

Inclusion

Content Validity Testing of the Community Life Engagement Guideposts Fidelity Scale --Manuscript Draft--

Manuscript Number:	INCLUSION-M-22-00005R2
Article Type:	Research Article
Keywords:	Community life engagement; intellectual and developmental disabilities; integrated employment; scale development
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Manuscript Region of Origin:	UNITED STATES
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Content Validity Testing of the Community Life Engagement Guideposts Fidelity Scale**Abstract**

The current study sought to address the lack of tools for defining and measuring the quality of day services and supports through the development of a statistically valid tool: the Community Life Engagement (CLE) Guideposts Fidelity Scale (GFS). A Delphi panel composed of 27 experts in the field of CLE reviewed and validated statements on the GFS. This review resulted in a 72-statement scale. All 72 statements demonstrate content validity ratio of .5 or higher. Findings showed that the panel eliminated statements that took focus away from the individual, statements that promoted specific practices, and statements that relied too heavily on the job-readiness aspects of CLE. Implications for the field as well as further testing and refinement of the GFS are also discussed.

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In fiscal year 2019, approximately 500,000 people with intellectual and/or developmental disabilities (IDD) in the United States received day services and supports through a state intellectual and developmental disabilities service agency, at a total cost of over \$5.7 billion (Winsor et al., 2021). National legislation and regulation have increasingly set the expectation that these services and supports will lead to an outcome of community life engagement (CLE), that is, access to and participation in the community as part of a meaningful day.

CLE activities may include volunteer work; postsecondary, adult, or continuing education; accessing community facilities such as a local library, gym, or recreation center; participation in retirement or senior activities; and anything else people with and without disabilities do in their off-work time (Sulewski et al., 2016). Supports for CLE may be referred to as community-based non-work, wraparound supports, holistic supports, or community integration services.

The Medicaid Home and Community Based Services (HCBS) Final Rule (Centers for Medicare and Medicaid Services, 2014a) calls for “full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, *engage in community life*, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS” (Centers for Medicare and Medicaid Services, 2014a, p. 249; emphasis added). The US Department of Justice, in settlement agreements with Rhode Island (United States v. State of Rhode Island, 2014) and Oregon (Lane et al. v. Brown et al., 2015), extended enforcement of the Americans with Disabilities Act and the *Olmstead v. LC* decision to mandate access to integrated community employment and day services and supports. In combination, these federal actions emphasize inclusive and integrated settings, creating the expectation for a transformation of the

existing system of day services and supports from one that is largely segregated to one focused on individual engagement in integrated, age-appropriate, community-based activities (Hall et al., 2018; Freeze et al., 2017).

In contrast to the emphasis on integration in national policy, in practice, many day services and supports continue to isolate and segregate individuals with intellectual and/or developmental disabilities. CMS, recognizing what Friedman (2020) cites as the “complex overhaul of a system where currently people have more so been physically relocated in the community rather than meaningfully integrated into it” (p.6), allowed states nine years (including two extensions), until March of 2023, to come into compliance with the ruling. But, as of this writing, CMS has only granted 21 states final approval of their HCBS transition plans (Centers for Medicare and Medicaid Services, 2023). Furthermore, the amount of flexibility given to states to define their HCBS service criteria has resulted in vast inconsistencies in service delivery (Friedman, 2022). Currently, nearly half of individuals receiving day services and supports are served in facility-based programs that are located in a setting where the majority of participants have a disability (Winsor et al., 2021, p. 15). Moreover, case study research has shown that even when services were purportedly community-based, they often did not achieve integration in practice. Many individuals still spent much of the day in a segregated day program setting and activities that did take place in the community only achieved integration at the most basic level of being physically present, as opposed to being fully included, valued, and engaged (Neely-Barnes & Elswick, 2016; McMichael & Peirce, 2015; Sulewski, 2010; Sowers et al., 1999). Concepts like community inclusion, social inclusion, and community participation have not been well defined and framed (Simplican, et al., 2015) and are generally perceived to be challenging to implement (McMichael-Peirce, 2015; Rosetti, 2015).

With many individuals lacking access to day services and supports that foster true community inclusion, people with intellectual and/or developmental disabilities have had limited opportunities for meaningful CLE activities that support career exploration for those not yet working or between jobs, supplement employment hours for those who are working part-time, or serve as a retirement option for older adults with intellectual and/or developmental disabilities (Sulewski et al., 2016). Individuals with intellectual and/or developmental disabilities are underrepresented in activities such as volunteering or involvement in community groups (Friedman & Spassiani, 2017; Miller et al., 2003; Rak & Spencer, 2015; Reilly, 2005; Verdonschot et al., 2009), and because of this, they typically have narrow social circles (Emerson et al., 2021; Emerson & McVilly, 2004; Lippold & Burns, 2009; Verdonschot et al., 2009). Social isolation is common, with research consistently suggesting that the social networks of people with intellectual and/or developmental disabilities are composed primarily of paid support staff, parents, and other individuals with disabilities (McMichael & Peirce, 2015; Abery & Fahnestock, 1994; Knox & Hickson, 2001; Lunsky & Neely, 2002).

These patterns point to a need for further guidance for service providers on how to transform their services and supports to both meet federal mandates around integration and address the gaps in CLE for people with intellectual and/or developmental disabilities. Beyond societal barriers, such as low expectations, there have been issues surrounding funding responsibilities; transportation; lack of training of front-line staff; and limited leadership, planning, and communication experience among agency leaders (Office of Disability Employment Policy, 2014; Rosenthal et al., 2012; West & Patton, 2010). Rogan and Rinne (2011) stated “moving to integrated community services necessitates a complete rethinking of mission, vision, values, and practices” (p. 250).

Impact of COVID-19

This lack of social integration and connection among people with intellectual and/or developmental disabilities has only been exacerbated by the COVID-19 pandemic. Turnover of direct support provider staff had already been a ‘crisis’ before the pandemic (Friedman, 2022), but in a national survey of service providers conducted in June 2020, 40% reported they had closed employment and/or day services due to the pandemic and 43% had laid off or furloughed staff (Association of Persons Supporting Employment First, 2020). A separate survey of direct support staff revealed that they had also seen an array of pandemic-related changes, such as working more hours per week (33%), working fewer hours per week (18%), working different shifts (30%), and working in different settings (29%; Hewitt et al., 2021). And even though CMS authorized a temporary amendment to their waiver programs, offering increased reimbursement rates for HCBS services provided during the pandemic, those increases mostly reimbursed supports for residential habilitation or to live in one’s own home (Friedman, 2022). These effects have left people with intellectual and/or developmental disabilities with even fewer supports and options for community participation than were available pre-pandemic (APSE, 2020; Bradley, 2020; Hewitt et al., 2021) leading to negative effects such as boredom (80%), mood swings or depression (57%), and loneliness (48%; Hewitt et al., 2021).

The longer-term impact of the COVID-19 pandemic on provider operations remains to be seen, but long-term effects are likely, given that staffing changes are a factor affecting individuals’ access to CLE. Providers experienced staffing shortages prior to the pandemic due to high turnover rates for direct support professionals (DSPs) who support individuals’ access to CLE and integrated employment. The threat of COVID-19 and the restrictions state policies imposed on workers considered “nonessential” exacerbated these shortages significantly as

providers laid off or furloughed many DSPs. Many other DSPs left for higher pay and better working conditions or to care for family members (Hewitt et al., 2021).

These staffing challenges, combined with the tight financial situation of many providers pre-pandemic, have led to difficulties maintaining operations (APSE, 2020; Thompson & Nygren, 2020). In fact, individuals with intellectual and/or developmental disabilities and their families reported significant reduction in the services they received during the pandemic (Neece et al., 2020).

As individuals, families, and service providers move forward, the creativity required to adapt to the pandemic has also provided lessons that could inform the transformation to more community-integrated support models. Providers have accelerated their adoption of both remote engagement and remote supports (Hoff, 2020; Lee, 2020; Sulewski, 2020). Others have sped up existing plans to transform to more integrated models by providing additional training to staff during facility closures, experimenting with increased individualized supports, or permanently closing facility-based programming (Institute for Community Inclusion, 2021).

With service providers needing to rapidly adapt to the evolving circumstances of the COVID-19 pandemic and staffing shortages, and with the deadline for the HCBS Final Rule implementation rapidly approaching (Centers for Medicare and Medicaid Services, 2020), there is more need than ever for guidance for service providers on how to provide services that support CLE.

Previous Research on Community Life Engagement

To address this area of need, our research team conducted a series of projects focused on supports for CLE. This body of work resulted in identification of a set of four CLE guideposts to serve as key principles that service providers can use to improve their day services and supports.

These four guideposts are: (1) individualize supports for each person, (2) promote community membership and contribution, (3) use human and social capital to decrease dependence on paid supports, and (4) ensure that supports are outcome-oriented and regularly monitored (Timmons & Sulewski, 2016).

We initially identified the guideposts through interviews of 13 experts in high-quality day services and supports that facilitate CLE (Timmons & Sulewski, 2016). We confirmed and further operationalized the guideposts through in-depth case studies at three exemplary day services and supports providers of various sizes in three states (Curren, Hall, & Timmons, 2017; Curren, Lyons, & Timmons, 2017; Tanabe, Sulewski, & Timmons, 2017; Tanabe, Timmons, & Sulewski, 2017). This research also served as the basis for a CLE Toolkit that we piloted with seven service provider organizations in two states (Sulewski et al., 2016). Results from this research indicated that providers who were providing integrated supports for CLE offered day services and supports that aligned with the four guideposts are providing high-quality CLE; and that the toolkit was helpful for providers seeking to improve their day services and supports.

The Current Study

The study described in this manuscript addressed a specific gap in the currently available tools for systems and provider transformation, that is, a lack of tools for defining and measuring service quality. Working group discussions with several members of the State Employment Leadership Network (<http://www.selnhub.org/home>) have indicated a lack of clear objectives, definitions, and quality measures as barriers to systems change (Sulewski & Timmons, 2015) and have identified development of new measures as a priority next step (Sulewski & Timmons, 2018). A 2016 report by the National Quality Forum (NQF) commissioned by the US Department of Health and Human Services raised similar issues. Among the problem areas

identified in that report were a lack of standardized measures and a lack of reporting requirements (NQF, 2016). The movement toward values-based purchasing models for Medicaid-funded services through efforts such as the Medicaid Innovation Accelerator Program (IAP) further underscores the need for better measurement tools (Centers for Medicare and Medicaid Services, 2014b; Health Care Payment Learning and Action Network, 2017). This study was an important step toward meeting those needs by generating and testing for content validity a Guideposts Fidelity Scale (GFS) that service providers can use to determine if their day services and supports are likely to lead to CLE.

Methods

A Delphi panel assessed the GFS for content adequacy. The Delphi method is a social research technique. The Delphi method's aim is to obtain a reliable consensus using a group of experts (Linstone & Turoff, 1975). The Delphi process has been widely used across multiple disciplines when developing assessment tools, most notably in establishing content or face validity (Fernández et al., 2017; Gómez et al., 2015; Mengual- Andrés et al., 2016; Vicente et al., 2017). It differs from other group-based research methods in four distinct ways: (1) the process ensures anonymity for all respondents; (2) the process is iterative, which provides opportunity for continuous and controlled feedback; (3) the method allows researchers to capture data that is statistically interpretable; and (4) the possibility of using email or online surveys as a means to communicate and gather information allows for participants to be geographically distributed (Lindqvist & Närdanger, 2007). Researchers also have noted that the Delphi approach minimizes the more undesirable aspects of group interaction, such as social pressure of majority opinion, forceful persuasion, and a desire to stand by a publicly expressed opinion. Direct debate that may take place in other forms of group processes is replaced by a carefully crafted process

of continual, individual data collection, along with feedback and synthesis of responses (Rowe & Wright, 1999).

We have successfully employed Delphi panels in previous projects, including identifying key policies and practices related to employment of people with intellectual and/or developmental disabilities (Sulewski, 2015) and identifying and ranking essential elements for organizational transformation away from sheltered workshops (Lyons et al., 2018).

Recruitment and Selection

We initially identified 53 experts in the field of CLE to participate in the Delphi panel. We generated this list through the research team's professional contacts and the CLE Project Leadership Team, which included collaborators at the Institute for Community Inclusion (ICI), State Employment Leadership Network (SELN), Association of People Supporting Employment First (APSE), and American Network of Community Options and Resources (ANCOR). The list included several people who had helped to shape the four guideposts for CLE through participation in the CLE case studies and toolkit pilot as well as other experts in related topics. One panelist manages a service provider nationally recognized for its focus on "integrated work." Another panelist developed a widely adopted toolkit that assists people with intellectual and/or developmental disabilities on how to form relationships within their communities. Five panelists were family advocates whose children had received varying degrees of successful day services from different providers, and several of the panelists had managed service providers that had received state-sponsored awards and commendations for their community integrated day services. In a final review of the list, the Project Leadership Team assisted with scaling the number down to 47 potential Delphi panel members.

We emailed an invitation to participate to each of those 47 individuals. The email included a link to a video recording explaining the background and objectives of the research, participant expectations, and how to complete the online survey. Thirty individuals agreed to participate. Of the 30 individuals who agreed to participate, 25 completed both rounds of surveying and two completed the second round only due to a technical error that deleted their first round responses.

The majority of the Delphi panel was female, white, reported having a master's degree, and had worked in either the intellectual and/or developmental disability (59%) or disability field (56%) for over 21 years. The age range of the panelists was diverse, with the majority being 41 years or older. Furthermore, most of the panelists were provider staff or leadership (41%). This excess of provider stakeholder panelists was an intentional choice on our behalf as the GFS is designed to be completed by individuals who either administer or manage the day services and supports at their provider agency. The other Delphi panelists were evenly distributed across the range of stakeholder groups. Finally, most of the panelists worked in the New England area (52%) with the others employed in the Midwest (22%), Southwest (11%), South (7%) and Northeast (7%) (see Table 1).

Measure

The GFS is designed to be a self-administered survey for service provider staff and management to assess how closely their day services and supports mirror the four CLE guideposts (Sulewski et al., 2016). Fidelity measures have been described as both an effective way to measure model adherence of a service and a way to gauge its improvement (Bond et al., 2000; Lloyd-Evans et al., 2016).

We constructed the GFS based on standardized methods of developing and validating a new instrument, adhering to the steps laid out by Churchill (1979) and Hinkin (1995). Those steps are 1) item generation, 2) content adequacy assessment, 3) questionnaire administration, 4) factor analysis, 5) internal consistency assessment, 6) construct validity, and 7) replication.

For the item generation step, we started with the Guideposts Self-Assessment Tool, initially developed as part of the CLE Toolkit. The Guideposts Self-Assessment Tool contains multiple statements reflecting key practices that operationalize each guidepost. For example, a statement under Guidepost 1 (individualize supports for each person) might read: “My organization tracks individuals’ preferences and makes them known to all staff working with that individual.” Respondents answer the extent to which they agree that statement reflects a practice at their organization on a 5-point Likert scale ranging from “Strongly Agree” (5) to “Strongly Disagree” (1).

Feedback on the self-assessment from participants in the CLE Toolkit pilot project showed that all either agreed or strongly agreed that the Guideposts Self-Assessment Tool was “easy to complete” and “helped me identify a gap in our [day services and supports related to] CLE.” One service provider stated, “The self-assessment helped in identifying strengths and weaknesses within our organization. It supported the development of individual and organizational goals.” Based on such feedback and the Guideposts Self-Assessment Tool’s basis in a research-based model of services and supports (the four CLE guideposts), we posited that the Guideposts Self-Assessment Tool could offer the foundation for a GFS.

We expanded the Guideposts Self-Assessment Tool by consulting a database of measures of home and community-based services developed by the University of Minnesota’s Rehabilitation Research and Training Center on Home and Community-Based Outcome

Measurement (RTCOM). We examined 119 available measures of home and community-based services for questions or themes that could be integrated into the GFS. The PLT examined measures including Social Acceptance Scale (SAS), The Quality of Life Questionnaire (CQL), The Arc's Self-Determination Scale (ASDS), and the Youth Services Survey (YSS). Ultimately, the team selected 37 questions from these measures to be adapted for the GFS. Questions added at this step included "I make long- range career plans" (Wehmeyer,1995) and "Staff were sensitive to my cultural / ethnic background" (Shafer & Temple, 2013).

Additionally, we hosted four focus groups for self-advocates. We asked self-advocates to comment on the proposed GFS statements as well as offer feedback and suggestions for additional statements. Feedback included "focus on what is important TO the individual, not FOR them" and, "a trusting relationship is built on communication between staff and the individual." Finally, the PLT reviewed the GFS statements and made additional recommendations.

Upon completion of the item generation step, the GFS contained 126 statements. Some of these statements contained similar ideas but were worded differently to assure that the statement chosen by the Delphi panel would best convey that particular aspect of CLE. Developing a surplus of statements was also based upon research that indicated approximately one half of items in a newly developed scale will be retained for use in the final scales, so twice as many items should be generated as will be needed for the final scale (Hinkin et al., 1997). With this 126-statement GFS, we moved on to step 2: content adequacy assessment via Delphi panel.

Data Collection

We completed two rounds of data collection between November 2020 and February 2021. Round 1 began by emailing a link to a Qualtrics survey containing the 126 draft GFS

statements organized by their corresponding CLE guidepost to the 27 Delphi panelists. Panelists were prompted to review each statement and then decide if the statement was “essential”, “useful, but not essential”, or “not essential” to understanding a provider’s fidelity to the corresponding CLE guidepost, based on Lawshe’s (1975) technique for assessing content validity via a Delphi panel. The survey then asked if panelists had any comments about the statement including if it should be reworded or if it would be a better fit under a different guidepost. We analyzed results from Round 1 and sent the refined GFS draft consisting of 95 statements back to the Delphi panelists to be rated in the same manner during Round 2.

Data Analysis

The content validity ratio (CVR) of the results of both rounds was conducted using SPSS Statistics 28. Lawshe’s formula, $CVR = (n_e - N/2)/(N/2)$, was applied where CVR = content validity ratio, n_e = number of panel members indicating “essential,” and N = total number of panel members (Lawshe, 1975). Additionally, we took panelists’ comments about the statements into consideration when deciding to retain or remove a statement.

Results

In Round 1, 85 statements produced an “essential” CVR of at least .5 (min = .52, max = 1.0), 14 statements produced a “useful, but not essential” CVR between .46 and .31, and 27 statements produced a “not essential” CVR between .28 and -.62. For the statements found “useful, but not essential”, the project team determined 11 of those statements could be removed and three would be reworded based on the comments from the Delphi panelists. For the statements found “not essential”, 20 were removed and seven statements were reworded based on comments from the Delphi panelists, leaving 95 statements to be rated in Round 2.

In Round 2, 74 statements produced an “essential” CVR between 1.00 and .56, seven statements produced a “useful, but not essential” CVR between .48 and .41, and 14 statements produced a “not essential” CVR between .31 and -.26. Having not received many edits to “essential” Round 2 statements, we decided to remove all statements with CVR less than .5 and conclude content validity testing. After removing those statements with low CVR as well as two duplicate statements, the refined GFS contained 72 statements that asked about all four CLE guideposts and that have CVR of .5 or higher (see Table 2).

Discussion

The purpose of this study was to develop a Community Life Engagement Guideposts Fidelity Scale (GFS) that demonstrated acceptable content validity. Two rounds of Delphi testing reduced the initial 126 statement draft of the GFS down to 72 statements, all of which have CVR of .5 or higher (see Table 3. for a list of sample items).

Non-Essential Item Themes

A review of Delphi panel members’ comments revealed three themes among items that were rated not essential, and as such were either eliminated or revised: 1) 22 statements that took focus away from the individual, 2) 12 statements that promoted specific practices, and 3) 10 statements that relied too heavily on the job-readiness component of CLE.

Statements that Took Focus Away from the Individual

Panel members saw some statements as shifting the focus from the core construct of individualizing supports for each person. For example, one statement read “My organization offers ways for groups of individuals to discuss and compromise on shared activities.” The statement produced a CVR of .04 with panelists commenting, “It might be practical, but there is a danger of drifting in the direction of congregate services” and “Activities are built around the

person. People should have the option to opt out of activities they are not interested in participating in, rather than compromising.” We eliminated this statement from the GFS.

Another statement read “My organization engages individuals' employers and other community members in person-centered planning.” This statement produced a negative CVR with panelists commenting that “(Engagement) should be defined by the individual” and “Specify that the engagement is based on the individual’s preferences.” While engaging people known to the individual when developing a person-centered plan is good practice, who specifically is involved (i.e. employers and community members) is not the essential element. Keeping in mind the feedback we received from self-advocates (“focus on what is important TO the individual, not FOR them”), we revised this statement in Round 2 to read “My organization includes in person-centered planning meetings the people the individual wants to be there,” which produced a CVR of .85.

Statements that Promoted Specific Practices or Required Specific Resources

Twelve statements that supported specific practices and resources also produced low CVR. One such statement read “My organization has the necessary availability and knowledge of technology to provide remote supports (i.e. supporting individuals via smartphone) as appropriate” which produced a CVR of .41. This statement was deemed “useful, but not essential”, citing that it was resource dependent and that comfort with technology should not be prioritized over other CLE-related skills when hiring staff. We eliminated this statement from the GFS.

Another statement not included in the final GFS was “My organization encourages peer-to-peer mentoring and training (e.g., an individual less comfortable with going to the gym is paired with another who is more comfortable there),” which produced a CVR of .04. Panel

members noted that while peer-to-peer mentoring is a creative method for fading paid staff supports, it is just one of multiple pathways to reach Guidepost 3 (use human and social capital to decrease dependence on paid supports). We replaced this statement with one that, while more general, better assesses how the provider makes use of existing natural supports, which is the core tenet of Guidepost 3: “My organization emphasizes building networks of support from family, friends, and community.” This statement produced a CVR of .85.

Similar statements that promoted specific practices or involved substantial resources such as offering training to outside entities about inclusivity and subcontracting with a third-party to provide travel training to individuals were also eliminated from the final GFS as they were deemed not essential by the Delphi panel.

Statements that Relied too Heavily on the Job-Readiness Component of CLE

While CLE is expected to both lead to and complement employment, unlike dedicated employment services, employment is not the main goal of CLE. Panelists noted the distinction between day services that are meant to develop life skills and employment services that train the individual in specific skills needed for specific jobs. For example, the statement “My organization prioritizes volunteer opportunities over recreational activities as a means of community engagement for individuals” produced a negative CVR of -0.52, and “My organization supports individuals to access community classes or training opportunities” produced a CVR of .11. Such statements were described in panel members’ comments as diminishing the amount of choice allowed to the individual while prioritizing goals that may or may not be appropriate for the individual. As one panelist noted, “the emphasis should be on *any kind* of opportunity that is in the community with peers without intellectual and/or developmental disabilities.” Eliminating such statements kept the GFS focused on prioritizing

the individual's interests, preferences, and needs using, instead, such statements as "My organization supports individuals to choose the activities they participate in" and "My organization emphasizes person-centered planning for individuals at intake."

Limitations

Literature has identified drawbacks to the Delphi panel technique. These include 1) the assumption that all panelists have the same level of expertise in the topic (which is typically not the case), potentially resulting in general perspectives as opposed to in-depth evaluations, and 2) the potential for researchers to mold the opinions of respondents based on the iterative nature of the Delphi process (Hsu & Sandford, 2007).

This study also employed a convenience sample consisting mainly of individuals already known to the ICI, many of whom still work closely with the organization. So, while the Delphi panel's experiences with CLE were diverse enough to produce a draft GFS that can be used by a variety of providers, the panel may have been less critical about its statements given their relationship with some members of the ICI staff (most GFS statements were rated essential in both rounds).

Conclusions and Directions for Future Research

This research has produced a draft GFS with acceptable content adequacy and has set the stage for further testing and refinement. The 72-item draft GFS is currently being piloted by service provider staff nationwide to test for internal consistency. Results from this piloting will allow for further refinement of the GFS statements as well as sufficient data to conduct a factor analysis of the responses. This GFS evaluation will continue to adhere to the steps of fidelity scale development laid out by Churchill (1979) and Hinkin (1995). Once these steps are completed, we expect that this version of the GFS can begin to be used in the field. While there

are other instruments that measure community inclusion and integration, the GFS is the first one designed specifically for intellectual and/or developmental disability service providers who wish to evaluate how their day services and supports lead to CLE. Using the research-based four guideposts for CLE, the GFS in combination with the CLE Toolkit can offer providers a statistically valid and reliable assessment of the current quality of their services along with strategies to align those services with the four guideposts, providing a clear standard of service quality and a path for consistent delivery that states currently lack (Friedman, 2022). We expect the GFS to be able to be completed quickly by provider staff and management and the results to point towards strategies in the toolkit which can be immediately implemented by providers with no outside training necessary. In this regard, we expect the GFS to be easily adoptable by all service providers regardless of their available staffing capacity and resources (APSE 2020; Hewitt et al., 2021; Thompson & Nygren, 2020)

Beyond the pilot testing stage, possible steps for further development of the GFS include assessment of construct validity and test-retest reliability, as well as confirmatory factor analysis with a new set of service provider respondents. Adhering to these proven models of scale development would further ensure that the GFS is the most statistically reliable and valid instrument to assess fidelity to the four CLE guideposts.

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Tables

Table 1.

Demographic Characteristics of the Delphi Panel

Characteristics	<i>n</i>	%
Gender		
Male	6	22%
Female	21	78%
Age Range		
31-40	6	22%
41-50	9	33%
51-60	4	15%
61-70	7	26%
71+	1	4%
Education		
College (either 2 or 4 years)	8	30%
Masters	16	59%
Doctorate	3	11%
Race		
American Indian or Alaska Native	2	7%
Asian	2	7%
White	23	85%
Years worked in Disability field		
Less than 10 years	3	11%

10-20 years	9	33%
21 years and more	15	56%
<hr/>		
Years worked in IDD field		
Unknown	2	7%
Less than 10 years	3	11%
10-20 years	6	22%
21 years and more	16	59%
<hr/>		
Source of Referral		
CLE Expert Interview	2	7%
PLT	8	30%
Referred by ICI Staff	3	11%
Referred by network partner	7	26%
SELN	7	26%
<hr/>		
Stakeholder Group		
Training or technical assistance provider	1	4%
Family member of a person with an intellectual disability	5	19%
Provider staff or leadership	11	41%
Researcher	5	19%
State agency staff	5	19%
<hr/>		
Region of		
Employment		
Midwest	6	22%
New England	14	52%
Northeast	2	7%
South	2	7%

Southwest	3	11%
Total	27	100%

Table 2.

GFS Statement Rating by Delphi Round

Statement Rating	Round 1			Round 2		
	<i>n</i>	Mean CVR	# Retained	<i>n</i>	Mean CVR	# Retained
Essential	85	.80	85	74	.78	72
Useful but not essential	14	.40	3	7	.44	0
Not essential	27	-.11	7	14	.12	0

Table 3.

Sample List of GFS Statements Organized by CLE Guidepost

CLE Guidepost	Sample GFS statements
1) Individualize supports for each person	<p><i>“My organization emphasizes person-centered planning for individuals at intake.”</i></p> <p><i>“My organization allows for flexibility in scheduling to accommodate real time changes in individuals' availability, such as illness or changes in work schedules.”</i></p>
2) Promote community membership and contribution	<p><i>“My organization connects individuals with activities at times and places where community members without IDD participate.”</i></p> <p><i>“My organization expects staff to actively seek out opportunities for engagement in the community.”</i></p>
3) Use human and social capital to decrease dependence on paid supports	<p><i>“My organization builds skills for appropriate social interaction during community activities (e.g. learning to arrive at a volunteer job on time and appropriately dressed)”</i></p> <p><i>“My organization provides training to staff on how to fade paid supports.”</i></p>
4) Ensure that supports are outcome-oriented and regularly monitored	<p><i>“My organization tracks progress toward each individual's own personal goals as established through person centered planning.”</i></p>

	<p><i>“My organization regularly reviews data and feedback collected and uses them to improve supports at the individual level.”</i></p>
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