overarching themes by two members of the research team. Themes from both reviews were compared and were identified to be in complete agreement.

Results

In total, 94 assessment forms were completed (56 service provider forms, 27 youth forms, 11 licensing specialist forms). Response rates were 100 percent for group home directors, direct care workers, licensing specialists, youth and case managers and 70 percent for placement specialist, indicating a that the majority of respondents who received a request to complete an assessment form followed-through. Complete data were available for 10 out of the 11 group homes. One group home was excluded due to not providing information on the forms that was sufficient to match the form to a specific group home. Descriptive characteristics for the 10 group homes included in the analyses are presented in Table 3.

TABLE 3: Group Home Characteristics (*n* = 10)

Variables	*n*	%
Program Model		
Emergency shelter	3	30%
House parent model	3	30%
Unspecified	4	40%
Referral sources		
Child welfare	10	100%
Juvenile justice	6	60%
Mental health	3	30%
Voluntary	5	50%
Age range of youth served		
6-10	9	90%
11-14	10	100%
15-18	10	100%
19-21	5	50%
Gender of youth served		
Girls only	1	10%
Boys only	1	10%
Both girls and boys	8	80%
Types of service provided		
Educational	10	100%
Vocational	8	80%
Recreational	10	100%
Family support	9	90%
Life skills/independent living	10	100%
Mental/behavioral health services	3	30%

Note. Multiple responses could be selected for Referral sources, Age range of youth served, and Types of services provided.

Analysis of Missing/NA Responses

Overall, item non-response due to respondents skipping items was minimal (<5% across forms). However, some items were rated as Not Applicable (NA) by a portion of youth and service providers. According to Widaman (2006), 25-50 percent missing on an item is considered high and >50 percent is considered excessive. Following this criteria, items with 25 percent or more NA responses were flagged for follow-up (see Appendix A). In the following sections, salient patterns of NA responses for the youth and provider forms and by the respondent type are presented.

Provider Form

As shown in the first table of Appendix A, three areas of NAs are common among all types of providers. First, items comprising Domain 5 (Professional and Competent Staff) had the highest proportion of NA responses across respondents. Specifically, these items ask about specialized areas of staff training (i.e., evidence-based practices, trauma-informed care, pro-social skills). The open-ended responses showed that reasons for NAs vary between respondents. Comments from group care providers indicated these areas of training were not part of the pre-service training requirements while comments from case managers and placement coordinators indicated that they were uncertain whether group care staff received training in the specified areas and, therefore, could not rate the items.

Second, the Domain 3 item 'The program uses surveys to assess consumer satisfaction with services.' also had a high percent of NA responses across all types of providers. Comments from some group care providers indicated that satisfaction surveys (i.e., exit interviews) were completed by the community-based care agencies, and therefore, it may not need to be done by the group care provider.

Third, the Domain 2 item asking about programs' use of restraint or seclusion room placements as a form of behavior management received the highest proportion of NA responses across all types of providers. Comments indicated that many of the programs being assessed do not use these methods of behavior management or use them at a minimum.

Other items were rated as NA specifically among case managers and placement specialists. For example, in Domain 6 (Program Elements), a high percentage of case managers and placement specialists rated NA on the items asking about fidelity monitoring methods, changes made to improve the program within the past 12 months, and the occurrence of regular team meetings. These may reflect areas that only providers who work directly in the group home would have enough knowledge needed to provide an informed rating. Also, in Domain 8 (Pre-Discharge and Post-Discharge Processes), the vast majority of placement specialists rated NA on all items. This too may be related to the specific role of the placement specialists who facilitate the initial placement but are necessarily not involved in the process of preparing youth for discharge.

Youth Form

As shown in Appendix A, three patterns of NA are apparent for the youth form. First, similar to the provider form, items asking about programs use of restraints and seclusion rooms received the highest percent of NA responses from youth. Second, across domains, the items on programs' efforts to involve families in various aspects of care received a higher NA response among youth, some of whom indicated in their comments that they did not have contact with their family. Third, one-third of youth rated NA on the items asking about opportunities for vocational training and program staffs' efforts to connect youth with programs and services to help them following discharge.

Preliminary Internal Consistency Reliability Estimates

Preliminary analyses of internal consistency, a form of reliability, were performed on youth form (n = 27) and service provider form (n = 56). These analyses could not be performed on the licensing form due to the small sample of completed forms (n = 10). It is generally recommended that sample sizes of 50 or more are required to achieve adequate power for testing reliability of assessment scale scores.[35] Smaller samples may not yield sufficient power to detect item correlations. Although the sample size of youth is below 50, given that this is preliminary pilot data from which firm conclusions should not be drawn, we decided to analyze the internal consistency of the youth form. Generally, reliability coefficients that are $\geq$. 90 are considered excellent, $\geq$ .80 are considered good, and $\geq$ .70 are considered acceptable.

To address issues with missing data, we applied listwise deletion and imputation. Items with 50 percent or greater missing were excluded. A form of missing data imputation, the expectation-maximization (EM) algorithm was used for the remaining items with nonresponse rates below 50 percent. That is, a value is imputed for a missing value based on a combination of other information provided by the respondent, other respondent's ratings of the item, and the probability of the respondent's rating for the item.[c]

[c] EM is appropriate in conditions where data is missing at random (MAR; missing is not random but can be accounted for) or missing completely at random (MCAR; missing is independent of any other variables in the analysis). Little's Test is a diagnostic analysis that tests the null hypothesis that data are MCAR. A probability value of less than 0.05 supports that the data are not MCAR (null retained). The results of the Little's Test of MCAR were greater than p = 0.05 supporting that patterns of missing in the data were unrelated.

Overall these preliminary findings support that the total scale score and scores from six of the subscales of the youth form demonstrated acceptable to excellent internal consistency with the exception of two: Monitor and Report Problems and Professional & Competent Staff. The total scale score and half of the subscales scores of the provider form were in the acceptable to excellent range. Four of the subscales were below the .70 criteria. These initial findings are promising and suggest that items within the subscales are interrelated such that it could be argued that they measure a common construct. Reliability coefficients for both forms are presented in Table 4.

TABLE 4: Internal Consistency of the Self-Report Forms

	Youth (n =27)		Provider (n = 56)	
Subscale	**α**	**SEM**	**α**	**SEM**
Assessment, Admission, & Service Planning	.802	.411	.563[c]	.367
Positive, Safe Living Environment	.727	.209	.888	.176
Monitor & Report Problems	.467[a]	.496	.876	.064
Family, Culture, & Spirituality	.735	.309	.821	.223
Professional & Competent Staff	.313[b]	.259	.660[d]	1.12
Program Elements	.869	.190	.634[e]	.287
Education, Skills, & Positive Outcomes	.799	.338	.860	.334
Pre-Discharge/Post-Discharge Processes	.757	.477	.597	.762
Total Scale	**.904**	**.200**	**.731**	**.768**

Note. Items deleted from the Youth Form due to ≥ 50% missing = 'Staff use restraints and seclusion rooms only when there is no other way to keep us from getting hurt' and 'Staff use restraint or seclusion rooms to control our behavior more than they need to.' The one item deleted from the Service Provider due to ≥50% missing = 'Physical restraints are used at a minimum, only in emergencies involving imminent safety risks.' Little's Test Youth Form = X^2 (1406, N = 27) = 55.91, p = 1.00; Little's Test Provider Form = X^2 (3075, N = 56) = 1847.05, p = 1.00.

Themes from Triage Calls and Debriefing Session

Four themes were identified from the triage calls and the debriefing related to 1) manageability of the assessment; 2) applicability of items; 3) youth participation; and 4) the need to translate the forms into other languages.

Manageability of the Assessment

During the triage calls and the debriefing, the project team checked in with the licensing team to ask how the assessment affected their workload and whether it was manageable. The licensing team consistently expressed that providing oversight of the assessment and completing the licensing form felt manageable. Licensing staff reported taking anywhere from 20 minutes to two days to complete the assessment depending on what was happening in the office. They reported being able to complete most items using documents that were already being reviewed as part of the re-licensure process. The majority of the documents were already routinely requested or available in the program files. The licensing team indicated that having a list of suggested documents to review for each item was not necessary but may be helpful for newer staff.

During the debriefing, other participants reported that it was not difficult to access the form and that the process was relatively straightforward. During one call, there were questions about sampling procedures for group homes with multiple locations and specifically, whether and how to sample from each location. For example, some large-size group homes are campus-style and have one director managing a team of staff members, each of whom was assigned to a particular cottage, while many small group homes have only one to two staff in total.

[a] Deleting item 'I feel my concerns are taken seriously' and 'I have been given a survey asking how satisfied I am with the program' increases the alpha coefficient to .522 and .576, respectively.

[b] Deleting item 'I think the program supervisor is aware of what goes on around here' increased alpha to .631; This subscale was deleted from the Youth Form.

[c] Deleting items 'Assessment decisions are made in collaboration with a multidisciplinary treatment team' and 'Service/treatment plans include a focus on increasing family and natural supports.' increased alpha to .572 and .582, respectively.

[d] Deleting items 'During the past 12-months staff have received additional training to increase knowledge and skills needed to work with the youth in the program.' And 'Staff received regular supervision from program supervisors' increases alpha to .772 and .755, respectively.

[e] Deleting item 'The program has a method for assuring fidelity to the program's model' increases alpha to .797.

Applicability of Items

During another call, the licensing team reported receiving feedback that placement specialists felt they would not be able to respond to a number of items but that they would track this and try to do the best they could. This feedback was echoed during the debriefing. Placement specialists indicated they were not familiar enough with certain aspects of the group home environment or procedures, and therefore, did not feel prepared to respond to some of the questions. In one instance, a participant indicated that a teamwork approach among a group of case managers and placement specialists was used to complete the assessment form.

Youth Participation

Prior to the pilot there were some concerns regarding the accessibility of youth to complete the form, especially considering their ability to comprehend the items and sit through the entire assessment. It was reported that for the most part youth were willing to complete the surveys. On the few occasions when youth were not available during a site inspection, the licensing specialists were able to complete the assessment with the youth over the phone or schedule a follow-up visit.

Licensing specialists reported that the youth appeared to understand the questions, even the younger children. They observed that youth were completing the surveys very quickly. One licensing specialist reported checking in with the youth periodically to see if they had questions and to have them slow down. They reported the youth were 'pretty numb' about taking the surveys. Some youth had commented that the questions were repetitive and wondered if it was a 'trick' to keep them from 'Christmas tree-ing' the assessment.

Need to Translate Forms

The need for the forms to be translated was mentioned on a few occasions. There was one instance of a youth not being able to complete the form because it was not translated in his/her language. Specific languages mentioned included Spanish and Haitian Creole.

Summary of Lessons Learned

Strengths – What went well?

Drawing upon the combined and our experiences with the pilot study, we identified areas of strengths and challenges that needed to be addressed. Overall, the participants expressed support for the assessment. A number of participants said that they saw the value in it. They thought it could have a positive impact on group care. This support was demonstrated in participants' high level of willingness to engage in the process, which is reflected in the excellent response rates. Both the licensing team and providers reported that the assessment was manageable to complete and the process was straightforward. They felt the items were relevant and easy to comprehend. The preliminary findings support the feasibility of implementing a quality assessment for residential group homes within the state's licensing system. Results of the reliability analysis of the youth and provider forms were promising with both of the overall scales and most of the subscales demonstrating acceptable to excellent reliability. The results demonstrate that a promising foundation for the assessment has been established and provide critical insights to guide the next phase of development.

Obstacles – What Gaps and Challenges Were Identified?

There has been considerable discussion concerning the level at which the assessment should be completed and how to best approach sampling respondents. There are a number of factors to consider including at what level the results of a quality assessment can be generalized. Whether homes are assessed by the individual cottage, campus, or at the level of a program encompassing multiple facilities or campuses depends on the extent to which the results from an assessment of one setting or level are valid or can be meaningfully extended to another. Another key factor to is ensure an approach that captures the perspective of key stakeholders who are involved with, or affected by, group care and relatedly, to make an effort to achieve a reasonably representative sample while creating an overall assessment process that is feasible. Our experience during the feasibility pilot supports that further work is needed to address these complex and interrelated issues.

Using a multi-informant approach requires determining which areas of group home services each type of stakeholders would have sufficient knowledge or experience to assess. Our preliminary analysis of response patterns shed light on this question. Specifically, we found a substantial number of items in which case managers and placement coordinators often reported NA (i.e., not applicable). Although they work collaboratively with group home providers, not working at the setting may limit their capacity to respond to certain items. Our data also helped to identify items to target for revision— specifically, the items within subscales with lower reliability estimates.

Revisions

We used the data from the pilot study to guide revision to the items. First, unlike our initial approach of collecting one set of surveys from each licensed entity during the pilot, during the field test, this was changed so that one assessment is completed for each group home campus or location.

Second, to respond to the patterns of NA among case managers and placement specialists, we created an abbreviated provider form (Service Provider Form B). We applied liberal criteria in which items with 60 percent or higher missing due to NA ratings, were dropped from the form. We also excluded Domain 5 (Professional and Competent Staff) from both Service Provider Form B and the Youth Form, based on the results and the understanding that it may be unrealistic to expect respondents of these forms to be knowledgeable about the training and day-to-day supervision practices of group care providers.

Following an initial round of item revision, we sent the revised items out for feedback. This was incorporated into another round of item revision. Finally, two checklists designed to evaluate programs' use of an evidence-supported model of care and a trauma-informed approach were created to provide further guidance in rating these items.

Phase 4: Field Test

A second, larger implementation pilot (i.e., field test) is currently underway. The purpose of the field test is to evaluate the assessment in two DCF service regions using a larger sample of approximately 40 group homes. Data from the field test will guide further item selection/reduction and to perform additional tests of reliability and validity. We are also using similar methods to evaluate the implementation process.

The field test was initiated in March 2017 with data collection to conclude mid-August 2017 following a debriefing with project participants. The field test began with an orientation and training session in each region (i.e., Central, Northeast). Data is being collected from assessments forms, triage calls, and a debriefing. In addition, two site visits have taken place so that the project team could observe the re-licensure and assessment processes. To date, assessments are underway for 37 group homes (Central = 17; Northeast = 20).

Communication

The project team is engaging in efforts to disseminate project updates to the field. This has included preparing monthly progress reports that have been submitted to the FCC and two state webinars. The first webinar was held in December 2016 and focused on providing background information on the development of the standards and the assessment. During the second webinar in May of 2017, preliminary results from the feasibility pilot were discussed with participants.

Conclusion

Quality residential group care is an essential intervention to serve some of the most vulnerable children requiring out-of-home care. The aim of the quality standards initiative is to ensure children in group care receive quality care and to support group homes in providing that care. Substantial progress was achieved during the 2016-2017 fiscal year, including the completion of a draft quality assessment tool followed by a successful pilot study. Work on completing the next phases of this initiative is well-underway.

Appendix A

Provider Form Items with 25% or more Not Applicable by Respondent Type

	RGC Director (*n* = 12)		Direct Care Worker (*n* = 19)		Case Manager (*n* = 18)		Placement Coordinator (*n* = 7)	
Domain 1. Assessment, Admission, and Service/Treatment Planning	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
Service plans are reviewed and updated with the multidisciplinary treatment team at least every 90 days.	2	16.7	1	5.3	4	22.2	3	42.8*
Assessment decisions are made in collaboration with a multidisciplinary treatment team.	2	16.7	2	10.5	2	11.1	2	28.6*
Domain 2. Positive, Safe Living Environment								
Physical restraints and seclusions are used at a minimum, only in emergencies involving imminent safety risks.	8	66.7*	11	57.8*	8	44.4*	7	100*
Staff follow evidence-informed crisis management methods (e.g., NAPPI) and document incidents that occur.	1	8.3	2	10.5	0	--	2	28.6*
Written policies and practices are followed to protect youth from self-harm, including the use of risk assessments and safety plans.	0	--	1	5.3	2	11.1*	2	28.6*
Domain 3. Monitor & Report Problems								
The program uses surveys to assess consumer satisfaction with services	4	33.3*	1	5.3	7	38.9*	2	28.6*
Domain 5. Professional & Competent Staff								
All staff receive training in trauma-informed care.	3	25.0*	1	5.3	13	72.2*	3	42.8*
All staff receive training in evidence-based practice(s).	3	25.0*	4	21.1	13	72.2*	3	42.8*
Staff receive training in teaching and modeling pro-social skills	3	25.0*	2	10.5	13	72.2*	3	42.8*
The treatment team meets with clinical supervisors on a weekly basis.	4	33.3*	4	21.1	14	77.8*	3	42.8*
Staff behave in a professional manner when interacting with other staff, professionals, youth, and families.	1	8.3	0	--	5	27.8*	0	--
During the past 12-months staff have received additional training to increase knowledge and skills needed to work with the youth in the program.	0	--	2	10.5	13	72.2*	2	28.6*
Staff receive regular supervision from program supervisors.	0	--	1	5.3	9	50.0*	1	14.3
Domain 6. Program Elements								
The program has a clear program model that staff are trained in.	1	8.3	2	10.5	6	33.3*	1	14.2
The program has a method for assuring fidelity to the program's model	2	16.7	6	31.6*	11	61.1*	3	42.8*
During the past 12 months, the program has made changes to improve the care youth receive.	0	--	4	21.1	11	61.1*	4	57.1*
Regular staff meetings occur that are focused on youth progress, teamwork, and addressing program issues.	0	--	0	--	5	27.8*	2	28.6*
There is a minimum of two staff on duty at all times.	3	25.0*	1	5.3	4	22.2	2	28.6*
Staff are aware of medication adjustments, watch for any adverse side effects, and report any concerns.	0	--	0	--	3	16.7	2	28.6*
Domain 7. Education, Skills, & Positive Outcomes								
Comprehensive educational assessments are used to determine youths' educational needs.	2	16.7	2	10.5	4	22.2	3	42.9*
The program conducts on-going evaluation to inform service improvement.	1	8.3	1	5.3	5	27.8*	3	42.9*

	RGC Director (*n* = 12)		Direct Care Worker (*n* = 19)		Case Manager (*n* = 18)		Placement Coordinator (*n* = 7)	
Domain 8. Pre-Discharge/Post-Discharge Processes	***n***	**%**	***n***	**%**	***n***	**%**	***n***	**%**
Transition planning starts soon after admission and includes a focus on education and/or employment and other supportive service to help youth successfully transition from care.	1	8.3	1	5.3	2	11.1	2	28.6*
Transition plans include a focus on the continuity of family relationships.	1	8.3	1	5.3	2	11.1	2	28.6*
Discharge plans are designed to support youth's individual, on-going needs and long-term permanency objectives.	2	16.7	1	5.3	2	11.1	2	28.6*
Youth and their caregivers are connected with community resources and aftercare services.	2	16.7	0	--	3	16.7	4	57.1*
The program follows up with youth and their caregivers to ensure aftercare services and other supports are received.	2	16.7	3	15.8	5	27.8*	4	57.1*
The program follows-up with youth and their caregivers to assess permanency, educational, family, and community outcomes.	2	16.7	2	10.5	5	27.8*	4	57.1*

Note. * indicate items with 25% or greater NA responses. RGC = Residential group care; DCW = Direct care worker

Youth Form Items with 25% or more Not Applicable (*n* = 27)

Domain 1. Assessment, Admission, and Service/Treatment Planning	***n***	**%**
My service plan includes goals and expectations for my family.	7	25.9
Domain 2. Positive, Safe Living Environment		
Staff use restraints or seclusion rooms only when there is no other way to keep us from getting hurt.	21	77.8
Staff use restraints and seclusion rooms to control our behavior more than they need to.	21	77.8
Domain 4. Family, Culture, & Spirituality		
I am allowed to have home visits on a regular basis.	7	25.9
Domain 6. Program Elements		
There is a place where I can visit privately with my family.	7	25.9
Domain 7. Education, Skills, & Positive Outcomes		
I can receive job training for things like welding or cooking if I want it.	9	33.3
Domain 8. Pre-Discharge/Post-Discharge Processes		
Staff are helping me find other programs and services that will help me to be successful after I leave hear.	9	33.3
Staff are helping my family find other programs and services they need to help me be successful after I leave hear.	8	29.6

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