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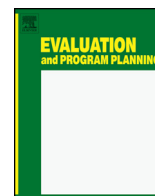
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The development and use of Provider Profiles at the organizational and systems level



Laura E. Gómez^{a,*}, Miguel Ángel Verdugo^b, Benito Arias^c, Patricia Navas^d, Robert L. Schalock^e

^a Department of Psychology, University of Oviedo, Plaza Feijoo, s/n, 33003 Oviedo, Spain

^b Institute on Community Integration (INICO), University of Salamanca, Avda. de la Merced, 109-131, 37005 Salamanca, Spain

^c Department of Psychology, University of Valladolid, Paseo de Belén 1, Campus Miguel Delibes, 47011 Valladolid, Spain

^d Nisonger Center, Ohio State University, 1581 Dodd Dr Columbus, OH 43210, United States

^e Hastings College, Nebraska, PO Box 285, Chewelah, Washington 99109, United States

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ABSTRACT

While the use of quality of life-related personal outcomes has been broadly reported during the last decade, little attention has been paid to the use of such data as a basis for developing and using Provider Profiles at the organizational and systems level. This article illustrates a way in which these evidence-based outcomes may be used not only to improve clinical decisions, but also managerial and policy strategies. To that end, the quality of life of 11,624 social service recipients was assessed by means of the application of the GENCAT Scale, a questionnaire to assess quality of life according to the eight-domain model (Schalock & Verdugo, 2002). Data were analyzed at organizational and the systems level in order to develop Provider Profiles. Once implemented, these profiles can be used to compare individuals in different diagnostic groups, develop province-level performance standards, encourage continuous program improvement, and guide the development of evidence-based policies

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1. Introduction

Care approach for people with disability and persons in dependent situations – those who traditionally have been recipients of social and human services – has been under an ongoing transformation during the last few decades toward more person-centered planning approaches in which self-determination, empowerment, inclusion, and rights are key aspects. Initially, the primary goal of care was to provide proper services – in terms of satisfying basic needs, providing care and cure (i.e., according to the medical model) – to all those needing attention (e.g., people with intellectual,

physical, and sensory disabilities, elderly people, people with mental health problems, people with drug dependences, as well as people with HIV/AIDS), highlighting the importance of habilitation and rehabilitation programs in which the quality was determined by the fulfillment of individual goals and planning. In the last two decades, however, the direction of these efforts has emphasized the implementation of individualized supports to enhance community inclusion and one's quality of life. In this context, the quality of life of social service recipients has taken a great importance as well as developing feedback systems to organizations and systems regarding their status on these outcomes.

The development and use of *Provider Profiles* of organizations providing social services in Spain that we discuss in this article constitutes a pioneer strategy in Europe. This strategy allows assessing evidence-based personal and organizational outcomes according to a quality of life model, which then provides guidance for developing and implementing social policies. *Provider Profiles* were implemented initially in 1998 by the ARC of Nebraska –a

* Corresponding author at: Department of Psychology; University of Oviedo, Plaza Feijoo, s/n, 33003 Oviedo, Spain. Tel.: +34 985 103372; fax: +34 985 104144.

E-mail addresses: gomezlaura@uniovi.es, lauraelisabet@gmail.com (L.E. Gómez), verdugo@usal.es (M. & Verdugo), barias@psi.uva.es (B. Arias), patricia.navasmacho@osumc.edu (P. Navas), rschalock@ultraplix.com (R.L. Schalock).

private, non-profit, statewide organization that stands with individuals and families in advocating and supporting Nebraskans with intellectual and developmental disabilities–, in conjunction with the Nebraska Department of Health and Human Services (The ARC of Nebraska, 2003). Since then, *Provider Profiles* are generally understood as composed of key performance indicators for each organization including: (a) aggregated quality of life-related personal outcomes of social service recipients (i.e., using an evidence-based quality of life conceptual and measurement framework); and (b) organizational data that may impact the quality of life of social service recipients (e.g., users to support staff ratio, type of provided services and supports, funding, or location).

This article describes a way in which these evidence-based outcomes – and the *Provider Profiles* that result – may be used not only to improve clinical decisions, but also to inform managerial and social policy strategies. Evidence-based outcomes are defined as measures obtained from the reliable assessment of quality of life domain-referenced indicators that are based on a cross-cultural validated quality of life and measurement model (van Loon et al., 2013, p. 80). Furthermore, evidence-based outcomes are a critical component of evidence-based practices in the sense that such outcomes can be used not only to develop and implement evidence-based practices, but also to assess their efficacy. These are defined as “practices that are based on current best evidence that is obtained from credible sources that used reliable and valid methods, and a clearly articulated and empirically supported theory or rationale” (Schalock, Verdugo, & Gómez, 2011, p. 274).

A key component of *Provider Profiles* is the presentation of assessed quality of life scores that can be aggregated at the level of the organization and system. Numerous quality of life models have been developed (e.g., Cummins, 2005; Felce, 1997; Renwick, Brown, & Nagler, 1996; World Health Organization, 1997). The quality of life conceptual and measurement model used as a basis for the *Provider Profiles* discussed in this article is the model proposed by Schalock and Verdugo (Gómez, Verdugo, & Arias, 2010; Schalock & Verdugo, 2002; Schalock & Verdugo, 2007; Schalock & Verdugo, 2012a; Schalock & Verdugo, 2012b; Schalock, Bonham, & Verdugo, 2008; Schalock, Keith, Verdugo, & Gómez, 2010), in which quality of life is understood as composed of eight domains: emotional wellbeing, physical wellbeing, material wellbeing, personal development, self-determination, social inclusion, interpersonal relationships, and rights. The cross-cultural validation of this model has been broadly reported (see Gómez, Verdugo, Arias, & Arias, 2010; Jenaro et al., 2005; Schalock et al., 2005; Wang, Schalock, Verdugo, & Jenaro, 2010). Furthermore, this model has been widely used to assess personal outcomes in multiple jurisdictions, including Nebraska (Keith & Bonham, 2005), Maryland (Bonham, Basehart, & Marchand, 2003; Bonham et al., 2004; Bonham, Volkman, & Sorensen, 2009), Holland (Claes, van Hove, Vandavelde, van Loon, & Schalock, 2012; van Loon et al., 2013), Alberta (Canada) (Edmonton Community Board for Persons with Developmental Disabilities, 2011), and Spain (Gómez, 2010, 2013).

The purpose of this article is to describe how quality of life scores can be used at both the organization and systems level to obtain not only a quality of life profile of each person assessed to guide person-centered programs (i.e., clinical decisions at the microsystem level; see van Loon et al., 2013) but also as a basis for the development and implementation of *Provider Profiles* for the organizations providing social services in Catalonia (Spain) (i.e., managerial decisions at the mesosystem or organizational level for implementing continuous program improvement). Additionally, these scores can be used to develop different performance standards (e.g., state-level standards, organizational-level standards, diagnostic groups-level standards), and to suggest strategies to improve scores in those quality of life domains in which the lowest scores are obtained (i.e., policy development and decisions

at the macrosystem level). In this way, throughout this work we use an ecological perspective (Bronfenbrenner, 1994; Schalock & Verdugo, 2002) in which microsystem refers to the immediate social settings that directly affect the person's life (such as family, home, peer groups, or workplace); mesosystem refers to the community, service agencies, and organizations that directly affect the functioning of the microsystem; and macrosystem refers to the overarching pattern of culture, social-political trends, economic systems, and society related factors that directly affect one's values, assumptions, and the meaning of words and concepts).

2. Methods

2.1. Participants

This study involved a total of 758 professionals, working at 154 organizations across 288 centers (one organization may be composed of different centers located in different places and providing different kinds of supports to different diagnostic groups), assessing the quality of life of 11,624 social service recipients in Catalonia (Spain). Among the social service recipients assessed there were people with intellectual disability, people with physical disabilities, people with sensory disabilities, elderly people, persons with mental health problems, people with drug dependences, and people with HIV or AIDS. The criteria to participate in the study were: (a) professionals must have known the person for at least three months and have had opportunities to observe them during prolonged periods of time in different contexts; (b) persons whose quality of life was assessed must be recipients of social services for at least three months and be at least 16 years old.

Among the 758 professionals completing the quality of life assessment, more than three quarters (83.4%) were women (only 126 of them were men). Their ages ranged between 19 and 64 years old ($M = 36.6$; $SD = 9.11$). Most of them were working as psychologists (16.9%), occupying managerial positions (14.8%), social workers (11.7%), nurses (10.4%), or educators (9.7%), but there were also a considerable number of instructors (5.8%), physiotherapists (5.2%), carers (4.4%), social educators (3.2%), and occupational therapists (2.4%). The remaining percent were composed of gerontologists, sociocultural workers, physicians, and guardians. Tenure ranged from 3 months to 37 years ($M = 8.45$; $SD = 6.83$), and most of them had been working with social service recipients for more than three years (83.6%). Each professional assessed a mean of 15 persons and a median of 9 (*inter-quartile range* = 12; *quartile deviation* = 6).

Participants whose quality of life was assessed were quite balanced according to their gender: 54.8% ($n = 6372$) were females. Their ages ranged from 16 to 111 years old ($M = 59.37$; $SD = 23.82$), although the mean age of women ($M = 66.70$; $SD = 23.67$) was higher than the mean age of men ($M = 50.49$; $SD = 20.67$). It was not surprising that age means were so high if we take into account that a significant percent of the assessed people were receiving services in day centers and homes for elderly. Actually, there were 4817 persons that can be considered elderly (i.e., were receiving supports in day centers or residences; were older than 65 years old, or older than 45 if they were persons with intellectual disability); among these, women showed a mean age of 85.21 ($SD = 7.57$), while the mean age of men was 81.44 ($SD = 8.47$). On the other hand, the prevalence of men is higher than women in the age group of 16–65 years old.

Concerning the diagnostic group, 42% of the sample were considered elderly (73.8% were female), 45.5% showed intellectual disability (58% were male), 10.8% had mental health problems (60% were male), 9.9% had physical disability (52% were female), 2.2% had sensory disabilities (54% were female), 1.9% had drug

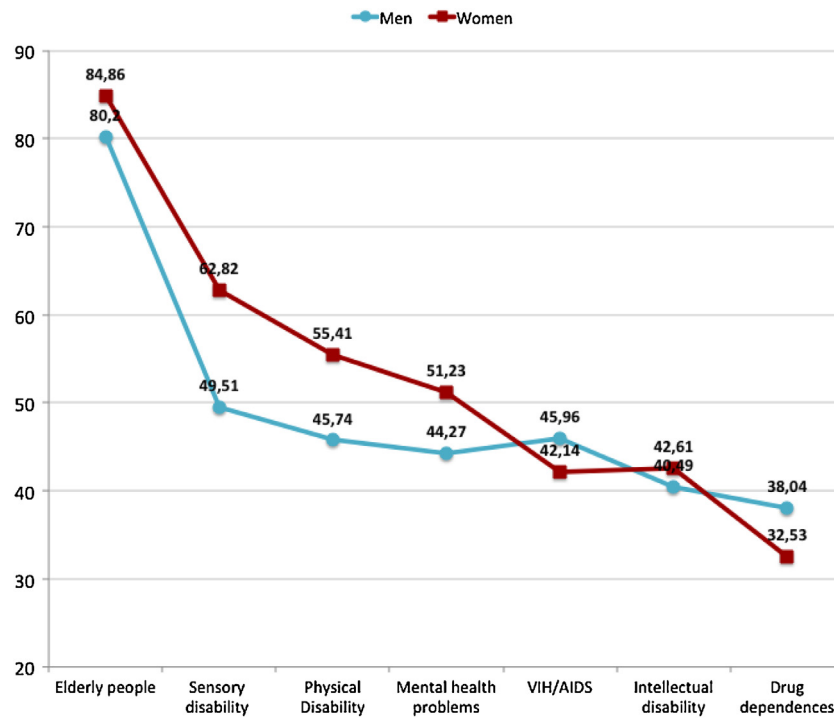


Fig. 1. Sample distribution by age, gender, and diagnostic group.

dependences (83% were males) and 0.4% had HIV or AIDS (98% were males). Mean ages by diagnostic groups are illustrated in Fig. 1.

There was an association between age and gender (*Contingency Coefficient* = .327; *p* = .000). In Fig. 2, representing the population pyramid by age and gender is represented, it can be seen that women represent the most numerous group in the highest age segments, while men are more numerous in the low ones. The contingency analysis shows that there was no independency between both variables (i.e., age and gender): ($\chi^2_{(15)} = 1237.084$; *p* = .000) (Fig. 3).

Data were collected in 154 organizations across 288 centers. The mean number of assessed people was 75 per organization (*range* = 5–424) and the median was 56 (*inter-quartile range* = 75.5; *quartile deviation* = 19.5); the mean number of assessed people per center was 40 (*range* = 1–424) and the median was 28 (*inter-quartile range* = 39; *quartile deviation* = 19.5). Centers were located in 86 different localities from Catalonia (Spain), though more than a quarter was in Barcelona (26.56%). The distribution was quite well balanced in relation to the different kinds of funding: 33.31% were public, while 24% were private; the remaining 42.69% were centers that combine public and private

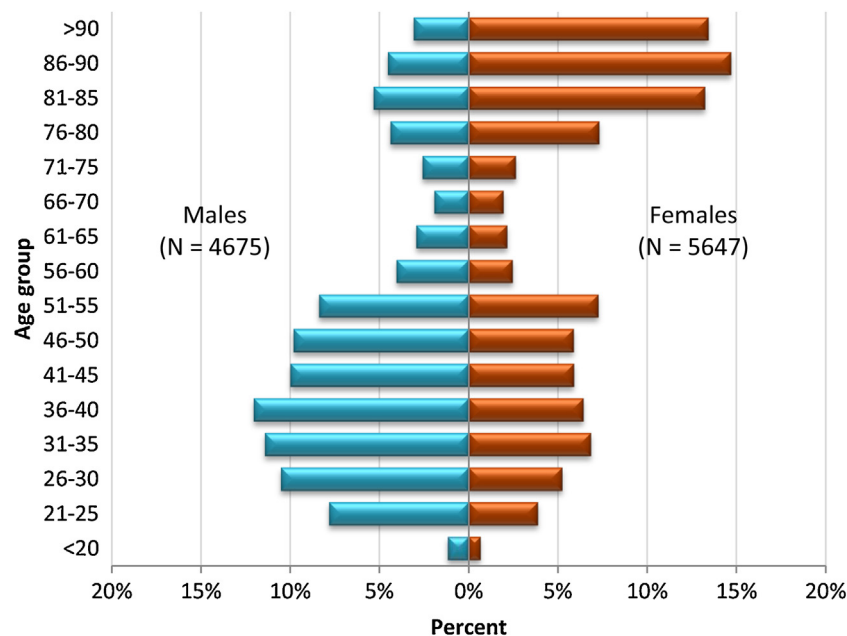


Fig. 2. Population pyramid by gender and age.

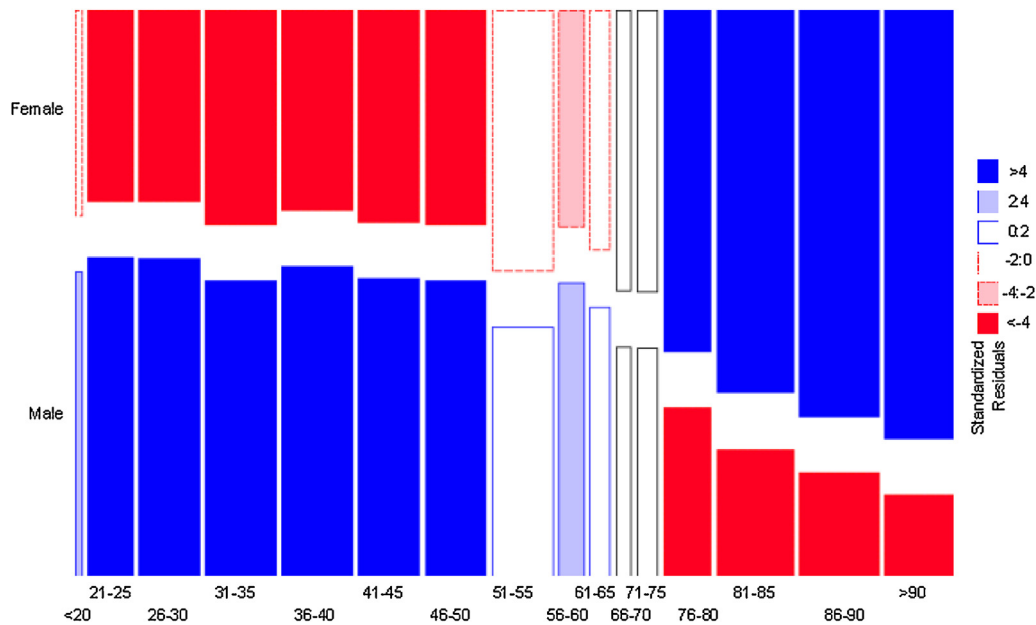


Fig. 3. Mosaic for sex and age (Pearson standardized residuals).

funds. Organizations provided services to a mean of 113 persons (range = 1–4150), and had between 1 and 663 staffs working full time, and between 1 and 379 working half time (this is 1–1042 staffs if we add those working half and full time). Finally, staff – recipient ratio ranged between 0.20 and 37.33.

2.2. Instruments

To obtain the information that was considered pertinent to develop the *Provider Profiles*, we used two data sources. First, each participating center completed a survey of sociodemographic data. Second, a professional at each participating center completed a questionnaire to assess the quality of life of each social service user: the GENCAT Scale (Verdugo, Arias, Gómez, & Schallock, 2008a, 2008b, 2009), which assesses the eight domains of the previously referenced quality of life conceptual model. Psychometric qualities of this scale include (Verdugo, Arias, Gómez, & Schallock, 2010): (a) reliability: evaluated by Cronbach's alpha index ($\alpha = .92$) and the standard error of measurement ($SEM = 6.92$); (b) construct validity: evaluated by means of Confirmatory Factor Analysis ($\chi^2/df = 2.87$; $GFI = .96$; $CFI = .97$; $RMSEA = .05$).

The first data set included the following socio-demographic information that, according to previous research (e.g., Bonham & Volkman, 2011; Keith & Bonham, 2005), may have an impact on the quality of the services provided by organizations: (a) information about the center (e.g., name of the center, name of the overall organization, postal address, geographical ambit, kind of funding); (b) information about the contact person in each center (e.g., e-mail, phone); (c) information about the service recipients (e.g., population or diagnostic groups, number of users); (d) information about the staff (e.g., number of professionals working at full and half time); (e) information about the services and supports that they provide; (f) a brief description of the activities that they put into practice to enhance their service quality; and (g) a maximum of three actions that they carry out to enhance the quality of life of their clientele.

The GENCAT Scale is an instrument that allows assessing quality of life-related personal outcomes. A third party respondent bases the assessment on a systematic observation and a deep knowledge of the person. The instrument contains 69 items that are included in Appendix A. The items are formulated as third-person

statements with an answer format of four frequency options (i.e., “never or hardly ever”, “sometimes”, “often”, “always and almost always”). Completing the scale takes around 15 min, after respondents are sensitized to its contents, format, and conceptual and measurement framework. More evidences about its validity and reliability can be found in Gómez (2010); Gómez, Arias, Verdugo, and Navas (2012); Gómez, Verdugo, Arias, and Navas, (2010); Verdugo et al. (2010); and Verdugo, Schallock, Gómez, and Arias (2007).

The GENCAT Scale provides differentiated standard scores to the different diagnostic groups, but also a generic one that is applicable to all them in order to facilitate comparisons. The general standards were used in this study to interpret the obtained scores. These standard scores are automatically calculated and provided by the Web-based application that was used to complete the Scale. Two standard scores (with their corresponding percentiles) were used: for each dimension ($M = 10$; $SD = 3$) and a Quality of Life Index for the whole scale ($M = 100$; $SD = 15$).

2.3. Procedure

An e-mail was sent to the organizations providing social services in Catalonia with the main goals of: (a) describing the aims of the research; (b) estimating the number of centers that were determined to get involved; and (c) calculating the potential number of social service recipients that could be assessed. We stressed that the participation should be voluntary, and the decision should be taken by each of the centers that could be part of the same organization. A total of 432 centers replied expressing their willingness to participate in the development of their *Provider Profiles* and pointed out a total of 21,746 social service recipients that may be potentially assessed.

Once we knew the potential population, we sent another e-mail to communicate the specific number of persons that each center should assess in order to develop a valid *Provider Profile*. We assumed a sampling error of 3% in most of the organizations, although for those whose number of users was greater than 100, the sampling error was increased to a maximum of 6%. The sampling error was determined by using a confidence level of .95% and a response distribution of $p = q = .5$. In other words, to develop a *Provider Profile* was necessary to assess between 75% and 100% of

Table 1
Descriptive statistics of raw scores obtained by all participants.

	N organization	N centers	N users	N assessed users	Response rate
Elderly homes	33	50	4589	2724	59.36
Elderly day centers	21	31	2203	1874	85.07
Physical disability	7	14	337	327	97.03
Intellectual disability	59	132	5430	4277	78.77
Mental health	11	24	436	403	92.43
Drug dependences	4	9	282	234	82.98
HIV/AIDS	3	4	55	50	90.91
EH & MH	1	1	4150	424	10.22
PD & ID	3	3	213	205	96.24
PD, ID, & MH	7	8	930	717	77.10
ID & MH	5	12	479	389	81.21

EH=elderly homes; MH=mental health; PD=physical disability; ID=intellectual disability.

the users in each center. Due to the size of some organizations, this requirement was reduced to 72–74% in two cases, to 51–52% in another two cases, and to 37% in only one. The social service recipients that we estimated were going to be assessed at this point were 18,337 persons. More data about the representativeness of the sample by type of service are shown in Table 1.

The data were collected by means of a Web application. This application included a specific area for each participating organization so that they could register their different centers. Once all their centers (the ones agreeing to participate) were registered, they could complete the socio-demographic survey – only one person in each center carried out this task (the one who was designated in each center with the role of “manager”). Once the “manager” had filled in the socio-demographic survey about their center, they registered the correspondent number of professionals that were going to participate in the study by completing the GENCAT Scale for the different users of their services. In order to distinguish the role of the latter from the role of the “manager”, they were designated and registered as “assessors”, since their task was to assess the quality of life of those persons that the “manager” had previously assigned to them. Therefore, the sampling was incidental, only based on the knowledge and the observation opportunities that professionals might have for every person.

In this way, each “assessor” first provided some data about themselves (e.g., age, gender, years of working experience) and about the person they were going to assess (e.g., age, gender, diagnoses). Next, they answered the 69 items composing the GENCAT Scale. When they pressed the “sent” button at the Web application, they were shown a table with the raw scores obtained in the scale by the person assessed, but also their corresponding standards and percentiles. Although initially the participation was estimated to involve 432 centers and 18,337 social service recipients, the final sample was composed of 288 centers and 11,624 clients (i.e., 67% of the estimated number of centers and 63% of the estimated number of clients).

Table 2
Descriptive statistics of raw scores obtained by all participants.

	EW	IR	MW	PD	PW	SD	SI	RI	Total
N items	8	10	8	8	8	9	8	10	69
Mean	23.61	27.96	29.21	21.53	27.38	22.46	23.56	34.82	210.54
Median	24	28	30	22	28	22	24	36	210
Standard deviation	5.01	4.95	3.19	5.03	3.38	7.46	4.16	4.14	25.76
Asymmetry	-0.42	-0.27	-1.79	-0.27	-0.96	0.12	-0.19	-0.56	-0.07
Kurtosis	-0.312	0.034	4.063	-0.342	1.216	-1.118	-0.301	-0.433	-0.245

EW=emotional wellbeing; IR=interpersonal relationships; MW=material wellbeing; PD=personal development; PW=physical wellbeing; SD=self-determination; SI=social inclusion; RI=rights.

3. Results

Descriptive analyses allow drawing conclusions about the quality of life of social service recipients in Catalonia that may be helpful to promote quality strategies at the organizational level and to guide policies at the macrosystem level. The development of *Provider Profiles* and their implementation will be illustrated, but before that we provide a brief synthesis of the specific results obtained by the sample in each quality of life domain and by specific diagnostic groups since this information may be helpful at the system level in order to develop social policies to enhance quality of life-related personal outcomes in those domains showing low achievement.

In this way *at the macrosystem level*, we can use the raw scores to make an easy interpretation of the quality of life shown by the sample. To do such interpretation, it must be taken into account that items are scored from 1 to 4; in such a way that a low score means a low quality of life and a high score means a high quality of life. Then the scores of the items conforming a domain are added up to obtain the raw score of the quality of life domain. In this way, participants showed a high quality of life in the sense that their mean scores, as it is shown in Table 2, highly exceeded the theoretical mean points of each domain and the total scale. In order to facilitate the interpretation, notice that the minimum score in every domain ranges from 8 to 10 and the maximum ranges from 32 to 40 (depending on the total number of items in each domain: 8–10 items).

As shown in Table 2, the highest scores were obtained in the domains of rights and material wellbeing. Personal development showed the lowest results and therefore might well be the priority of quality of life improvement strategies. In the same way, scores obtained in self-determination, social inclusion, and emotional wellbeing deserved to be highlighted because of being very improvable. Intermediate scores were, on the other hand, found for the domains of physical wellbeing and interpersonal relationships.

As reflected in Fig. 4, if we analyzed the raw scores obtained by the different diagnostic groups involved (i.e., intellectual disability, sensory disability, physical disability, elderly, drug dependences, mental health problems, and HIV/AIDS), we found that all of them coincided with obtaining the highest scores in rights. Elderly obtained lower scores in personal development, and people with physical and sensory disabilities, while persons with intellectual disability showed the lowest scores in self-determination. People with drug addictions and problems of mental health seemed to find most difficulties in the items related to emotional wellbeing. Finally, persons with AIDS or HIV achieved the lowest scores for the area of social inclusion.

At the organizational level, socio-demographic and quality of life-related personal outcomes can be aggregated by centers to obtain a *Provider Profile*. As shown in Fig. 5, each participating center was provided with: (a) a summary of its sociodemographic data (i.e., name, address, number of recipients, number of professionals, kind of funding, etc.); (b) the means of raw scores

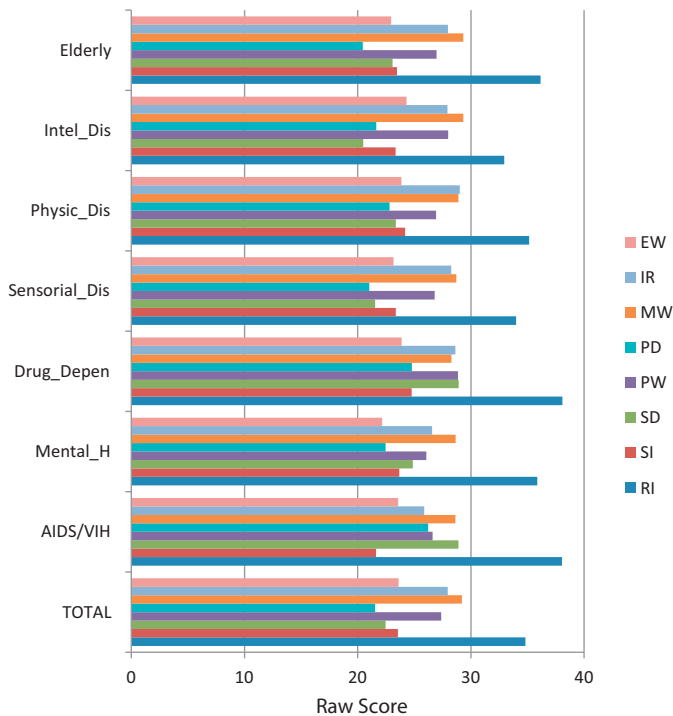


Fig. 4. Quality of life-domain scores by diagnostic groups; Intel_Dis = Intellectual disability; Physic_Dis = Physical disability; Sensorial_Dis = Sensory disability; Drug_Depen = Drug dependences; Mental_H = Mental health problems.

obtained by all its assessed individuals in each item conforming the scale; (c) a summary of scores obtained by all its users that included the mean score of the aggregated items for the eight domains, with its corresponding standard scores and percentiles; (d) a center's quality of life profile (i.e., a graphic representation of their results using the standard scores); (e) the organization's quality of life profile (note that an organization could be composed of different centers) that was based on the aggregated outcomes obtained by all the recipients attending the centers that belonged to that organization; (f) the diagnostic group's quality of life profile (i.e., aggregated scores of the diagnostic groups to which services were addressed to, such as persons with intellectual disabilities, or elderly); and (g) the social service recipients' quality of life profile obtained by aggregating the scores of all participants in this study.

4. Discussion

The primary purpose of this article is to illustrate the development and implementation of *Provider Profiles* in order to help decision-making at the organizational and system level. Although the goal of this study does not consist in showing the way in which individual profiles can be used at the microsystem (for very recent examples, see Claes et al., 2012; van Loon et al., 2013), we would point out very briefly that the quality of life-related personal outcomes for each participating person are also helpful for organizations to develop person-centered planning and supports at the microsystem level. In this way, a person's quality of life profile (based on individual personal outcomes) could be compared with the quality of life profile of the center, with the quality of life profile of the specific diagnostic group (e.g., persons with intellectual disability), and with the quality of life profile of social service recipients – all them based on aggregated personal outcomes.

When using the *Provider Profiles by organizations*, the responsibility of interpreting the specific results obtained resides in the centers themselves, since they must take into account that

the results of this assessment do not necessary mean a high or low success of their practices and activities, but they can be explained together with many other reasons that nothing have to be with them. In this way, it is the centers' responsibility to discern which outcomes are improbable by organizational actions and which ones could be better explained by other causes not related to their work or under their control. For this reason, we emphasize that these *Provider Profiles* are just a starting point to develop evidence-based practices, a mere baseline, that should be completed with other periodical assessments –ideally, yearly assessments. Along this line, the major goals of the centers should be also analyzed, taking into account a group perspective involving stakeholders, in order to establish relations between obtained results and possible strategies to enhance them. Some guidelines to improve quality of life-related personal outcomes at organizations can be found in Aveyard and Davies (2006), Gaugler (2005), Schalock and Verdugo (2012a); and in Schalock, Verdugo, Bonham, Fantova, & Van Loon (2008).

When using the *Provider Profiles at the system level*, the analyses of aggregated quality of life-related personal outcomes may be very helpful to guide the development and implementation of social policies to enhance quality of life of social service recipients. As Shogren and Turnbull (2010) pointed out, the international public policies about collectives at risk of social exclusion (especially, those for people with intellectual and developmental disabilities) try to promote and implement concepts and principles that are: (a) person-centered (e.g., self-determination, social inclusion, empowerment, individualized supports); and (b) organization and system-centered (e.g., positive attitudes, no discrimination, coordination, collaboration). For instance, Walsh et al. (2010) found three factors that are related to public policies as great predictors of quality of life-related personal outcomes: participation opportunities (e.g., more chances to keep in contact with relatives and friends), life conditions (e.g., more normalized conditions of life), and supports to professional skills (e.g., communication skills).

The results obtained at the community level in Catalonia (i.e., macrosystem level: results obtained by all participants) should play a promoting or stimulating function to develop strategic actions by the government and other organisms in their way to improve the quality of life of the citizens. In this sense, with the goal of developing specific actions to improve results in those domains in which the lowest results were shown, it is interesting to compare the results of this study (carried out in 2010) with a previous one carried out three years before (2007) with a representative sample of social services in Catalonia ($N = 3029$) (see Gómez, 2010, 2013; Verdugo et al., 2008a, 2008b, 2009, 2010). Such comparison is illustrated in Fig. 6, where it can be seen that the scores do not differ in a significant way from the first to the second assessment, except for self-determination and rights, in whose cases the size effects are very low (Cohen's $d = 0.223$ and 0.252 , respectively). These results emphasize the need for public and social policies to focus on the improvement of quality of life-related personal outcomes especially in personal development, but also in social inclusion, self-determination, and emotional wellbeing. Our findings, pointing out personal development as the key domain to improve quality of life-related personal outcomes, are consistent with those found in other studies conducted with similar populations (e.g., Bonham et al., 2003, 2004; Bouffard, 2012; Emerson et al., 2001; Perry & Felce, 2005). The specific guidelines that were suggested to the Government of Catalonia and organizations are summarized in Table 3.

The development and implementation of *Provider Profiles* is a pioneer experience not only in Spain, but in Europe as well. We consider that we are at an ideal moment to go beyond the application of the quality of life concept not only to the

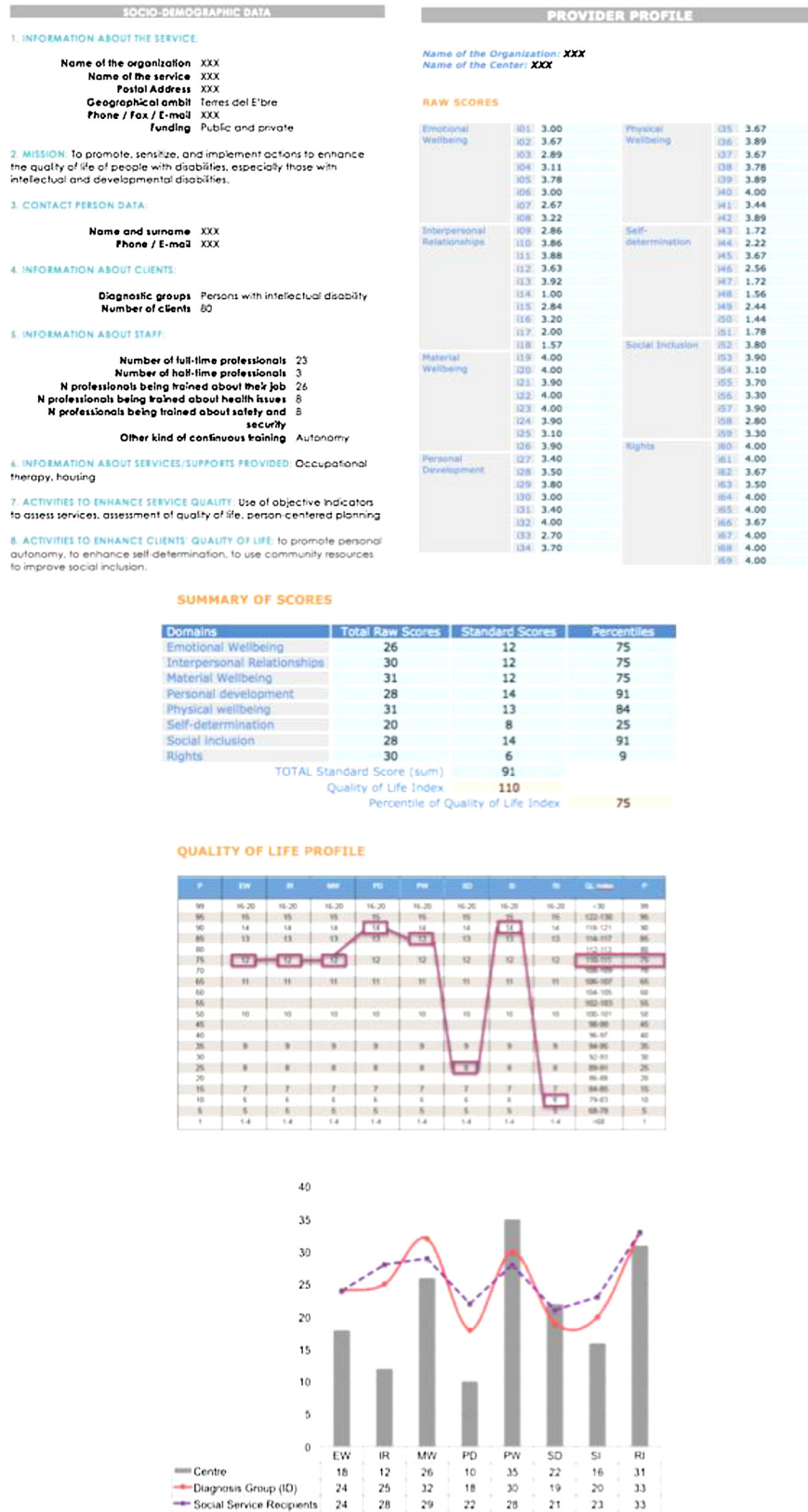


Fig. 5. Summary example of a Provider Profile.

microsystem level (to make clinical decisions and provide person-centered supports) but also to the mesosystem and macrosystem, to enhance their effectiveness and efficiency. Quality of life scores obtained from the use of a reliable and valid measure provides

organizations and systems with relevant information to organizations and policy developers that is helpful to guide the implementation of interventions for quality improvement, to monitor and guide organizational processes of change, to guide

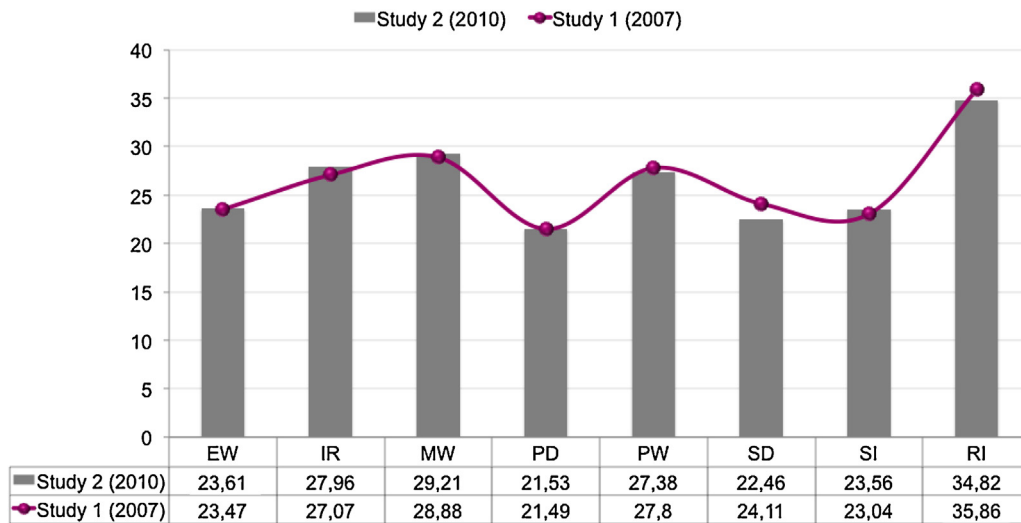


Fig. 6. Quality of life-related outcomes at the macrosystem level (raw scores).

Table 3

Recommendations to improve quality of life.

Enhance quality of life-related personal outcomes in personal development and inclusion as highest priority.
 Improve users' incomes, either by helping them to get better-remunerated jobs or by standing for better social benefits.
 Provide more and better information about the users' rights, and empower them to defend and exercise them.
 Try to improve health status of users (i.e., pain, discomfort, or inability to carry on a normal life) by providing them more supports in daily life activities, technical assistance, and health promotion interventions.
 Develop programs to promote social and family relations, paying special attention to couple and sexual relationships.
 Promote the possibilities to take decisions and make elections by implementing programs focused on autonomy and self-determination.
 Enhance self-concept and satisfaction of users (e.g., humor and resilience workshops).
 Facilitate the access to new technologies (e.g., cellular, computer, internet).
 Guarantee the participating of users in the development of their individual-centered planning.
 Promote the use of community environments and facilities, search for and promote natural supports (relatives and friends), and facilitate friendships outside the social service facility.

evidence-based practices, and to improve quality of life outcomes of service recipients. We consider that this information also impacts significantly the relationships between service recipients and providers, given that the *Provider Profiles* allow recipients to have a better view of the services that either they are currently receiving or that they can choose. In this way, we can also have an influence on the system of provision of services by encouraging quality, personal outcomes, and transparency. This experience has a main goal of highlighting the level of quality of life and the needs of a very broad number of persons who need and use social and human services. This experience is an unprecedented effort in Spain for the transparency, accessibility and facilitation of decision-making. However, such information would be only helpful when professionals, organizations, and policy makers update and review it constantly, when they reflect deeply about the real needs and aspirations of social service recipients (Keith & Bonham, 2005; Schalock and Verdugo, 2012a, 2012b).

Nevertheless, this work is not free from limitations, and these provide some suggestions for future research directions. Most

crucially, we must note the limitations associated with assessing quality of life-related personal outcomes from the perspective of other persons who are not the social service recipients. In this sense, we think that reports of others who know them well are needed, but we cannot forget or omit self-reports that reflect the values underlying the quality of life concept (e.g., inclusion, empowerment, equity, and self-determination) and the principles underlying the disability rights movement underscoring the right that individuals have to express their own feelings about their quality of life. Therefore, our challenge is to include self-reporting in the development of *Provider Profiles* in order to move toward more holistic approaches.

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Appendix A

EMOTIONAL WELLBEING.		SOCIAL INCLUSION.	
1.	He/she is satisfied with their present life	52.	He/she frequents communal areas (public swimming pools, cinemas, theaters, museums, libraries...)
2.	He/she shows symptoms of depression	53.	His/her family provides support whenever needed
3.	He/she is happy and in a good mood	54.	There are physical, cultural or social barriers that hinder his/her social inclusion
4.	He/she expresses feelings of helplessness or insecurity	55.	He/she lacks the necessary support for taking an active part in everyday life in their community
5.	He/she shows symptoms of anxiety	56.	His/her friends provide support whenever it is needed
6.	He/she is satisfied with themselves	57.	The service he/she attends encourages them to take part in community activities
7.	He/she has problems of conduct	58.	The only friends he/she has are the ones who attend the same service
8.	He/she is motivated when performing some kind of activity	59.	He/she is rejected or discriminated against by others
INTERPERSONAL RELATIONSHIPS.		RIGHTS.	
9.	He/she does things they enjoy with other people	60.	His/her family violates their privacy (reading their letters, entering without knocking...)
10.	The relations with his/her family are as they would like them to be	61.	He/she is treated with respect in their environment
11.	He/she complains about a lack of close friends	62.	He/she has information on their basic rights as a citizen
12.	He/she has a negative view of their friendships	63.	He/she finds it difficult to defend their rights when these are violated
13.	He/she says they feel undervalued by their family	64.	The service he/she attends respects their privacy
14.	He/she finds it difficult to start up a relationship with a potential partner	65.	The service he/she attends respects their possessions and their ownership rights
15.	He/she gets on well with their colleagues at work	66.	One or more of his/her legal rights have been impaired (citizenship, vote, legal processes, respect for their beliefs, values, etc.)
16.	He/she says they feel loved by the people who are important to them	67.	The service he/she attends respects and defends their rights (confidentiality, information on their rights as a user...)
17.	Most of the people with whom they interact are in a similar situation to their own	68.	The service respects the privacy of his/her information
18.	He/she has a satisfactory sex life	69.	He/she is exposed to exploitation, violence or abuse
MATERIAL WELLBEING.			
19.	Where he/she lives stops them from leading a healthy life (noise, fumes, odors, gloom, lack of ventilation, damage, inaccessibility...)		
20.	His/her workplace complies with rules on health and safety		
21.	He/she has the material possessions they need		
22.	He/she is unhappy with where they live		
23.	Where he/she lives is clean		
24.	He/she has enough money to cover their basic needs		
25.	He/she does not earn enough to be able to afford luxuries		
26.	Where he/she lives has been adapted to their needs		
PERSONAL DEVELOPMENT.			
27.	He/she finds it difficult to cope with everyday situations		
28.	He/she has access to new technologies (Internet, mobile phone, etc.)		
29.	The work they do enables them to learn new skills		
30.	He/she finds it difficult to effectively deal with the problems they have to face		
31.	He/she does their work competently and responsibly		
32.	The service he/she attends caters for their personal development and the learning of new skills		
33.	He/she is involved in the drafting of their own individual program		
34.	He/she lacks motivation at work		
PHYSICAL WELLBEING.			
35.	He/she finds it difficult to sleep		
36.	Technical aids are available if he/she needs them		
37.	He/she has healthy eating habits		
38.	His/her state of health allows them to lead a normal life		
39.	He/she maintains good personal hygiene		
40.	The service he/she attends supervises the medication they take		
41.	His/her health problems cause them pain and discomfort		
42.	He/she finds it difficult to access healthcare resources (preventive care, GP, at home, in hospital, etc.)		
SELF-DETERMINATION.			
43.	He/she has personal targets, goals and interests		
44.	He/she decides how to spend their free time		
45.	The service he/she attends caters for their preferences		
46.	He/she defends their ideas and opinions		
47.	Other people decide upon his/her personal life		
48.	Other people decide how he/she spends their money		
49.	Other people decide what time he/she goes to bed		
50.	He/she organizes their own life		
51.	He/she chooses who they live with		

Lessons Learned

Provider profiles are an organizational strategy that could be used to improve effectiveness and efficiency of organizations. A consistent result in studies related to the development of *Provider profiles* is the need of making greater efforts in the achievement of better results in the domain of personal development and self-determination. Probably, a change in the way we consider to persons at risk of social exclusion or in situation of dependence may give rise to a substantial improvement of these results. Therefore, the key may be in not considering and treating them as clients, with a passive role, but as citizens with an active role within the organizations.

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Laura E. Gómez, Ph.D., is assistant professor at the University of Oviedo, and researcher on disabilities at the Institute on Community Integration (INICO) at the University of Salamanca. Her research interests include quality of life in the field of intellectual disability and other groups at risk of social exclusion, person-centered planning, individualized supports, evidence-based practices, social and human services, and adaptive behavior. She has developed together with Prof. M. A. Verdugo, B. Arias, and R. L. Schalock several measurement tools for quality of life: the GENCAT Scale, the San Martin Scale, The Integral Scale, The Fumat Scale, and the INICO-FEAPS Scale.

Miguel Ángel Verdugo, Ph.D., is full professor (Department of Personality, Assessment and Psychological Treatments) and director of the Research Institute on Community Integration (INICO) at the University of Salamanca. Director of the Information Service on Disability of the Ministry of Health, Social Policy and Equality in Spain. Director of the *Master in Integration of People with Disabilities: Quality of life* since 1990 and also of the Latin American Program of this degree since 1993. Director of the scientific Journal *Siglo Cero*.

Benito Arias, Ph.D., is a full professor of psychology at the University of Valladolid (Spain), and researcher on disabilities at the Institute on Community Integration (INICO, University of Salamanca). His research interests are focused on the analysis of behavior disorders in people with intellectual disabilities and the development and validation of assessment instruments on adaptive behavior, support needs and quality of life.

Patricia Navas, Ph.D., is a postdoctoral researcher at Ohio state University Nisonger Center (Columbus, Ohio, United States of America). Her research interests include adaptive behavior in people with intellectual and developmental disabilities with special emphasis in the diagnostic process, quality of life in the field of intellectual disability and other groups at risk of social exclusion, evidence-based practices, and human rights. Her current research lines are also focused on the development of assessment instruments through Item Response Theory (IRT) methodology.

Robert L. Schalock, Ph.D., is professor Emeritus at Hastings College (Nebraska) and Adjunct Research Professor at the Universities of Kansas (Beach Center on Disabilities), Salamanca, Gent, and Chongqing (Mainland China). His national and international work has focused on the conceptualization and measurement of quality of life and the supports paradigm. He has been involved in the development and evaluation of community based programs for persons with intellectual and closely related developmental disabilities.