Residential Group Care Accountability System
ANNUAL REPORT

Department of Children and Families
Office of Child Welfare
October 1, 2019

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Purpose

The Florida Department of Children and Families (Department) engaged the Florida Institute for Child Welfare (Institute) to develop and validate an assessment tool to measure, document, and facilitate quality services in Department licensed residential group homes. The Quality Standards for Group Care was established to set core quality standards for residential group care to ensure that each residential program is managed equally to provide high-quality services to the children in their care.

Requirements outlined in section 409.996(22), Florida Statutes, require the Department, in collaboration with the 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 6 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 (FCC) 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 Institute, 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 & Report Problems
4. Family, Culture, & Spirituality
5. Professional & Competent Staff
6. Program Elements
7. Education, Skills, & Positive Outcomes
8. Pre-Discharge/Post-Discharge Processes

The Department asked the Institute to take the lead on development of a project plan that consisted of eight phases including:

1. Advocacy and engagement
2. Development of core quality performance standards
3. Development of a quality assessment tool
4. Feasibility pilot
5. Implementation pilot
6. Statewide implementation
7. Full validation study and evaluation
8. Full implementation and on-going evaluation

Oversight Activities

Accountability System

During the FY 2018-2019 report year, the Department and the Institute completed phase six of the project plan which included the Group Care Quality Standards Assessment (GSQSA) Statewide Pilot. The pilot commenced April 2, 2018, for a period of 12 months. During the pilot, the GSQSA was implemented across all six regions of Florida, assessing the full population of group homes and shelters. Upon completion, the Institute evaluated the assessment procedures and tools across all service regions to optimize performance in preparation for a year-long validation study in 2020. Data collected during this phase included completed GCQSA forms from providers, monthly triage calls with regional licensing teams and technical support, and post-pilot debriefing with participants.

Quality Standards Assessment Tool

With an approved set of quality standards and project plan, the Department asked the Institute to take the lead on the development and validation of an assessment tool designed to measure residential group providers within the eight domains. The GCQSA is comprised of four separate forms which include: 1) Service Provider Form A, 2) Service Provider Form B, 3) Youth Form, and 4) Licensing Specialist Form. The assessment tool consists of three types of questions: structural, process, and experiential. Structural items measure the infrastructure of the care setting (e.g. staffing, policies, resources), process items measure the extent to which providers consistently provide services that follow recommended guidelines, and experiential items measure

experiences of consumers and providers within the care setting. The Institute utilized an investigative approach to develop fully-informed ratings for providers. These ratings were gathered through multiple sources to include document reviews; observations; interviews with program directors, staff, and youth; experience; and judgment.

As the Department enters into phase seven of the project plan, the Institute will begin validating the assessment tool. As a part of this effort, the Institute completed an extensive report entitled, An Assessment of Quality Standards for Florida's Department of Children and Families Licensed Residential Group Homes: Fiscal Year 2018-2019 Final Report. This report provides a detailed description as to:

- Statewide implementation data analysis and process evaluation;
- Early impacts from providers;
- Partial assessment form validation results; and
- Next steps towards full validation and evaluation.

See Appendix A for the full report titled: *An Assessment of Quality Standards for Florida's Department of Children and Families Licensed Residential Group Homes: Fiscal Year 2018-2019 Final Report*

Conclusion

The Department continues to advance towards completion of the statutory requirements and goals associated with the Quality Standards for Residential Group Homes contained in section 409.996, Florida Statutes. The completion of the statewide pilot, as of April 1, 2019, represents progression into the final phases of the quality standards planning project. Feedback from group care providers provides an early indication that the assessment tool is being used, as intended, to facilitate a process for quality improvement based on these standards. During the project interim, the Department recommends the continued use of the quality group care assessment amongst providers, keeping assessment links open for users, and granting the team access to tracking reports to record completion rates.

The next action items include the Department and Institute adding items to the assessment tool based on Family First Prevention Services Act (FFPSA) requirements, examining the reliability and validity of the assessment scores, facilitating a statewide training and orientation for the validation study, and commencing the validation study starting in January 2020.

Appendix A

An Assessment of Quality Standards for Florida's Department of Children and Families Licensed Residential Group Homes: Fiscal Year 2018-2019 Final Report

June 28, 2019

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An Assessment of Quality Standards for Florida's Department of Children and Families Licensed Residential Group Homes: Fiscal Year 2018-2019 Final Report

EXECUTIVE SUMMARY

Effective July 1, 2017, Section 409.996 (22), of the Florida Statute, was amended requiring the Department of Children and Families (DCF or Department) to develop a statewide accountability system for residential group care providers based on measurable quality standards. The accountability system must be implemented by July 1, 2022. In collaboration with the Florida Coalition for Children (FCC) and the Florida Institute for Child Welfare (FICW), the Department established a core set of quality standards for licensed group homes. The department engaged the FICW to develop and validate a comprehensive assessment tool, the *Group Care Quality Standards Assessment* (GCQSA), designed to operationalize the quality standards. The GCQSA will serve as the core measure for the statewide accountability system. The quality accountability system initiative draws upon research and empirically-driven frameworks to transform residential services through the integration of research-informed practice standards, on-going assessment, and continuous quality improvement.

The purpose of the statewide pilot was to begin implementing the GCQSA in all six regions, giving stakeholders in each region an opportunity to become familiar with the assessment while providing careful monitoring and on-going technical support. From the statewide pilot, based on a sufficiently large sample, the research team will examine internal consistency reliability and factorial validity of the domains scores of the GCQSA. Assessment data were collected for one-year from the full population of licensed residential care programs throughout Florida. Analyses of these data are currently underway. This report summarizes the results from analyses completed to date.

The adjusted sample included 160 programs and 223 licensed facilities. There was a total of 1,516 assessment forms completed by youth (450 forms, 29.7%), direct care workers (450 forms, 29.7%), group home directors/supervisors (272 forms, 17.9%), lead agencies (183 forms, 12.1%), and licensing specialists (161 forms, 10.6%). Sixty-one percent of residential programs in the sample are traditional group homes followed by nearly 20 percent shelters and 19 percent designed to serve specialized population (e.g., CSEC, maternity) or other.

The majority of residential programs (63.6%) use a shift care model while 36.4% reported using a family-style model. Less than half of the residential programs in the sample are nationally accredited. Of the 65 accredited programs across the state, the majority use shift-care models. Services most often provided include educational training and supports, recreation, life skills development/independent living, and discharge planning. With the exception of recreation, most of these services are provided both on and off-site. Mean scores on five-point scale (1 = not at all, 5 = completely) indicated that, overall, programs are 'somewhat' trauma-informed (M = 3.06, SD = 1.51) with most reporting staff are trained in trauma-informed care and adhere to principles of trauma-informed care (promote psychological and physical safety, trust, choice, and empowerment). Less than half reported routinely screening youth for trauma and traumatic stress or providing trauma education to youth and families as part of their approach.

Steps toward validating the GCQSA are underway, beginning with the Youth Form. Cronbach's alpha coefficients were above .80 for all seven domains indicating good internal consistency. Results from a confirmatory factor analysis are promising but further analyses are needed to improve model fit and to identify items to eliminate or retain.

As the analyses of the statewide pilot data continues, additional descriptive findings for group homes will be presented describing service approaches and characteristics of youth and residential care staff. In addition to the Youth Form, the other forms of the GCQSA will also be included in psychometric analyses. Additional analyses may include examining inter-item correlations, using methods of item-response theory to examine item difficulty and reliability, and exploring correlations between assessment scores, program characteristics (e.g., accreditation status) and other piloted measures thought to be potential correlates of quality care (e.g., youth injury, staff injury, runaway episodes, law enforcement calls to campus). In addition, inter-rater reliability and agreement will be assessed for the youth, lead agency, director care worker, and director forms. Finally, a content analysis of technical support call notes and text responses from the GCQSA will be conducted to identify process-related themes from the perspective of key stakeholders. The results from the statewide pilot will be used to finalize the assessment tool for the final validation study and to refine training and implementation procedures.

Background

Effective July 1, 2017, Section 409.996 (22), of the Florida Statute was amended requiring the Department of Children and Families (DCF or Department) to develop a statewide accountability system for residential group care providers based on measurable quality standards. The accountability system must be implemented by July 1, 2022. In collaboration with the Florida Coalition for Children (FCC) and the Florida Institute for Child Welfare (FICW), the Department established a core set of quality standards for licensed group homes. The department engaged the FICW to develop and validate a comprehensive assessment tool, the *Group Care Quality Standards Assessment* (GCQSA), designed to operationalize the quality standards. The GCQSA will serve as the core measure for the statewide accountability system. The quality accountability system initiative draws upon research and empirically-driven frameworks to transform residential services through the integration of research-informed practice standards, on-going assessment, and continuous quality improvement.

Description of the Literature

Quality social services have been defined as "the degree to which interventions influence client outcomes in desired ways in applicable domains while being delivered in a sensitive manner consistent with ethical standards of practice and the best available practice knowledge" (Megivern et al., 2007, p. 118). Concerns and debates about quality residential care are longstanding. To address this, researchers, providers, and policy-makers have proposed establishing quality standards for residential care for children and adolescents (Boel-Studt & Tobia, 2016; Farmer, Murray, et al., 2017; Lee & McMillen, 2008). Federal guidelines, such as the Adoption and Safe Families Act of 1997 and the Family First Prevention Services Act of 2017 place child well-being at the center of the quality debate (Wulczyn, Barth, Yuan, Harden, & Landsverk, 2017). For example, FFPSA requires that children are cared for in "a setting providing high-quality residential care" (section 472(k)(2)(D)).

In an effort to identify the elements of quality residential programming, Huefner (2018) reviewed seven published sources promoting quality standards specifically for residential treatment. The results of the review supported that quality encompasses a diverse set of criteria, including assessment, treatment planning, safety, family engagement, cultural competence, effective treatment, competent staff, positive outcomes, and aftercare. The quality standards generated from the review represent the culmination of the best available evidence providing a starting framework to guide further development and, the eventual validation, of practice standards for residential care.

Three quality measures for children's residential programs have been developed including the Child Welfare League of America Quality Indicators (CWLA QI; Carman & Farragher, 1994), Boys Town Performance Standards for Residential Care (BT PS; Daly & Peter, 1996), and the Building Bridges

Initiative Self-Assessment Tool (BBI SAT, 2009). Each self-assessment survey is comprised of domains within which practices and conditions relevant to service delivery are assessed that providers can use to identify strengths and weaknesses to guide service improvement. Although contributing useful examples and guidance for structuring and scaling quality indicators, to date, none of the measures have been validated. In their review of two of the quality measures, the CWLA QI and BT PS, Lee and McMillen (2008) note that neither measure provides clear guidance for scoring and interpretation and that the items appear to be equally weighted (i.e., given equal priority) despite some items measuring practices related to ensuring youth's safety while others are geared toward issues of wellbeing or the integration of best practices. Additionally, the measures were developed with minimal input from different stakeholders which can lead to privileging certain perspectives and questions of validity (note the BBI SAT is an exception).

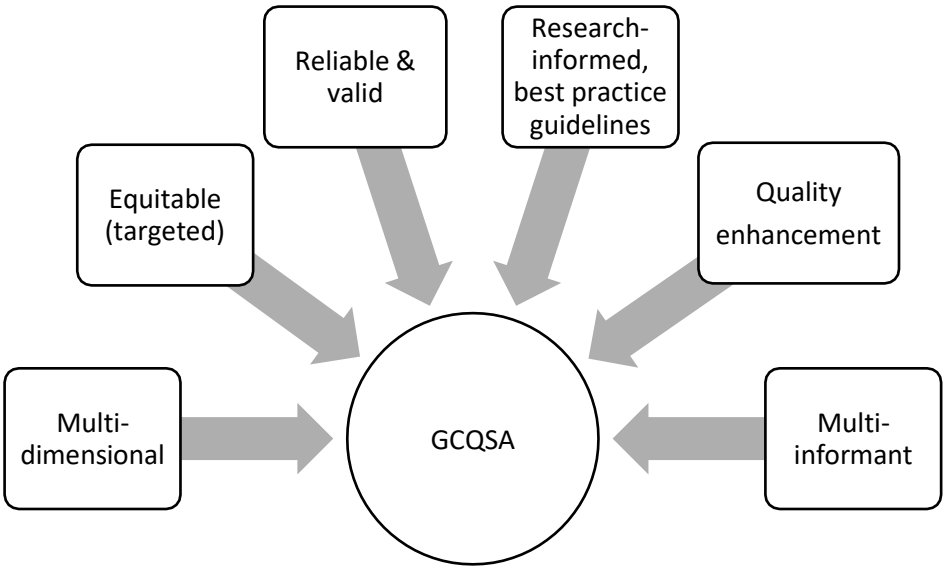
Florida's Group Care Quality Standards Initiative is a collaboration between the Florida Department of Children and Families (DCF), the Florida Institute for Child Welfare (FICW), the Florida Coalition for Children (FCC), academic researchers, child advocates, and service providers and consumers aimed at improving the quality and effectiveness of residential care. The initiative draws upon research and empirically-driven frameworks to transform residential services for children and adolescents through the integration of research-informed practice standards, on-going assessment, and continuous quality improvement. Appendix A summarizes the eight-phased implementation plan guiding development and the process of scaling up the GCQSA and the proximal alignment with implementation science and practice.

The DCF, in partnership with the FCC, convened the Group Care Quality Standards Workgroup, comprised of 26 members including group care providers and child advocates throughout Florida with research support provided by the FICW and Boys Town National Research Institute. The workgroup was tasked with developing a set of research-informed quality standards for licensed residential group homes. Huefner's (2018) consensus of proposed practice standards provided the workgroup with a working list of standards grounded in empirical research and best practice guidelines. Lead by FCC Residential Committee leadership, members of the workgroup divided into task groups assigned to discuss the proposed standards within a specific practice domain to select and adapt standards for Florida's group homes. The standards identified by the task groups were reviewed and compiled into one document, resulting in the published guide, *Quality Standards for Group Care* (Group Care Quality Standards Workgroup, 2015). The guide outlines a set of 59 quality practice standards in the following eight domains:

1. Assessment, Admission, and Service 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

Following the Department's approval, the FICW was engaged to lead efforts to develop and validate an assessment tool designed to operationalize the standards. The research team began with establishing a conceptual framework (Figure 1) to guide the process and ensure the approach and resulting assessment was consistent with the aims and vision of the Department and Workgroup.

Figure 1. Group Care Quality Standard Assessment (GCQSA) Conceptual Framework



Following the completion of the initial draft of the GCQSA, efforts toward validation began with establishing content validity (i.e., Do the items reflect the constructs they were designed to measure?) assessed by a panel of 16 experts (Boel-Studt et al., 2018). Elements of ecological validity (i.e., Do the concepts being measured have 'real world' applicability and practicability?) were evaluated during the feasibility study and implementation pilot. Preliminary estimates of internal consistency (i.e., Are items that are designed to measure the same constructs correlated?) were examined during these early phases to provide initial evidence of one form of reliability based on a small preliminary sample (Boel-Studt, Huang, & Harris, 2018). Taken together, the findings from these earlier phases were used to refine the assessment tool and implementation process.

The statewide pilot study represents a major step toward full implementation. The purpose of the statewide pilot was to begin implementing the GCQSA in all six regions, giving stakeholders in each region an opportunity to become familiar with the assessment while providing careful monitoring and on-going technical support. From the statewide pilot, based on a sufficiently large sample, the research team will examine internal consistency reliability and factorial validity of the domains scores of the GCQSA. The following sections present the methods and results of analyses that have been completed to date followed by interim conclusions and a summary of next steps.

METHODOLOGY

Design

The pilot began with a day-long orientation and training held in each of Florida's six regions. Training and orientation sessions included group care providers, lead agency personnel, and the regional licensing teams and were facilitated by the principle investigator and DCF project leads. Applying similar methods as in the two previous pilots and a population-based design, GCQSA data were collected for all Department licensed group homes and shelters throughout Florida. Process data were collected via technical support calls and survey data to evaluate implementation. Data collection was carried out over one-year (April 2, 2018 – April 30, 2019) and was coordinated with the annual re-licensure inspections conducted by the regional licensing teams. A live statewide debriefing webinar with providers was held May 23, 2019. During the webinar, preliminary results from the pilot were presented and participants were given opportunities to provide feedback and ask questions.

Data Collected

The primary measure for this study was the GCQSA. The licensing teams facilitated completion of the GCQSA for each group home. For each group home or shelter, a licensing specialist, lead agency, group home director and a minimum of two youth and two direct care workers, completed GCQSA forms.

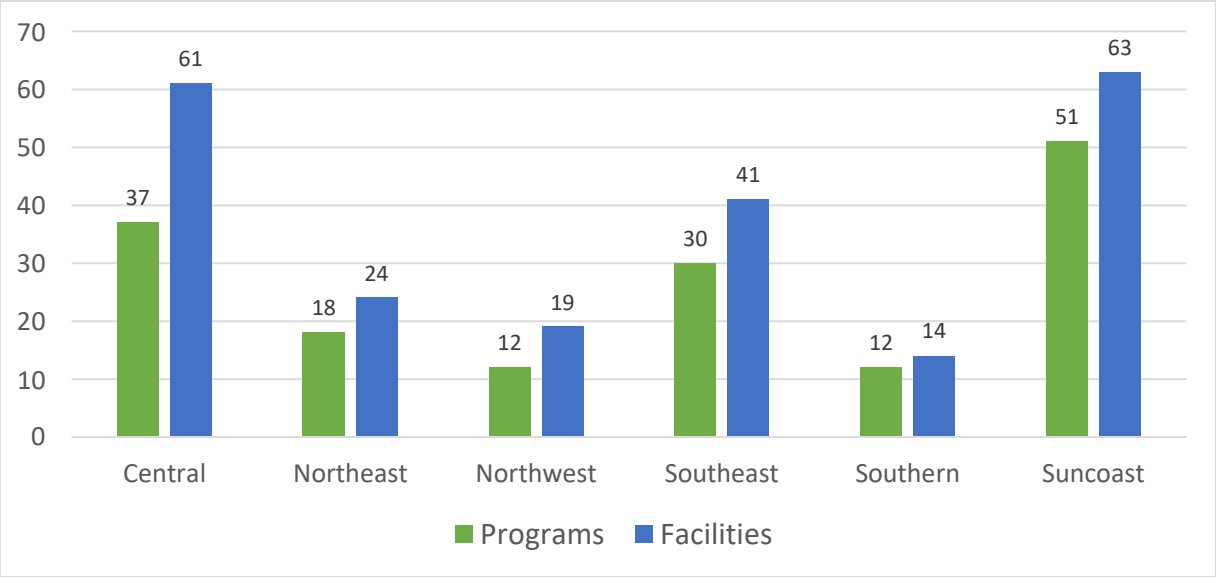
Implementation process data were collected from a combination of open text items on the GCQSA requesting participant feedback and documented technical support calls with the regional licensing team. A total 61 technical support calls were held with the licensing teams throughout the pilot.

RESULTS

Sample

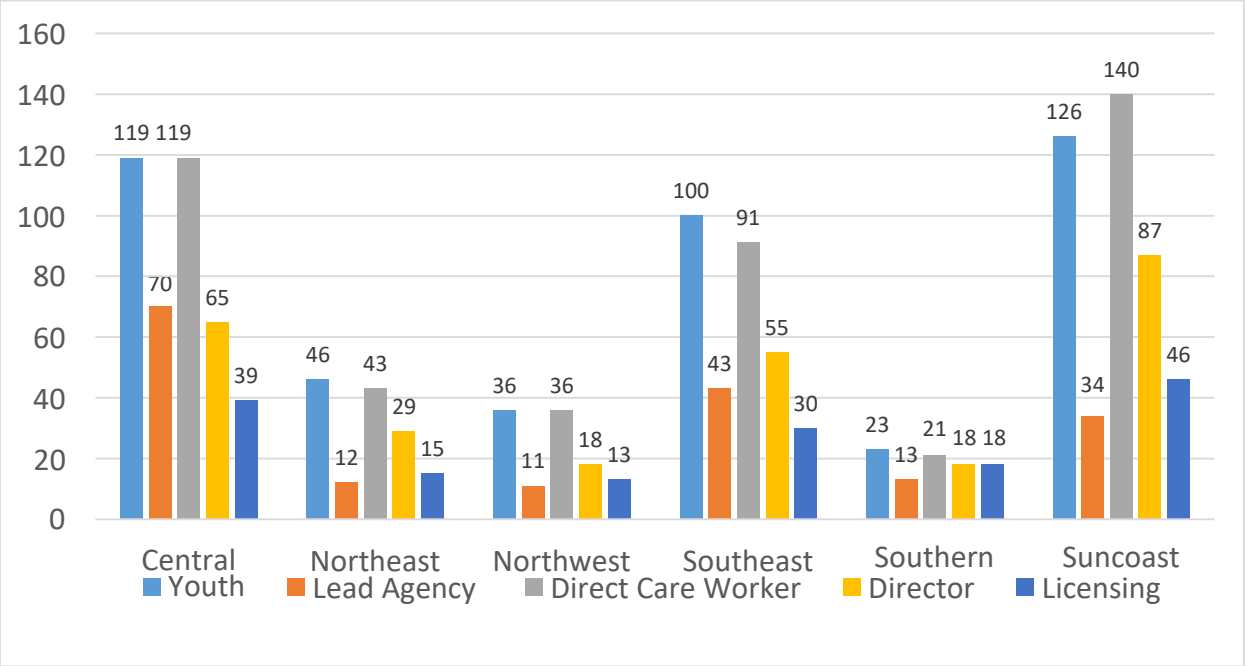
Residential care programs were defined as group homes and/or shelters within an agency using the same model and that are located within the same region. Based on this definition, the sample included 169 programs for which at least one survey was completed. This encompassed 238 licensed facilities. During the one-year pilot study, nine residential programs including 15 licensed facilities discontinued operations. This included Florida Baptist Group Homes resulting in the closure of 10 licensed facilities (Central = 2, NE = 2, NW = 3, Southern = 2, Suncoast = 1). Other closed programs included Ikare Youth and Family Services, Inc (facility = 1) in the Northeast and the Peak Group Homes in Suncoast region (facilities = 2). In the Northwest region the Susanna Wesley Emergency Shelter (facility = 1) and the Travis Tringas facility of CIC (facility = 1) were also closed and/or non-operational. The adjusted sample, accounting for closures, includes 160 programs and 223 licensed facilities. Within programs, the number of facilities ranged from one to six (median = 1; mean = 1.37, standard deviation = .88). Figure 1 shows the distribution of programs and licensed facilities across Florida's six regions.

Figure 2. Regional Distribution of Residential Programs and Licensed Facilities (N = 160)



There was a total of 1,516 completed assessment forms. Of the total, 450 (29.7%) were youth forms and 450 (29.7%) were direct care worker forms, followed by 272 (17.9%) director/supervisor, 183 (12.1%) lead agency, and 161 (10.6%) licensing specialist forms. From the total, 433 (28.6%) of the assessment forms were completed for programs in the Suncoast region, followed by 412 (27.2%) Central, 319 (21.0%) Southeast, 145 (9.6%) Northeast, 114 (7.5%) Northwest, and 93 (6.1%) Southern. Figure 2 shows the distribution of form completion by respondent type across regions.

Figure 3. Distribution of Quality Standards Forms Completed by Type and Region (N = 1516)



Completion Rates

One purpose of the statewide pilot was to evaluate a revised sampling procedure based on results from the previous smaller pilots. For each assessed program, a minimum of two youth from each licensed facility, one representative from the lead placement agency, two direct care workers from each licensed facility, one director, and one licensing specialist were asked to complete surveys. Providers had the option of inviting more than the minimum of two youths and direct care workers per facility to participate in the assessment. Providers chose this option in several cases. Completion rates were calculated based on the minimum sampling criteria. This information can inform future decisions about how to best approach sampling methods including setting minimum requirements for the Quality Standards Assessment.

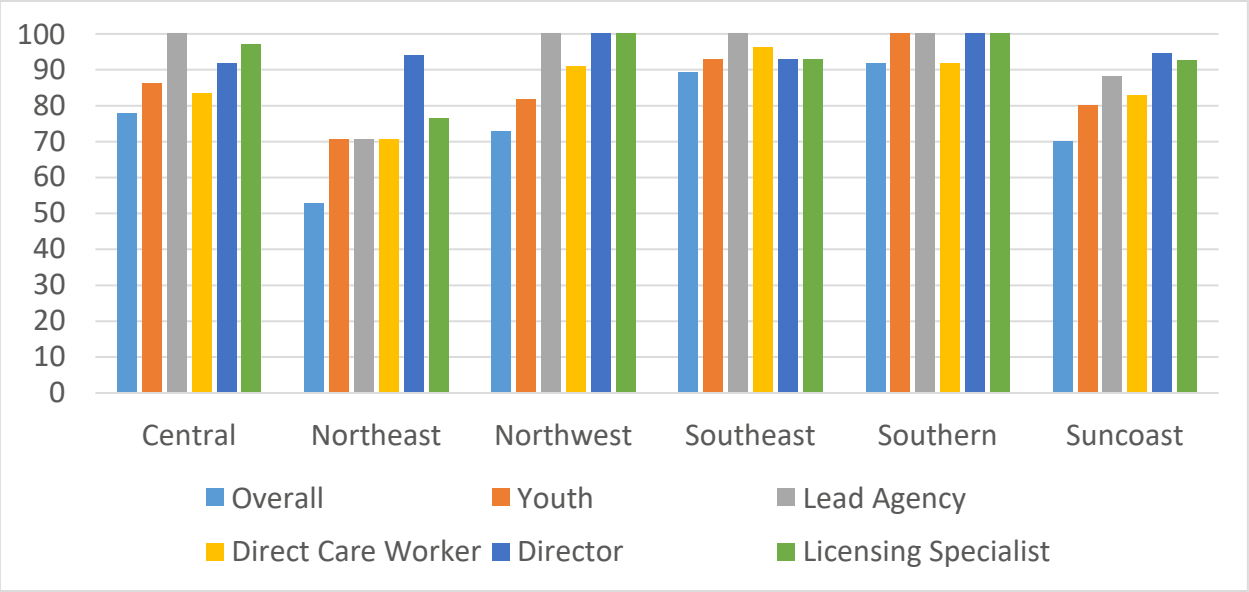
Seven programs were excluded in the calculation of completion rates due to having only 1-2 forms completed. This occurred most for programs with relicensing inspections scheduled near the beginning or end of the statewide pilot which may have resulted in data collection being discontinued prior to programs having sufficient time to complete all of the assessments. In four instances, assessment forms were incomplete due to program closures resulting in the decision to exclude the program in calculating completion rates. Completion rates for some included programs were also adjusted for circumstances that were beyond the control of the provider or licensing team that prevented forms from being completed. These included the following: the program had no identifiable lead agency (n = 5), no youth or only one meeting criteria to participate in assessment (n = 6), programs had only one staff and director (n = 3), no youth were placed at the time of the assessment (n = 5), no staff were available at the time of the assessment (n = 1) and youth declined to participate (n = 4).

Table 1 shows the completion rates for the aggregated sample adjusted for excluded programs and other factors impeding form completion. Completion rates were high for overall programs and at the level of the respondents. Overall, 107 (70.1%) programs had all forms completed based on the minimum sampling criteria. Of the 151 programs included in the calculation of completion rates, the large majority had forms completed by directors and licensing specialists and the majority also had forms completed by lead agencies, direct care workers, and youth supporting a high level of participation across the state. Completion rates by region are shown in Figure 4.

Table 1. Completion Rates Across Programs and Respondents Statewide (*N* = 151)

	# Programs with Minimum Forms Completed	Completion Rate
Overall	107	70.1%
Youth	121	80.1%
Lead Agency	133	88.1%
Direct Care Worker	125	82.7%
Director/Supervisor	143	94.7%
Licensing Specialist	140	92.7%

Figure 4. Completion Rates by Program and Respondents by Region



Residential Care Programs

Examining Table 2, the majority (61%) of the 152 programs with available data on program types were traditional group homes (non-therapeutic or not designed to provide services to a specified specialized population). This was followed by nearly 20 percent shelters with the remaining 19 percent designed to serve specialized population or other. The other category contained hybrid programs that combined different models (e.g., shelter + traditional group home) or those that did not fit into one of the pre-existing categories (e.g., wilderness camp). Figure 5 shows the regions largely follow the aggregate trends in types of residential care programs.

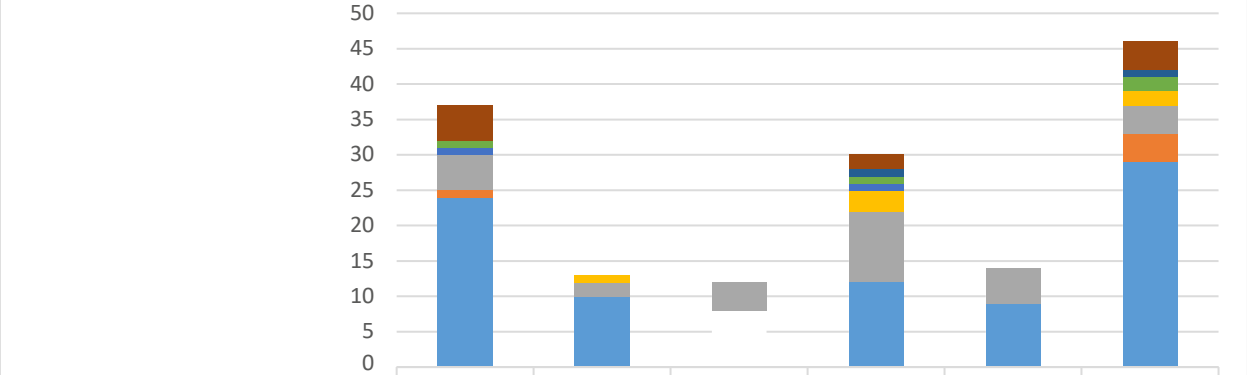
Table 2. Type of Group Care Programs (*N* = 152[1])

	Number	Percent
Traditional Group Home	92	60.5%
Therapeutic Group Home	5	3.3%
Shelter	30	19.7%
Maternity Home	6	3.9%
Crossover/DJJ	2	1.3%
Sexually Exploited (CSEC)	4	2.6%
Special Needs/Medically Fragile	2	1.3%
Other	11	7.2%
Total	152	100%

- Maternity + Traditional (1)
- BHOS (2)
- Emergency Shelter (runaway, CINS/FINS) (2)
- Enhanced Group Care (Trauma-informed, Therapeutic) (1)
- DJJ/Severe Behavioral Issues (1)
- Shelter + Group Home (1)
- Brain Injury (1)
- Traditional + CSEC (1)
- Wilderness Camp (1)
- Wilderness + Transitional Group Home (1)

[1] Count is based on program data from licensing and director forms and include programs excluded from calculation of completion rates due only 1 form completed.

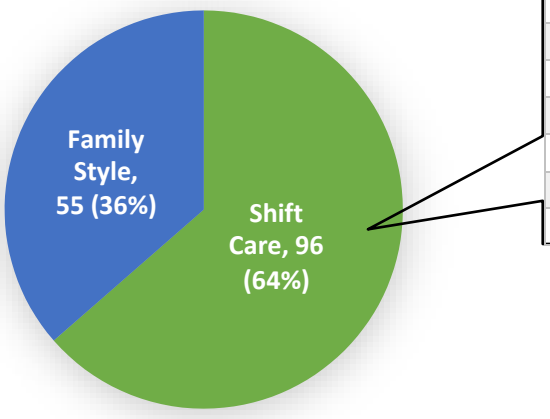
Figure 5. Regional Distribution of Residential Programs Types (*N* = 152)



	Central	Northeast	Northwest	Southeast	Southern	Suncoast
Other	5	0	0	2	0	4
Special Needs/Medically Fragile	0	0	0	1	0	1
CSEC	1	0	0	1	0	2
Crossover/DJJ	1	0	0	1	0	0
Maternity	0	1	0	3	0	2
Shelter	5	2	4	10	5	4
Therapeutic	1	0	0	0	0	4
Traditional	24	10	8	12	9	29

The majority of residential programs (63.6%) use a shift care model while 36.4 percent reported using a family-style model. The distribution of residential models across the state and regionally are shown in Figure 6.

Figure 6. Shift-Care and Family-Style Residential Programs (*N* = 151)



	Shift Care	Family Style	Total
Central	20 (55.6%)	16 (44.4%)	36 (100%)
Northeast	8 (61.5%)	5 (38.5%)	13 (100%)
Northwest	8 (66.7%)	4 (33.3%)	12 (100%)
Southeast	24 (80%)	6 (20%)	30 (100%)
Southern	8 (57.1%)	6 (42.9%)	14 (100%)
Suncoast	28 (60.0%)	18 (39.1%)	46 (100%)

Assessing accreditation status in Table 3 shows that less than half of the residential programs in the sample are nationally accredited. Of the 65 accredited programs across the state, the majority use shift-care models. This trend was observed across nearly all regions with the exception of the Northeast region where one of the two accredited programs was a shift-care model and the other a family-style home.

Table 3. National Accreditation Status of Residential Programs by Region and Model

	Total Accredited	**Shift-Care**	**Family-Style**
	Number (%)	**Number (%)**	**Number (%)**
Statewide (*n* = 150)	65 (43.3%)	49 (75.4%)	16 (24.6%)
Central (*n* = 36)	19 (52.8%)	13 (68.4%)	6 (31.6%)
Northeast (*n* = 13)	2 (15.4%)	1 (50%)	1 (50%)
Northwest (*n* = 12)	9 (75%)	6 (66.7%)	3 (33.3%)
Southeast (*n* = 30)	16 (53.3%)	15 (93.8%)	1 (6.3%)
Southern (*n* = 13)	6 (46.2%)	4 (57.1%)	2 (33.3%)
Suncoast (*n* = 46)	13 (28.3%)	10 (76.9%)	3 (23.1%)

As can be seen in Table 4, the services most often provided included educational training and supports, recreation, life skills development/independent living, and discharge planning. Educational services, life skills development/independent living and discharge were most often provided both on and off-site while recreation was most often provided off-site.

Table 4. Residential Program Services (*N* = 146)

	Service Provided	On-site	Off-site	Both	Directly	Externally	Both
	# (%)	# (%)	# (%)	# (%)	# (%)	# (%)	# (%)
Educational	139 (95%)	34 (24.5%)	20 (14.4%)	85 (61.2%)	16 (11.7%)	38 (27.7%)	83 (60.6%)
Vocational	89 (64%)	20 (18.3%)	48 (44%)	41 (37.6%)	13 (12%)	43 (39.8%)	52 (48.1%)
Recreation	136 (96.5%)	21 (15.3%)	8 (5.8%)	108 (78.8%)	26 (19.1%)	3 (2.1%)	107 (78.7%)
Family support	113 (79%)	28 (22.2%)	29 (23%)	69 (54.8%)	30 (25%)	22 (18.3%)	68 (56.7%)
Medical/ Nursing	97 (68.8%)	20 (16.9%)	58 (49.2%)	40 (33.9%)	12 (10.1%)	59 (49.6%)	48 (40.3%)
Mental/ Behavioral Heath	121 (85.8%)	29 (21.8%)	30 (22.6%)	74 (55.6%)	29 (19.9%)	41 (31.3%)	61 (46.6%)
Case management	105 (75%)	38 (29.9%)	29 (22.8%)	60 (47.2%)	37 (29.6%)	37 (29.6%)	51 (40.8%)
Life skills/ Independent living	137 (97.9%)	57 (42.2%)	3 (2.2%)	75 (55.6%)	53 (39%)	4 (2.9%)	79 (58.1%)
Parent training/ education	67 (48.6%)	21 (21.9%)	32 (33.3%)	43 (44.8%)	21 (30.7%)	42 (36.8%)	37 (32.5%)
Family counseling	94 (67.6%)	31 (27.2%)	42 (36.8%)	41 (36%)	35 (30.7%)	42 (36.8%)	37 (32.5%)
Discharge planning	128 (92.1%)	69 (52.3%)	10 (7.6%)	53 (40.2%)	62 (47.3%)	7 (5.3%)	62 (47.3%)
Aftercare	77 (55.8%)	24 (22.6%)	38 (35.8%)	44 (41.5%)	33 (30.8%)	33 (30.8%)	41 (38.3%)
Other	29 (43.3%)	--	--	--	--	--	--

Note. Other includes the following services: 30 and 60 day check-ins with parents, civic/volunteerism, conflict resolution, driver's license permit, equine therapy, extended foster care, family vacations, family visitation, follow-up/check-in, kickboxing, mentoring, neuropsychological evaluation, nutrition training, psychiatric services, psychoeducation groups, service referrals, spiritual guidance, substance abuse counseling, therapy, volunteer training, anger management/A&D groups, assessment and service plans, career/college planning, dance, discovery science club, game and movie nights, hair care, I/L skills, neuropsychiatric monitoring, referral, research, transportation.

Trauma-informed Residential Care

Programs' use of trauma-informed approaches were rated on a scale of 1-5 with higher scores indicating the program meets all criteria for trauma-informed care. Mean scores indicated that, overall, programs are 'somewhat' trauma-informed (M = 3.06, SD = 1.51). Program ratings are presented in Figure 7 and Figure 8 shows the percentage of programs meeting elements of a trauma-informed approach.

Figure 7. Ratings of Trauma Informed Approach in Residential Programs (*N* = 146)

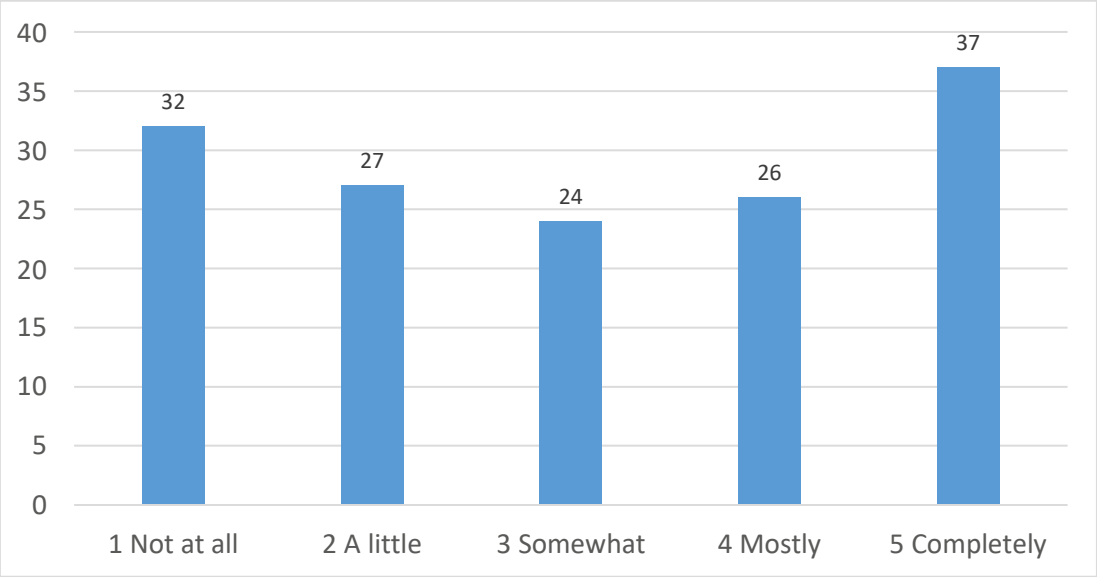
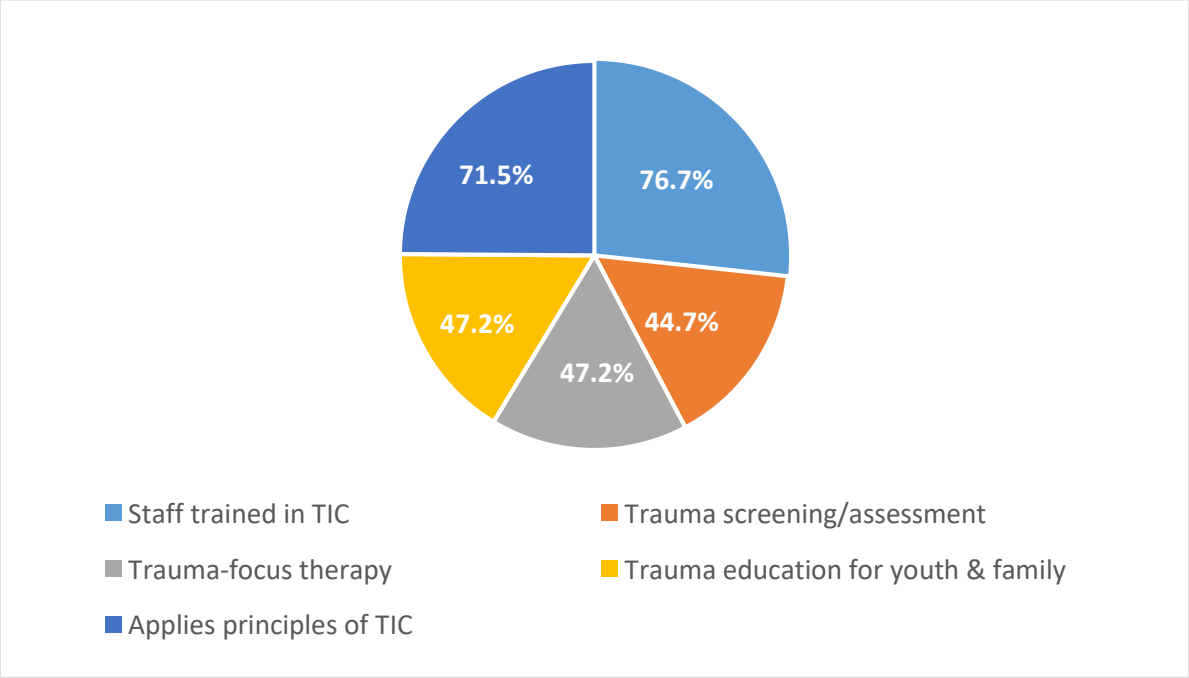


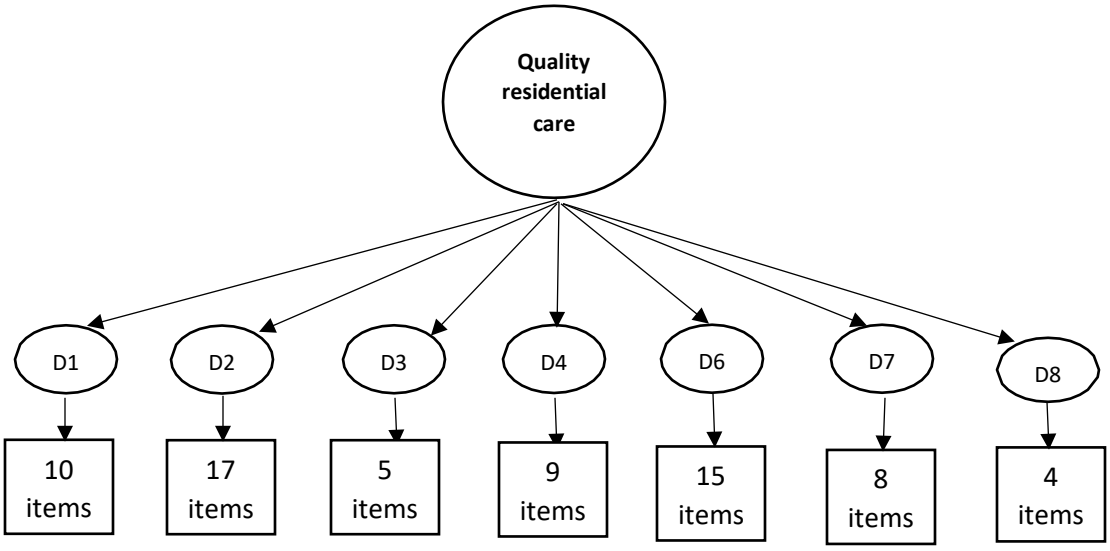
Figure 8. Elements of Trauma-Informed Approaches Among Residential Programs (*N* = 150)



Group Care Quality Standards Assessment-Youth Form Validation Results

Figure 9 shows the multidimensional measure of quality in residential care. Each domain represents a key area of practice contributing to overall quality of care. The figure depicts the hypothesized latent structure underlying the Youth Form with the items capturing the observable practice elements within each domain. Across domains, the Youth Forms includes 68 items.

Figure 9. Domains and Number of Items Comprising the GCQSA Youth Form



Note. D1 = Assessment, Admission, and Service Planning; 2 = Positive, Safe Living Environment; D3 = Monitor and Report Problems; D4 = Family, Culture, and Spirituality; D6 = Program Elements; D7 = Education, Skills, and Positive Outcomes; D8 = Pre-Discharge/Post Discharge Processes. Domain 5 (Professional, Competent Staff) is not measured on the Youth Form.

Item analysis (Missing Data, Skewness, Kurtosis)

Missing data was minimal across items. Instances of missing were minor ($\leq$ 10%; Widaman, 2006) for all items. Due to minimal issues with missing, listwise deletion was applied for reliability analyses. Applying Kline's threshold where values of skewness should be < 3.0, items 7 (skewness = -3.38) and 8 (skewness = -3.04) of Domain 4 and items 3 (skewness = -4.24) and 5 (skewness = -3.01) of Domain 6 were marginally skewed. These items were flagged and subsequent reliability analyses were performed with and without the items to examine impact on reliability estimates, which were found to have a negligent impact on reliability coefficients.

Reliability analysis

Cronbach's alpha coefficients were computed using SPSS for each domain scale. Reliability coefficients of .70 or higher are considered as evidence of acceptable (or better) reliability. Additionally, alphas-if-item deleted were calculated to indicate whether specific items should be retained. Table 5 displays the alpha (α) for each scale and, below, the adjusted alphas if the corresponding item were deleted are reported. For instance, D1 (Assessment, Admission, and Service Planning) has an alpha of .870. If item 1 of this scale were deleted from the scale, the alpha would drop slightly to .867. This suggests the item contributes unique variance to the overall scale.

As shown in Table 5, all items across the eight scales were high, exceeding .80. However, for Domain 2, the alpha coefficient could be increased slightly by dropping items 11 and 15. Dropping item 2 from Domain 3, item 9 from Domain 4 and item 8 from Domain 6 would marginally improve alphas for these respective scales (see item descriptions in Table 6).

Table 5. Cronbach's Alpha of Eight Domains and Alpha if Item Deleted of 68 Scale Items (*N* = 365)

	D1: Assessment	D2: Positive	D3: Monitor	D4: Family	D6: Program	D7: Education	D8: Discharge
Items	α = .870	α = .884	α = .833	α = .875	α = .923	α = .872	α = .862
1	.867	.877	.816	.870	.918	.852	.837
2	.858	.876	**.840**	.853	.919	.853	.809
3	.859	.874	.800	.851	.920	.871	.858
4	.853	.877	.772	.857	.920	.851	.791
5	.858	.876	.767	.865	.920	.857	
6	.863	.876		.854	.916	.853	
7	.860	.879		.866	.918	.849	
8	.857	.876		.858	**.929**	.865	
9	.848	.875		**.881**	.918		
10	.849	.879			.916		
11		**.887**			.918		
12		.876			.914		
13		.879			.915		
14		.876			.914		
15		**.886**					
16		.879					
17		.879					

Table 6. GCQSA-Youth Form Items Flagged for Possible Deletion

Domain/Item #	Item Description
D2: Item 11	In this program, kids don't bully or threaten each other
D2: Item 15	Staff use restraints or time out rooms only when there is no other way to keep us from getting hurt.
D3: Item 2	Staff told me how to file a private complaint (grievance) about problems I might see or have here.
D4: Item 9	I am allowed to go places where I can practice my beliefs (like a church, temple, mosque) if I want to.
D6: Item 8	There are at least two staff on duty at all times except when we are sleeping.

Confirmatory Factor Analysis

Confirmatory factor analysis was performed in Mplus version 11. Model fit was assessed using the following measures of fit: Chi-square statistic is insignificant at the 0.05 alpha level, the Chi-square/degrees of freedom ratio is less than 3, the TLI and CFI values are greater than .90, RMSEA value is lower than .08, and the SMRS is less than .10.

As shown in Table 7, the Chi-square statistics was significant and TLI and CFI were less than .90 for the initial model (model 1). Therefore, based on items that were flagged from the reliability analysis and modification indices suggesting a reduction of the $\chi^2 \geq$, error variances were allowed to correlate for selected items within the same domains (4 items within domain 2; 2 items within domain 7). Although

still slightly below recommended fit criteria, allowing correlated error variances between selected items substantially improved model fit. Subsequent analyses will be performed to reach recommended model fit and to determine items to drop or keep including examining inter-item correlations, item factor loadings, and using methods of item response theory. These analyses are currently underway.

Table 7. Model Fit from Confirmatory Factor Analysis of the 7-Factor GCQSA-Youth Form

Model (items)	χ^2	*df*	χ^2/df	TLI	CFI	RMSEA	SRMR
1 (68 items)	4966*	2189	2.27	.76	.77	.05	.06
2 (68 items)	4209*	2185	1.92	.82	.83	.05	.06

Note. df = degrees of freedom; TLI = Tucker Lewis Index; CFI = Comparative Fit Index; RMSEA = Root mean error of approximation; SRMR = Standardized root mean square residual.
*$p < .05$.

DISCUSSION

The purpose of the statewide pilot was to begin implementing the GCQSA in all six regions, giving stakeholders in each region an opportunity to become familiar with the assessment while providing careful monitoring and on-going technical support. From the statewide pilot, based on a sufficiently large sample, the research team will examine internal consistency reliability and factorial validity of the domains scores of the GCQSA. Assessment data were collected from one-year from the full population of licensed residential care programs throughout Florida. Analyses of these data are currently underway. This report summary the results from analyses completed thus far.

The adjusted sample included 160 programs and 223 licensed facilities. There was a total of 1,516 assessment forms completed by youth (450 form, 29.7%), direct care workers (450 forms, 29.7%), group home directors/supervisors (272 forms, 17.9%), lead agencies (183 forms, 12.1%), and licensing specialists (161 forms, 10.6%). Sixty-one percent of residential programs in the sample are traditional group homes followed by nearly 20 percent shelters and 19 percent designed to serve specialized population (e.g., CSEC, maternity) or other.

The majority of residential programs (63.6%) use a shift care model while 36.4 percent reported using a family-style model. Less than half of the residential programs in the sample are nationally accredited. Of the 65 accredited programs across the state, the majority use shift-care models. Services most often provided included educational training and supports, recreation, life skills development/independent living, and discharge planning. With the exception of recreation, most of these services are provided both on and off-site. Mean scores indicated that, overall, programs are 'somewhat' trauma-informed (M = 3.06, SD = 1.51) with most reporting staff are trained in trauma-informed care and adhere to principles of trauma-informed care (promote psychological and physical safety, trust, choice, and empowerment). Less than half reported routinely screening youth for trauma and traumatic stress.

Steps toward validating the GCQSA are underway, beginning with the Youth Form. Cronbach's alpha coefficients were above .80 for all seven domains indicating good internal consistency. Results from a confirmatory factor analysis are promising but further analyses are needed to improve model fit and to identify items could be dropped from the assessment.

As the analyses of the statewide pilot data continues, additional descriptive findings for group homes will be presented describing services approaches and characteristics of youth and residential care staff. In addition to the Youth Form, the other forms of the GCQSA will also be included in psychometric analyses. Additional analyses may include examining inter-item correlations, using methods of item-

response theory to examine item difficulty and reliability, and exploring correlations between assessment scores, program characteristics (e.g., accreditation status) and other piloted measures thought to be potential indicators of quality care (e.g., youth injury, staff injury, runaway episodes, law enforcement calls to campus). Finally, a content analysis of technical support call notes and text responses from the GCQSA will be conducted to identify process-related theme from the perspective of key stakeholders. The results from the statewide pilot will be used to finalize the assessment tool for the final validation study and to refine training and implementation procedures.

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Appendix A.

Florida Quality Standards Initiative Implementation Framework