

OMB Approval No.: 0980-0162

Expiration Date: pending

**AR State Council for Department of Disabilities**

**Five Year State Plan**

**For Year 2017**

AR State Council for Department of Disabilities

**Identification**

\* - Required field

Part A: State Plan Period: **10-01-16 through 09-30-21**

Part B: Contact Person: **Eric Munson**

Contact Number: **5016822912**

Contact Email: **eric.munson@dfa.arkansas.gov**

PART C: Council Establishment

Date of Establishment: **07-30-15**

Authorization Method: **Executive Order**

Authorization Citation: **EO 15-19**



**Council Membership [Section 125(b)(1)-(6)]**

\* - Required field

**Council Membership Rotation Plan \***

Council members are eligible to consecutively serve two (2) five (5) year terms. Upon completion of these two, consecutive terms, a Council member will be eligible for another appointment after an absence of one (1) year. State Agency representatives serve "at the will of the Governor" and have terms that do not have expiration dates. Council members who were appointed to "fill" a previous appointee's term are eligible to complete the service of their predecessor and they remain eligible to serve an additional appointment of 2 consecutive 5 year terms.

Agency/Organization	Gender	Geographicals
<ul style="list-style-type: none"> <li>• Rehab Act : A1</li> <li>• IDEA : A2</li> <li>• Older Americans Act : A3</li> <li>• SSA, Title XIX : A4</li> <li>• P&amp;A : A5</li> <li>• University Center(s) : A6</li> <li>• NGO/Local : A7</li> <li>• SSA/Title V : A8</li> <li>• Other : A9</li> <li>• Individual with DD : B1</li> <li>• Parent/Guardian of child : B2</li> <li>• Immediate Relative/Guardian of adult with mental impairment : B3</li> <li>• Individual now/ever in institution : C1</li> <li>• Immediate relative/guardian of individual in institution : C2</li> </ul>	<ul style="list-style-type: none"> <li>• Male : M</li> <li>• Female : F</li> <li>• Other : O</li> </ul>	<ul style="list-style-type: none"> <li>• Urban : E1</li> <li>• Rural : E2</li> </ul>
	<b>Race/Ethnicity</b>	
	<ul style="list-style-type: none"> <li>• White, alone : D1</li> <li>• Black or African American alone : D2</li> <li>• Asian alone : D3</li> <li>• American Indian and Alaska Native alone : D4</li> <li>• Hispanic/Latino : D5</li> <li>• Native Hawaiian &amp; Other Pacific Islander alone : D6</li> <li>• Two or more races : D7</li> <li>• Race unknown : D8</li> <li>• Some other race : D9</li> <li>• Do not wish to answer : D10</li> </ul>	

Council Members										
First Name	Last Name	MI	Gender	Race/Ethnicity	Geographical	Agency/Organization Code/Citizen Member Representative	Agency/Organization Name	Appt Date	Appt Expired Date	Alt/Pr for St Agen Rep Name
Craig	Cloud		M	D1	E1	A3	Division of Aging & Adult Services, Arkansas Department of Human Services	12-01-15	12-01-99	
David	Deere		M	D1	E1	A6	Partners for Inclusive Communities, University of Arkansas	12-01-15	12-01-19	
Katherine	Donoven		F	D1	E1	B2		12-01-15	12-01-16	
Syard	Evans		F	D1	E1	A9	Arkansas Support Network	12-01-15	12-01-20	
C.W.	Gardenhire		M	D1	E2	B2		12-01-15	12-01-19	
Mark	George		M	D1	E1	B2		12-01-15	12-01-19	
Ke'Arus	Henderson		M	D2	E1	B1		12-01-15	12-01-17	
Kasey	Hodges		F	D1	E1	B1		12-01-15	12-01-20	
Carrie	Hollis-Anthony		F	D1	E2	A7	First Step, Inc.	12-01-15	12-01-17	
Kimberly	Horton		F	D1	E2	B2		12-01-15	12-01-17	
Chris	Johnson		M	D1	E1	B2		12-01-15	12-01-18	
Ludwick	Koslowski		M	D1	E1	B1		12-01-15	12-01-19	
Tom	Masseau		M	D1	E1	A5	Disability Rights Arkansas	12-01-15	12-01-20	
Alan	McClain		M	D1	E1	A1	Arkansas Rehabilitation Services	12-01-15	12-01-99	
Annette	Mencer		F	D1	E1	B2		12-01-15	12-01-19	
Rhonda	Saunders		F	D1	E1	A2	Arkansas Department of Education Special Education Division	12-01-15	12-01-99	none
Andrea	Reaves		F	D1	E1	B1		12-01-15	12-01-20	
Christopher	Tebbetts		M	D1	E2	B1		12-01-15	12-01-17	
Maria	Villagran		F	D5	E1	B2		12-01-15	12-01-16	
Stacey	Sebree		F	D1	E1	B2		12-01-15	12-01-18	
Judy	Watson		F	D1	E1	C2		12-01-15	12-01-16	
Toni	Roy		F	D1	E1	A4	Division of Medical Services, Department of Human Services	12-01-15	12-01-99	none
Melissa	Stone		F	D1	E1	A8	Developmental Disabilities Services, Department of Human Services	12-01-15	12-01-99	none

**Council Staff [Section 125(c)(8)(B)]**

\* - Required field

Disability data of Council staff will be collected. Response is voluntary and information shared will be kept confidential and serve for data purposes only. Self-identification of disability will be captured in the following manner:

**Race/Ethnicity**

- White, alone : D1
- Black or African American alone : D2
- Asian alone : D3
- American Indian and Alaska Native alone : D4
- Hispanic/Latino : D5
- Native Hawaiian & Other Pacific Islander alone : D6
- Two or more races : D7
- Race unknown : D8
- Some other race : D9
- Do not wish to answer : D10

**Disability Options**

- Yes : Y
- No : N
- Does not wish to answer : DWA

**Gender**

- Male : M
- Female : F
- Other : O

Council Staff								
Position or Working Title	FT	PT	Last Name of person in position	First Name of person in position	MI	Gender	Race/Ethnicity	Disability
Executive Director	<input checked="" type="radio"/>	<input type="radio"/>	Munson	Eric		M	D1	N
Business Operations Specialist	<input checked="" type="radio"/>	<input type="radio"/>	Lewellen	Assiah		F	D1	N
Program Planner/Manager	<input checked="" type="radio"/>	<input type="radio"/>	Wilson	Diana		F	D1	N

**The Designated State Agency [Section 125(d)]**

\* - Required field

**The DSA is \***Council Itself  Other Agency Agency Name **Department of Finance & Administration**DSA Official's name **Larry W. Walther, Director**Address **1509 West 7th Street, 4th floor**Phone **501-682-2242**Fax **501-682-1029**Email **larry.walther@dfa.arkansas.gov****Direct Services [Section 125(d)(2)(A)-(B)]**

Does it provide or pay for direct services to persons with developmental disabilities?

Yes  No **DSA Roles and Responsibilities related to Council [Section 125(d)(3)(A)-(G)]****Describe DSA Roles and Responsibilities related to Council \***

Serve as financial point of contact, provide fiscal support and perform the role of disbursing agent; ensures proper fiscal controls are in place and utilize fund accounting procedures as prescribed by the State and DHHS Secretary for accurate tracking, reconciliation and reporting of federal payments, and track and report non federal match in accordance with federal requirements; submit financial reports as deemed necessary by Council and the federal agency; assist with other fiscal support duties as mutually agreed upon by the parties.

**Memorandum of Understanding/Agreement [Section 125(d)(3)(G)] \***

Does your Council have a Memorandum of Understanding/Agreement with your DSA?

Yes  No 

Calendar Year DSA was designated [Section 125(d)(2)(B)]\* 12-31-69



## State Information

\* - Required field

Racial and Ethnic Diversity of the State Population	
Race/Ethnicity	Percentage Of Population
White, alone*	71.3 %
Black or African American alone*	16.6 %
Asian alone*	1.2 %
American Indian and Alaska Native alone*	0.6 %
Hispanic or Latino (of any race)*	7.9 %
Native Hawaiian & Other Pacific Islander alone*	0.2 %
Race unknown*	0 %
Two or more races *	2.2 %
Some other race*	0 %
Do not wish to answer*	0 %

Poverty Rate\* 18.7%

### State Disability Characteristics

\* - Required field

#### Prevalence of Developmental Disabilities in the State\*

**Explanation\*** The prevalence of "mental retardation" and closely related developmental disabilities was determined to be 1.58% of the general population based on the National Health Interview Survey-Disability Supplement (NHIS-D). This analysis reported an "MR only" prevalence rate of 0.78% for all ages, and prevalence for persons with MR and DD over 18 years of age of 7.9 per 1,000 (0.79%) (p. 244). This rate is used in the "State of the States in Developmental Disabilities", which states there are 4.7 million people with intellectual and developmental disabilities in the U.S.

Residential Settings*					
Year*	Total Served*	A. Number Served in Setting of 6 or less (per 100,000)*	B. Number Served in Setting of 7 or more (per 100,000)*	C. Number Served in Family Setting (per 100,000)*	D. Number Served in Home of Their Own (per 100,000)*
2013	6746	137.067	90.905	69.074	21.391
2012	6812	137.159	94.129	66.223	17.429

## Demographic Information about People with Disabilities

\* - Required field

People in the State with a disability	Percentage
Population 5 to 17 years	6.7%
Population 18 – 64 years	15%
Population 65 years and over	42.6%

Race and Ethnicity	Percentage
White alone	17.3%
Black or African American alone	17%
American Indian and Alaska Native alone	24.6%
Asian alone	5.4%
Native Hawaiian and Other Pacific Islander alone	21.5%
Some other race alone	6%
Hispanic or Latino (of any race)	5.4%
Two or more races	16.5%
Do not wish to answer	5.4%

Educational Attainment Population Age 25 and Over	Percentage with a disability	Percentage without a disability
Less than high school graduate	24.7%	11.6%
High school graduate, GED, or alternative	38.7%	33.2%
Some college or associate's degree	26%	30.2%
Bachelor's degree or higher	10.6%	24.9%

Employment Status Population Age 16 and Over	Percentage with a disability	Percentage without a disability
Employed	20.2%	64.2%
Not in labor force	76.4%	31.6%

<b>Earnings in Past 12 months Population Age 16 and Over with Earnings</b>	<b>Percentage with a disability</b>	<b>Percentage without a disability</b>
Earning \$1 to \$4,999 or less	18.2%	11%
Earning \$5,000 to \$14,999	22.7%	16.7%
Earning \$15,000 to \$24,999	17.3%	18.3%
Earning \$25,000 to \$34,999	12.4%	15.7%

<b>Poverty Status Population Age 16 and Over</b>	<b>Percentage with a disability</b>	<b>Percentage without a disability</b>
Below 100 percent of the poverty level	23.1%	15%
100 to 149 percent of the poverty level	16.1%	10.6%
At or above 150 percent of the poverty level	60.7%	64.9%

**Portrait of the State Services [Section 124(c)(3)(A)(B)]**

\* - Required field

**Health/Healthcare \***

Access to health insurance is one of the most positive aspects of services for individuals with intellectual and developmental disabilities (I/DD) in Arkansas. Yet, health outcomes for the group continue to be problematic.

Access to health care is more than a simple function of having insurance. According to data from the Centers for Disease Control and Prevention (CDC), 98.2% of people age 18-44 who have a disability have health insurance, while 95% of their peers without a disability have health insurance. Yet the same report notes that 53% of those with a disability were prohibited by cost from seeking medical care, while only 20.6% of those without a disability couldn't seek care because of cost. It is easy to underestimate the role of deductibles, co-pays, and transportation costs on access to care.

While 65.3% of persons age 45-64 who have a disability report having poor to fair health, only 12.0% of their non-disabled peers report that status. People with disabilities are more likely to have chronic conditions or unhealthy lifestyle choices when compared with their non-disabled peers. They are more likely to be obese (45.8% versus 31.3) and to smoke (33.3% versus 20.7%). They are also less likely to meet guidelines for aerobic and muscle strengthening exercise (12.4% versus 20.1% for age 18-44 and 5.5% versus 12.7% for age 45-64). The same trends hold true for mental and emotional health with 52.7% versus 14.5% of 18-44 year-olds reporting ever being depressed, along with 50.4% versus 13.8% of 45-64 year-olds and 26.6% versus 10.4% of those over 65. One bright spot for health behaviors of people with disabilities is binge drinking, with 9.4% of people with disabilities reporting that behavior compared with 14.9% of those without disabilities.

When looking at health care coverage by race, one finds that fewer people who are white with disabilities (67.2%) have coverage than do people who are black with disabilities (73.4%) or multirace (88.9%). No data was given for Hispanics. In spite of this data, people with disabilities who are multirace report having poor to fair health more frequently (54%) than do people who are black (52%) or white (49.1%).

There are many specialized health care services for children with disabilities offered at Arkansas Children's Hospital (ACH) and at their outreach clinics in northwest Arkansas. There are fewer such options for adults. One bright spot on that front is a relatively new genetics clinic at University of Arkansas for Medical Sciences (UAMS). Not only do they provide clinical services to adults with Down syndrome and other genetic conditions, but they also work to address a wide range of social and emotional needs of the patients.

The state Title V Children's Services agency provides case management, specialized medical care and rehabilitation services for children and youth with special health care needs. Their services include medical and surgical treatment, therapies, appliances, medications, and care coordination. This program is the only payment source for a number of Hispanic families, who do not qualify for other government programs. When these youth reach adulthood, they often have no way to pay for their services.

Mental health services are often accessed through the system of community mental health centers. These centers, which serve every county in the state, are operated by community-based organizations that are monitored by the state. They are partially funded by through federal funds and provide services on a sliding fee scale. Additionally, there are a number of private providers through which persons may receive services.

The Division of Behavioral Health Services is the agency that monitors the organizations that operate the Community Mental Health Centers. They have initiated a system of care approach to providing services to children and adolescents with mental illness. This approach expects the family or adolescent to be the key person on the care team, along with the professionals. It also seeks to integrate all of the services the person receives, whether or not that services is identified as a mental health therapy. It seeks to include therapists, along with school personnel, church leaders, rehabilitation counselors, and others involved with the child.

Other collaborative health care initiatives include the Crime Victims with Disabilities Project, a program facilitated through Arkansas's UCEDD; Women Be Healthy, a program that trains providers to instruct women with mild to moderate intellectual disabilities about health and breast and cervical cancer screenings and promotes the active participation of women in their healthcare choices; and healthy lifestyles classes that are designed to help people with disabilities to be able to make healthy choices.

As is the case in many other states, autism has gained a more prominent role in the service system. According to the Autism and Developmental Disabilities monitoring program at the CDC, the autism spectrum disorder (ASD) prevalence in AR is 1:65 (1:40 for boys and 1:172 for girls) affecting approximately 4800 children in the state (CDC, 2014). Several programs have been developed to meet the service needs of children with autism. Autism Speaks has funded a site of the Autism Treatment Network at UAMS/ACH, which provides assessments and follow-up care for children and adolescents with ASD. Through the Autism Integration Grant, UAMS is working to coordinate services for children with autism and to train providers through the Community-based Autism Liaison and Treatment (CoBALT) program and the Extension for Community Healthcare Outcomes (ECHO) program. CoBALT trains teams of health care providers to be able to diagnose or rule out ASD. While the wait time is still long for an assessment, CoBALT has reduced the average wait time by three months. ECHO uses videoconferencing to provide education, training, and engagement opportunities for primary health care providers concerning autism. While these two programs are focused on health care providers, their patients will be the ultimate beneficiaries. The Arkansas Autism Partnership provides intensive interventions for children with autism, who are under age seven. That program is limited to serving no more than 100 children at any given time. Unfortunately, much work needs to be done on the adult service side for people with autism. Among other needs, adults with autism report desiring more social interactions and employment opportunities.

Fetal alcohol spectrum disorders (FASDs) are a set of conditions with similar impact, but with much less recognition by society or even the medical community. Alcohol exposed pregnancies can result in significant neurological deficits, which can lead to problems with cognition and/or behavior. Recent studies show that FASD occurs in 2.4% to 4.8% of the population, making it likely the most common

developmental disability. Even though it is quite common, it is seldom diagnosed. Many students being served in public schools under the severe emotional disturbance category, youth in the juvenile justice system, and adults in prison have undiagnosed FASD. The Division of Children and Family Services has established a program to provide supports to the children they serve, who have FASDs. There are few other systems in place to address the state's needs regarding prevention, diagnosis, treatment, and supports for persons with an FASD. There has been limited training about the condition through a grant from the CDC and a community-based organization is organizing to help establish services.

Participants in community meetings and focus groups identified a number of concerns related to health care that fall into three major areas.

(1) Arkansas needs more clinical services many areas of the state. While services are good in central and northwest Arkansas, other areas often have limited specialists and therapists. For example, an eight county region doesn't have a single pediatrician. Services for patients over age 21 was noted as a particular need. Making greater use of satellite offices, telemedicine, and therapy assistants were identified as possible ways to address some of the shortages.

(2) A second need identified was to have better communication, marketing of programs, and education about services. The participants felt that both families and health professionals lack adequate knowledge of programs in the state. They want help with understanding waiver programs, the Affordable Care Act, Community First Choice Option, and eligibility assessments. Better communication among health professionals and between health professionals, I/DD providers and patients/families was requested. They also desire better promotion of fitness programs.

(3) Mental health services need to be strengthened. Participants identified the need to improve access to mental health services, as well as making mental health services more appropriate for people with I/DD and better integrating those services with their DD services. Mental health care in nursing homes was specifically cited as needing improvement.

### **Employment \***

Among persons without disabilities aged 18 to 64, 72.7% are employed (51.4% were full-time). Conversely, 28.2% of people with disabilities in the same age group are employed (16.6% were full-time). The employment gap between people with and without disabilities increased 3.2% between 2010 and 2011. The disparity between employment for people without disabilities and for people with disabilities is the seventh greatest in the country. For people receiving SSI, 80% never have a job during their lifetime and receive an average of \$500,000 in payments over their lifetime. The total expenditure of benefits for people with disabilities in 2012 was \$1,951,608,000. Failure to employ persons with disabilities not only cost taxpayers to provide benefits, but also reduces the quality of life for the individual. More than any other factor, employment has a positive effect on quality of life and health outcomes. It is the ticket out of poverty for many with disabilities. Hispanic and Marshallese participants in focus groups noted that language barriers make finding work more difficult than it would be otherwise.

Arkansas continues to operate a number of sheltered workshops, where workers receive very limited pay for the work that they do, often being paid per item produced. According to the 2015 State of the States in Developmental Disabilities report, Arkansas served 97 persons in supported employment, which is 8% of the total DD workforce. The state's expenditures for supported employment were less than 1% of the total amount spent for services for persons with IDD.

Current practices often look at the individual's deficits and determine that they have a disability that is too severe to work or that the person is not ready to work. Data reveals that there is a \$1.5 billion cost benefit from individuals who are in supported or integrated employment. A majority of states are working on a policy that says employment should be the first option for individuals with developmental disabilities. These policies indicate that all people with disabilities shall be afforded full, unrestricted opportunities to pursue gainful employment regardless of level of disability. Arkansas was an early adopter of an Employment First policy.

The state agencies with lead responsibility for employment of people with disabilities are Arkansas Rehabilitation Services (ARS) and the Division of Workforce Service. They also work with a number of private sector employers who are looking at hiring workers with I/DD. A group of employers in northwest Arkansas are working to establish a chapter of the U.S. Business Leaders Network. In 2012, ARS received 8,533 general applications and 591 applications from persons who are blind. They helped obtain 2,933 jobs for people with disabilities.

Both northwest and central Arkansas have Project SEARCH sites. Project SEARCH is a one-year internship program for individuals with developmental disabilities who desire sustainable, competitive employment. Project SEARCH provides real-life work experiences combined with training in employability and independent living skills.

Arkansas has one of six PROMISE grants that focuses on post-secondary employment of students who receive SSI. Arkansas PROMISE is a research project open to 2000 youth ages 14 to 16 who currently receive SSI benefits. For 1000 of the youth, PROMISE will provide additional services to youth and their families to support their education and career goals. Services include: intensive case management, two paid competitive work experiences, education and employment training and support for youth and families, health and wellness training, and benefits counseling. The study will determine if the services provided can increase the number of youth who become employed.

Community meetings and focus groups produced a number of recommendations to improve employment outcomes. Ending sheltered workshops was strongly endorsed. A number of ideas focused on developing competitive employment opportunities. These included outreach to business owners to help them see the value persons with disabilities bring to the work site. They suggested that this might be accomplished by working through Chambers of Commerce and by spotlighting model employers. Other recommendations focused on things such as supported employment and recruiting more job coaches and giving them more training. Other suggestions centered around skills training for people with disabilities that is more targeted to current job skills that are needed and thinking of jobs other than ones traditionally earmarked for people with disabilities. Some participants commented on youth

employment and transitioning from school to work. They suggested that there be more internships and job placements that begin earlier. They wanted to see better education about programs that support employment, such as WIOA, Ticket to Work, and tax incentives. They cited a connection between employment and transportation to work. A number of families are starting businesses in which their children with I/DD can be employed along with others with I/DD and with employees without disabilities.

#### **Informal and formal services and supports \***

##### **Informal and formal services and supports:**

While most of the focus on home and community-based services tends to be on those paid by Medicaid, we know that a much greater number of people are supported by family caregivers. In Arkansas, 7,287 live with caregivers over the age of 60. This is 19% of the state total, compared to the national average of 17%. For this group of caregivers, one of their biggest concerns is what will happen to their family member when the caregiver can no longer provide care.

While there is a rich array of programs offering supportive services, many people in the state note that they need support that either doesn't exist or they cannot find. There are a number of programs that maintain a resource directory or database. Unfortunately, many people are not aware of the directories. The Aging and Disabilities Resource Center, the Family to Family Health Information Center, and the University of Arkansas at Little rock operate three of the notable directories.

There are several organizations and that have support services as a key part of their mission. In addition to operating a resource directory, the Family to Family program employs a group of regional coordinators who provide information about the health care system to families with children with special health care needs. The coordinators are themselves parents of children with health conditions. A similar program of the Division of Developmental Disabilities Services, the Parent Advisory Council (PAC) is a group of parents and guardians of children with special health care needs (CSHCN) and is committed to advocacy and educating other families, government agencies and healthcare professionals on issues that affect children with special health care needs. The PAC has representatives from across the state of Arkansas who meet quarterly with service providers and agencies for collaboration. The Center for Exceptional Families operates the Parent Training and Information Center for the state. This program provides education and support for families regarding special education. Arkansas CPRC does similar work in northwest Arkansas but focuses on Hispanic and Marshallese families.

With the increase in the number of diagnosed cases of autism, a number of support programs have emerged. The Arkansas Autism Resource and Outreach Center is a not-for-profit organization that works with families of children with a new diagnosis of autism. They help the families better understand the condition, know the first steps they should take to receive the services and supports they need, and to connect with other families. Project Connect has identified resources for children with autism in each region of the state and has published a guide for families. The Autism Implementation Grant is a new project that is working to develop a more integrated system of care for children with autism and their families. Since Hispanic families may access information through different sources and to overcome language and cultural barriers, a new organization is being formed. Autismo Arkansas is a joint venture between the Autism Treatment Network, Leadership Education in Neurodevelopmental Disabilities (LEND), University of Arkansas for Medical Science, and the Mexican Consulate that will do outreach to Hispanic families with a child on the spectrum. It is being formed by a developmental and behavioral pediatrician, who is originally from Mexico.

For the past ten years, respite has been consistently mentioned near the top of needs assessments. The Arkansas Lifespan Respite Coalition is dedicated to developing more respite options in the state. There are several limited programs in the state that offer respite services, but each is for a specific population. While they are most welcome, none of these programs comes close to meeting the needs for respite. A number of churches are stepping up to fill some of the need for supports, with respite being the most common service offered and parents night out programs being a common format for support. A couple of churches offer SibShop, a support for siblings of children with disabilities. Most of the support groups and informal programs are conducted in English only, which makes accessing these services even more difficult for people for whom English is not their preferred language.

Participants in community meetings and focus groups identified a number of additional areas where they feel additional supports are needed. By far, the most common need voiced was a need for more information. Among other options, participants suggested that a program of home visits for families with young children to educate them about services

They cited that legal issues often go unmet. Many families need assistance with setting up special needs trusts. Persons with disabilities may not be able to make choices or to even have input into their preferences due to laws and policies about guardianship. Among Hispanic and Marshallese families, the need for services and trainings in their native language, materials in their language, and translation services were key needs. Other needs that were voiced were help with meeting daily needs such as food and equipment, being unwelcome at church because of a child's behavior, more support groups, connecting with families in other states, help transitioning into the community, and more training on positive behavior supports.

#### **Interagency Initiatives \***

One of the most promising projects of collaboration in recent years is Arkansas PROMISE. A condition of the PROMISE grant is that a number of programs that serve adolescents on SSI must integrate their services. This has brought together the Department of Education/Office of Special Education, Arkansas Rehabilitation Services, Division of Workforce Services, Department of Human Services, Department of Health, Department of Higher Education, SOURCES for Community Independent Living Services, and three units of the University of Arkansas. While integrating services is a requirement for this grant, one of the goals of the grant maker is to influence the way that services are delivered in the routine work of the agencies.

In the fall of 2010, the Governor issued an Executive Order that established Arkansas's Employment First Task Force. Because this was created by an Executive Order and not legislation with an end date, the Employment First Task Force was guaranteed not to be a temporary collaborative effort. A number of agencies continue to work together to improve employment outcomes.

The Autism waiver was developed as a direct result of the on-going collaborations of the members of the Arkansas Legislative Task Force to Study Autism. This Task Force is chaired by a member of the legislature and its composition involves several stakeholder agencies and advocates.

The Aging and Disabilities Resource Center brought together a number of stakeholders to develop a no wrong door system to access services for people across the lifespan.

### Quality Assurance

Arkansas has several programs and activities dedicated to quality assurance. Most, however, are internal programs. No matter how serious the attempts to insure quality, persons outside the agency tend to question the ability of an agency to police itself. The Department of Human Services, Division of Developmental Disabilities (DDS) has a Quality Assurance Section that consists of five units: Certification and Licensure, Psychology, Outreach, Information and Referral, and Waiver Medicaid Income Eligibility Unit. Together, the Quality Assurance Section works to ensure that persons with developmental disabilities have access to quality services that are "custom-designed" to enable them to live independently and productively as valued members in their communities. The Assistant Director of the QA Section is responsible for coordinating development of policy pertinent to the Section. The Assistant Director also hears appeals from service providers and from individuals regarding pertinent issues.

The Office of Long-term Care (OLTC) licenses and inspects nursing facilities (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#1>), intermediate care facilities for persons with intellectual and developmental disabilities (ICF/IDD) (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#2>), assisted living facilities (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#5>), residential care facilities (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#3>), adult day cares and adult day health cares (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#4>), post-acute head injury retraining residential facilities (<http://humanservices.arkansas.gov/dms/pages/facilityTypes.aspx#7>). OLTC also investigates complaints against long-term care facilities and their employees (<http://humanservices.arkansas.gov/dms/Pages/oltcConsumers.aspx#9>), administers the TEFRA program (<http://humanservices.arkansas.gov/dms/Pages/oltcConsumers.aspx#11>), licenses nursing facility administrators (<http://humanservices.arkansas.gov/dms/Pages/oltcProviders.aspx#10>), administers criminal background checks for long-term care facility employees (<http://humanservices.arkansas.gov/dms/Pages/oltcRegulations.aspx>), oversees the Certified Nurse Aide (CNA) training and certification program (<http://humanservices.arkansas.gov/dms/Pages/oltcRegulations.aspx>), and determines medical eligibility for Medicaid for long-term care facility placement and waiver services (<http://humanservices.arkansas.gov/dms/Pages/oltcRegulations.aspx>).

The Department of Human Services, Division of Children and Family Services (DCFS) operates the child protection services program for the state. They have several units that provide specialized services that benefit children with DD. The Child Protective Services Unit currently has approximately 115 contracts throughout the state. They are community based to increase the strength and stability of families. Services are referred by DCFS caseworkers and often court-ordered by juvenile judges as part of a case plan. Currently, there are several services/programs being offered by the Child Protection Unit including counseling, in-home support, language interpreters, parenting education/support services, supervised visitation, support groups, in-home parenting services. The Specialized Placement Unit provides technical and financial assistance county offices requiring help in locating and/or finding placements for children with emotional and/or behavioral problems. The Division provides these services through contracts with private providers or medical providers. Arkansas System of Care (AR SOC) is a collaborative network of community-based services and supports that are organized to meet the challenges of children and youth with moderate to severe mental health needs and their families. Families and youth work in partnership with public and private organizations so services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs.

In a similar manner, Adult Protective Services works to protect adults from sexual, physical, emotional, or financial abuse. In addition to state agencies, there are several other programs that work for protection of persons with disabilities and to assure quality in service programs. Disability Rights Arkansas takes an active role in monitoring congregate care facilities. In recent years, they have issued reports on abuse at the Arkansas State Hospital and Human Development Centers (HDC). Most recently they reported on conditions of facilities at HDCs, excessive use of seclusion and restraints, and a death at an HDC. Arkansas Autism Resource and Outreach Center works with parents of children with autism spectrum disorders to understand the condition and the rights of children and their families. One of the areas of their work is supporting parents as they seek the rights of their children. Partners for Inclusive Communities, the University Center for Excellence in Developmental Disabilities (UCEDD) for the state, operates programs that work to prevent rape and sexual assault of people with disabilities and to support crime victims with disabilities. Those programs work with the criminal justice system in the state, along with victim assistance programs and DD programs to assist them to better understand each other's role and responsibilities.



Arkansas Children's Hospital, Legal Aid of Arkansas, and Walmart have partnered to establish a medical-legal partnership that provides services such as utility service recovery for the child's home health care, assistance negotiating with a landlord over the environment of an apartment, or access to appropriate special education services. There are several areas needing development that will provide protections and assurance of quality services. Persons with disabilities need to provide advocacy for the rights of people with IDD and for quality services. While there are strong individual advocates in the state, there is not a strong network of either persons with IDD or families of children with IDD. There are two struggling groups and one newly formed group of self-advocates. Arkansas People First is the group with the longest standing. They had an active network of local chapters for a number of years, which was supported by the DD Council. Several years ago, that funding ended, which resulted in a gradual decline of the organization. Today there are four active chapters and several long-time board members who are scattered throughout the state. SALT was started about three years ago, also supported by Council funding. This group has struggled to grow beyond the core membership of about 15 members statewide. Most recently, Arkansas Leaders in Action, organized with support from Partners and CURRENTS, a rehabilitation services training center. Leaders in Action, a cross-disability group, includes members of People First and SALT, and has about 20 members. There is much work to do develop self-advocacy in the state. Self-advocates can probably do more to advance quality assurance in the Arkansas than any other approach.

Training about rights of persons with disabilities and their families is a key component of quality assurance. Two agencies provide training about rights regarding special education are The Center for Exceptional Families, which serves the state, and Northwest Arkansas Community Parent Center, which serves Hispanic and Marshallese families. The Family to Family Health Information Center provides education to families of children with special health care needs. While those programs provide great training, they cannot reach all of the families needing services. Neither do they serve adults. Much attention is needed to help the DD community know their rights and how to insure that they receive quality services.

Work needs to be done to change laws and policies to allow self-determination for persons with IDD. State laws and agency policies are oriented to family members becoming guardians for individuals with IDD, with limited guardianship or facilitated decision-making rarely considered as options.

Several issues of quality assurance were identified as priorities during the community meetings, including excessive use of restraints, the need for an independent agency providing oversight for service providers, quality ratings for programs, removing barriers to voting by people with IDD, the need to expand person-centered planning, and programs to provide care when aging caregivers are no longer able to provide care.

### **Education/Early Intervention**

In 2013, a total of 8.1% of students aged 6-21 in Arkansas were in special education. Most of the students spent more than 40% of their time in regular education classes (83.5%, compared to the national rate of 81.2%). In the 2011-12 school year, Arkansas had a graduation rate among its special education students of 82.5%, which was significantly better than the national rate of 64.6%. Likewise, the dropout rate of 14.6% was better than the national rate of 19.7%. In spite of those impressive results, there are many concerns on the part of parents. The Legislative Task Force on Autism has taken up the issue of the use of seclusion and restraints. Currently, schools do not have to report their use of seclusion and restraints. Guidelines have been developed calling for schools to report their incidents, which will provide data to see if it is actually being overused.

Hispanic and Marshallese parents report needing more language services to be able to understand what is happening at school. They reported a need for interpreters who are properly trained. They often need advocates to help their children receive the services they are entitled to have. Marshallese families have an additional challenge since they are not eligible for Medicaid, due to the Compact of Free Association, unless they are citizens. The compact allows persons from the Marshall Islands to freely travel to the United States and to remain as long as desired, but prohibits them from receiving services from the federal government. Both Marshallese and Hispanic families report needing teachers and tutors who are fluent in their languages. While the number of staff who speak Spanish is increasing, few staff speak Marshallese. Marshallese families often encounter problems because they do not know the disability that their child has. In their culture, a person either has a disability or they don't. They don't distinguish one type of disability from another.

Participants in community meetings and focus groups had several issues of concern with public schools and early intervention. They were concerned about the lack of identification of children for First Connections, the early intervention program for the state. There continues to be a misunderstanding about early intervention with people thinking there must be a diagnosis in order to receive services. However, there needs to be a more robust screening program to help identify eligible children. They also wanted to see more attention to social and emotional development in infants and toddlers. Participants wanted to see teachers receive better preparation for special education and particularly wanted to see more training on the use of positive behavior supports. A number of participants mentioned the need to improve transition services for high school students, including better coordination between special education and Arkansas Rehabilitation Services. They wanted to see transition planning begin earlier than currently happens and wanted to see more use of internships.

### **Housing**

Whether or not you have a disability, having a home largely depends on a person's income. The federal government considers a home affordable if a household pays less than 30% of their gross income for housing, including utilities. According to 2015 Worst Case Housing Needs the nation has a critical shortage of affordable housing that becomes even worse when one also considers accessibility. The shortage also increases the cost of renting. Households with disabilities are more likely to have low incomes and have to spend a bigger portion of total income on housing. A low-income household may not have sufficient money for other necessities such as food, clothing, and childcare. Historically, renter households are more likely than owner households to be cost-burdened.

The report Shut Out, Priced Out, and Segregated: The Need for Fair Housing for People with Disabilities includes these findings that create barriers to people with disabilities being housed: 1) a lack of basic access in every home; 2) lack of education among housing professionals about accessibility; 3) unemployment, poverty and the lack of buying power among people with disabilities makes housing unaffordable; 4) the lack of rental subsidies; 5) insufficient housing and support services; 6) housing owned by providers, not individuals; and, 7) lack of access to public transportation options.

Arkansas has a Housing Trust Fund that is dedicated to providing funding to increase the affordable, accessible housing stock in the state. Unfortunately, there has never been a dedicated funding stream for the Trust Fund. Housing Arkansas is an advocacy organization that is dedicated to finding a consistent funding stream.

There are long lists of people waiting to receive rental assistance in the form of Section VIII vouchers. There may also be challenges finding property owners who will accept vouchers.

### **Transportation**

Arkansas has 31 of its 75 counties (41%) with no public transit. Of the counties that have public transit, 8 are urban systems and 7 are rural, regional systems. In many of the counties the service is limited. In many of the urban systems there are large areas of the city with no service. While all public transit systems are required to also operate paratransit, not all of those services are practical to use, given some of the regulations in place. Many families do not have reliable, personal transportation. Much of the transportation that is provided is done at the program level. Persons needing to go places that are not on the route or the schedule for provider agencies may not be able to travel where they need to go. This is a particular challenge for anyone wanting to work and needing transportation. That scenario has caused a number of people to abandon their attempt to work.

The Arkansas Highway and Transportation Department, through the Section 5310 - Elderly Persons and Persons with Disabilities Project, provides capital assistance for specialized equipment and vehicles for private, nonprofit organizations to help meet the transportation needs of individuals with disabilities.

Participants in community meetings identified the need for better sidewalks, bike lanes, and trails. A good public transit system can be rendered unusable if one cannot get to the bus stop. They also identified that people need to be taught to how to use public transit. They noted that scheduling issues can limit the use of public transit. According to the participants, more drivers are needed and they need better training and supervision.

### **Child Care**

DHS Division of Child Care and Early Childhood Education (DCCECE) has made major advances in the quality of child care in recent years. Under their leadership, Arkansas was an early leader in publicly funded pre-K, Arkansas Better Chance (ABC). The Division has established a program, Better Beginnings, that incentivizes providers to improve the quality of their services. Better Beginnings establishes a tiered rating system for centers that exceed the minimum licensure standards are eligible for enhanced funding. DCCECE has also led the way to assist centers to include children with disabilities. They currently have a contract with the UCEDD to provide training for licensed centers to assist them to include children with disabilities in their programming. That contract also provides training and technical assistance for centers to include English language learners in their centers. That program also provides training in the use of interpreters and is currently developing a certification for interpreters in education settings. Even with these efforts, however, many families are encouraged to place their children in specialized, segregated treatment centers. This direction of the families toward segregated centers often comes from health care providers. Many families are never presented with the benefits of inclusion.

Participants in community meetings and focus groups noted the importance of child care as a factor in whether or not a person is employed. They cited the need for more vouchers for the state to cover part or all of the cost of child care. With people working shifts with a variety of hours, more after hours care options are needed. Summer options for school-aged children with a disability are also a critical need. More supports are needed for children with mental illness. Emergency and respite care options are needed. Parents often have difficulty finding anyone they trust to care for children with medical or behavioral needs.

### **Recreation**

Recreation is an area of life that is sometimes overlooked by disability advocates. Yet, recreation is the part of life that most people identify as giving them the greatest joy. It can also be an important part of a healthy lifestyle. Arkansas is adding new recreation options for people with disabilities each year. The state parks have a guide that shows the level of accessibility for each state park. National Center on Health, Physical Activity and Disability (NCHPAD) maintains a list of city parks that have some accessibility features and includes 15 parks in Arkansas on that list. The City of Little rock employs a Director of Therapeutic Recreation.

Community Connections provides recreational activities for youth with disabilities that includes dance, theatre, soccer and flat football. I CAN! of Arkansas offers six program areas: dance, soccer, art, music, disc golf, and cheerleading. Miracle League Baseball is another notable inclusive recreational program that encourages individuals with disabilities to participate in baseball. Other programs that provide options are Challenged Outdoorsmen of America, fishing derbies, Boys and Girls Scouts, Special Olympics, Camp Aldersgate, and Silver Sneakers.

The Disability and Health Program at Partners for Inclusive Communities has joined with AARP to promote livable communities. These are communities that incorporate community design in ways that make the streets and sidewalks, not only accessible, but inviting to walk or roll to move about the neighborhoods. By integrating exercise into the daily routings of people including people with disabilities, recreation becomes an integrated part of everyday life.

The Jones Family Center is a particularly notable resource in northwest Arkansas. It is fully accessible and includes a range of free recreation activities, including ice skating, volleyball, basketball, a walking/running track, pool, a fitness center and gym and trails. It is a regular destination for families in the region, including Hispanic and Marshallese families. In fact, it is become a gathering place and information center for these groups.

While there is an array of options for recreation, the availability varies significantly by region. For most of the state, recreation is provided largely by DD provider agencies and is not integrated. Options for adults are also more limited than are those for children.

Participants at community meetings and focus groups asked for more opportunity to meet people of the opposite sex. They wanted to see more events at parks and recreation centers and to promote those activities better. Even though options are expanding, there is still a need for even more options. They would like to have transportation to natural attractions. Participants would like to see a website that lists accessible options for recreations. They saw lack of transportation, money and volunteers as barriers to participation.

**Analysis of the State Issues and Challenges [Section 124(c)(3)(C)]**

\* - Required field

**Criteria for eligibility for services \***

Arkansas uses a categorical definition for eligibility for developmental disability services, which prevents some individuals, who are eligible under the federal definition, from receiving services. In order to be eligible, a person must be diagnosed with intellectual disability, cerebral palsy, autism, epilepsy, or spina bifida. In addition to developmental disability services, eligibility for programs such as early intervention and special education are found to be misunderstood by a number of families. This was evidenced by persons participating in community meetings and focus groups. Some thought they must have a diagnosis to receive early intervention services. Children eligible for special education are often delayed in receiving services because parents don't know the process of asking for an evaluation for eligibility. Others found the application process for developmental disabilities services to be so burdensome that they decided not to apply. Other participants cited the lengthy wait time for diagnostic evaluations to be a barrier to timely initiation of services. The asset test for services, \$2,000 for an individual and \$3,000 for a couple, was also noted as a significant barrier to receiving services and a disincentive for seeking employment. These challenges around eligibility criteria result in several problems. Many children eligible for the early intervention program, First Connections, are not identified and don't receive services. This causes children to miss a critical period of effectiveness of interventions. Families participating in the information gathering sessions reported spending large sums of money on services that could have been covered by state and federal programs

**Analysis of the barriers to full participation of unserved and underserved groups of individuals with developmental disabilities and their families \***

Through the data gathered for this analysis, there are several groups that were found to be underserved, including persons diagnosed with both developmental disabilities and mental illness, persons from racial and ethnic minority groups, persons who are LGBTQ, and persons living in rural areas of the state.

For those with a dual diagnosis of developmental disability and mental illness, Medicaid will only pay according to the primary diagnosis, thus making it difficult for the individual to receive the full range of services needed. Participants in community meetings and focus groups identified a need to integrate services for the two conditions. They also noted a limited number of mental health providers in many areas of the state, which often requires the person to travel a great distance to receive services. As a result of these challenges, many mental health needs go untreated.

Among members of minority groups, communication about the services that are available is an often identified need. In general, African Americans receive services in similar percentages as the white community. The same is not true for people who are Hispanic or Marshallese. One reason for that disparity is that some of the people in those groups have limited English language skills. The state has made progress in providing information in Spanish, but challenges still exist. Even when materials are published in Spanish, there are a limited number of workers who speak Spanish. The same situation applies to people who speak Marshallese, although there are even fewer materials in their language and interpreters are rare. For both groups, many people receive their information about services through channels that may be different from those of other cultures. Those channels are not always used to reach these populations. Another barrier to services for people from the Hispanic and Marshallese communities is a lack of reliance on governmental programs for people with developmental disabilities. Additionally, some Hispanics do not have documentation that allows them to participate in governmental programs. The Compact of Free Association that permits free movement from the Marshall Islands to the United States and access to employment in the U.S., also stipulates that they may not participate in certain U.S. programs, including Medicaid. In addition to state agencies, there are several agencies in the state that do considerable outreach to communities with limited English proficiency, including the Arkansas Minority Health Commission, Arkansas Advocated for Children and Families, Legal Aid of Arkansas, Legal Services, and consulates for the Marshall Islands and Mexico.

Members of the LGBTQ community noted that agency policies often prevent them from staying at shelters for people who are homeless or for victims of domestic violence. Many of these programs are operated by faith-based organizations that are not subject to the same rules as governmental programs. Given the high rates of homelessness and victimization among this community, they often encounter this barrier.

Given the rural nature of most of the state and the lack of public transit systems, transportation is a significant barrier to full participation. Problems with transportation were addressed earlier in this document. These problems prevent participation in everything ranging from work to shopping and recreation.

Attitudes about people with disabilities continue to be a major barrier to full participation. Many in the state believe that full participation is not possible and that segregated services are in the best interest of persons with disabilities. Others believe that persons with significant disabilities cannot be served in the community and need to be institutionalized. This belief is found in the general public, policy makers, and families of people with disabilities.

**The availability of assistive technology \***

A number of participants in community meetings and focus groups expressed a need for additional assistive technology. Medicaid limits on the types and frequency of technology purchases is one of the limiting factors. Others noted that they are unaware of AT options that might improve their lives and result in greater inclusion in the community. In spite of those limitations, there are several programs dedicated to addressing assistive technology needs.

One significant assistive technology (AT) resource for individuals with disabilities is Increasing Capabilities Access Network (ICAN), a program that is federally funded through Arkansas Rehabilitation Services (ARS). ICAN has an established relationship with the DD Network partners in the state and has a mission to improve the accessibility of assistive technology for individuals and families across the state. ICAN maintains an equipment database where people have an opportunity to search for desired equipment and/or recycle assistive equipment. Through this program, individuals/professionals may access trainings that provide Continuing Education Credits (CEC's) and Continuing Rehabilitation Credits (CRC's). ICAN's services also include: AT for the Kitchen; employment; recreation and sports; computer assistance and transition assistance. Individuals that are transitioning into more independent living environments may receive services that include the availability of floor plan recommendations and information about other agency resources. ICAN often has interactive demonstrations and/or booths at conferences and events around Arkansas. For individuals who are interested in other opportunities for AT services around the state, ICAN has an events calendar that lists different meetings, including faith-based and community initiatives.

Another program that offers assistive technology services is the Arkansas Technology and Curriculum Access Center (TCC), a collaborative partnership between the Arkansas Department of Education, Special Education Unit and Easter Seals of Arkansas. Individuals may receive equipment on loan, in-service training, consultations, and evaluations through this program. The services are offered through the Outpatient Services Center and on-site through contracts with individuals, agencies, and school districts. Web conferencing is another service option. Loaned equipment may be loaned for a six week trial period "at a cost of 2% of the replacement cost". Another component of TCC is a consultation service called Effective Systems Lead to Effective Schools. This program analyzes the systems that currently exist or are in need of development to encourage the achievement of proficiency goals for students. TCC has sponsored AT conferences, with sessions on varying topics including curriculum design and standards for students who are users of assistive technology.

The Telecommunications Access Program (TAP), through Arkansas Rehabilitation Services, provides free telecommunications equipment to eligible Arkansans who have hearing, mobility, speech, visual or cognitive disabilities. For program eligibility, individuals must meet the following criteria: 1) be an Arkansas resident; 2) have personal telecommunication service(s); 3) have certification of disability that prohibits the use of a standard telephone; and 4) have an income that is less than \$50,000 a year (more than \$50,000 may qualify for shared cost option).

Finally, the Department of Human Services (DHS) Developmental Disabilities Services (DDS) Division has an adaptive equipment services program with therapeutic and augmentative equipment. The equipment must be required for the individual to increase, maintain or improve their ability to perform daily life tasks.

**Waiting Lists \***

Numbers on Waiting Lists in the State						
Year	State Pop (100,000)	Total Served	Number Served per 100,000 state pop	National Average served per 100,000	Total persons waiting for residential services needed in the next year as reported by the State, per 100,000	Total persons waiting for other services as reported by the State, per 100,000
2014	29.664	4154	140.037	151	0	99.617
2013	29.591	4173	141.021	171	0	95.4

**a. Entity who maintains wait-list data in the state for the chart above**

Case Management authorities  Providers  Countries  State Agencies  Other

**b. There is a statewide standardized data collection system in place for the chart above**

Yes  No

**c. Individuals on the wait-list are receiving (select all that apply) for the chart above**

- No Services
- Only case management services
- Inadequate services

**d. To the extent possible, provide information about how the state places or prioritizes individuals to be on the wait-list**

- Comprehensive services but are waiting for preferred options
- Other

Use space below to provide any information or data available related to the response above

The Division of Developmental Disabilities Services list the criteria for selection for entrance into the waiver is as follows: A. In order of waiver application eligibility determination date for persons determined to have successfully applied for the waiver, but who through administrative error, were or are inadvertently omitted from the waiver wait list. B. In order of waiver application eligibility determination date of persons for whom waiver services are necessary to permit discharge from an institution, i.e., ICF/MR residents, nursing facility residents, and Arkansas State Hospital patients; or admission to Supported Living Arrangements (group homes and apartments). C. In order of date the Department of Human Services (DHS) custodian chose waiver services for eligible person in the custody of DHS Division of Children and Family Services or DHS Adult Protective Services. D. In order of waiver application eligibility determination date for all other persons. Selection for priority consideration is in the order identified above. When more than one category of priority is identified in a ranking, the order of release shall be by date of eligibility determination within each category. Releases occur only when there is a vacant waiver slot.

**e. Description of the state's wait-list definition, including the definitions for other wait lists**

In order to qualify for the wait-list, one must meet the eligibility requirements for developmental disabilities services (financial eligibility and a diagnosis of intellectual disability, autism, cerebral palsy, epilepsy, or spina bifida) and meet the level of need for services at an ICF/IDD.

**f. Individuals on the wait-list have gone through an eligibility and needs assessment**

Yes  No

Use space below to provide any information or data available related to the response above

Arkansas requires persons who apply for the waiver to go through the regular eligibility assessments for entry into services as described above. The state has also instituted an assessment of the level of support needed for all persons on the waiver and has applied that to persons on the wait-list.

**g. There are structured activities for individuals or families waiting for services to help them understand their options or assistance in planning their use of supports when they become available (e.g., person-centered planning services)**

Yes  No

**h. Specify any other data or information related to wait-lists**

none

**i. Summary of Waiting List Issues and Challenges**

Arkansas has 2940 persons on the wait-list for Home and Community-based Services. This list has grown by several hundred people in recent years and continues to grow. Some people have been on the list for more than nine years. The last few years, more people have entered priority categories than the number of open slots for the waiver, causing people to have a higher number on the list than they had in the previous year. The number of people on the wait-list is more than one-third of the people in the state who are eligible for services. The waiver wait-list was one of the most common needs identified through the community meetings and focus groups. The specific concerns noted were: 1) a lengthy wait list to receive services; 2) a confusing application process; 3) the need for more direct support professionals, 4) a need to increase the rate of pay for direct support professionals; and 5) a need to modify the diagnostic criteria used to determine eligibility.

**Analysis of the adequacy of current resources and projected availability of future resources to fund services \***

Funding limits are the reason that the waiver wait-list is long and growing. This continues to be the major focus of participants in the community meetings and focus groups, as well as for advocacy groups and service providers. There are, however, several other funding challenges.

The state legislature established a Task Force to recommend changes to the Medicaid program in the state, including long-term services and supports. The Task Force contracted with a consulting firm to advise the legislature on Medicaid reform. The top recommendation from the consulting group is to change the way long-term services are delivered in the state by shifting the balance of services from institutional-based care to community-based care. They also recommended using a third party to determine eligibility for Medicaid service, rather than service providers determining eligibility for their own clients. Their recommendations included using savings from their recommended revisions to eliminate the wait-list. They also recommended converting to a managed care model for long-term services and supports, with an expectation that it will improve quality of care at the same time it reduces costs. The Task Force voted on its recommendations to the full legislature in March and the Governor called a special session for April, in which the full General Assembly decided which reforms to implement.

Over the last several years, the state developed the Healthcare Payment Improvement Initiative that could impact how individuals with DD would receive services. Individuals receive services on a fee for service basis. The Payment Improvement Initiative would pay for services on a pre-determined level of support needed.

Service providers note several financial pressures that make it difficult to continue providing services at the level they have historically done. Over a number of years, there have been limited increases in the rates paid for delivering services. These increases have not come close to meeting the rate of inflation, which makes it difficult to maintain the same level of long-term services and supports. A recent change prompted by the Department of Labor's rules about overtime pay for direct support workers has improved conditions for the workers, but has placed additional financial stressors on providers.

**Analysis of the adequacy of health care and other services, supports, and assistance that individuals with developmental disabilities who are in facilities receive \***

There are at least two components to the quality of health care in facilities: care provided by physicians and the medical team and that delivered by the other staff at the facilities. Most physicians profess to lack the knowledge and skills necessary to provide competent care to patients with developmental disabilities. In general, developmental pediatricians are seen as the specialists that possess those qualities, although the pediatricians usually argue that they are not trained to treat adults. There is a need for physicians who are trained to provide services to adults with developmental disabilities.

Even though most persons with disabilities have Medicaid coverage, there are shortcomings with that coverage. For example, Medicaid will not cover most dental services. It was only after years of advocacy that extractions were covered. Most of the people with disabilities who receive good oral care are clients of programs who have worked out a special arrangement with a local dentist.

The second component of health care is provided by staff of the facilities. On that front, things have been much less positive. Over the past year, Disability Rights Arkansas published two separate reports about neglect or improper care at an ICF/IDD. The first report documented poor conditions of the physical plant and the high rate of use of seclusion and restraints. In one facility of 131 residents, there were 52 reports of aggressive/destructive/self-injurious reports during one month. Mechanical restraints were used 52 times during that month and chemical restraints 17 times. Even within the State facilities, this usage is 900% higher than a similar facility. The second report concluded lack of supervision of a 24 year old female resident that had a history of choking incidents.

**To the extent that information is available, the adequacy of home and community-based waivers services (authorized under section 1915(c) of the Social Security Act(42 U.S.C. 1396n(c))) \***

During community forums and focus groups, although participants did not identify large numbers of concerns with their home and community-based waiver services, there were major concerns identified in some specific areas. A need for respite care and transportation were major barriers identified to receive meaningful program assistance for self-advocates and for parents of Arkansans with developmental disabilities. The overwhelming concern about the waiver among the participants was the large number of people on the waiver waiting list and the length of time that many of them have been there.

**Rationale for Goal Selection [Section 124(c)(3)(E)]**

\* - Required field

**Rationale for Goal Selection \***

Working with its DD Network Partners and utilizing the information contained in the comprehensive statewide assessment, the Council worked for several months in refining the five-year-state-plan goals that became a part of this Plan. Public comments were sought and received that were also considered to assure that the Council submitted a set of goals that addressed the most pressing needs of the iDD community. The non-English speaking community of the Marshall Islands was identified as a significant area of need in the northwest area of Arkansas. Because of first the language barrier and then the cultural differences that the parents of children with intellectual and developmental disabilities face in their community, the goal of assisting both the Marshallese and the fast-growing English as a second-language population in Arkansas quickly became a goal. The Council designed goals that addressed needs identified in the comprehensive statewide needs assessment with the possibility of making a difference by considering both the funding level that the Council had and the potential cost of the programs that would support our goals. As always, the Council made decisions that would give the DD community the most assistance possible with the funds available for that purpose.

**Collaboration [Section 124(c)(3)(D)] \***

The Council continues to work on the expansion of community supports and services, supporting the self-advocacy network and employment. The Council works closely with the Arkansas Developmental Disabilities Service Division (DDS) of the Department of Human Services state agency, Disability Rights Arkansas and the UCEDD in identifying common goals and leveraging funding among those agencies and with the Council to provide for needs identified in the Comprehensive Statewide Assessment and striving to avoid the duplication of services. DDS is in the third year of a collaboration with several DD stakeholders, and the Council has already begun investigating the use of an interagency agreement to move the program forward at a faster pace.

The agency members of the Governor's Council on Developmental Disabilities and its self-advocate members provide a broad cross section of thoughts regarding the DD community in Arkansas and gives the Council opportunities to hear from many viewpoints on the needs of that community.



## 5 Year Goals

**Goal #1: People with DD and their families will be active in advocacy activities that improve their lives and the lives of others and the service system.**

### Descripton \*

The Council will provide funding to strengthen a statewide advocacy organization to increase membership and collaborate with the developmental disabilities network to employ a statewide coordinating who is a self advocate to support self advocates and their families.

### Expected Goal Outcome \*

Increased activity and participation by self-advocates, increased number of self-advocates with leadership training; increased leadership and engagement from self-advocates.

### Objectives

- Objective 1.** Each year of the five year plan, the Council will provide support to strengthen a statewide self-advocacy organization by increasing activity and participation by self-advocates in Arkansas.
- Objective 2.** The Council will provide consultation, support and assistance to self-advocacy organizations to increase leadership and participation in self-advocacy.

**Goal #2: People with DD and their families will have increased access to community support and services.**

### Descripton \*

The Counsel will create an RFP that will support a community partner in each of the state's five regions in strengthening access to information and training and will fund a regional community partner to reduce barriers to supports and services for people with iDD in the Marshallese population in northwest Arkansas and to implement services.

### Expected Goal Outcome \*

Increased access to community support and services, reduction of barriers when accessing information and services for non-English speaking and English as a Second Language individuals with developmental disabilities and their families.

### Objectives

- Objective 1.** Provide support to community partners to strengthen access to information, training and education for Arkansans with developmental disabilities and their families about available programs and services within the State
- Objective 2.** To address targeted disparity, the Council, together with partners in Northwest Arkansas, will work with Marshallese people with intellectual and developmental disabilities to reduce language barriers when accessing information and services.
- Objective 3.** The council will collaborate with regional community partners to identify and prioritize strategies to reduce barriers to supports and services for Arkansas with iDD who do not speak English and/or speak English as a second language

**Goal #3: The Arkansas DD Council will collaborate with state agencies and community programs to improve competitive, integrated employment of Arkansans with developmental disabilities.**

### Descripton \*

The Council will participate and advocate the work of the Employment First Task Force to advocate for legislative and policy changes designed to increase competitive, integrated employment. Meaningful involvement by self-advocates in Employment First Initiatives will be a major part of this Goal with a request for a community partner to assist people with DD with the shift from sheltered employment to competitive, integrated employment working in round table meetings with self advocates, their families and employers.

### Expected Goal Outcome \*

Increase employment services for self advocacy, support potential legislation in this area. Increase opportunities for individuals with developmental disabilities to be engaged in competitive, integrated employment through ongoing expansion of Employment First activities.

### Objectives

- Objective 1.** The Council will promote participation of people with DD in Employment First activities and similar community programs to advocate for legislative and policy changes to increase competitive, integrative employment.
- Objective 2.** Support increased capacity of vocational service providers and employers to provide opportunities for competitive integrated employment of people with DD.

**Evaluation Plan [Section 125(c)(3) and (7)]**

\* - Required field

**Evaluation Plan \***

The evaluation of the success of the goals and objectives of the Arkansas DD Council will be evaluated by the Council in their quarterly meetings by reviewing meeting agendas and self-advocate surveys. The staff of the Council will track legislation that is proposed related to the services for the IDD in Arkansas and will provide reports on that legislation to all Council members. The Policy and Public Outreach Committee will review comments from the website and report on use of the website for information or publications. The Council members will have evaluations from any community partners assisting in the successful achievement of our goals. Minutes from taskforce meetings, roundtable meetings and reports from the Council's partners will assist in the achievement of Goal 3. The monitoring of agencies participating in interagency agreements and sub grantees that are awarded during the grant period will provide valuable information to the Council on the successful achievement of the goals it has set for itself in its 2017-2021 five-year plan.

**Logic Model**

\* - Required field

**Logic Model \***

<http://www.ddcouncil.org/uploads/arlogicmodel.pdf> (<http://www.ddcouncil.org/uploads/arlogicmodel.pdf>)

**Projected Council Budget [Section 124(c)(5) (B) and 125(c)(8)]**

\* - Required field

Goal	Subtitle B \$	Other(s) \$	Total
People with DD and their families will be active in advocacy activities that improve their lives and the lives of others and the service system.	\$195,176.00	\$65,059.00	\$260,235.00
People with DD and their families will have increased access to community support and services.	\$208,381.00	\$69,460.00	\$277,841.00
The Arkansas DD Council will collaborate with state agencies and community programs to improve competitive, integrated employment of Arkansans with developmental disabilities.	\$120,000.00	\$40,000.00	\$160,000.00
General management (Personnel, Budget, Finance, Reporting)	\$191,334.00	\$102,032.00	\$293,366.00
Functions of the DSA	\$38,267.00	\$12,756.00	\$51,023.00
Total	\$753,158.00	\$289,307.00	\$1,042,465.00

**Assurances [Section [124(c)(5)(A)-(N)]**

\* - Required field

Written and signed assurances have been submitted to the Administration on Intellectual and Developmental Disabilities, Administration for Community Living, United States Department of Health and Human Services, regarding compliance with all requirements specified in Section 124 (C)(5)(A) -- (N) in the Developmental Disabilities Assurance and Bill of Rights Act.

**Approving Officials for Assurances**

For the Council (Chairperson)

**Designated State Agency**

A copy of the State Plan has been provided to the DSA

**Public Input And Review [Section 124(d)(1)]**

\* - Required field

**Describe how the Council made the plan available for public review and comment. Include how the Council provided appropriate and sufficient notice in accessible formats of the opportunity for review and comment \***

Each section of the Arkansas Governor's Council on Developmental Disabilities 5-year state plan was made available on the State Website and on the website for the Council. Comments were sought after the Goals and Objectives were published and the comments received tracked the path that the Council had chosen for its work plan for the first two years of the Five-Year-State- Plan. The Council members disseminated the information from the Goals, Objectives, Activities and 2017 and 2018 work plans to others in the DD Community, and those items were sent to the list of providers of services to Arkansans with iDD.

**Describe the revisions made to the Plan to take into account and respond to significant comments \***

Services and activities were included in the Plan that were emphasized in comments from the public. The Council was gratified to see that many of the comments received stressed areas that the Council also had deemed important for the iDD Community in Arkansas.