

Quality is Multidimensional

Practices associated with improved outcomes have been used as the basis for developing quality standards.

Research-based approaches to quality standards has shown that no one dimension defines quality care.

Quality residential care entails a diverse set of criteria:

- **Assessment and service planning** (e.g., assessment-driven services, individualized service planning, measurable goals)
- **Positive and safe environment** (e.g., no abuse, youth rights respected, effective crisis management, prevention of self-harm)
- **Monitor and report problems** (e.g., staff report problems, grievance process, independent audits, stakeholder satisfaction)
- **Family, culture, and spirituality** (e.g., families involved in treatment decisions, culturally sensitive, reunification focus)
- **Professional and competent staff** (e.g., qualified staff, comprehensive training, criminal screening, supportive supervision)
- **Effective program elements** (e.g., family-like program, normalization activities, collaborative care, evidence-based practices, trauma informed, quality improvement emphasis)
- **Education, skills, and outcomes** (e.g., academic testing, special education support, skill development, vocational training)
- **Transition planning and aftercare** (e.g., transition and discharge planning, aftercare services, follow-up outcomes)



The development of quality standards based on research findings

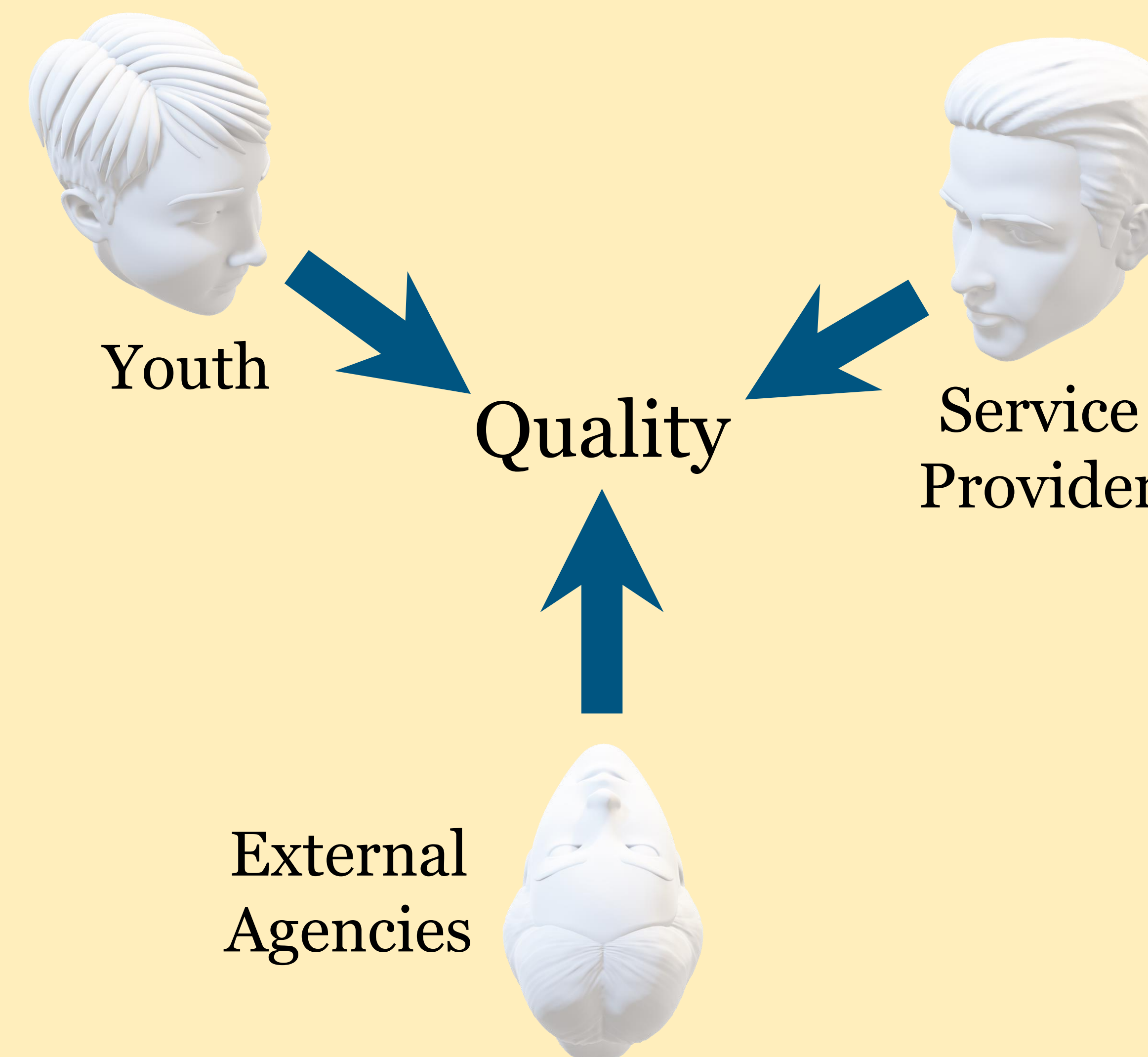
- An integration of current best-evidence to inform practice
- A solid example of translational research to practice

Measurement Requires Multi-Perspectives

Multi-perspective measurement is necessary to obtain a balanced assessment of residential care quality.

There are three distinct classes of participants in the residential care process:

- Those receiving care (youth)
- Those providing care (service provider)
- Those providing funding and oversight (external agencies)



Each is an important source of information about how well the organization is performing.

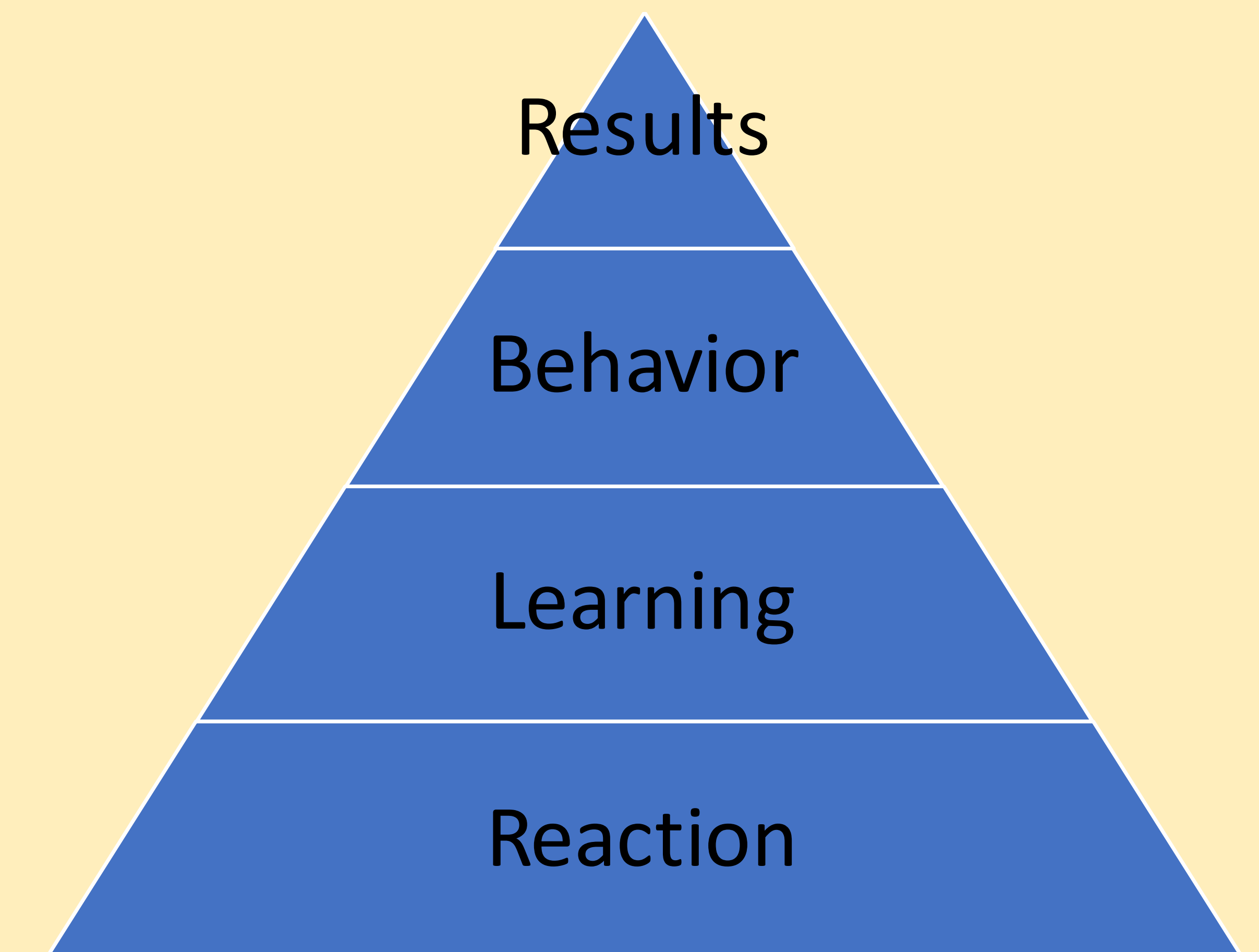
- Youth
 - There are aspects of quality that youth do not experience directly (e.g., accreditation, staff training)
 - Every standard should contribute to the overall impact of the program – youth should have the best sense of this
- Service providers
 - Includes management, clinical supervision, and direct care staff
 - Group directly responsible for program quality and CQI
- External agencies
 - Need to see quality standards in daily practices, as they provide funding, licensure, and accreditation
 - Evidence of quality of care serves a critical advocacy function that insulates programs from unfavorable critiques

Evaluation of Quality is Multi-Level

When evaluating the impact of quality standards for residential care, there are four important levels to consider

Following Kirkpatrick's model (1970), each successive level is built on information provided by the lower levels

- Reaction (Satisfaction)
 - The most basic level
 - Important, but a low bar that tends to be highly skewed
 - Measuring satisfaction is one of the quality standards
- Learning (Knowledge)
 - In addition to satisfaction, there needs to be learning about what and how to do things
 - Education, rationales, skill development are examples
- Behavior (Actions)
 - Additionally, there needs to be changes in behavior
 - Such as decreases in problem behavior and increases in prosocial behavior
 - Positive change in behavior during residential stay is essential
- Results (Outcomes)
 - The most advanced level, and the most challenging to measure
 - Specifically, this examines post-departure outcomes
 - Post-departure outcomes are especially strong evidence of a program's quality of care



Outcomes are the ultimate indication of quality of care

Inter-program outcomes are necessary for determining return on investment

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