2016

An Internal Evaluation of a Health Program for Adults with Mild, Moderate, and Severe Intellectual Disabilities

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Digital Object Identifier: https://doi.org/10.13023/ETD.2016.465

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AN INTERNAL EVALUATION OF A HEALTH PROGRAM FOR ADULTS WITH MILD, MODERATE, AND SEVERE INTELLECTUAL DISABILITIES

Dissertation

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Education in the College of Education at the University of Kentucky

By
Shelley C. Sellwood-Davis

Lexington, Kentucky

Director: Kelly Bradley, Ph.D, Professor, College of Education, Department of Educational Policy and Evaluation
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2016

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Adults with intellectual disabilities are not only more likely to be obese, but they are also more prone to medical complications, including diabetes, cardiovascular disease, thyroid disorder and osteoporosis. Therefore, health programs targeting this population are becoming more frequent in nature, and learning what makes such programs effective will be important in serving this population. A health program for adults between the ages of eighteen and forty with mild, moderate, and severe intellectual disabilities was evaluated in order to learn how the individual health program could be improved and in what ways the program itself could serve as a model for health programs serving a similar population elsewhere. In evaluating the health program, the researcher collected data from the residents of the program, the residents’ legal guardians or representative, staff members, and administrators. Data were gathered through both qualitative and quantitative methods of observations, questionnaires, focus groups, and interviews. This study serves to provide future researchers with a model for not only other health programs, but for any researchers hoping to involve individuals with all mild, moderate, or severe intellectual disabilities.

KEYWORDS: health program; evaluation; physical activity; intellectual disabilities; developmental disabilities.
AN INTERNAL EVALUATION OF A HEALTH PROGRAM FOR ADULTS WITH MILD, MODERATE, AND SEVERE INTELLECTUAL DISABILITIES

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December 3, 2016
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I have often heard people say that the measure of a person can be told in who she surrounds herself with. If that is the case, I would certainly be deemed far wiser and more gracious than I am. Without such support surrounding me throughout this journey, it would never have been realized or even dreamed. First, my committee chair, Dr. Kelly Bradley, was alongside me from the moment I entered the program. It was because of what I was able to learn from her teaching style that I had the confidence to move forward and begin the daunting task of completing my dissertation. Along the way, her support and honesty were unmatched and I simply cannot thank her enough. I was absolutely honored the day that Dr. Kleinert agreed to serve on my committee. He did this knowing that he would be retired when I was in the midst of the process. He provided such constant feedback on so many drafts that I could never thank him enough for his expertise and the role model that he serves to be. It humbled me to have Dr. Bradley and Dr. Kleinert as such active members of my doctorate experience.

After doing much smaller-scale evaluations with Dr. Bradley, I was certain that I wanted my dissertation to be an evaluation, as well. However, finding a program that is open to such an evaluation could have been a difficult process. I am so thankful that Stewart Home & School and its administration allowed me to conduct such honest research on their campus.

Finally, there are not enough words to thank all of my families and friends who have encouraged, supported, cheered, and believed in me along the way. They have made and continue to make all the moments of my life unbelievably blessed. I do not deserve them, but am so grateful each day for them. To my husband and the family we
are beginning, the unconditional love you provide astounds me. I love you beyond words.
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CHAPTER I

INTRODUCTION

In this chapter, the basic parameters of intellectual disabilities and health are described. The definition, prevalence (both in the United States and in the state of Kentucky), and implication of having an intellectual disability are described. In addition, health is defined and health programs are discussed, with a particular focus on health programs that serve individuals with intellectual disabilities. This chapter will describe individuals with intellectual disabilities and health programs separate initially and then will weave the two topics together.

While the specific number of people living in America with an intellectual disability is an often-debated topic, most studies agree that between one and three percent of Americans have an intellectual disability (The Arc, 2015). According to The Arc (2015), this represents approximately 4.6 million Americans (Larson, Lakin, Anderson, Kwak, Lee, & Anderson, 2000). This statistic is based upon the definition of an intellectual disability as a disability which is onset prior to the age of 18 and significantly impacts a person’s intellectual functioning and adaptive behavior (American Association of Intellectual and Developmental Disabilities, 2015).

Moreover, the Centers for Disease Control and Prevention found that in 2009 and 2010 more than 35 percent of the U.S. population was obese (Ogden, Carroll, Kit, & Flegal, 2012). The likelihood of being overweight for people with intellectual disabilities is even higher, and in 2008, the Centers for Disease Control and Prevention (2012) reported a 58 percent higher rate of obesity in adults with intellectual disabilities compared to adults without intellectual disabilities. Therefore, it is evident that the topic
of obesity amongst those living with an intellectual disability is important on a national level.

Within the state of Kentucky, there are as many as 75,000 individuals with developmental disabilities\textsuperscript{1}, including individuals with intellectual disabilities (Kentucky Cabinet for Health and Family Services, 2016). In 2013, it was reported that 68 percent of Kentucky adults with intellectual disabilities were either obese or overweight, as indicated by their body mass indexes (National Core Indicators, 2015). Given the sizeable number of people in Kentucky with intellectual disabilities who are obese, there is a need for further information and measures as to how to decrease such an alarming statistic.

Programs targeting health promotion and education have grown in number, popularity, and benefit in recent years. In fact, billions of dollars have been given out for the development of health programs by a variety of sources including the U.S. Department of Health and Human Services’ National Institutes of Health to private foundations, such as the Bill & Melinda Gates Foundation and The Kresge Foundation. However, the majority of these programs are aimed toward specific groups, most recently children. Though the need for health programs for people with intellectual disabilities is

\textsuperscript{1} Because there is no credible source for the number of individuals with intellectual disabilities residing in Kentucky, the number of individuals with developmental disabilities was cited as a substitute. A developmental disability is defined as “a severe, chronic disability” with the onset occurring before the age of 22 and “is attributable to a mental or physical impairment or a combination, is likely to continue indefinitely, results in substantial functional limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the individual’s needs for a combination and sequence of special, interdisciplinary or generic services, individual supports, or other forms of assistance” (Developmental Disabilities Assistance and Bill of Rights Act, 2000; The Arc, 2015).
well established, people with intellectual disabilities are currently being underserved, both in the number of health programs available and the funding for such programs (Peterson, Peterson, Lowe, & Nothwehr, 2009).

To further understand why people with intellectual disabilities are in need of health programs, it must be recognized that people with intellectual disabilities are at an increased risk for medical complications like obesity, as well as diabetes, thyroid disorders, osteoporosis, and cardiovascular disease (Bittles, Petterson, Sullivan, Hussain, Glasson, & Montgomery, 2002; Calders et al., 2011). The likelihood for the onset of these diseases increases with insufficient health, especially a lack of physical activity and a higher incidence rate of obesity (Janicki, Davidson, Henderson, McCallion, Taets, & Force, 2002; Peterson, Janz, & Lowe, 2008). As the statistics have demonstrated, by adulthood, a person with intellectual disabilities is more likely to be obese and to live a sedentary lifestyle (Bittles et al., 2002). The most common cause of death for people with intellectual disabilities is cardiovascular disease; the likelihood for this is greater in people with intellectual disabilities than those without intellectual disabilities (Janicki, et al., 2002).

Stewart Home & School

With the need for health for people with intellectual disabilities in mind, the evaluator set out to evaluate a current health program. In doing so, the details of a currently existing health program could offer insight and ideas for others interested in beginning health programs, while also informing the health program on ways to improve. As noted previously, the obesity rate for people with intellectual disabilities in the state of Kentucky is higher than the national average (National Core Indicators, 2015).
Therefore, the evaluation site’s location in the state capitol of Frankfort, Kentucky is particularly beneficial. More specifically, located on 850 acres, Stewart Home & School is a unique facility which provides residential care and a pre-academic and academic curriculum for its residents. Stewart Home & School is a private, non-accredited school that serves solely individuals with intellectual disabilities. In totality, Stewart Home & School has 360 residents2 whose diagnoses range from Down syndrome, Fragile X syndrome, autism spectrum disorder, Cerebral Palsy, Williams syndrome, to traumatic brain injury. The tuition of Stewart Home & School is roughly $3,100 per month.

Because there is no contract for any length of stay at Stewart Home & School, some of the residents come for very short periods of time (days, weeks, or months) and some stay for much longer (the oldest female resident has been at Stewart Home & School for 68 years) (M. Christmas, personal communication, March 25, 2015).

Stewart Home & School’s mission is to provide “a community where people live in a nurturing environment, and participate in programs designed to specifically meet their individual needs” (Stewart Home & School, 2015). Stewart Home & School’s philosophy is “center[ed] on providing opportunities for the pursuit of happiness—a lifestyle of choice for its [residents] and their families” (Stewart Home & School, 2015). Thus, Stewart Home & School provides more than a typical residential school in that it is a community that provides enrichment and activities for its residents.

As Figure 1 depicts, the administration of Stewart Home & School oversees the residential department, the pre-academic and academic departments, and other internal departments, such as maintenance, laundry, information technology, public relations,

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2 The total number of Stewart Home & School residents is based upon enrollment data from March 2015.
human resources, and a portion of the medical department. However, the administration of Stewart Home & School does not oversee the nutritional services. In April of 2014, Stewart Home & School contracted its nutritional services to Creative Dining Services. Creative Dining Services provides services for universities, nursing homes, and corporations across the United States. Its stated mission is “valu[ing] integrity, working in open and trusting relationships, [and] delivering fresh, sustainable, innovative, customized hospitality experiences to our clients” (Creative Dining Services, 2014).

Stewart Home & School’s medical department consists of four nurses, additional staff members, a Medical Office Coordinator, and a nurse practitioner. The Medical Office Coordinator oversees the medical department. While the Medical Office Coordinator and all other medical office employees are Stewart Home & School employees, the nurse practitioner is not. The nurse practitioner is overseen by a private physician who operates out of an office not associated with Stewart Home & School.

![Stewart Home & School Organizational Structure](image)

*Figure 1. Stewart Home & School Organizational Structure*
The health program of Stewart Home & School has slowly grown and developed over time. Most notably, Stewart Home & School’s fitness center was built in 2003. For the purposes of this evaluation, the health program has been divided into the following broad components:

1. Nutritional and Dietary Services
2. Health Curriculum
3. Extracurricular Activities

**Evaluation Design**

A process-based, internal, program evaluation will be conducted. A process evaluation is “the systematic collection of information on a program’s inputs, activities, and outputs, as well as the program’s context and other key characteristics” (Centers for Disease Control and Prevention, 2008). There are four different purposes of a process evaluation—program monitoring, program improvement, building effective program models, and program accountability. This evaluation strives to achieve the goals of both program monitoring and program improvement, particularly as the improvements relate to stakeholder satisfaction.

This evaluation aims to identify and depict the key components of the health program within Stewart Home & School and to evaluate the effectiveness of the implementation of those components of the health program. Stewart Home & School has minimal written goals, objectives, and expectations associated with the health program, because flexibility is seen as core to what Stewart Home & School is and how it operates (S. Bell, personal communication, March 25, 2015). The goals that Stewart Home & School have established regarding its health program are to “encompass the mental,
physical and spiritual well-being of all [residents] and staff” (S. Bell, personal communication, March 25, 2015).

[Broadly speaking, the health program includes the] fitness center and physical education classes, sports participation, body weight and blood work monitoring, diet and nutrition planning, smoking cessation programs, along with medical oversight, counseling services, education and training for making healthy choices, character education and self advocacy. Stewart Home & School is devoted to enhancing the health of all who are involved in its community. The health of every person involved at Stewart Home & School is essential to its commitment to enrich and enhance the lives of its residents. (Stewart Home & School, 2015)

Given that Stewart Home & School has brief goals and objectives and that there are no known established models on how to evaluate the health knowledge or physical activity of individuals with intellectual disabilities, an established framework was needed to be modified appropriately to evaluate Stewart Home & School’s health program (Brehmer-Rinderer, Zigrovic, & Weber, 2014). Therefore, an outside framework, RE-AIM, was utilized to evaluate the effectiveness of the implementation of the health program. This framework was selected as most appropriate, because of the unique nature of Stewart Home & School. Other health program evaluations have utilized different frameworks, primarily because they evaluated programs for children or utilized specific goals of the unique program to guide those evaluations. RE-AIM, which stands for reach, efficacy, adoption, implementation, and maintenance, is used for public health
programs to determine their effectiveness (Hyndman, Benson, & Telford, 2014). The RE-AIM framework will be discussed in more detail in Chapter III.

“When a concept embedded within a question is complex, or difficult to measure, then multiple complementary approaches might be employed to examine the various facets of the questions” (Alkin, 2011, p. 154). As Alkin has articulated, it is often helpful to begin with quantitative methods and, with those data established, one can delve into the topics and trends that appear with a qualitative perspective (Alkin, 2011). With that approach in mind, this evaluation will consist of quantitative data from the questionnaires combined with the qualitative data resulting from the observations, focus groups, and interviews.

**Aims of the Study**

The purpose of this study is to provide an evaluation of the current health program at Stewart Home & School. Therefore, the evaluator hopes that the evaluation allows Stewart Home & School and its administrators to determine the direction of the health program in the future. Aside from the direct impact to Stewart Home & School, this study aims to have a further-reaching impact. Larry Green said, “If we want more evidence-based practice, then we need more practice-based evidence” (Green & Ottesen, 2004). Though Mr. Green’s statement was specifically referring to the medical field, the same is true for the research needed about health programs. Analyzing health programs being practiced, such as this evaluation, will help direct research in the future. Because there is limited research on health programs for people with intellectual disabilities, an in-depth analysis and evaluation of the Stewart Home & School health program will provide specific examples and discussions on what portions of the program are perceived to be
most beneficial and could be replicated elsewhere. Seeing as Stewart Home & School is entirely residential, it offers the unique opportunity to evaluate a holistic health program. Therefore, the implications of the evaluation could be helpful for programs with a range of health-related focuses.

In addition, this evaluation will feature a model to evaluate health programs for people with intellectual disabilities that is inclusive for all people with intellectual disabilities. As current research has focused on health programs aimed at including people primarily with mild or moderate intellectual disabilities, there is a need for research that includes individuals with more severe intellectual disabilities. This study hopes to serve as an example of how the data collection process can be adjusted to allow for all people with intellectual disabilities to be included and sampled. Overall, not only does this evaluation aim to include all people with intellectual disabilities throughout the research process, but it hopes to provide a framework to better inform researchers how to do so. The framework utilized in this health program could be utilized to evaluate other health programs involving people with intellectual disabilities.

**Research Questions**

The purpose of this evaluation is to provide Stewart Home & School with feedback for its health program and to allow Stewart Home & School to internally assess what programs are worthy of continuing, what areas can be expanded upon, and what areas may not be meeting the goals established by Stewart Home & School, according to the stakeholders. Overall, the goal of this evaluation is to determine the future direction of Stewart Home & School’s health program and, as a result of these findings, to
positively impact other health programs for people with intellectual disabilities. The specific research questions of this evaluation are:

1. What are the components of the health program?
2. How are the health program components being implemented?
3. According to the goals of the health program components, what are the various stakeholders’ perceptions on the effectiveness of the health program at Stewart Home & School?

**Role of the Evaluator**

The evaluator was an employed member of Stewart Home & School throughout the evaluation. More specifically, the evaluator worked in Stewart Home & School’s administration, though not serving as a direct supervisor for any of the staff members involved with the evaluation. This allowed for full disclosure from staff members, administration, residents, and the families of residents. In addition, because there is an established relationship and a better understanding of the programs in place, the evaluator was able to conduct a larger, more expansive evaluation. However, because the evaluation was internal, there was the potential for evaluator bias. To help prevent this, the evaluator engaged in member checking, to ensure that those participating in the evaluation are represented accurately (Glesne, 2011). The only adjustment, in this process, was modifications that were necessary to ensure the residents were also given the opportunity to review their input, but in a manner that ensured they were accurately providing feedback to the evaluator.
Definition of Terms

Given the nature of this study, the reader needs to be acquainted and familiar with several terms.

**Obesity** is when a person’s weight is “higher than what is considered [to be] a healthy weight” (Centers for Disease Control and Prevention, 2012). A person is determined to be obese when his or her body mass index is 30.0 or higher (Centers for Disease Control and Prevention, 2012).

**Body mass index**, often times referred to as BMI, is the calculation of a person’s weight divided by the person’s height (Centers for Disease Control and Prevention, 2012). Body mass index is used as a “screening tool but is not diagnostic of the body fatness or health of an individual” (Centers for Disease Control and Prevention, 2012).

**Evaluation** simply stated [is] “judging the merit or worth of an entity” (Alkin, 2011, p. 9). More specifically, this study is a process evaluation, which is discussed in more detailed in Chapter I.

**Stakeholders** are “all of those individuals who have an interest in the program that is to be evaluated” (Alkin, 2011, p. 41). They are often divided into two categories, those that are internal to the organization and those that are external to the organization. Both groups are worthy of consideration through the evaluation process.

**Intellectual disability** is the onset of a disability prior to the age of eighteen that is “characterized by significant limitations in both intellectual functioning and in adaptive behavior” (American Association of Intellectual and Developmental Disabilities, 2015).

**Intellectual functioning** is “intelligence [or] general mental capacity, such as learning,
reasoning [and] problem solving” (American Association of Intellectual and

**Adaptive behavior** “is the collection of conceptual, social, and practical skills that are
learned and performed by people in their everyday lives” (American Association of
Intellectual and Developmental Disabilities, 2015). An intellectual disability is distinctly
different than a person who is limited to having a physical, visual, or auditory disability.

Much of the United States, particularly for funding purposes, identifies an intellectual
disability as a person who has an intelligence quotient, more commonly referred to as an
IQ, of below 70 (American Association of Intellectual and Developmental Disabilities,
2015; Beart, Hardy, & Buchan, 2005).

**Chapter Summary**

This chapter briefly outlines the need for an evaluation of a health program for
adults with intellectual disabilities. After providing an overview of the evaluation site,
the problem is stated as is the purpose and aims of the study and the research questions
are included. In addition, the role of the evaluator is discussed. Finally, key definitions
that are necessary for a full understanding of this evaluation are included.
CHAPTER II

REVIEW OF LITERATURE

This chapter begins with a quick glimpse of the overall health of American adults and then more specifically discusses the health of adults with intellectual disabilities. The evaluator then discusses physical activity recommendations for people with intellectual disabilities, followed by nutritional recommendations. The need for health programs for people with intellectual disabilities is discussed, along with a presentation of significant research findings. Finally, the theory for planned behavior’s relevancy is outlined, along with how the theory applies to not only people with intellectual disabilities, but the specific setting of Stewart Home & School.

The Centers for Disease Control and Prevention (2015) found that 34.9 percent or 78.6 million of United States adults are obese. There are a number of preventable illnesses, even deaths, that result from obesity, such as heart disease, stroke, type 2 Diabetes, and certain types of cancer (Centers for Disease Control and Prevention, 2015). Because of the health implications of obesity and the fact that medical costs for people who are obese are, on average, $1,429 more than a person who is a healthy weight, much attention has been given to people who are obese and, more recently, to see if there are trends amongst those who are obese (Centers for Disease Control and Prevention, 2015).

Health of People with Intellectual Disabilities

People with intellectual disabilities are living longer; in 2000, there were more than 640,000 people with intellectual disabilities over the age of 60 in the United States and by 2030, this figure is expected to more than double (Heller, Janicki, Hammel, & Factor, 2002; Robinson, Dauenhauer, Bishop, & Baxter, 2012). This increase in life
expectancy is expected to continue, as access to medical care is made more readily for all populations and the education of appropriate health care, along with the general expansion of the medical field (Robinson et al., 2012).

Studies have found that both women and men with intellectual disabilities had a higher incident rate of obesity at 43.2 percent and 34.3 percent, respectively (Hsieh, Rimmer & Heller, 2013). Further, not only are adults with intellectual disabilities more likely to be obese than adults without intellectual disabilities, but women with intellectual disabilities are more likely to be morbidly obese than men with intellectual disabilities (Hsieh et al., 2013). Additional risk factors for high incidence rates of obesity include being on medication, lack of physical activity, poor diet, and having Down syndrome (Hsieh et al., 2013).

**Physical Activity**

The United States Department of Health and Human Services (2008) recommends that adults with intellectual disabilities should engage in the same time and frequency of physical activity as adults without intellectual disabilities. The only exception to be made is when an individual has a physical disability that might require accommodations, though certainly not inactivity (United States Department of Health and Human Services, 2008). More specifically, an adult, between the ages of 18 and 64 should engage in 150 minutes of moderate to intense physical activity per week (United States Department of Health and Human Services, 2008). It is recommended that this physical activity be distributed throughout the week in allotments of a minimum of 10 minutes. This physical activity should be aerobic in nature, whereas additional physical activity should focus upon strength-training and muscle-building. This form of physical activity (strength
training) should be done twice per week (United States Department of Health and Human Services, 2008).

In comparative studies, people with intellectual disabilities have been found to be 40 percent less physically active than those without intellectual disabilities (Einarsson, Ólafsson, Hinriksdottir, Johannsson, Daly, & Arngrimsson, 2015). Other research that has focused on heart rate, as a result of physical activity, has found that there was not sufficient range in the heart rate of people with intellectual disabilities and that only 32 percent of the heart rate reserves were utilized while exercising (Waninge, van der Putten, Stewart, Steenbergen, van Wijck, van der Schans, 2013). An increase of physical activity amongst adults with intellectual disabilities is needed to maintain ideal health.

**Nutrition**

Overall, the prevalence of obesity is twice as high in people with intellectual disabilities as it is in those without intellectual disabilities (Ptomey & Wittenbrook, 2015). Unless there is a unique nutritional need (such as an allergy or intolerance), the nutrition of people with intellectual disabilities should be treated no differently than of that in the general population (Ptomey & Wittenbrook, 2015). Further research in this area has not been conducted because nutritionists have not published a dietary intake assessment specifically for people with intellectual disabilities. The problems in developing such an assessment include difficulties that having an intellectual disability introduces, such as deficits in the areas of comprehension, memory, and literacy (Humphries et al., 2009); on the other hand, the lack of research may be due to the assumption that the nutritional needs of people with intellectual disabilities are thought not to be any different from that of those without intellectual disabilities.
As Humphries Traci, and Seekins (2009) have noted, the need for the improved nutrition of people with intellectual disabilities has been emphasized by the Surgeon General on at least two occasions since 2002, including The Surgeon General’s Call to Action for Improving the Health of Persons With Mental Retardation (United States Department of Health and Human Services, 2005) and the report, Closing the Gap: A National Blueprint for Improving the Health of Individuals With Mental Retardation (United States Public Health Service, 2002).

**Health Programs**

Health, according to the World Health Organization, is “a state of physical, mental, and social well-being and not simply the absence of disease or infirmity” (World Health Organization, 1946, p. 100). Therefore, maintaining one’s health is a lifelong process. Further, the World Health Organization has defined health promotion as “the process of enabling people to increase control over and to improve their health” (Nutbeam, 1998).

Because people with intellectual disabilities face unique barriers to participating in health intervention programs, these interventions must be modified so as to accommodate their needs (Stanish & Frey, 2008). Studies with a focus on such programs have found that participants generally enjoy their involvement in the program and that there are few, if any, adverse effects (Calders et al., 2011). The favorable effects of tailored intervention programs have been documented by all too many researchers. Programs that focused on teaching participants how to be physically active found that people with intellectual disabilities were able to affect positive changes in their body, with increased muscle mass and a decrease in fat (Stanish & Frey, 2008). Further, research has demonstrated that programs instructing a new behavior, such as the addition of a daily
physical activity routine, can result in long-term behavior change (Stanish & Frey, 2008). Such programs utilized different strategies, with several introducing the assistance of exercise partners without intellectual disabilities, while others focused on behavior reinforcement programs, such as the use of a token economy where behavior modification is encouraged by reinforcing positive behaviors with rewards or “tokens” (Bennet, Eisenman, French, Henderson, & Shultz, 1989; Stanish & Frey, 2008; Tomporowski & Jameson, 1985).

Tailored intervention programs should include nutritional coaching, education on physical activity, and specific instructions and examples of appropriate physical activities (Phillips & Holland, 2011; Stanish & Frey, 2008). These programs should teach the participants to engage in at least 30 minutes of physical activity, five days a week (U.S. Department of Health and Human Services, 2000). While there is not as much research regarding the number of steps per day that is ideal for a person, current initiatives, such as America on the Move and Steps to a Healthier U.S., articulate that 10,000 steps per day is ideal for adequate physical health (Stanish & Draheim, 2005). However, only 21 percent of people with intellectual disabilities were found to be obtaining this daily step recommendation (Stanish & Draheim, 2005). Research on more general physical activity found that between 17 and 33 percent of people with intellectual disabilities were engaging in the adequate physical activity set forth by the U.S. Department of Health & Human Services (Stanish, Temple, & Frey, 2006; Temple, Frey, & Stanish, 2006). More specifically, only 19 percent of Kentucky adults with intellectual disabilities regularly engaged in moderate exercise (which the study defining regular exercise as exercise that
occurs at least three times per week for 30 minutes per day) (National Core Indicators, 2015).

As Doody & Doody (2012) and Aldridge (2010) have discussed, the coaching of and knowledge acquired from such health programs is necessary for individuals to live independent lives. Self-efficacy is the “confidence a person has in his or her ability to perform a behavior, including confidence in overcoming barriers to perform the behavior” (Peterson et al., 2009, p. 488). High self-efficacy has been identified as an important trait for people with intellectual disabilities to have in order to live independently (Aldridge, 2010; Doody & Doody, 2012). In addition, self-efficacy has a strong positive correlation with physical activity (Peterson et al., 2009). Thus, as one has high self-efficacy, that person is also involved in higher amounts of physical activity. Yet, there remains a lack of literature on how such health programs impact the self-efficacies of people with intellectual disabilities (Peterson et al., 2009).

In recent years, research on health programs for people with intellectual disabilities has recognized the importance of the assistance and support of caretakers, families, and, most commonly, assisting staff (Peterson et al., 2009). The staff providing care for people with intellectual disabilities noted that limited choices for activities in the community and minimal financial resources were the greatest barriers to physically active lifestyles (Messent, Cooke, & Long, 1998). An additional study found that the staff’s outcome expectations were critical to the success or failure of the person with the intellectual disability (Heller, Hsieh, & Rimmer, 2004).

As noted previously, the majority of studies on health programs have involved participants with mild to moderate intellectual disabilities (Beart et al., 2005). Thus,
there is little known on how health intervention programs impact individuals with more severe disabilities. Research has found that the average life expectancy for people with mild, moderate, and severe disabilities is 74.0, 67.6, and 58.6 years, respectively (Bittles et al., 2002). Therefore, there is an established need for research and health programs which target people with intellectual disabilities of all levels (Bittles et al., 2002).

Theory of Planned Behavior

To help ensure that this evaluation is done so in the best interest of individuals with intellectual disabilities, a theory was selected to guide the research process. After all, selecting a theoretical model for the evaluation of health programs is considered to be a best practice (Bodde, Seo, Frey, Lohrmann, & Van Puymbroeck, 2012; Drum et al., 2008). For the purposes of this evaluation, the theory of planned behavior was utilized to analyze the components and implementation of the health program (Ajzen, 1991). The theory of planned behavior is based upon the idea that a person’s behavior is based on the person’s “attitude toward the behavior, subjective norms, and perceived behavioral control” (Bodde et al., 2012, p. 118).

The portion of the theory that makes it so applicable for people with intellectual disabilities is that the model can only be utilized if people have control of their behaviors (Bodde et al., 2012). Given the circumstances of the lives of people with intellectual disabilities, there are situations when people with intellectual disabilities do not have control over their choices, whether that stems from a lack of access or the means to do so. Therefore, effective health programs for people with intellectual disabilities will take this into account and tailor their programs around this idea (Bodde et al., 2012). Because Stewart Home & School’s mission is based upon creating “an environment of choice” for
the residents, the theory of planned behavior is ideal (S. Bell personal communication, April 28, 2015; Stewart Home & School, 2015). Stewart Home & School’s Director emphasized the goal as much in saying, the health program “as well as the setting give individuals at Stewart Home & School a broad array of choice in scheduling meaningful pursuits and enhancing mental health” (S. Bell, personal communication, April 28, 2015). While this theory is most often utilized prior to conception of the program, in this evaluation this theory was instead utilized to assess if, when the residents had control of their behavior, the program was effective; on the other hand, if the residents did not have control, then this theory could indicate that more opportunities for choice be given to the residents.

Chapter Summary

This chapter has reviewed the research on the health of people with intellectual disabilities, along with the recommendations for the physical activity and nutrition for people with intellectual disabilities. Further, information, specifically barriers, were provided on the development and implementation of health programs for people with intellectual disabilities. Finally, this chapter concluded with research on the theory of planned behavior, which is being used to help ensure the research is focused upon individuals with intellectual disabilities and ensuring their voices and choices are given priority.
CHAPTER III

METHODOLOGY

This chapter begins by describing the nature of the internal evaluation, defining the health program for the purposes of the evaluation, and identifying the health program components. The stated goals and objectives of each health program are outlined and the primary stakeholders that were included are described. In addition, the data collection process and methods are presented and the utilization of the RE-AIM framework is set forth. Finally, the evaluator discusses how the data were analyzed.

In order to obtain the necessary access and to have rapport with the stakeholders, the evaluator was an employee at Stewart Home & School. As such, the evaluator was familiar with nearly all of the stakeholders. For those stakeholders who attended or worked for Stewart Home & School, the evaluator saw and interacted with those individuals on a regular basis.

With an internal evaluator, the participants were familiar with the person gathering the data. In addition, the evaluator was more likely to find stakeholders that were willing participants. However, the evaluator made it exceptionally clear that there should be no burden placed upon them to participate in the study nor would there be a benefit in doing so. In addition, every conceivable risk was minimized as much as possible. Of primary importance, a written statement from Stewart Home & School was obtained ensuring that no participants were impacted based upon their decision to participate and/or the results of the study.
Defining the Health Program

Because Stewart Home & School is a residential facility, many components could have arguably been included as part of the health program. This evaluation identified three key groups as part of the health program: nutritional services, pre-academic and academic curriculum, and the extracurricular activities. More specifically, those three components were divided into the following sub-categories:

1. Nutritional and dietary services
2. Pre-academic and academic curriculum
   a. Fitness
   b. Health and wellness
   c. Grooming
   d. Yoga
   e. Physical education
3. Extracurricular activities
   a. Special Olympics
   b. Recreational activities

There were other activities that could have been classified as health related at Stewart Home & School, but they were not evaluated for this study. Most notably, the medical department was not included, because preventative care was beyond the scope of the evaluation. Due to Stewart Home & School’s size and the extent of the many activities, it was necessary to focus on the key activities that involved the most residents. Additional activities that were not assessed were ones that only applied to a small group of residents or the activities were so specialized that they would be best evaluated
separately within a unique framework, such as the equestrian program. Overall, this setting provided the opportunity for the health field to learn about specific examples in which people with intellectual disabilities were living and in which ways their health program was effective and where improvements could be made.

Within the health program, Stewart Home & School had more specific goals and objectives for each of the individual components that were being assessed. The specific goals for each component are identified in Table 1.

Table 1

Health Program Objectives

<table>
<thead>
<tr>
<th>Health Program Component</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional and Dietary Services</td>
<td>Creative Dining Services’ goal is to “deliver fresh, sustainable, innovative, [and] customized hospitality experiences” (Creative Dining Services, 2015). With three meals per day, Creative Dining Services strives to provide meal plans adjusted for residents’ unique dietary needs, including diets ranging from 1,500 to 2,500 daily calories (Creative Dining Services, 2015).</td>
</tr>
<tr>
<td>Curriculum: Fitness</td>
<td>With safety as the priority, the fitness class aims to teach residents to work out daily for 45 minutes with a combination of cardiovascular and strength-training exercises to the best of their physical capabilities (Stewart Home &amp; School, 2015).</td>
</tr>
<tr>
<td>Curriculum: Health and Wellness</td>
<td>The primary objective is to teach residents physical and emotional wellness (Stewart Home &amp; School, 2015). The class covers topics including nutrition, physical activity, proper hygiene, senses and body systems, character building, environmental health, safety and first aid, communication skills, and appropriate manners (Stewart Home &amp; School, 2015). The course aims to teach residents to make healthy choices independent of the class and assistance (Stewart Home &amp; School, 2015).</td>
</tr>
<tr>
<td>Curriculum: Grooming</td>
<td>Through “consistent repetition and hands-on practice” the goal of the grooming class is to teach personal care skills that will become a part of the “[residents’] daily routine[s] and [will] encourage independence (Stewart Home &amp; School, 2015). Personal care skills include not only daily hygienic tasks, but teaching residents to wear weather-appropriate attire and table manners (Stewart Home &amp; School, 2015).</td>
</tr>
</tbody>
</table>
Table 1 (continued)

| Curriculum: Yoga | The yoga class aims to teach the residents “relaxation techniques, improve the residents memories and the ability to focus, provide physical benefits, such as increased muscle tone, balance, body awareness, flexibility and overall strength and endurance” and, through its practice “to improve the self-esteem and self-confidence” of the [residents]” (Stewart Home & School, 2015). |
| Curriculum: Physical Education | The goal of physical education class is to “increase and improve motor skills development” (Stewart Home & School, 2015). Stewart Home & School aims to achieve this through playing games, teaching the rules of sporting activities, and emphasizing the importance of teamwork (Stewart Home & School, 2015). |
| Extracurricular Activities: Special Olympics | Since 1968, the mission has been “to provide year-round sports training and athletic competition in a variety of Olympic-type sports for... adults with intellectual disabilities, giving them continuing opportunities to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship” (Special Olympics, 2015). |
| Extracurricular Activities: Recreational Activities | During recreational activities, the aim is to allow residents to have less-structured activity time, so that they learn how to manage their time and enhance decision-making skills (Stewart Home & School, 2015). These activities occur both on and off campus and encourage residents to try new things (Stewart Home & School, 2015). |

**Stakeholders**

Without question, the most relevant stakeholders were the residents attending Stewart Home & School. At the time of the evaluation, Stewart Home & School served 360 residents of all ages; the residents varied in their ages, diagnoses, and demographic information. For the purposes of this evaluation, the residents who were between the ages of 18 and 40 were assessed. At the time of the evaluation, there were 127 residents who fell within that age range. Figure 2 demonstrates the variation of the residents’ ages amongst the selected age range.
The residents who were included in the evaluation have intellectual disabilities which ranged from mild to moderate to severe disabilities. These diagnoses included Down syndrome, autism spectrum disorder, Fragile X disorder, Williams syndrome, Prader Wili Syndrome, and traumatic brain injury. As Figure 3 illustrates, the majority of the residents who were included in this evaluation have what is medically defined as an intellectual disability. Therefore, they do not have a more specific diagnosis that causes the intellectual disability, but they may have additional diagnoses, for example, obsessive compulsive disorder.
The residents in this sample were from 29 states and one country, with the most residents, 25, from the state of Tennessee, followed by 17 residents from Georgia. The state of origin is determined by where the resident’s guardian or closest living relative lived. Therefore, in some cases, it does not indicate that the resident was born in that state.

The families of the residents were also stakeholders. For some of the residents, this was a parent, and for others it was a sibling, distant relative, or, perhaps, a family friend. This stakeholder was even more significant because he or she is likely financially supporting the resident to be at Stewart Home & School or, if nothing else, is in support of the decision for the resident to be attending Stewart Home & School. As aforementioned, the resident’s guardian was a parent, sibling, etc., or their legal representative. The legal representative was the person closest to the resident who served to provide consent; in the case that there was not a formal guardian; hereafter the resident’s family member or legal representative will be referred to as guardian.

Additional stakeholders included the staff members, with a focus on those implementing different aspects of the health program, and the administrators of Stewart Home & School. Not to be overlooked, there were other stakeholders, who, for the purposes of this evaluation, were not assessed and included, but they should not be discounted. Most notably, they include the remainder of Stewart Home & School’s employees and those in the medical profession, specifically any physicians who directly cared for Stewart Home & School residents. Ultimately, the employees selected were ones who were indentified to be central to the health program; further, no medical
professionals were included because this evaluation focuses on the health program, rather
than medical care, whether it be preventative or otherwise.

Data Collection

To answer the research questions, the evaluator collected data about the health program as Table 2 demonstrates.

Table 2

Data Collection

<table>
<thead>
<tr>
<th>Level</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Observations</td>
</tr>
<tr>
<td></td>
<td>Focus Groups</td>
</tr>
<tr>
<td></td>
<td>One-on-one Interviews</td>
</tr>
<tr>
<td>Staff Members</td>
<td>Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Observations</td>
</tr>
<tr>
<td></td>
<td>One-on-one Interviews</td>
</tr>
<tr>
<td>Administrators</td>
<td>Questionnaire</td>
</tr>
<tr>
<td></td>
<td>One-on-one Interviews</td>
</tr>
<tr>
<td>Guardians</td>
<td>Questionnaire</td>
</tr>
<tr>
<td></td>
<td>One-on-one Interviews</td>
</tr>
</tbody>
</table>

To ensure that the residents were involved in the research process and all accommodations necessary were taken to ensure both their assent and active participation, the evaluator followed the Universal Design of Learning guidelines (National Center on Universal Design for Learning, 2014). The Principles of Universal Design “promote accessibility” and can be utilized by a variety of professionals including architects, engineers, product designers, researchers, and educators (The Center for Universal Design, 1997). Those specific for educators, focus upon “providing multiple means of engagement, representation, and action & expression” (National Center on Universal Design for Learning, 2014). Throughout the data collection process, every
measure was taken to follow the principles, as they help ensure accessibility by providing “extra supports, interventions, equipment, and adjustments to the environment to ensure inclusion… in all respects” (Gordon & O’Leary). More specifically, these guidelines were taken into account in both broad and specific ways from designing the research process to creating the instruments used in the research process.

**Collection Method**

Four different data collection methods were utilized to assess Stewart Home & School’s health program—observations, questionnaires, focus groups, and individual interviews. The observations allowed the evaluator to see the level of involvement from the residents and staff members. Observations helped the evaluator to answer the research questions regarding what the components of the health program were and how the program was being implemented. Further, the information gleaned from the observations allowed the evaluator to describe the specifics of the program components and to have a better understanding for how the components worked, which was particularly helpful when conducting focus groups and doing interviews.

While the observations were being conducted, questionnaires were distributed. The questionnaires (Appendices G and H) asked specific questions regarding the level of physical activity, the nutrition provided to residents, and the amount and frequency of involvement in additional health program components, such as the curriculum courses. The questionnaire for residents (Appendix G) was different from the questionnaire for staff, administrators, and guardians (Appendix H), who received the same questionnaire. The questionnaire attempted to discern if the residents felt they were meeting the objectives for each component of the health program; for instance, if the resident was in
grooming class, he or she answered a question about personal hygiene skills. Both questionnaires focused on learning if the goals of the components of the health program were being met.

After observations and questionnaires were completed, focus groups were held with one stakeholder group—residents. There were two focus groups for residents that allowed the residents to discuss their experiences of the health program and whether the components of the health program were meeting their stated objectives. The focus groups were small with four to five participants in each focus group. This allowed for different opinions, but also encouraged all participants to share their experiences. The focus group followed up on the results of the questionnaire and asked elaborating questions. The entirety of the results of both focus groups were recorded and transcribed verbatim.

Following the focus groups, semi-structured one-on-one interviews were conducted with four residents, four staff members, two administrators, and three guardians. The interviews were also recorded and transcribed verbatim. With the knowledge and data from the observations and questionnaires combined with the specific experiential details gleaned from the focus groups and interviews, there was a plethora of information about the components of Stewart Home & School’s health program.

Participants

In order to participate in any stage of the evaluation, all participants were requested to initially provide consent. Staff members and administrations provided consent for themselves (Appendix A). Guardians provided consent for themselves (Appendix C) and for the resident to whom they served as guardian (Appendix B).
Residents were requested to review an assent form (Appendix D). Further, given the unique population, each time that research occurs, the resident was asked to verbally provide consent. If this consent was not verbally given, then the resident was not asked to participate for any additional stages.

Residents were included based upon their received consent. Any residents whose guardians provided consent and who also assented were asked to complete a questionnaire. From those residents, a random sample was selected to be included in the focus groups and then once again for the interviews. This was necessary, because it was important that no bias was placed on a resident’s perceived ability to communicate. Thus, it was not necessarily the case that a resident was in a focus group to be interviewed. The samples occurred independently of one another. This allowed the evaluator to include the most number of residents and to ensure that residents of all ranges of disability level were included in equal measure. When the random sample occurred, necessary accommodations were made to ensure the residents were able to answer and respond as necessary. For example, the resident questionnaire (Appendix G) included pictures to make it more accommodating and to help ensure that the residents understood what was being asked of them. Further, the focus groups were led with accommodations such as visuals used, when necessary, and with the opportunity for each resident to share their experience with each question, which allowed for a very rich, useful discussion. Accommodations were made throughout the data collection process to ensure inclusion of all residents.

All staff members identified as participating within any of the health program components that consented to be a part of the research were included. The researcher
selected four to be interviewed by randomly sampling from those who provided consent. Similarly, all relevant administrators who provided consent were included. There were two administrators who were identified for overseeing a direct component of the health program; both administrators consented and, thus, both were interviewed. All guardians that signed the consent form were asked to complete a questionnaire. From those who provided consent, a random sample was done to determine who was interviewed.

Following the interviews, the evaluator engaged in the “validation procedure” of member checking (Alkin, 2011). Throughout the interview, the evaluator reiterated what the participant said, to ensure that the participant felt correctly understood. To ensure that the residents were actively engaged in member checking, the evaluator met individually with each participant involved in focus groups and interviews and provided the residents with a verbal review of the focus group and/or interview in which the resident was involved. This ensured that the residents engaged in member checking.

**RE-AIM Framework**

Given that Stewart Home & School did not have identified goals and objectives established for each component, it was necessary for the evaluator to first identify these goals, in discussions with the administration and in reviewing Stewart Home & School materials. After identifying these, an outside framework was needed to effectively assess and evaluate the health program components. Given the unique nature of Stewart Home & School’s health program, the RE-AIM framework was selected, as it has been utilized previously with health programs, and because of the flexibility it offers.

The RE-AIM framework was developed for public health programs to ensure that those health programs were effective (Cheney & Yong, 2014). RE-AIM stands for reach,
efficacy, adoption, implementation, and maintenance, respectively (Hyndman et al., 2014). More specifically, the framework evaluated how the program reached out to the target population; it assessed the effectiveness of the program; it analyzed how the program was adopted and subsequently implemented; the framework evaluated the ongoing maintenance of the program (Hyndman et al., 2014). This framework was combined to determine if the health program was indeed effective. For the purposes of this evaluation, effectiveness was defined as “the degree to which an intervention has an impact on important outcomes at individual, organizational, and population levels” (Bryant, Altpeter, & Whitelaw, 2006, p. 202).

Based upon, Hyndman et al.’s (2014) interpretation of the RE-AIM framework, the evaluator developed a framework to guide and align the evaluation with the RE-AIM framework, while situating it within Stewart Home & School’s goals and objectives. Utilizing the model of Glasgow’s (2006) application of the RE-AIM framework, the health program is depicted in Table 3.

Table 3

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Method of Evaluation</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>Number of residents actively involved in the health program</td>
<td>Observations</td>
</tr>
<tr>
<td></td>
<td>Staff involved in the implementation of the health program</td>
<td>Stewart Home &amp; School records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Questionnaires distributed to all stakeholders</td>
</tr>
<tr>
<td>Be effective in producing Stewart Home &amp; School’s desired outcomes</td>
<td>Residents, staff, administrators, and guardians’ perceptions of the efficacy of the health program, as determined by Stewart Home &amp; School’s stated goals for each component</td>
<td>Interviews and focus groups with residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interviews with administrators, staff members, and guardians</td>
</tr>
</tbody>
</table>
Table 3 (continued)

| Be adopted across Stewart Home & School | Number of health program components being implemented  
|                                           | Willingness of the entirety of Stewart Home & School to incorporate health program ideals, based upon stakeholders’ feedback  
|                                           | Observations  
|                                           | Questionnaires distributed to all stakeholders  
|                                           | Interviews and focus groups with residents  
|                                           | Interviews with administrators and staff members  
| Be consistently implemented by trained staff | Experience of staff member(s)  
|                                           | Qualifications of staff member(s)  
|                                           | Consistency, based upon stakeholders’ feedback  
|                                           | Observations  
|                                           | Questionnaires distributed to all stakeholders  
|                                           | Interviews and focus groups with residents  
|                                           | Interviews with administrators and staff members  
| “Long-lasting maintenance effects” (Glasgow, 2006.) | Planned or proposed (depending on stakeholder) health program changes, improvements and future direction.  
|                                           | Discussion of necessary future evaluations on the health program  
|                                           | Interviews and focus groups with residents  
|                                           | Interviews with administrators and staff members  

Because the health of people with intellectual disabilities was the very topic of this evaluation, people with intellectual disabilities’ levels of involvement were, therefore, priority. Thus, individuals with intellectual disabilities were involved in every phase of data collection. In fact, Stewart Home & School residents were the only stakeholders to be involved in each phase of data collection.

With the goals and objectives established, it was important to encourage Stewart Home & School to develop a logic model to understand the organization of its efforts and to engage in a discussion of what the program would entail (Alkin, 2011). Stewart Home
& School did not have a logic model for the health program. Alkin suggested that the evaluator should not create a logic model alone, but should engage with the organization to form the logic model together. Therefore, the evaluator worked with the administrators of Stewart Home & School to create a simple logic model for the health program; this is depicted in Figure 4.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities</td>
<td>Routine physical activity</td>
<td>Increase in opportunities for physical activity</td>
<td>Improved health</td>
</tr>
<tr>
<td>Equipment</td>
<td>Dietary plan</td>
<td>Increase in physical activity level</td>
<td>Improved well-being</td>
</tr>
<tr>
<td>Financial means</td>
<td>Nutrition, physical activity, and proper hygiene education</td>
<td>Nutritious meals</td>
<td>Reduction in medical risk factors</td>
</tr>
<tr>
<td>Administrative time and oversight</td>
<td>Recreation activities</td>
<td>Utilization of motor skills</td>
<td>Ability to exercise independently</td>
</tr>
<tr>
<td>Staff time, assistance, training, and knowledge</td>
<td></td>
<td></td>
<td>Increased health knowledge</td>
</tr>
</tbody>
</table>

*Figure 4. Logic Model*

While Figure 4 depicts the inputs, activities, outputs, and outcomes of Stewart Home & School’s health program, this evaluation only focused primarily upon the first two columns—the inputs and activities of the health program. The evaluation, particularly the interview and focus group portion, discussed perceived outputs that were mentioned by stakeholders. However, it is important to outline the entirety of the health program,
including the outputs and outcomes to understand how they interacted. The logic model helps stakeholders, most notably those who implemented the program, to understand the significance of the inputs and activities and to visually see how their work could lead to desirable outcomes.

**Data Analysis**

The data gathered were analyzed by looking at the following research questions, previously discussed in Chapter I, and the RE-AIM framework, according to Table 3.

1. What are the components of the health program?
2. How is the health program being implemented?
3. According to the goals of the health program components, what are the various stakeholders’ perceptions on the effectiveness of the health program at Stewart Home & School?

After the data were collected, they were coded. First, the data were coded according to the component of the health program. Within that coding, the data were then broken down into sub-categories that helped provide answers to the second and third research questions regarding the implementation and effectiveness of the health program. These sub-categories were based upon the five categories of the RE-AIM framework, reach, efficacy, adoption, implementation, and maintenance. Within these codes, strengths and weaknesses of both the specific components and the overall health program began to emerge and themes developed from the coded data.

More specifically, the data from the observations were utilized as descriptive data to help the evaluator describe the components of the health program. The notes were recorded and were coded and then analyzed for emerging themes. The data from the
questionnaires were quantified and, where applicable, measures of central tendency were reported, in addition to the range of those results, so as to better understand the perspectives of the health program. Finally, both the focus groups and the interviews of the participants were analyzed according to the protocol described above, by first dividing the information by component, next into the five RE-AIM sub-categories, and then by finding themes.

Chapter Summary

This chapter first defined who the stakeholders were and then, with that explanation, detailed how those stakeholders were included in the collection of the data for the evaluation. In addition, the evaluator provided a description of how the framework was applied after the collection of the data. Ultimately, this chapter detailed how the evaluator analyzed the data collected.
CHAPTER IV
RESULTS AND ANALYSIS

This chapter outlines the results of the observations, questionnaires, focus groups and interviews of the residents, guardians or legal representatives, staff, and administrators. To do so, the characteristics of the research participants are discussed, along with the steps taken during the data collection process by the evaluator. Next, the theory of planned behavior and how it was utilized to ensure participation from the residents is presented. With this information described, the findings will be discussed in order of research question within the RE-AIM framework.

Characteristics of the Research Participants

The evaluator contacted the guardians of 127 residents at Stewart Home & School with two research participation opportunities, the first for guardians and the second for residents, to whom the guardian serves, to participate. Of those 127 contacted, 55 guardians provided consent for their residents to participate and 50 of those guardians consented to participate in the study, as well. Thus, this is a response rate of 43.3 percent for the residents and 39.4 percent for the guardians.

The evaluator met individually with each resident and reviewed the assent form. Of those 55 residents, 42 were on-campus and able to participate in the evaluation. Of those 42 residents, two dissented. This dissent manifested itself in several forms, one resident refused to meet with the evaluator. Therefore, the evaluator went to the resident’s classroom and he/she indicated in non-verbal cues and mannerisms that he/she did not wish to participate. Another resident refused to stay in the room and indicated in verbal cues and mannerisms that he/she did not wish to participate. Table 4 illustrates the
descriptive statistics of the participants whose guardians provided consent and who assented.

Table 4

*Resident Descriptive Statistics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>47.5</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>26-30</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>30-35</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>36-40</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>14</td>
<td>35.0</td>
</tr>
<tr>
<td>Down syndrome</td>
<td>6</td>
<td>15.0</td>
</tr>
<tr>
<td>Down syndrome and autism spectrum disorder</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Williams syndrome</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>20.0</td>
</tr>
</tbody>
</table>

The residents who participated in the evaluation were diverse in their ages and diagnoses. While these residents all assented to be participants in the evaluation, only 37
of the residents assented to completing the questionnaire. There were no dissents when the residents were randomly selected to be a part of focus groups and/or interviewed.

Table 5 depicts the descriptive statistics of those guardians who consented to participate in the study. One noteworthy statistic is that the only consenting guardians were parents of the residents. This is surprising because guardians include individuals that are siblings, closest living relatives, or perhaps a family friend, yet none of those individuals consented for their resident to participate. This can be partially explained given that the age range of residents included was 18 to 40, and thus, most residents are young enough to still have living parents.

Table 5

Guardian/Legal Representative Descriptive Statistics

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
<td>34.0</td>
</tr>
<tr>
<td>Female</td>
<td>33</td>
<td>66.0</td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>50</td>
<td>100.0</td>
</tr>
<tr>
<td>Sibling</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Twelve staff members were contacted via email with the opportunity to participate in the evaluation and four consented to participate. This represents a response rate of 33.3 percent. In addition, both of the administrators contacted consented to
participate, with a response rate of 100 percent. To understand the overall total number of participants and how many were from each of the four stakeholder groups, Figure 5 represents the participants in the evaluation process.

In total, 37 questionnaires were completed from the 40 residents whose guardians provided consent and who assented. Of the 50 guardians who consented to participate, 22 returned their questionnaires, via mail, fax, or email, depending on their personal preferences. All four of the staff members who consented returned their questionnaire forms, as did both administrators who consented to participate. Table 6 details this information, as well as the response rate of those who were asked to complete questionnaires and those who returned the questionnaires.
Table 6

*Questionnaires*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Response Rate % (after receiving consent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardian</td>
<td>22</td>
<td>44.0</td>
</tr>
<tr>
<td>Resident</td>
<td>37</td>
<td>92.5</td>
</tr>
<tr>
<td>Administrator</td>
<td>2</td>
<td>100.0</td>
</tr>
<tr>
<td>Staff</td>
<td>4</td>
<td>100.0</td>
</tr>
</tbody>
</table>

One guardian questionnaire had to be dropped from being only partially completed, and six of resident questionnaires were excluded, due to invalidity, as the evaluator noted ‘strongly disagree’ in response to if the responses accurately reflected the opinions of the residents. This was primarily perceived due to either a lack of a response or the resident having echolalic speech.

**RE-AIM Framework Overall Findings/Research Question 1 & 2:**

**What are the components of the health program?**

**How are the components of the health program being implemented?**

With the RE-AIM Framework as the guide, the first and second research questions, regarding the components of the health program and how each component is implemented, are answered.

**Nutritional and Dietary Services**

Creative Dining Services delivers three meals per day to each residence hall, where residents have their meals in dining rooms. The meals are served based upon residents’ nutritional needs, including accounting for allergies, choking hazards, and the
caloric diet that each resident is placed upon when enrolling in the school. These three meals are served to residents by a supervising staff member and, often times, with other residents assisting in the process.

While there are some exceptions, the majority of residents are on one of three diets. The first is known as consistent carbohydrate, designed specifically for those residents who have diabetes or similar medical conditions, and is approximately 1,500 calories per day. The standard diet is 2,000 calories per day; the most calorically dense diet is called high calorie/high protein and provides roughly 2,500 calories per day.

With Glasgow’s application of the RE-AIM framework, Stewart Home & School’s health program components have been broken down, by RE-AIM component, how that was measured and the overall findings. Table 7 depicts the findings of the nutritional and dietary services.

Table 7

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>• Observations</td>
<td>All residents receive 3 meals per day served by Creative Dining Services. If residents are off-campus with Stewart Home &amp; School, food is served from local restaurants or residents may be off-campus with the guardians.</td>
</tr>
<tr>
<td>• Number of residents actively participating</td>
<td>• Stewart Home &amp; School records</td>
<td></td>
</tr>
<tr>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• Questionnaires distributed to all stakeholders</td>
<td></td>
</tr>
<tr>
<td>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of the dietary services as determined by the stated goals</td>
<td>Questionnaires distributed to all stakeholders</td>
<td>Questionnaires demonstrate that stakeholders agree that Creative Dining Services has improved nutritional services.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>• Goals: “deliver fresh, sustainable, innovative, [and] customized hospitality experiences” (Creative Dining Services, 2015)</td>
<td>• Interviews and focus groups with residents</td>
<td>• Interviews from administrators, staff members, residents, and guardians indicated the need for fresher food, served more palatably.</td>
</tr>
</tbody>
</table>

| Be adopted across Stewart Home & School | Observations | Meals are consistently, without fail, provided to residents three times per day. |
| Are the dietary services being implemented? | Questionnaires distributed to all stakeholders | According to staff member and administrator interviews, Creative Dining Services works well in meeting the unique needs for residents. |
| Willingness of staff members to incorporate overall health program ideals | Interviews and focus groups with residents | |
| | Interviews with administrators and staff members | |

| Be consistently implemented by trained staff | Observations | Creative Dining Services has been operating for the past two years. |
| Experience of staff member(s) | Questionnaires distributed to all stakeholders | The manager began at Stewart Home & School two years ago as did the employees he/she oversees, though some of those have changed in the last two years. |
| Qualifications of staff member(s) | Interviews and focus groups with residents | Employees hold their food handling license, along with the manager’s educational training and experience working with food management. |
| Consistency of nutritional and dietary services | Interviews with administrators, staff members and guardians | |

Table 7 (continued)
“Long-lasting maintenance effects” (Glasgow, 2006)
- Planned or proposed dietary changes, improvements, and future direction
- Necessary future evaluations on the nutritional services

- Interviews and focus groups with residents
- Interviews with administrators and staff members
- The need for fresher food was discussed by several stakeholder groups.
- Data analysis of the focus groups found a trend in the decline in the presentation and food quality recently.

Table 7 (continued)

Most notably, Creative Dining Services is not only new and establishing a reputation, but it is a reputation that has not been consistent and has been met with mixed reviews, by all of the stakeholders, most notably and with the most frequency, the residents.

Further, perhaps one of the most significant restraints of Stewart Home & School’s health program, noted during observations and in administrator and staff interviews, is the lack of autonomy that residents are able to exercise in regards to their food selection. While the residents are able to select what food they would like to eat when off campus, when they are on-campus, they are unable to make such selections. This presents a significant opportunity for improvement in the nutritional and dietary services program.

**Pre-academic and Academic Curriculum: Fitness**

The fitness center is consistently open five days per week and most residents typically take it as part of their course schedule during a 45 minute class. There are 208 residents that take it during such time. Additional, though not quantifiable, residents utilize the fitness center when it is open as part of recreational activities on evenings and weekends. The 208 residents who take fitness as part of their schedule are led by the
instructor to do cardio three days per week and strength training two days a week. The fitness center consists of 20 treadmills, four stationary bicycles, four recumbent bicycles, a walking track, an elliptical, an arc trainer, and weight lifting equipment. During each period, the fitness center ranges in occupancy from 15 to 25 residents. Figures 6 and 7 illustrate the frequency of participation in the fitness center from the residents, along with what activity they engage in when they are in fitness class (residents were able to note more than one activity for participation).

![Days Per Week of Exercise](image)

**Figure 6.** Resident Questionnaire: How many days per week do you work out in the fitness center?

![Exercise Activities](image)

**Figure 7.** Resident Questionnaire: How do you exercise in the fitness center?
Table 8 illustrates the RE-AIM components, the ways each component was measured, and the major findings of the fitness class.

Table 8

*Fitness RE-AIM Findings*

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
</table>
| **Reach all medically approved residents**  
  • Number of residents actively participating |  
  • Observations  
  • Stewart Home & School records  
  • Questionnaires distributed to all stakeholders |  
  • Modifications are made on an individual basis to allow residents to participate as much as they are physically able.  
  • Offered to those in pre-academic and academic programs.  
  • 208 total residents participating.  
  • 83.8 percent of residents in sample participated in fitness regularly. |
| **Be effective in producing Stewart Home & School’s desired outcomes; perceptions of efficacy of the fitness center as determined by Stewart Home & School’s stated goals**  
  • Goals: Teach residents to work out daily for 45 minutes with cardiovascular and strength-training exercises (Stewart Home & School, 2015). |  
  • Questionnaires distributed to all stakeholders  
  • Interviews and focus groups with residents  
  • Interviews with administrators, staff members, and guardians |  
  • Questionnaires indicated that residents are consistently receiving cardiovascular workout and the majority agreed about strength training, but with less favorability.  
  • Trends from focus groups and interviews indicated an acknowledgment and appreciation for the fitness center. |
<table>
<thead>
<tr>
<th>Be adopted across Stewart Home &amp; School</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the fitness center being implemented?</td>
</tr>
<tr>
<td>• Willingness of staff members to incorporate overall health program ideal.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Be consistently implemented by trained staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience of staff member(s)</td>
</tr>
<tr>
<td>• Qualifications of staff member(s)</td>
</tr>
<tr>
<td>• Consistency of fitness center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaires distributed to all stakeholders</td>
</tr>
<tr>
<td>Interviews and focus groups with residents</td>
</tr>
<tr>
<td>Interviews with administrators and staff members</td>
</tr>
</tbody>
</table>

| Fitness is being implemented successfully and encouraged by staff and administrators to residents and guardians. |
| It is recommended for residents to take year round, as opposed to only during particular semesters, as is routine with other classes. |
| The fitness instructor attends monthly weight meetings sharing feedback and concerns. |
| The fitness instructor implements a program that focuses on lower body health, as directed by administration. |

| Fitness is offered five days a week, as a class in a resident’s schedule or the resident can add it to his/her schedule during his/her homeroom period or occasionally during the evenings and on weekends. |
| The fitness instructor has worked at Stewart Home & School for 26 years and started the current fitness program when the facilities were built in 2003. |
| The fitness instructor was a collegiate athlete, holds state track records, and two years ago obtained certification in personal training. |
Based upon the discussion of the focus groups and interviews, the fitness class seemed to be described as critical and noteworthy to Stewart Home & School’s health program. It, along with the instructor, was discussed with accolades by all stakeholders. The overall trend in interviews was to refer to the fitness center as the “heart” of the health program.

**Pre-academic and Academic Curriculum: Health and Wellness**

Health and wellness class is offered as part of a resident’s class schedule with approximately 85 residents taking the class during the fall semester. The 45 minute class provides residents with a curriculum on various body systems (circulatory, skeletal, muscular, digestive, nervous, etc.), nutrition, hygiene, physical activity, emotional health and character, and sun & weather safety. The class size ranges from 11 to 15 residents.

Table 9 depicts the RE-AIM components, the ways in which the components were measured and the major findings of the health and wellness class.
Table 9

Health and Wellness RE-AIM Findings

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
</table>
| Reach all medically approved residents  
• Number of residents actively participating | Observations  
• Stewart Home & School records  
• Questionnaires distributed to all stakeholders | 85 total residents participating.  
• Offered to residents in both pre-academic and academic programs.  
• 81.0 percent of residents in sample were in health and wellness class. |
| Be effective in producing Stewart Home & School’s desired outcomes; perceptions of efficacy of the health and wellness class as determined by Stewart Home & School’s stated goals  
• Goals: Teach residents physical and emotional wellness and to make healthy choices independent of the class and assistance (Stewart Home & School, 2015). | Questionnaires distributed to all stakeholders  
• Interviews and focus groups with residents  
• Interviews with administrators, staff members, and guardians | Questionnaires presented favorable opinion of the class meeting its goals, with the mentioned need to focus on encouraging residents to engage in making healthy decisions outside of class.  
• During the teacher’s interview, he/she highlighted the focus of the class being to learn how to live safely and practice a healthy lifestyle independent of support and encouragement. |
| Be adopted across Stewart Home & School  
• Is the health and wellness class being implemented?  
• Willingness of staff members to incorporate overall health program ideals. | Observations  
• Questionnaires distributed to all stakeholders  
• Interviews and focus groups with residents  
• Interviews with administrators and staff members | The health and wellness class is taught to seven classes and additional residents upon request.  
• The class schedule changes three times a year, to allow residents to take different classes.  
• The health and wellness teacher modifies curriculum seasonally, such as teaching sun safety during the summer or weather safety during the winter. |
Residents were consistently able to provide varying answers of what they have learned in health and wellness class. In interviews, administrators highlighted the strengths that the health and wellness class provided in reiterating what residents were learning elsewhere in the curriculum. Further, the teacher articulated that one of his/her goals was to encourage independence and the ability to exercise healthy choices when presented with food selection.
Pre-academic and Academic Curriculum: Yoga

Yoga is offered as an additional class that a resident can take as little or much as he or she wants, though the instructor recommends residents and guardians to consider three classes per week. Each class is 45 minutes in length at a cost of $12. These classes are offered at various times throughout the week, including in the morning, afternoon, and in the evening. According to Stewart Home & School records, the yoga class is based on a curriculum that includes 14 elements to educate residents on a variety of topics, such as biology, anatomy, and art. These records detail that each class consists of a warm-up involving deep-breathing and posture work, poses intertwined with activities and games, and concludes with savasana yoga, focusing on relaxing. Each class has roughly nine residents.

The RE-AIM components, the measure of those components, and the major findings of the yoga class are shown in Table 10.

Table 10

Yoga RE-AIM Findings

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>Observations</td>
<td>Offered to residents in pre-academic and academic programs.</td>
</tr>
<tr>
<td>Number of residents actively participating</td>
<td>Stewart Home &amp; School records</td>
<td>At the time of evaluation, there were 44 total residents participating.</td>
</tr>
<tr>
<td></td>
<td>Questionnaires distributed to all stakeholders</td>
<td>27.0 percent of residents in sample have taken yoga class</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participation is an additional cost at $12 per class, though this was not mentioned by residents or guardians as a barrier for participation.</td>
</tr>
</tbody>
</table>
Table 10 (continued)

<table>
<thead>
<tr>
<th>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of the yoga class as determined by Stewart Home &amp; School’s stated goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals:</strong> Teach “relaxation techniques, improve… the ability to focus, provide physical benefits, such as increased muscle tone, balance, body awareness, flexibility and overall strength and endurance” and, through its practice “to improve… self-confidence” (Stewart Home &amp; School, 2015).</td>
</tr>
<tr>
<td><strong>Questionnaires</strong> distributed to all stakeholders</td>
</tr>
<tr>
<td><strong>Interviews and focus groups with residents</strong></td>
</tr>
<tr>
<td><strong>Interviews with administrators, staff members, and guardians</strong></td>
</tr>
<tr>
<td><strong>Questionnaires indicated that many did not have knowledge of yoga, but those that did were overwhelmingly in agreement that it is meeting its goals.</strong></td>
</tr>
<tr>
<td><strong>Trends in interviews indicated that guardians were pleased with the addition of yoga to the health program.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Be adopted across Stewart Home &amp; School</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is the yoga class being implemented?</strong></td>
</tr>
<tr>
<td><strong>Willingness of staff members to incorporate overall health program ideal.</strong></td>
</tr>
<tr>
<td><strong>Observations</strong></td>
</tr>
<tr>
<td><strong>Questionnaires distributed to all stakeholders</strong></td>
</tr>
<tr>
<td><strong>Interviews and focus groups with residents</strong></td>
</tr>
<tr>
<td><strong>Interviews with administrators and staff members</strong></td>
</tr>
<tr>
<td><strong>Yoga class is the most recent component to be offered, and has been offered consistently since 2010.</strong></td>
</tr>
<tr>
<td><strong>Yoga is offered for any resident up to three times per week.</strong></td>
</tr>
<tr>
<td><strong>Residents can take yoga classes as often (up to three times per week) or as infrequent as they like (for example, monthly).</strong></td>
</tr>
</tbody>
</table>
Table 10 (continued)

<table>
<thead>
<tr>
<th>Be consistently implemented by trained staff</th>
<th>Observations</th>
<th>There is only one yoga instructor at Stewart Home &amp; School.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience of staff member(s)</td>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• The yoga instructor is an independent contractor and has worked with Stewart Home &amp; School for six years.</td>
</tr>
<tr>
<td>• Qualifications of staff member(s)</td>
<td>• Interviews and focus groups with residents</td>
<td>• The yoga instructor holds YogaKids certification.</td>
</tr>
<tr>
<td>• Consistency of the yoga class</td>
<td>• Interviews with administrators, staff members and guardians</td>
<td>• The yoga instructor implemented the yoga program and, thus, has been the only yoga teacher.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“Long-lasting maintenance effects” (Glasgow, 2006)</th>
<th>Interviews and focus groups with residents</th>
<th>No discussed changes for the yoga program by the administrators, staff members, residents, or residents’ guardians.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Planned or proposed changes, improvements, and future direction for yoga class</td>
<td>• Interviews with administrators and staff members</td>
<td></td>
</tr>
<tr>
<td>• Any necessary future evaluations on the yoga class</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The most recent addition to Stewart Home & School’s health program, yoga class, was discussed favorably throughout focus groups and interviews. Though not articulated, yoga has less participation, given that it is an additional expense and thus, is not an option for all residents.

Pre-academic Curriculum: Grooming

At the time of evaluation, the grooming class was being taken by 60 residents as part of their daily class schedule (Monday through Friday). The 45 minute class focused on personal hygiene skills and encouraging independence (Stewart Home & School,
The classroom features several sinks to allow residents to practice their hygienic skills with a hands-on approach. The class size ranges from seven to 11 residents.

The RE-AIM components, measurements of those components, and the key findings for the grooming class are identified in Table 11.

### Table 11

**Grooming RE-AIM Findings**

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>Observations, Stewart Home &amp; School records, Questionnaires distributed to all stakeholders</td>
<td>Offered only in the pre-academic program, unless otherwise requested by a resident’s guardian. At the time of the evaluation, there were 60 total residents participating. 2.7 percent of residents in sample were in grooming class.</td>
</tr>
<tr>
<td>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of the grooming class as determined by Stewart Home &amp; School’s stated goals</td>
<td>Questionnaires distributed to all stakeholders, Interviews and focus groups with residents, Interviews with administrators, staff members, and guardians</td>
<td>Questionnaires were not able to accurately access stakeholders’ perception, given that the resident questionnaires are not available. Of those aware and informed of grooming class, the feedback was favorable that the class is achieving its hygiene objectives.</td>
</tr>
</tbody>
</table>

Goals: Teach personal care skills that will become a part of the “[residents’] daily routine[s] and [will] encourage independence (Stewart Home & School, 2015).”
Table 11 (continued)

<table>
<thead>
<tr>
<th>Be adopted across Stewart Home &amp; School</th>
<th>Be consistently implemented by trained staff</th>
<th>“Long-lasting maintenance effects” (Glasgow, 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the grooming class being implemented?</td>
<td>• Experience of staff member(s)</td>
<td>• Planned or proposed changes, improvements, and future direction for the grooming class</td>
</tr>
<tr>
<td>• Willingness of staff members to incorporate overall health program ideal.</td>
<td>• Qualifications of staff member(s)</td>
<td>• Any necessary future evaluations on the grooming class</td>
</tr>
<tr>
<td>• Observations</td>
<td>• Consistency of the grooming class</td>
<td></td>
</tr>
<tr>
<td>• Questionnaires distributed to all stakeholders</td>
<td></td>
<td>• Interviews and focus groups with residents</td>
</tr>
<tr>
<td>• Interviews and focus groups with residents</td>
<td></td>
<td>• Interviews with administrators and staff members</td>
</tr>
<tr>
<td>• Interviews with administrators and staff members</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Little was learned about the grooming class, because the majority of residents and guardians did not have experience with the class and were unable to share feedback.

However, during staff and administrator interviews, the need for a grooming class that is
offered to all residents was discussed at length. This class would not only allow residents
to practice their hygiene and self-care skills, but encourage all residents to become more
independent.

**Pre-academic Curriculum: Physical Education**

The physical education class is held in Stewart Home & School’s gymnasium. Physical education is a class offered as part of a daily class schedule to residents who are in the pre-academic program. Each class lasts for 45 minutes and starts off with a cardiovascular exercise, followed by the residents doing a skills-based activity. The class size ranges from five to 14 residents.

In Table 12, the RE-AIM framework is applied to the physical education class by detailing how the framework was measured and the overall findings are included.

Table 12

*Physical Education RE-AIM Findings*

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
</table>
| Reach all medically approved residents | • Observations  
• Stewart Home & School records  
• Questionnaires distributed to all stakeholders | • Offered only in the pre-academic program, unless otherwise requested by a resident’s guardian.  
• At the time of the evaluation, 78 total residents participated.  
• 24.3 percent of residents in sample were in physical education |
Table 12 (continued)

<table>
<thead>
<tr>
<th>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of the physical education class as determined by Stewart Home &amp; School’s stated goals</th>
<th>Questionnaires showed that stakeholders perceived that physical education teaches teamwork and responsibility for one’s health.</th>
<th>Questionnaires showed that stakeholders perceived that physical education teaches teamwork and responsibility for one’s health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Goals: “[I]ncrease and improve motor skills development” (Stewart home &amp; School, 2015).</td>
<td>Through observations, it was found that the teacher’s schedule and multiple responsibilities is a challenge for consistency, though this was not mentioned by any stakeholder group.</td>
<td></td>
</tr>
<tr>
<td>Be adopted across Stewart Home &amp; School</td>
<td>Be consistently implemented by trained staff</td>
<td>Be consistently implemented by trained staff</td>
</tr>
<tr>
<td>• Is the physical education class being implemented?</td>
<td>• Experience of staff member(s)</td>
<td>• There is only one physical education teacher.</td>
</tr>
<tr>
<td>• Willingness of staff members to incorporate overall health program ideal.</td>
<td>• Qualifications of staff member(s)</td>
<td>• The physical education teacher has worked at Stewart Home &amp; School for 15 years and has been the physical education instructor throughout that time.</td>
</tr>
<tr>
<td></td>
<td>• Consistency of the physical education class</td>
<td>• Consistency of the physical education class</td>
</tr>
<tr>
<td>• Observations</td>
<td>• Observations</td>
<td>• There is only one physical education teacher.</td>
</tr>
<tr>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• The physical education teacher has worked at Stewart Home &amp; School for 15 years and has been the physical education instructor throughout that time.</td>
</tr>
<tr>
<td>• Interviews and focus groups with residents</td>
<td>• Interviews and focus groups with residents</td>
<td>• The physical education teacher has a college degree.</td>
</tr>
<tr>
<td>• Interviews with administrators, staff members, and guardians</td>
<td>• Interviews with administrators, staff members and guardians</td>
<td></td>
</tr>
</tbody>
</table>
Table 12 (continued)

<table>
<thead>
<tr>
<th></th>
<th>•</th>
<th>•</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The physical education teacher also oversees the fishing,</td>
<td>• Due to the need for the teacher during the summer months to</td>
<td>• The need for consistency with the teacher during the summer</td>
</tr>
<tr>
<td>tennis, swimming, and golf programs.</td>
<td>participate in activities related to fishing, tennis, swimming,</td>
<td>months was not articulated by any of the stakeholders, but noted</td>
</tr>
<tr>
<td>• Due to the need for the teacher during the summer months to</td>
<td>and golf, the teacher is often out of the classroom and a</td>
<td>during observations.</td>
</tr>
<tr>
<td>participate in activities related to fishing, tennis,</td>
<td>substitute is used.</td>
<td></td>
</tr>
<tr>
<td>swimming, and golf, the teacher is often out of the classroom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and a substitute is used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Long-lasting maintenance effects” (Glasgow, 2006)</td>
<td>• Interviews and focus groups with residents</td>
<td></td>
</tr>
<tr>
<td>• Planned or proposed changes, improvements, and future</td>
<td>• Interviews with administrators and staff members</td>
<td></td>
</tr>
<tr>
<td>direction for the physical education class</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any necessary future evaluations on the physical education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>class</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Similar to the grooming class, physical education is only offered to residents in the pre-academic program, unless otherwise requested by residents and/or their guardians. With that being said, the need for it to be offered to those in the academic program was not discussed by any of the stakeholders. The primary challenge of the physical education class is the lack of consistency of the teacher during the summer months. The teacher highlighted the difficulty of consistently reaching all of the residents, who are at varying levels of disability and whose interests in sports and physical activity differ greatly.
**Extracurricular Activities: Special Olympics**

Stewart Home & School works with Special Olympics of Kentucky and participates in all nine sports that Special Olympics of Kentucky offers, including basketball, cheerleading, track and field, swimming, soccer, softball, equestrian, flag football, and bowling. The school has multiple teams in each sport, to allow for residents to participate despite range in skill and experience levels. Each sport consists of practices, games, and regional and state tournaments. Participation in Special Olympics sports is voluntary, based upon the guardian providing permission and the resident’s willingness. There is a charge for participation in each sport that varies from sport to sport, depending on the travel involved, hotel accommodations during tournaments and staff time. Residents can participate in as many Special Olympics sports as they like, depending on their interests.

Special Olympics according to the RE-AIM components and the major findings are outlined in Table 13.

**Table 13**

*Special Olympics RE-AIM Findings*

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>• Observations</td>
<td>• Individual sports were offered to residents at any athletic level, from beginner to advanced</td>
</tr>
<tr>
<td></td>
<td>• Stewart Home &amp; School records</td>
<td>• At the time of evaluation, 120 total residents participated.</td>
</tr>
<tr>
<td></td>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• 80.6 percent of residents in sample were in Special Olympics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offered in nine sports, with the following participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Basketball—70 residents</td>
</tr>
</tbody>
</table>
Table 13 (continued)

<table>
<thead>
<tr>
<th>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of Special Olympics as determined by Special Olympics stated goals</th>
<th>Questionnaires distributed to all stakeholders</th>
<th>Questionnaires presented highly favorable opinions of the Special Olympics program from all stakeholders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Goals: “[T]o provide year-round sports training and athletic competition in a variety of… sports for… adults with intellectual disabilities, giving them… opportunities to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of… friendship” (Special Olympics, 2015).</td>
<td>• Interviews and focus groups with residents</td>
<td>• Interviews and focus groups reiterated the positive opinion of the program.</td>
</tr>
<tr>
<td>• Cheerleading—16 residents</td>
<td>• Cheerleading—16 residents</td>
<td></td>
</tr>
<tr>
<td>• Track and field—30 residents</td>
<td>• Track and field—30 residents</td>
<td></td>
</tr>
<tr>
<td>• Swimming—16 residents</td>
<td>• Swimming—16 residents</td>
<td></td>
</tr>
<tr>
<td>• Soccer—30 residents</td>
<td>• Soccer—30 residents</td>
<td></td>
</tr>
<tr>
<td>• Softball—40 residents</td>
<td>• Softball—40 residents</td>
<td></td>
</tr>
<tr>
<td>• Equestrian—12 residents</td>
<td>• Equestrian—12 residents</td>
<td></td>
</tr>
<tr>
<td>• Flag football—22 residents</td>
<td>• Flag football—22 residents</td>
<td></td>
</tr>
<tr>
<td>• Bowling—30 residents</td>
<td>• Bowling—30 residents</td>
<td></td>
</tr>
</tbody>
</table>
### Table 13 (continued)

<table>
<thead>
<tr>
<th>Be adopted across Stewart Home &amp; School</th>
<th>Be consistently implemented by trained staff</th>
<th>The Special Olympics program includes practices that occur on campus, in all the sports, games that occur off and on-campus, and regional and state tournaments that occur across the state of Kentucky.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the Special Olympics program being implemented?</td>
<td>• Experience of staff member(s)</td>
<td>• Each sport is an additional charge to play, with the cost differing with each sport. This cost covers things including cost of transportation to and from games and hotel accommodations during regional and state tournaments.</td>
</tr>
<tr>
<td>• Willingness of staff members to incorporate overall health program ideal.</td>
<td>• Qualifications of staff member(s)</td>
<td>• Sports are offered year-round, depending on the season the sport is offered.</td>
</tr>
<tr>
<td></td>
<td>• Consistency of the Special Olympics program</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Observations
- Questionnaires distributed to all stakeholders
- Interviews and focus groups with residents
- Interviews with administrators and staff members

- The Special Olympics program includes practices that occur on campus, in all the sports, games that occur off and on-campus, and regional and state tournaments that occur across the state of Kentucky.

- Each sport is an additional charge to play, with the cost differing with each sport. This cost covers things including cost of transportation to and from games and hotel accommodations during regional and state tournaments.

- Sports are offered year-round, depending on the season the sport is offered.

- There is only one Special Olympics coordinator, but many staff members serve as coaches for the athletic teams.

- Special Olympics coordinator has worked at Stewart Home & School for 11 years and been in the role of coordinator for one year.

- Special Olympics coordinator has a college degree.
Table 13 (continued)

<table>
<thead>
<tr>
<th>“Long-lasting maintenance effects” (Glasgow, 2006)</th>
<th>Interviews and focus groups with residents</th>
<th>There were no discussed or proposed changes to the Special Olympics program by administrators, staff members, residents, or residents’ guardians.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Planned or proposed improvements, changes, and future direction for the Special Olympics program</td>
<td>• Interviews with administrators and staff members</td>
<td></td>
</tr>
<tr>
<td>• Necessary future evaluations on the Special Olympics program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Special Olympics was consistently described and offered as a strength of the school’s health program. Without fail, each interviewee was unable to articulate any ways in which the Special Olympics program could expand. Though not articulated by stakeholders in focus groups, interviews or questionnaires, Special Olympics is an activity that could be prohibitive in that it is an additional cost; however, unlike yoga, the number of participants has not been impacted by the cost.

**Extracurricular Activities: Recreational Activities**

Recreational activities are offered each weekday evening for 90 minutes, from 6:00 to 7:30 p.m. and for three periods on Saturday and Sunday, from 8:30 until 11:30 a.m., 1:00 to 4:30 p.m., and 6:00 to 7:30 p.m. Recreational activities are mandatory for the 267 residents on regular care, whereas the 93 residents who are on the more independent living can choose whether or not they want to attend each evening and weekend. Recreational activities consist of a variety of options, of which residents are able to choose which activity they would like to participate in and for how long, often times moving from activity to activity. Activities that are offered include dances, bingo,
athletic games, computer room, television room, religious services on appropriately observed days, trips off-campus, and more.

Table 14 details the RE-AIM components, the measurement method of each component, and the overall findings of the recreational activities in Stewart Home & School’s health program.

Table 14

Recreational Activities RE-AIM Findings

<table>
<thead>
<tr>
<th>RE-AIM Component</th>
<th>Measure</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach all medically approved residents</td>
<td>Observations</td>
<td>Offered to all residents; attendance is mandatory for all residents on standard</td>
</tr>
<tr>
<td>• Number of residents actively participating</td>
<td>Stewart Home &amp; School records</td>
<td>care, whereas it is optional to those on independent living.</td>
</tr>
<tr>
<td></td>
<td>Questionnaires distributed to all stakeholders</td>
<td>• There are 267 standard-care residents in total who were required to attend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>recreational activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 96.8 percent of residents in sample stated that they attend recreational activities.</td>
</tr>
</tbody>
</table>
Table 14 (continued)

<table>
<thead>
<tr>
<th>Be effective in producing Stewart Home &amp; School’s desired outcomes; perceptions of efficacy of recreational activities as determined by Stewart Home &amp; School’s stated goals</th>
<th>• Goals: Allow residents to have less-structured activity time, so that they may learn how to manage their time and learn decision-making skills (Stewart Home &amp; School, 2015).</th>
<th>• Questionnaires distributed to all stakeholders • Interviews and focus groups with residents • Interviews with administrators, staff members, and guardians</th>
<th>• Questionnaires from all stakeholders presented that recreational activities is achieving its objectives. • Interviews and focus groups discussed the need for more activity offerings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be adopted across Stewart Home &amp; School</td>
<td>• Are the recreational activities being implemented? • Willingness of staff members to incorporate overall health program ideal.</td>
<td>• Observations • Questionnaires distributed to all stakeholders • Interviews and focus groups with residents • Interviews with administrators and staff members</td>
<td>• Recreational activities are offered each weekday evening and throughout the day on weekends year-round. • The class schedule changes three times a year, to allow residents to take different classes.</td>
</tr>
</tbody>
</table>
Table 14 (continued)

<table>
<thead>
<tr>
<th>Be consistently implemented by trained staff</th>
<th>Observations</th>
<th>There is one Recreational Director, an Assistant Recreational Director and numerous recreational staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Experience of staff member(s)</td>
<td>• Questionnaires distributed to all stakeholders</td>
<td>• The Recreational Director has worked at Stewart Home &amp; School for 14 years and has served as the director for four years.</td>
</tr>
<tr>
<td>• Qualifications of staff member(s)</td>
<td>• Interviews and focus groups with residents</td>
<td>• Different recreational activities are offered, depending on the day, including dances, bingo, sports competitions, game rooms, computer rooms, movie rooms, outdoor activities, and, occasionally, though not with regularity, the opportunity to work out in the fitness center.</td>
</tr>
<tr>
<td>• Consistency of recreational activities</td>
<td>• Interviews with administrators, staff members and guardians</td>
<td>• Long-lasting maintenance effects” (Glasgow, 2006)</td>
</tr>
<tr>
<td></td>
<td>• Planned or proposed changes, improvements, and future direction for recreational activities</td>
<td>• There is one Recreational Director, an Assistant Recreational Director and numerous recreational staff.</td>
</tr>
<tr>
<td></td>
<td>• Any necessary future evaluations on recreational activities</td>
<td>• Different recreational activities are offered, depending on the day, including dances, bingo, sports competitions, game rooms, computer rooms, movie rooms, outdoor activities, and, occasionally, though not with regularity, the opportunity to work out in the fitness center.</td>
</tr>
<tr>
<td></td>
<td>• Interviews and focus groups with residents</td>
<td>• Trend in interviews and focus groups from residents showed a need for increased offerings in structured activities.</td>
</tr>
<tr>
<td></td>
<td>• Interviews with administrators and staff members</td>
<td>• Trend in interviews and focus groups from residents showed a need for increased offerings in structured activities.</td>
</tr>
</tbody>
</table>

When asked which activity was preferred, the question was met with mixed and conflicting opinions from the questionnaires to what was vocalized in the focus groups and interviews of residents. In the questionnaires, eight of 31 residents, or 25.8 percent
noted that their favorite thing to do during recreational activities was hang out with their friends. However, during focus group and interviews, the residents seemed more varied in their responses, some wanting the time to spend with their friends and be independent, whereas others mentioned the need for increased structured activities.

**Research Question 3: According to the goals of the health program components, what are the various stakeholders’ perceptions on the effectiveness of the health program at Stewart Home & School?**

To answer the final research question on the effectiveness of each component of the health program, the evaluator designed questionnaires distributed to all stakeholders, asking questions regarding each component and if each component was achieving its specific goals. In addition to this, during the focus groups and interviews, the evaluator was able to elaborate on these to learn more about the stakeholders’ perceptions. Each component will be discussed separately, with the information from the questionnaires and other key data that were illuminated and repeated during focus groups and interviews utilized. The analysis of the questionnaire is broken down by stakeholder group, with the exception of staff members and administrators. For the purpose of easier analysis and because the data were very similar overall and less robust when separated, the staff and administrators’ responses to the questionnaire have been combined.

**Nutritional and Dietary Services**

Central to Stewart Home & School’s health program is the nutritional and dietary services offered. Given the recent changes in the services, the school has recognized the need for additional expertise in Creative Dining Services.
To determine the effectiveness of the nutritional program, the stakeholder’s feedback is combined. Figure 8 depicts a surprising difference in that 100 percent of staff and administrators agreed or strongly agreed that the food is cooked properly, fresh and is palatable and 95 percent of guardians agreed, whereas 84 percent of residents felt the same. While this is still overwhelmingly positive, this difference is noteworthy, particularly in regards to food, as the residents are the ones consuming it on a daily basis.

Figure 8. Questionnaire: Based on what I have tried and/or is reported to me by residents, Stewart Home & School’s food is cooked properly, fresh, and is palatable.
As Figure 9 depicts, 91 percent of guardians and 94 percent of residents agreed or strongly agreed that the food was nutritious, whereas slightly less staff and administrators, at 83 percent, answered the same.

Figure 9. Questionnaire: The food served at Stewart Home & School is nutritious.

Because Creative Dining Services had only been collaborating with Stewart Home & School for the past two years, this provided the opportunity for the evaluator to compare the nutritional program before Creative Dining Services’ involvement and after. As Figure 10 shows, residents felt that meals primarily consisted of fresh food, but even more so since Creative Dining Services’ collaboration.
Figure 10. Resident Questionnaire: The food at Stewart Home & School consists of meals with primarily processed foods or fresh food?

Figure 11 elaborates on the same topic, from the perspective of the staff, administrators, and guardians. All guardians, aside from the many that identified they did not have the knowledge to comment, and staff administrators felt that the food had improved.

Figure 11. Questionnaire: Since Creative Dining Services’ involvement, the food served at Stewart Home & School has improved.
Figures 10 and 11 are overwhelmingly positive and indicate that all stakeholders agreed that Creative Dining Services had improved the food. One of the focus groups for residents included an elaborate discussion of Creative Dining Services’ initial success, but more recent regression in food quality. However, all of the residents agreed that Creative Dining Services had continued to be an improvement.

**Pre-academic and Academic Curriculum: Fitness**

The fitness center’s goals involved providing both a cardiovascular and strength workout for the residents in order to encourage them to become more active. The residents’ questionnaire results, detailed in the previous section and in Figures 6 and 7, demonstrate that most residents worked out in the fitness center five times a week; in addition, residents primarily reported doing cardiovascular exercises, including walking the track, bicycling, and the treadmill. Only three of 31 residents, or 9.7 percent, reported lifting weights. Figure 12 reiterates this finding in that staff, administrators, and guardians unanimously ‘strongly agreed’ and ‘agreed’ that the fitness provided an adequate cardiovascular workout. Yet, Figure 13 illustrates that 100 percent of guardians ‘strongly agreed’ and agreed’ that the fitness center provided an adequate strength-building workout, whereas 17 percent of staff and administrators disagreed. This aligns with the findings that more residents reported doing cardiovascular exercises as opposed to strength training exercises.
Figure 12. Questionnaire: The fitness center provides a cardiovascular workout that adequately meets the physical fitness needs of the residents.

According to the stakeholders, as seen in Figure 14, the fitness center is effective in increasing a resident’s personal responsibility for maintaining his or her own health.

Figure 13. Questionnaire: The fitness center provides a strength-building workout that adequately meets the physical fitness needs of the residents.
Figure 14. Questionnaire: Because of the fitness class, the residents are more responsible for maintaining their health.

Overall, the stakeholders articulated that the fitness center was effective with cardiovascular exercise, but some indicated a need for additional strength-training workouts. With this being said, in Chapter II it was outlined that research indicates that the critical need for people with intellectual disabilities is to have aerobic activity with strength-training being secondary to it (United States Department of Health and Human Services, 2008). Therefore, though the responses were not quite as favorable for the strength-training program, research indicates that it is not as significant.

Pre-academic and Academic Curriculum: Health and Wellness

The health and wellness class offered to residents aimed to teach residents physical and emotional wellness independent of the class. Figure 15 shows that staff, administrators, and guardians, who were able to answer, all ‘strongly agree[d]’ and ‘agree[d]’ that the class taught nutrition and physical activity.
Aside from teaching those concepts, the class aimed to encourage residents to be more responsible for their own health. As Figure 16 indicates, the majority of staff and administrators, at 66 percent, guardians, at 64 percent, and residents, 74 percent, felt the class was effective. On the other hand, 17 percent of staff and administrators, four percent of guardians, and three percent of residents, disagreed that the class was effective in encouraging personal responsibility for one’s health.

*Figure 15.* Questionnaire: In the health and wellness class, residents learn about nutrition and physical activity.
According to the stakeholders, the health and wellness class effectively taught residents physical and emotional wellness. In addition, the majority of stakeholders felt that the class taught residents to maintain their health independently, though this remained the challenge of the class and an area for improvement.

Pre-academic and Academic Curriculum: Yoga

As the newest addition to Stewart Home & School’s health program, the goal of yoga was to teach residents specific relaxation techniques, flexibility, posture, and to
improve the self-confidence of the residents. The responses evaluating yoga indicated that the majority of residents and guardians and a significant percentage of the staff and administrators did not have enough knowledge about the yoga program. As Figure 17 demonstrates, all stakeholders, with knowledge of the program, ‘strongly agreed and ‘agreed’ that the class taught residents how to breathe properly.

![Circle chart showing responses of stakeholders regarding breathing]

Figure 17. Questionnaire: In yoga class, residents learn how to breathe properly.

In addition, Figure 18 demonstrates that all stakeholders, with knowledge of the yoga program, ‘strongly agreed’ and ‘agreed’ that yoga is effective in teaching residents to stretch.
Figure 18. Questionnaire: In yoga class, residents learn how to stretch.

Figure 19 illuminates that all staff, administrators, and guardians agreed that yoga was effective in teaching residents how to improve their posture; further, the majority of residents agreed, with seven percent disagreeing. Given the small sample size, this seven percent represents two residents.
Figure 19. Questionnaire: In yoga class, residents learn how to improve their posture.

As can be seen in Figure 20, all stakeholders indicated that the residents in yoga are more responsible for maintaining their health.
Figure 20. Questionnaire: Because of yoga class, residents are more responsible for maintaining their health.

Figure 21. Questionnaire: I feel more confident in myself, because of what I have learned in yoga class.

When asked the open-ended question of what specific things they learned from yoga, residents answered very similarly, as Figure 22 depicts.
Overall, those with experience with yoga class have indicated that the program is meeting its stated goals.

**Pre-academic Curriculum: Grooming**

Similarly to yoga, many stakeholders, mainly guardians and residents, indicated that they did not have knowledge of the grooming program. In fact, of the 31 residents who completed questionnaires, only one had ever had grooming class. Therefore, the residents’ questionnaires were excluded from this portion of the evaluation.

As depicted in Figure 23, those who indicated knowledge of the program agreed that grooming class teaches residents personal hygiene.
Figure 23. Questionnaire: In grooming class, residents learn personal hygiene.

Similarly, Figure 24 shows that grooming class had been effective in teaching residents their personal hygiene.

Figure 24. Questionnaire: Because of grooming class, residents learn personal hygiene.

Given that only one resident had knowledge of the grooming class and minimal guardians had knowledge of it, it was not discussed in their focus groups or interviews. The staff and administrators responded favorably in that the grooming class was meeting its objectives. The need for a grooming class in the academic program is apparent in the
lack of information, given the lack of stakeholder experience, and from administrator interviews.

**Pre-academic Curriculum: Physical Education**

The physical education class’ goal is to improve motor skills development and teach teamwork. While many stakeholders did not have knowledge of the physical education class, those that did, in Figure 25, indicated that the class was effective in teaching residents how to be a part of a team.

*Figure 25. Questionnaire: In physical education class, residents learn how to work as a member of a team.*
In addition, Figure 26 shows that stakeholders with knowledge all noted that the physical education class encouraged residents to be more responsible for maintaining their own health.

Figure 26. Questionnaire: Because of physical education class, residents are more responsible for maintaining their health.

It would benefit the evaluation and provide more feedback if more stakeholders had knowledge of the physical education class. However, those that did have knowledge of the program indicated that it is meeting its stated goals.

**Extracurricular Activities: Special Olympics**

The Special Olympics program aimed to encourage residents to be more physically active, to improve their level of activity, and to be more independent in their health and sharing their knowledge with others. As Figure 27 shows, the staff, administrators, and guardians all ‘strongly agreed’ and ‘agreed’ that Special Olympics improves residents’ physical fitness.
Figure 27. Questionnaire: By playing in Special Olympics sports, residents improve their physical fitness.

The majority of residents, guardians, staff, and administrators also have experienced that the Special Olympics program encourages responsibility for one’s health.
Figure 28. Questionnaire: Because of Special Olympics, residents are more responsible for maintaining their own health.
Figure 29 details that 75 percent of residents felt more confident in their abilities, as a result of playing a Special Olympics sport, with two residents, or 6 percent, disagreeing.

\[
\text{Residents}
\]

\[
\begin{array}{c|c|c|c|c|c}
& \text{Strongly agree} & \text{Agree} & \text{Disagree} & \text{Strongly disagree} & \text{Not applicable} \\
\hline
0\% & \text{19\%} & \text{39\%} & \text{6\%} & \text{0\%} & \text{19\%} \\
\hline
\end{array}
\]

*Figure 29. Questionnaire: By playing in a Special Olympics sport, I feel more confident in my abilities.*

Overall, the Special Olympics program has been met without critique. The program appeared to be meeting its stated goals, according to the stakeholders, and to be effectively involving a number of residents.

**Extracurricular Activities: Recreational Activities**

Stewart Home & School’s recreational activities program is perhaps the most significant time the residents have to practice autonomy and make their own choices while on-campus. Figure 30 indicates that staff, administrators, guardians, and the majority of residents ‘strongly agreed’ and ‘agreed’ that residents were able to choose what activities they wished to participate in during recreational activities, with seven percent of residents indicating that that had not been their experience.
Figure 30. Questionnaire: During recreational activities, residents are able to choose in which activities to participate.

Figures 31 and 32 demonstrate that guardians and residents have all experienced that recreational activities allow residents to manage their time and practice decision-making skills, whereas 67 percent of staff and administrators agreed, with 16 percent disagreeing.
Figure 31. Questionnaire: During recreational activities, residents learn how to manage time and practice decision-making skills.

Figure 32. Resident Questionnaire: During recreational activities, I learn how to manage time and practice decision-making skills.
Overall, the results from the questionnaires for recreational activities primarily indicate that the majority of stakeholders have found they are effective in meeting their stated goals of encouraging decision-making skills and time management. The focus groups illuminated the need for an increase in structured activities during recreational activities, while also maintaining the fundamental goal of recreational activities to allow residents to select which activities in which they wish to participate.

**Application of the Theory of Planned Behavior**

Given Stewart Home & School’s focus on the individual residents and tailoring the school to accommodate each resident, the theory of planned behavior was used to assess if the health program was teaching residents decision-making skills and, if so, if the residents were able to utilize those decision-making skills. The theory of planned behavior’s applicability for people with intellectual disabilities enabled the evaluator to apply it to the research process. Thus, during the design of the questionnaire and questions for the focus groups and interviews, this was taken into account. For example, in the questionnaire, stakeholders were asked about individual components and their effectiveness in increasing residents’ responsibility for maintaining their personal health.

In the questionnaire, stakeholders agreed that several components of the health program were effective in teaching residents to be more responsible for their own health. These successful components include fitness class, health and wellness class, yoga class, physical education class, and Special Olympics. Further, during focus groups and interviews, various stakeholders discussed the appreciation they had for Stewart Home & School’s focus on teaching ongoing lessons on health, its importance, and how to take responsibility for one’s health.
In both of the focus groups and in the interviews, residents and staff members discussed the need for residents to exercise decision-making skills regarding food selection. Because all meals were served to residents when they were on-campus, they were never given the opportunity to choose food for themselves. In an administrator’s interview, the administrator discussed the mentality of viewing meals off-campus as the opportunity to “splurge”. Therefore, when the residents were off-campus, they did not necessarily view these opportunities as ones to practice the skills they had learned in classes and elsewhere at Stewart Home & School, but as their opportunity to eat however they wish. The need for residents to exercise more informed decision-making in regards to what they eat is needed.

The purpose of recreational activities was perhaps most aligned, of all Stewart Home & School’s health program components, with the theory of planned behavior. After all, the goal of recreational activities was to allow residents to practice their decision-making skills and to manage their time. In questionnaires, the majority of all stakeholders found that the recreational activities program was effective in achieving these goals. However, during the resident focus groups, residents discussed the need for additional activities to be offered. With this being said, the majority of residents who responded to the questionnaire also answered that hanging out with their friends was their favorite activity. This could be because activities that they like are not being offered or because that is what they choose to do. Therefore, the recreational activities program needs to increase the structured activities that are offered, yet it must be done so in a manner that continues to allow residents to exercise their decision-making skills.
Stewart Home & School’s goal of allowing residents to choose as much about their lives as possible seems to be occurring and effective, for the most part. Most notably, Stewart Home & School needs to assess the nutritional and dietary services and investigate ways to allow residents to make additional decisions to reinforce their health teachings. Stewart Home & School has had success in many of the health program components through instilling lessons of independence and autonomy in the residents.

Chapter Summary

This chapter presented the results of the evaluation of Stewart Home & School’s health program. First, the stakeholders’ demographic information, as necessary, was analyzed through descriptive statistics. In addition, the RE-AIM framework was applied by analyzing the research findings for each health program component in order to answer the research questions about each health program and the implementation of each one. Then, the final research question was answered by applying the questionnaire results, along with data collected from observations, focus groups, and interviews, to determine the effectiveness of each component. Ultimately, the application of theory of planned behavior during the research process was discussed.
CHAPTER V

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

The fifth and final chapter will reiterate the purpose of the evaluation, discuss the research questions, and outline the research methods. The summary of findings is highlighted for each health program component, along with additional findings during the evaluation. Finally, limitations to evaluation, recommendations for future research and final conclusions are offered.

The evaluation was a process-based, internal program evaluation. While the evaluation identified the key components of the health program and evaluated the effectiveness of those programs, the evaluator had to first assemble the stated goals of each component, as Stewart Home & School did not have any of this information articulated or compiled. Upon further investigation through Stewart Home & School records and interviews with staff members and administrators, the goals for each program became clear. With these goals detailed, the evaluator assessed the effectiveness of each program based on the stakeholders’ perceptions with the assistance of the theory of planned behavior. This information was combined utilizing the RE-AIM framework to understand each component, its implementation, and, ultimately, its effectiveness. More specifically, RE-AIM assesses the reach, efficacy, adoption, implementation, and maintenance of each health program component.

With this framework in place, the evaluator had three primary research questions. The first question asked what the components of the health program were. Next, the evaluator sought to learn about the implementation of each component of the health program. Finally, the evaluator sought to learn if each health program component was
effective, based upon Stewart Home & School’s stated goals for it, according to feedback from stakeholders.

Four primary stakeholders were identified to include in the evaluation: residents, guardians of residents, staff members, and administrators. All of the stakeholders were asked to complete a questionnaire designed by the evaluator utilizing the theory of planned behavior. Observations were done in components with staff members and residents who consented to participate in the research process. Due to complications this introduced, such as additional staff members being present, the evaluator discussed specifics of each component with administrators to learn more about each one. In addition, the evaluator held two focus groups with residents. Following these focus groups, the evaluator held interviews with four staff members, two administrators, three guardians, and four residents. Upon gathering the information, the evaluator compiled descriptive statistics of the evaluation participants, coded the focus groups and interviews to find trends, and analyzed the questionnaires by stakeholder.

Overall, the purpose of this evaluation extends further than providing an evaluation of the current health program. Specifically, this evaluation attempts to provide a model for including people with intellectual disabilities in the research process. Further, the evaluation details a specific health program and, in doing so, portions of the health program may be generalizable to other health programs in different settings.

Summary of Results

After interviews with administrators and an analysis of Stewart Home & School’s records, the first research question was answered by identifying the key components of the health program. While many components could have been arguably included, only
those with the most relevancies and the most resident participation were included. These components included nutritional and dietary services, fitness classes, health and wellness classes, yoga classes, grooming classes, physical education classes, Special Olympics, and recreational activities.

Two years ago, Stewart Home & School’s nutritional and dietary services were taken over by Creative Dining Services. Creative Dining Services delivers three meals per day, based upon each resident’s diet program. Because each meal is prepared for the residents, they are not able to put their autonomy into practice in the selection of their meals.

The fitness class is offered to every resident in 45 minute increments and provides cardiovascular and strength-training workouts. The health and wellness class is offered to residents who select to include it as part of their course schedule. The 45 minute class period focuses on physical and emotional well-being to teach residents how to be independent. The yoga class offers a 45 minute session of stretching, poses and concludes with relaxation exercises. The grooming class is offered to residents in the pre-academic program and through hands-on lessons teaches personal hygiene and grooming. The physical education class is also offered for 45 minute periods as part of residents’ course schedule who are in the pre-academic program. The class teaches residents teamwork, hand-eye coordination, and requires residents to engage in physical activity. The Special Olympics program offers nine sports that residents can participate in through practices, games, and regional and state tournaments. Finally, the recreational activities program provides residents with the opportunity to select in what activity to participate and for what duration they would like to do so.
The final research question asked if the health program components were effective, according to the stakeholders. Through the data collection process, the evaluator found that, overall, the majority of stakeholders found the components of the health program to be effective. The majority of stakeholders agreed that the nutritional services provided nutritious, fresh, and palatable meals; in addition, the stakeholders also agreed that the quality of the food has improved with the involvement of Creative Dining Services. In addition, the fitness center was found to be providing a primarily cardiovascular workout that teaches residents to take ownership of their health; however, some stakeholders felt the strength-training program could be improved. Future evaluations may want to assess if the lack of strength-training is because the residents are hesitant to do this, or there is a lack of emphasis from the instructor, as this remains unclear. Further, the health and wellness class was found to be teaching about nutrition and physical activity and encouraging residents to put those skills to practice in their own lives. Overall, all informed stakeholders agreed that yoga class is achieving its goals of teaching flexibility, improving posture and proper breathing. Though the information on grooming was lacking as most participants reported a lack of knowledge of the class, both staff members and administration expressed a need for a grooming class offered to the academic program, as well. Further, the physical education class was found to be meeting its objectives of teaching teamwork, but the inconsistency of the teacher due to seasonal activities was clear during observations. The Special Olympics program was overwhelmingly felt to be achieving the goals of residents improving their physical fitness and instilling confidence in the residents. Stakeholders acknowledged the importance of recreational activities and the effectiveness of the program. However,
residents expressed the need for additional structured, but optional activities. Though the health program and its components can improve and needs were articulated, the overall consensus from all stakeholders was one of pride in Stewart Home & School’s current health program.

Additional Findings

One of the primary goals of this evaluation was one that was not listed in the research questions presented, but was more fundamental to the evaluation proposed. The evaluator attempted to do a research study that included people with intellectual disabilities of all levels, including mild, moderate and severe levels of disability. Further, the evaluator wished to create a model of research where people with intellectual disabilities were involved in every stage of the research process; in fact, people with intellectual disabilities were the only stakeholder group that were involved in each stage of data collection—observations, questionnaires, focus groups and individual interviews.

The challenge of this undertaking was ensuring that all of the data collected were accurate. The evaluator designed steps to help alleviate this concern. At the completion of each questionnaire, there were prompts requesting the evaluator to note the person with intellectual disabilities’ ability to complete it, document what assistance was required, and to articulate the degree to which the information was thought to accurately reflect the resident’s thoughts. Of the questionnaires, six were excluded due to invalidity, for example, the resident exhibited no response or immediate echolalia.

Throughout the process, the evaluator used the learning tools that allow for engagement, representation and expression as outlined by the guidelines in the Universal Design for Learning (National Center on Universal Design for Learning, 2014). The
evaluator used the Universal Design for Learning not only to collect data appropriately, but also to assess and evaluate the health program; in fact, the evaluator took these guidelines into account when collecting data, specifically in the questions asked during focus groups and interviews. In the engagement guidelines, Universal Design for Learning discusses optimizing autonomy (National Center on Universal Design for Learning, 2014). The evaluator took this into account when analyzing the data. After all, one of the most significant recommendations was to provide more autonomy for residents for their food selection. Further, the guidelines recommended providing alternatives for information, which was done in a variety of ways including reading aloud the questionnaire to the resident and documenting his/her answers, and utilizing visuals, as opposed to requiring the resident to respond verbally (National Center on Universal Design for Learning, 2014).

To expand upon the use of these tools, the evaluator found that the use of visual tools was especially successful. Many residents did not respond to the questionnaire answers with verbal responses, perhaps because they were unable or hesitant to do so, but were immediately able to indicate their responses by selecting visuals. In addition, many residents felt more comfortable with the questionnaire being read to them, while the evaluator documented their responses. This option was selected by the majority of residents. Overall, the evaluator strived to provide numerous alternatives and, in doing so, felt confident that the data included and used for the evaluation accurately expressed the residents’ opinions and experiences.

Further, the evaluator took additional measures to ensure that all residents felt that the evaluator’s transcriptions of the focus groups and interviews accurately reflected their
opinions. This occurred, by individually meeting with each resident who participated in the focus groups and/or interviews and reviewing all of the evaluator’s overall findings and trends of the focus group or interview. While all residents agreed with the findings, it also allowed for some of the residents to expand on their experiences with the health program components. Member checking for the other stakeholder groups was done during the interviews, by reiterating what the person said or the finding. However, it was necessary to be done individually and after the fact with the residents to ensure that they fully expressed their opinions, they were not influenced by other residents in the focus group, and it allowed them the opportunity to process the questions and discussion. Finally, and perhaps most importantly, member checking allowed the evaluator to ensure that the residents were coping with the information they shared in an appropriate way and did not feel any discomfort having expressed their experiences.

**Limitations**

While the holistic nature of the health program is a strength, it also presents an overall limitation. After all, the setting being evaluated was very unique, in that it was a residential program that provides classes. Because there are not many programs like it in the country, there are not many settings where it could be replicated. Thus, the evaluation was done by component, in the hopes that individual components may have generalizability in other settings.

When contacting guardians to complete consent forms on behalf of the residents, the evaluator received multiple questions regarding the residents’ abilities to participate. Rather than introduce any bias, the evaluator consistently explained the aim to include all disability levels and that participation was voluntary. Due to these questions, the
evaluator reasons that some guardians may not have felt their residents could contribute to the research process, given their level of disability and, thus, did not complete a consent form. Therefore, the resident participants with severe disabilities may have been underrepresented.

The most surprising part of the evaluation to the evaluator was the lack of response from staff members. While the evaluator was pleased with the number of guardians, residents, and administrators to participate in the evaluation, the same was not true for Stewart Home & School’s staff members. The staff members were contacted three times with the opportunity to participate and only four of the twelve staff members consented to participate. It is hypothesized that the evaluator being an employee, specifically an administrator, of Stewart Home & School contributed to this, along with the knowledge that the study was an evaluation of the health program. Though being an employee of Stewart Home & School afforded the evaluator with additional opportunities and knowledge, it may have impacted the staff member’s willingness to participate in the evaluation. The evaluator emphasized that it was not an evaluation of any individuals, but of the overall program, the staff members may have felt uneasy or uncomfortable by this particularly with the general connotation of the term evaluation. This impacted the evaluation because it limited the evaluator from doing observations. In the future, an outside evaluator could be utilized, at least to engage staff members, or other terminology could be utilized rather than the word evaluation to better illustrate the purpose of the research.
Recommendations for Future Research

Of primary purpose, the evaluator set out to do an evaluation about people with intellectual disabilities involving people with intellectual disabilities throughout the process. As discussed particularly in Chapter II, often people with intellectual disabilities are not involved and, if they are, only people with mild intellectual disabilities are included in the research process. This evaluation primarily hopes to dispel researchers of this practice and, rather, to encourage researchers and future evaluators to include people with all intellectual disabilities throughout the research process, by modifying the way in which they gather their research. Research that involves and truly includes the population being discussed will certainly be more fruitful and beneficial. This evaluation is richer, as a result.

In addition to the inclusion of people with intellectual disabilities in the research process, future evaluations could also benefit in utilizing the tools, frameworks, and research strategies that were used in this evaluation. For example, the evaluator has described ways to alter the research process and modify steps in the data collection process. In addition, the RE-AIM framework could be applied to other health programs without already developed evaluation frameworks.

For the purposes of this evaluation, the evaluator only assessed the health program for the residents between the ages of 18 and 40. Future research regarding health programs for people with intellectual disabilities of all ages, both younger, and older, would be beneficial. The trend of health programs for children was discussed in Chapter I. Therefore, the need for research is less for those under 18 and primarily for those over 40. Most notably, because people with intellectual disabilities are living much
longer than anticipated and have life-spans nearly as long as people without intellectual disabilities (Heller et al., 2002; Robinson et al., 2012), exploring health programs for people over 40 would be very helpful.

Further, for the purposes of this evaluation, the evaluator assessed each health program component broadly. It would be beneficial if, during future research, more information was gleaned about specific instruction materials and methods that are effective in teaching people with intellectual disabilities to take responsibility for their health. This would benefit other health programs whose goals are also to teach people with intellectual disabilities to be more independent.

Additionally, future research at Stewart Home & School should focus upon the outputs of the health program. As the logic model (Figure 4) detailed, this evaluation primarily focused upon the inputs and activities, rather than the outputs and outcomes. Future evaluations involving potential outputs and outcomes, such as focusing upon the residents’ specific health measures, such as body mass indexes, along with other key measures, could benefit the health program and help direct Stewart Home & School’s health program.

**Final Conclusions**

Overall, the stakeholder’s perceptions of Stewart Home & School’s health program were overwhelmingly positive. While occasionally individuals expressed dissatisfaction with a particular component’s ability to meet a stated goal, no stakeholder expressed overall disappointment with the program. The health program components appear to be meeting their stated goals, though several areas for improvement were noted. The most significant finding surrounds the residents’ lack of decision-making
opportunities in the nutritional program. This will allow the residents not only to exercise the skills they are learning elsewhere in the program, but also allow Stewart Home & School to meet its overall goals of providing a setting that allows residents to be as independent as possible.
Appendix A

Letter of Consent for Observations, Questionnaire, and/or Interview of Staff Members and Administrators

Consent to Participate in a Research Study

AN INTERNAL EVALUATION OF A HEALTH PROGRAM FOR ADULTS WITH MILD, MODERATE, AND SEVERE INTELLECTUAL DISABILITIES

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about Stewart Home & School’s health program. You are being invited to take part in this research study because of your involvement/knowledge of the health program. If you volunteer to take part in this study, you will be one of about 268 people (127 Stewart Home & School residents, 127 guardians/legally authorized representatives, 2 administrators, 12 staff members) to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Shelley Sellwood-Davis, a student in the University of Kentucky Department of Educational Policy Studies & Evaluation. She is being guided in this research by Dr. Kelly Bradley, her faculty advisor. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to evaluate the health program at the Stewart Home & School. By doing this study, we hope to learn if the most significant people both involved with and affected by the program are satisfied with the program. In no way will the results of the evaluation be used to individually evaluate specific individuals.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You should participate in this study only in you have involvement in (or oversee the involvement of) Stewart Home & School’s health program.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at Stewart Home School. The observations will take place while you are involved with the program in the natural setting. The
questionnaire should require no more than one hour to complete. You may need to visit the investigator in an office at Stewart Home & School for the focus group and/or interview. Each of these would take between 30 and 60 minutes. The total amount of time you will be asked to volunteer for this study is three hours (aside from observational time) over the next three months.

**WHAT WILL YOU BE ASKED TO DO?**

If you agree to be in this study, you may be observed, asked to complete a questionnaire, be included in a focus group or interviewed. The questionnaire, focus group, and interview will include questions about your experience with the program and your opinions on the program. The focus group will take roughly 60 minutes to complete; the interview will take roughly 30 minutes to complete. Both the focus group and the interview will be tape-recorded, unless is otherwise requested. If you participate in a focus group or an interview, you will be given the opportunity to provide feedback to ensure you were properly understood.

Every person who provides consent will be asked to complete a questionnaire and could be, if applicable, observed either administering or participating in the health program. From those who provide consent, a random sample will be done to determine who will be included in focus groups and/or interviews.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

**WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

You will not get any personal benefit from taking part in this study.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide not to take part in this study, your decision will have no effect on your position within Stewart Home & School or the quality of care, services, etc., received.

**IF YOU DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.
WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep confidential all research records that identify you to the extent allowed by law. We may be required to show information which identifies you to people who need to be sure we have conducted the research correctly; these people would be people from such organizations as the University of Kentucky.

We will keep all materials confidential to the furthest extent possible. Participants should understand that the researcher cannot guarantee confidentiality of information shared during the focus groups due to the inability to control other participants sharing information. The researcher will stress the importance of confidentiality with all focus group members.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. All data and audio recordings will be kept on a personal password protected computer or external hard drive, with reported identifiable data stored separately from other data in an encrypted password protected file. Paper records will be kept in a locked filing cabinet.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you or if they find that your being in the study is more risk than benefit to you.
WHAT ELSE DO YOU NEED TO KNOW?

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Shelley Sellwood-Davis at scse222@uky.edu or the faculty advisor, Dr. Kelly Bradley at kdbrad2@uky.edu. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8:00 a.m. and 5:00 p.m. EST, Monday through Friday at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

_________________________________________    ____________
Signature of person agreeing to take part in the study   Date

_________________________________________    ____________
Printed name of person agreeing to take part in the study

_________________________________________    ____________
Name of (authorized) person obtaining informed consent   Date
Appendix B

Letter of Consent for Guardians/Legally Authorized Representative to Complete to Provide Consent for Resident Observations, Questionnaire, Focus Group and/or Interview

Consent to Participate in a Research Study

AN INTERNAL EVALUATION OF A HEALTH PROGRAM FOR ADULTS WITH MILD, MODERATE, AND SEVERE INTELLECTUAL DISABILITIES

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about Stewart Home & School’s health program. You are being invited to take part in this research study because you serve as the guardian or legally authorized representative of a Stewart Home & School resident. The resident is being asked to participate in this study, because of his or her involvement in the health program. If you provide consent for your resident to participate in this study, he or she will be one of about 268 people (127 Stewart Home & School residents, 127 guardians/legally authorized representatives, 2 administrators, 12 staff members) to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Shelley Sellwood-Davis, a student in the University of Kentucky Department of Educational Policy Studies & Evaluation. She is being guided in this research by Dr. Kelly Bradley, her faculty advisor. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to evaluate the health program at the Stewart Home & School. By doing this study, we hope to learn if the most significant people both involved with and affected by the program are satisfied with the program. In no way will the results of the evaluation be used to individually evaluate specific individuals.

ARE THERE REASONS WHY THE RESIDENT SHOULD NOT TAKE PART IN THIS STUDY?

You should not provide consent for the resident to participate if he or she does not have involvement in Stewart Home & School’s health program.
WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at Stewart Home School. The observations will take place while the resident is involved with the program in the natural setting. The questionnaire should require no more than one hour to complete. The resident may need to visit the investigator in an office at Stewart Home & School to participate in the focus group and/or interview. Each of these would take between 30 and 60 minutes. The total amount of time the resident will be asked to volunteer for this study is three hours (aside from observational time) over the next three months.

WHAT WILL THE RESIDENT BE ASKED TO DO?

If you agree for the resident to be in this study, he or she may be observed, asked to complete a questionnaire, be included in a focus group or interviewed. The questionnaire, focus group, and interview will include questions about his or her experience with the program and his or her opinions on the program. The focus group will take roughly 60 minutes to complete; the interview will take roughly 30 minutes to complete. Both the focus group and the interview will be tape-recorded, unless is otherwise requested. If he or she participates in a focus group or an interview, he or she will be given the opportunity to provide feedback to ensure he or she was properly understood.

For research purposes, some medical information about the resident may be accessed, including the diagnosis of the resident.

Every person who provides consent will be asked to complete a questionnaire and could be, if applicable, observed either administering or participating in the health program. From those who provide consent, a random sample will be done to determine who will be included in focus groups and/or interviews.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things the resident will be doing will have no more risk of harm than the resident would experience in everyday life.

WILL THE RESIDENT BENEFIT FROM TAKING PART IN THIS STUDY?

The resident, nor you, will not get any personal benefit from taking part in this study.

DOES THE RESIDENT HAVE TO TAKE PART IN THE STUDY?

If you decide for the resident to take part in the study, it should be because you really want him or her to volunteer. He or she will not lose any benefits or rights he or she would normally have if you choose not to volunteer him or her. If you do provide
consent for the resident to participate, the resident will also be asked to sign an assent form, in order to participate.

You or the resident can stop participation at any time during the study and still keep the benefits and rights you had before volunteering. The resident will be notified of what the verbal and hand signals are to cease participation immediately. If you decide for the resident not to take part in this study, your decision will have no effect on your or the resident’s relationship with the Stewart Home & School or the quality of care, services, etc., received.

IF YOU AND THE RESIDENT DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you and the resident do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU AND THE RESIDENT TO PARTICIPATE?

There are no costs associated with taking part in the study.

WILL YOU AND/OR THE RESIDENT RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You and the resident will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT THE RESIDENT GIVES?

We will make every effort to keep confidential all research records that identify you or the resident to the extent allowed by law. We may be required to show information which identifies you or the resident to people who need to be sure we have conducted the research correctly; these people would be people from such organizations as the University of Kentucky.

Your and the resident’s information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You and the resident will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your and the resident’s name and other identifying information private.

We will keep all materials confidential to the furthest extent possible. Participants should understand that the researcher cannot guarantee confidentiality of information shared during the focus groups due to the inability to control other participants sharing information. The researcher will stress the importance of confidentiality with all focus group members.
We will make every effort to prevent anyone who is not on the research team from knowing that you or the resident gave us information, or what that information is. All data and audio recordings will be kept on a personal password protected computer or external hard drive, with reported identifiable data stored separately from other data in an encrypted password protected file. Paper records will be kept in a locked filing cabinet.

**CAN THE RESIDENT TAKING PART IN THE STUDY END EARLY?**

If you decide to provide consent for the resident take part in the study you and the resident still have the right to decide at any time that you or the resident no longer wants to continue. You and the resident will not be treated differently if you or the resident decides to stop taking part in the study.

The individuals conducting the study may need to withdraw the resident from the study. This may occur if the resident is not able to follow the directions given or if they find that the resident’s being in the study is more risk than benefit to the resident.

**WHAT ELSE DO YOU OR THE RESIDENT NEED TO KNOW?**

There is a possibility that the data collected from the resident may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you or the resident unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

**WHAT IF YOU OR THE RESIDENT HAS QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Shelley Sellwood-Davis at scse222@uky.edu or the faculty advisor, Dr. Kelly Bradley at kdbrad2@uky.edu. If you have any questions about the resident’s rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8:00 a.m. and 5:00 p.m. EST, Monday through Friday at 859-257-9428 or toll free at 1-866-400-9428. An extra copy of this consent form is enclosed for you to keep.
Name of person participating in the study (resident name)

Printed name of Guardian or Legally Authorized Representative

Signature of Guardian or Legally Authorized Representative  Date
Appendix C

Letter of Consent for Guardian/Legally Authorized Representative to Complete to Provide Consent for Their Own Participation for Questionnaire and/or Interview Consent to Participate in a Research Study

AN INTERNAL EVALUATION OF A HEALTH PROGRAM FOR ADULTS WITH MILD, MODERATE, AND SEVERE INTELLECTUAL DISABILITIES

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about Stewart Home & School’s health program. You are being invited to take part in this research study because you serve as the guardian or legally authorized representative of a Stewart Home & School resident and have knowledge of Stewart Home & School’s health program. If you participate in this study, you will be one of about 268 people (127 Stewart Home & School residents, 127 guardians/legally authorized representatives, 2 administrators, 12 staff members) to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Shelley Sellwood-Davis, a student in the University of Kentucky Department of Educational Policy Studies & Evaluation. She is being guided in this research by Dr. Kelly Bradley, her faculty advisor. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to evaluate the health program at the Stewart Home & School. By doing this study, we hope to learn if the most significant people both involved with and affected by the program are satisfied with the program. In no way will the results of the evaluation be used to individually evaluate specific individuals.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You should not participate if you do not have knowledge of Stewart Home & School’s health program.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at Stewart Home School. The questionnaire will be mailed to you and should require no more than one hour to complete. The interviews will occur in person, if possible, and over the phone, if more convenient. The
interviews should take no more than 60 minutes. The total amount of time you will be asked to volunteer for this study is two hours over the next three months.

**WHAT WILL YOU BE ASKED TO DO?**

If you agree to be in this study, you will be asked to complete a questionnaire and may be interviewed. The questionnaire and interview will include questions about your experience with the program and your opinions on the program. The interview will take roughly 30-60 minutes to complete. The interview will be tape-recorded, unless otherwise requested. If you participate in an interview, you will be given the opportunity to provide feedback to ensure you were properly understood.

Every person who provides consent will be asked to complete a questionnaire. From those who provide consent, a random sample will be done to determine who will be interviewed.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

To the best of our knowledge, the things you will be doing will have no more risk of harm than you would experience in everyday life.

**WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

You will not get any personal benefit from taking part in this study.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer.

You can stop participation at any time during the study and still keep the benefits and rights you had before volunteering. If you decide not to take part in this study, your decision will have no effect on your or the resident’s relationship with the Stewart Home & School or the quality of care, services, etc., received.

**IF YOU DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.

**WHAT WILL IT COST YOU TO PARTICIPATE?**

There are no costs associated with taking part in the study.
WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep confidential all research records that identify you to the extent allowed by law. We may be required to show information which identifies you to people who need to be sure we have conducted the research correctly; these people would be people from such organizations as the University of Kentucky.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. All data and audio recordings will be kept on a personal password protected computer or external hard drive, with reported identifiable data stored separately from other data in an encrypted password protected file. Paper records will be kept in a locked filing cabinet.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions given or if they find that your being in the study is more risk than benefit to you.

WHAT ELSE DO YOU NEED TO KNOW?

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?
Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Shelley Sellwood-Davis at scse222@uky.edu or the faculty advisor, Dr. Kelly Bradley at kdbrad2@uky.edu. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8:00 a.m. and 5:00 p.m. EST, Monday through Friday at 859-257-9428 or toll free at 1-866-400-9428. An extra copy of this consent form is enclosed for you to keep.

_________________________________________
Name of person participating in the study

_________________________________________    ____________
Signature of person participating in the study    Date
Appendix D

Assent Form for Residents for Questionnaires, Observations, Focus Groups, and/or Interviews

An Internal Evaluation of a Health Program for Adults with Mild, Moderate, and Severe Intellectual Disabilities

You are invited to be in a research study being done by Shelley Sellwood-Davis from the University of Kentucky. You are invited because you are a resident at Stewart Home & School.

If you agree to be in the study, you will be watched while you are in classes and participating in activities. You might be asked to answer questions on a survey, be involved in a group discussion with other residents of the school for no longer than sixty minutes or one hour, and/or you might be asked more questions individually by Shelley Sellwood-Davis for no longer than thirty minutes.

You will not receive any form of payment for participating in the study.

Your family or guardian will know that you are in the study. If anyone else is given information about you, they will not know your name. A number or initials will be used instead of your name.

If something makes you feel bad while you are in the study, please tell Shelley Sellwood-Davis immediately. If you decide at any time you do not want to finish the study, you may stop whenever you want.

You can ask Shelley Sellwood-Davis questions any time about anything in this study. You can also ask your family members or guardian any questions you might have about this study. Being in the study is up to you, and no one will be mad if you do decide now or later to not participate. You agree that you have been told about this study and why it is being done and what to do.
Appendix E

Resident Participation Protocol

Purpose: The primary objective is for all residents to be active participants throughout the research process. Therefore, the residents are the only stakeholders who are involved in each method of data collection (observations, questionnaires, focus group, and one-on-one interviews). In an effort to involve all people with intellectual disabilities, no residents (who fall within the stated age range) will be excluded from the research process.

Residents Involvement & Necessary Adjustments in Data Collection Process

All residents must first have consent forms that both they have completed and their guardian/closest relative have completed.

Observations: All residents (with stated consent) will be observed without exception.

Questionnaire: All residents (with stated consent) will be asked to complete the questionnaire. Prior to the completion of the questionnaire, homeroom teachers will be contacted and asked what additional assistance individual residents will require. Additional assistance that will be provided will include reading questionnaire allowed, transcribing responses for residents, providing questionnaire in a larger font, and any other assistance deemed reasonable that is requested.

Focus Group: Residents (with stated consent) will be randomly selected to participate in the focus groups. The primary/homeroom teacher of each resident will be consulted for any necessary accommodations. Such accommodations include the assistance of a staff member, ability to write responses (rather than share with focus group), utilizing a sign language interpreter, and any other assistance deemed reasonable that is requested.

One-on-one Interviews: Residents (with stated consent) will be randomly selected to be interviewed individually with the researcher. The homeroom teacher of each resident will be consulted for any necessary accommodations. Such accommodations include the assistance of a staff member, ability to write responses (rather than verbally reporting answers), utilizing a sign language interpreter, and any other assistance deemed reasonable that is requested.
Appendix F

Observation Guide

Health Program: ______________________________  Date: __________________

Time Began: _______________   Time Concluded: _______________

# of Instructors/Staff Members: ___________  # of Residents Present: ____________

Age Range of Residents: _______________________

Health related activity underway? YES NO

If yes, description of activity:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

If not, what was going on during the observation?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Engagement of residents in activity:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Additional Areas of Observation:

- Were all of the residents equally engaged in the activity underway?
- How active is the teacher/staff member in the activity? What is that person(s) role(s)?
- Overall implementation of specific program
- Any additional health information that is noteworthy (posters on wall, residents’ work, etc.)?

Following the observation:

Was the activity meeting any of the stated goals of the specific activity/class?
Appendix G

Resident Questionnaire

Please circle the answer that best shows your thoughts on Stewart Home & School’s health program.

How many times per week do you exercise in the fitness center?

0  1  2  3  4  5  6

How do you exercise in the fitness center? (Circle all that apply.)

Treadmill  Walking the track  Bicycle  Lifting weights  Not Applicable

The food served at Stewart Home & School tastes good and I enjoy eating it.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

The food served at Stewart Home & School is nutritious/healthy.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

Which better represents the food that Stewart Home & School served two years ago?

Meals with primarily processed food  (Food that is not fresh, such as from a can or food that has been frozen)  Meals with primarily fresh food
Which better represents the food that Stewart Home & School serves today?

Meals with primarily processed food  (Food that is not fresh, such as from a can or food that has been frozen)  Meals with primarily fresh food

During recreational activities, I am able to choose in which activities I want to participate.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

During recreational activities, I learn how to manage my own time.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

During recreational activities, I learn how to make my own decisions.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

What’s your favorite activity to participate in during recreational activities?

________________________________________________________________________
________________________________________________________________________

The following items refer to specific classes/activities. Only answer the questions, if you have taken the class/activity in the last year (if you can’t remember, ask and we will help).

Health & Wellness

In the health & wellness class, I have learned how to be healthier and take better care of myself.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

What have you learned in health and wellness class to live a healthier life?

________________________________________________________________________
________________________________________________________________________

Grooming

Before grooming class I had difficulties taking care of my personal hygiene (bathing myself, brushing my teeth, applying deodorant, brushing my hair).

Strongly Agree           Agree           Disagree          Strongly Disagree          Not Applicable

Since taking grooming class, I have learned how to take care of my personal hygiene (bathing myself, brushing my teeth, applying deodorant, brushing my hair).

Strongly Agree           Agree           Disagree          Strongly Disagree          Not Applicable

Because of grooming class, in which of the following ways have you improved the most?

Brushing teeth       Applying deodorant       Brushing hair       Bathing       Not Applicable

What specific things did you learn from the grooming class?

________________________________________________________________________
________________________________________________________________________
**Physical Education**

In the physical education class, I have learned how to work as a member of a team.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

What do you have to do work as a part of a team?

________________________________________________________________________
________________________________________________________________________

**Yoga**

In yoga class, I have learned how to breathe properly.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

In yoga class, I have learned how to stretch.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

In yoga class, I have learned how to improve my posture.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

I feel more confident in myself, because of what I have learned in yoga class.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>
What specific things did you learn from yoga class?

Special Olympics (Soccer, Basketball, Flag Football, Track, Swimming, Softball, Bowling, Golf, Cheerleading, Tennis)

In what Special Olympics sport(s) do you participate? (Circle all that apply.)

- Soccer
- Basketball
- Flag Football
- Track & Field
- Softball
- Swimming
- Bowling
- Golf
- Cheerleading
- Tennis

By playing in a Special Olympics sport, I feel more confident in my abilities.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

Because I play in a Special Olympics sport, I feel healthier.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

**To be completed by staff member, if resident needed assistance completing questionnaire:**

What assistance was needed for the resident to complete the questionnaire?

I am confident that the answers accurately reflect the resident’s opinions and experiences of the health program?

Strongly Agree  Agree  Disagree  Strongly Disagree
Appendix H

Staff/Administrator/Guardian Questionnaire

Please circle the answer that best describes your opinion of Stewart Home & School’s health program.

The fitness center provides a cardiovascular workout that adequately meets the physical fitness needs of the residents.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

The fitness center provides a strength-building workout that adequately meets the physical fitness needs of the residents.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

Because of the fitness class, the residents are more responsible for maintaining their health.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

Based on what I have tried and/or is reported to me by residents, SH&S’s food is cooked properly, fresh, and is palatable.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

The food served at Stewart Home & School is nutritious.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

Since Creative Dining Services’ involvement, the food served at Stewart Home & School has improved.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable

The following items refer to specific classes/activities. Only answer the questions, if you have specific experience with the class/activity. If you do not have knowledge of the class/activity, please circle Not Applicable.

During recreational activities, the residents are able to choose in which activities to participate.

Strongly Agree       Agree       Disagree       Strongly Disagree       Not Applicable
During recreational activities, residents learn to manage time and practice decision-making skills.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

**Health & Wellness**

In the health & wellness class, residents learn about nutrition and physical activity.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

Because of the health & wellness, residents are more responsible for maintaining their health.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

**Grooming**

In grooming class, residents learn how to do their personal hygiene.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

Because of grooming class, residents are more responsible for maintaining their health.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

**Physical Education**

In physical education class, residents learn how to work as a member of a team.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

Because of physical education class, residents are more responsible for maintaining their health.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

**Yoga**

In yoga class, residents learn how to breathe properly.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable

In yoga class, residents learn how to stretch.

Strongly Agree  Agree  Disagree  Strongly Disagree  Not Applicable
In yoga class, residents learn how to improve their posture.

*Strongly Agree*   *Agree*   *Disagree*   *Strongly Disagree*   *Not Applicable*

Because of yoga class, residents are more responsible for maintaining their health.

*Strongly Agree*   *Agree*   *Disagree*   *Strongly Disagree*   *Not Applicable*

**Special Olympics** (Soccer, Basketball, Flag Football, Track, Swimming, Softball, Bowling, Golf, Cheerleading, Tennis)

By playing in Special Olympics sports, residents improve their physical fitness.

*Strongly Agree*   *Agree*   *Disagree*   *Strongly Disagree*   *Not Applicable*

Because of Special Olympics, residents are more responsible for maintaining their health.

*Strongly Agree*   *Agree*   *Disagree*   *Strongly Disagree*   *Not Applicable*
Appendix I

Resident Focus Group Protocol

1. Let’s talk about health. What does health mean?

2. How does Stewart Home & School try to keep you healthy?

3. In what activities/classes are you involved?
   a. As specific activities are named, ask what the purpose/point of those classes/activities is.
   b. What have you learned in those classes/activities?
   c. Which activities/classes do you like the most?
   d. Which help you learn the most about how to take care of yourself and be healthy?

4. We’ve talked about the components of the health program, what other health related classes or activities could Stewart Home & School add that you would like to take or be involved with?

5. What could be better about the health program at Stewart Home & School?
Appendix J

Resident Interview Protocol

1. How long have you been a resident at Stewart Home & School?

2. What do you think of Stewart Home & School’s health program?

3. What kinds of activities and classes focus on health?

4. Which of those have you participated in?

5. Which of those activities/classes did you like?
   a. What did you do in those classes/activities that helped you learn the most about how to be healthy?

6. Which programs could be better? How so?

7. Do you think you are healthier now than you were before you became a resident at Stewart Home & School?
Appendix K

Administrator Interview Protocol

1. Please tell me about your role at Stewart Home & School.

2. What do you see as the goal of Stewart Home & School’s health program?

3. What components does Stewart Home & School’s health program include? What areas/classes/activities are involved?

4. What areas of the health program are the most difficult to achieve?

5. What do you see as the weaknesses of Stewart Home & School’s health program?

6. What are the greatest strengths of Stewart Home & School’s health program?

7. How do you see Stewart Home & School’s health program improving/expanding in the future?
Appendix L

Guardian Interview Protocol

1. Please tell me about ___________ (insert name of resident) at Stewart Home & School.
   a. How long has he or she been at Stewart Home & School?

2. For your resident, what does Stewart Home & School offer for his/her health?
   Both in providing for it and teaching residents how to manage their own health.

3. What components does Stewart Home & School’s health program include? What areas/classes/activities are involved?
   a. In which areas is your resident involved?
   b. If time, discuss specific strengths and weaknesses of those components.

4. What do you hope ___________ (insert name of resident) will learn about health at Stewart Home & School?

5. What are the weaknesses of the current health program at Stewart Home & School?

6. What are the greatest strengths of Stewart Home & School’s health program?

7. How would you like to see Stewart Home & School’s health program expand?

8. What additional offerings could most benefit the residents?
Appendix M

Staff Interview Protocol

1. Tell me about __________ (the health component of the health program) that you are responsible for. (for example, the fitness center)
   a. How long have you been in this role?
2. What do you see at the goal of __________ (the health component that you are responsible for)?
3. What are the challenges in achieving that/those goal(s)?
4. What improvements could be made to make that/those goal(s) more achievable and to better serve the health of the residents?
5. If time allows: what improvements could be made to other components of the health program?
Appendix N

Resident Questionnaire Visuals

STRONGLY AGREE          AGREE

DISAGREE               STRONGLY DISAGREE
References


Caton, S., Chadwick, D., Chapman, M., Turnbull, S., Mitchell, D., & Stansfield, J.


a fitness and health education program on adults with down syndrome. American Journal on Mental Retardation, 109(2), 175-185.


Promotion, 21, 2–12.


Vita

Shelley C. Sellwood-Davis

Educational Institutions Attended and Degrees Awarded

University of Kentucky  Masters of Public Administration, Nonprofit Management
  May 2011

Hanover College  Bachelor of Arts, Sociology, Theology
  May 2008

Professional Positions

August 2012 – Present  Assistant Director
  Stewart Home & School

September 2011 – July 2012  U.S. Peace Corps Volunteer
  Macedonia

June 2010 – August 2011  Communications Coordinator
  Kentucky Nonprofit Network

August 2009 – June 2010  AmeriCorps Educator
  Franklin County High School

Awards

2011  Martin School Graduate Ceremony Student Speaker

2008  Henry C. Long Citation for Scholarship and General Excellence

2008  Recipient of the J. P. Endowment Award for Student Publishing

Selected Presentation