MINUTES OF MEETING
BOARD OF DEVELOPMENTAL DISABILITIES SERVICES
November 6, 2013
Booneville Human Development Center
Booneville, Arkansas

A regular meeting of the Board of Developmental Disabilities Services (DDS) was held on November 6, 2013 at the Booneville Human Development Center in Booneville, Arkansas.. The meeting convened at 1:00 p.m. pursuant to the call of the Vice Board Chair.

MEMBERS PRESENT: Mr. David Rosegrant, Ms. Artie Jones, Ms. Sally Hardin, Ms. Suzann McCommon, Dr. Linda Selman and Mr. Darrell Pickney. Absent was Mr. Robert James.

STAFF PRESENT: Dr. Charlie Green, Ms. Margo Green, Mr. Forrest Steele, Mr. Jeff Gonyea, Ms. Judy Adams, Mr. Calvin Price, Ms. Debbie Eddington, Mr. James Brader, Ms. Tammy Benbrook, Mr. Dale Woodall, Ms. Sarah Murphy, Ms. Angela Green, Mr. Mark Wargo, Mr. Jerry Wilkins, Mr. Mike Wyrick, Mr. Jerry Cravens, Mr. Roy Roberson, Ms. Vanessa Wyrick, Ms. Katherine Marsden, Mr. Jodi Nichols and Ms. Shelley Lee.

OTHERS PRESENT: Arkansas State Senator Gary Stubblefield, City of Booneville Mayor Jerry Wilkins, Ms. Loretta Alexander, Mr. Wes Eddington, Ms. Jan Fortney, Ms. Rita Hoover, Mr. Paul Rainwater, Ms. Deborah Rainwater, Mr. Richard Bokker, Ms. Julia Frost, Ms. Carol Sherman, Ms. Annette Matthews, Ms. Betty Rosegrant, Ms. Carol Sheets, Mr. Mike Candill, Ms. Christy Wooten, Mr. Josh Wooten, Mr. Larry Taylor, Dr. Frank Selman, Mr. Ben Finley, Ms. Ethel Finley, Ms. Rita Edwards, Director Tom Masseau and Ms. Susan Pierce from Disability Rights Center and Ms. Amy Ford, Attorney General's Office.

Mr. David Rosegrant, Board Chair, called the meeting to order and welcomed everyone in attendance.

Mr. Rosegrant called for a motion on the minutes from the August 1, 2013 regular meeting of the Board of DDS.

Ms. Suzann McCommon made a motion the minutes from the August 1, 2013 regular meeting of the Board of DDS be approved. Mr. Darrell Pickney seconded the motion which passed unanimously.

There were no subcommittee meetings so no subcommittee reports will be given.

Mr. Rosegrant invited consumers, advocates and guests to address the Board. Ms. Rita Hoover, parent of a client who resides at Conway HDC, stated she had questions for the Board but would like to wait until the reports have been given if that is okay with the Board. Mr. Rosegrant asked what the pleasure of the Board would be of this request and the Board's response was agreeable to Ms. Hoover's request.

Mr. Jeff Gonyea, Superintendent at Booneville HDC, presented the report for the human development centers (HDCs) and reminded the Board that monthly reports for the HDCs were included in the Board packets. Mr. Gonyea presented items of interest about each HDC along with recent survey results as provided to him by each Superintendent.

Following the presentation of HDC reports, Mr. Pickney stated he had been reviewing the monthly reports in the packets the last few quarters. He expressed the challenges listed each month and questioned why some of the topics were listed when in his opinion there are much more important challenges for the HDCs that should be addressed. Dr. Green explained that the topics chosen by the superintendents were items listed in the Belief Based Performance Management criteria and that the centers were working toward meeting those goals. Ms. McCommon stated that sick leave usage, employee morale, incentives and retention were large and important challenges and she is pleased that these topics are addressed on the monthly report. Mr. Pickney agreed and stated he felt "staffing" should be a priority every month.

At this time, Dr. Green thanked Jeff Gonyea, Booneville HDC and the City of Booneville for their hospitality, lunch, the support of the community and for providing a tour to everyone at the Booneville HDC campus. He also thanked everyone for coming to Booneville for the meeting and acknowledged that it was a long distance to travel for many people in attendance.

Dr. Green began his report by referring to the information and handout of the *DDS Plan for Systems Change 2011* regarding the transfer of children's beds at Conway HDC, which has been a concern for some of the parents at Conway. Dr. Green asked DDS Asst. Director James Brader and Shelley Lee to give an update on the location of the beds and the status of emergency admissions of children at the HDCs. First Step obtained 16 beds; Rainbow of Challenges of Arkadelphia obtained 24 and Arkansas Pediatric Facility (APF) obtained 5. Conway will continue to take emergency children's admissions as needed at the facility. Ms. Sally Hardin then asked if Conway would admit children to their facility and Dr. Green answered yes they would take children on an emergency basis, respite or regular admission as needed but encouraged parents to consider other facilities. (See attachment 1:1)

The second topic was the Booneville HDC's capital requests. A handout of *Capital Projects and ARRA Projects* was provided to the DDS Board members. Appropriation, one time money requests, depreciation, left over surplus money and ranking by DHS agency was discussed. (See attachment 1:2)

Next, the tour of the buildings at Booneville and the DDS Task Force was discussed Dr. Green explained that the Task Force will be looking at the resources and client composition on all the campuses and making recommendations. Some of the key areas that will be reviewed by the Task Force will be the general trends in our population, which is becoming older and exhibiting more behavioral problems. Mr. Pickney stated he was concerned that we asked for money at BHDC for a Dually Diagnosed Program instead of improvements and this could be very misleading. He stated he had contacted a Legislator and they agreed that the wording could have been clarified to be more specific to help us get the money needed to accommodate Booneville's need. Dr. Green apologized if this was misleading but noted that at the executive level, this was the routine manner in which such requests are made.

Mr. Pickney stated that the Board Members, staff, parents and even clients need to be more involved in advocating and communicating with the Governor and their respective legislators through documents, meetings and calls to get the needs of the human development centers known.

Ms. Hardin said she feels Booneville has been neglected. She said she felt they were promised money for two years and didn't receive any and have been promised opening of other buildings on campus and these commitments still have not come through. Ms. Hardin said they need to know what to expect next to get something completed at Booneville.

Dr. Green explained that the Task Force will be making recommendations. There will be no money raised through the issuance of bonds, but there may be an opportunity to request capital improvement funding in the 2015 regular session of the legislature. Mr. Pickney requested that the board review the recommendations as well.

The Task Force list in section V.B. of the Board Packet was viewed. Dr. Green emphasized that there are members from different associations, families, advocate groups and individuals that have an interest in HDC services. James Brader has done a wonderful job of coordinating, planning and leading the group. Mr. Pickney stated he is paranoid that the Task Force is just a group to plan a way to close the centers and has wondered why some of the private interest representatives are members of the task force. Dr. Green explained to the Board that all task force members have experience in this area, and that it was important to have varying perspectives on the issue participating in the process. Ms. Selman also expressed her concerns of the Task Force and cited examples of some community based services she had experience with that could not handle some of our clients and their service needs.

Sally Hardin and Darrell Pickney both wanted to thank Dale Woodall and Jeff Gonyea at this time for all their hard work for getting the BHDC Recreation Center completed.

Sally Hardin stated she wanted to ask why there was a limited number of meeting agenda items allowed at this meeting. Mr. Rosegrant stated he was giving consideration to the length of time it took for many attendees to drive to Booneville and the scheduled tour of the campus. Ms. Hardin and Mr. Pickney stated they did not think there should be a limited number of agenda items because the board only meets quarterly, and there may be many topics to discuss and it was their duty to represent the clients.

Darrell Pickney asked if he could object to changing the Functional Bed Capacity from last Board Meeting. He said he would like to make a motion not to reduce the functional bed capacity.

Dr. Green explained that the "functional bed capacity" of a center means the number of "real beds" that are available for use given the center's resources. The superintendents at each facility was responsible for setting the criteria, and with the assistance of their professional staff determined how many beds can be operational due to staffing, room size, adaptive equipment, needs, age, gender, unique-client characteristics and behaviors, etc. The functional capacity of a center is determined using a set of factors that are not subject to being impacted by the Board passing this motion.

The Board further discussed the issue and Mr. Pickney eventually withdrew his motion.

Mr. Rosegrant then invited members of the public to address the Board.

Several parents asked to make comments regarding their children at the Conway Human Development Center. Parents who spoke stated they were happy with the services at Conway and requested that their children be able to stay at the facility. Dr. Green thanked the parents for their comments and also urged them to provide their requests and concerns to the Task Force.

Mr. Richard Bokker, President of the Booneville HDC Parents Group, voiced his concerns regarding the old buildings at Booneville, and noted that two of the buildings need to be torn down before they injure some of the clients. Mr. Bokker asked Dr. Green and Mr. Woodall to check in to these requests to remove these buildings from the grounds.

Mr. Tom Masseau from the Disability Rights Center of Arkansas thanked the Board and the Task Force for coming together and reviewing all the needs of the human development centers. He stated he looks forward to working with the human development centers and the task force. He also thanked the parents for voicing their comments about their children and that he also has a child with a disability and can personally relate to their concerns.

Mr. Pickney stated his opposition to Mr. Masseau's statements regarding the HDCs and to the inclusion of the Disability Rights Center (DRC) staff member on the task force.

Senator Gary Stubblefield introduced himself to the group and stated he had taken in all the concerns, comments and suggestions and is looking forward to going back to his colleagues and discussing the information and will assist in any way he can be of service. He thanked the parents, staff and Board for their time and commitment to the clients.

Ms. Rita Hoover asked about the empty buildings at the Alexander property and wondered if this might be converted to general revenue for the other centers. Dr. Green stated that Pathfinders has leased most of the former Alexander campus, but the big Bond Building has not been leased and was not in the condition for leasing. Offers had been made to other state agencies to possibly use the building but none accepted. It does not appear economically feasible to renovate the structure for any alternative use with the asbestos and other problems.

Ms. Carole Sherman spoke to the group regarding *Senator Harkin's Summary Report.* She highlighted her concerns regarding the Olmstead Plan and DHS DDS/Alternative Community Services (ACS) services. The Board thanked Ms. Sherman for her comments and information. (See attachment 1:3)

Mr. Rosegrant, Board Chair, stated there was not a scheduled Administrative Services Committee meeting but it is the time of year that the DDS Board reviews the Travel Methodology so that Board Members can be reimbursed for their services through the state system. Ms. Suzann McCommon made a motion to accept the Travel Methodology rates for 2014. Ms. Sally Hardin seconded the motion. Motion passed unanimously.

At this time, the election of DDS officers for 2014 year was also conducted. Ms. Suzann McCommon made a motion to accept the following slate of officers: David Rosegrant – Chairman, Artie Jones- Vice Chairman and Sally Hardin as Secretary. Darrell Pickney seconded the motion. Motion passed unanimously and the gavel was retained by Mr. Rosegrant.

Before adjournment, David Rosegrant on behalf of Developmental Disabilities Services (DDS) and the Board presented Ms. Margo Green with a plaque of appreciation for her service as a Superintendent at two facilities for the past twenty six years.

Mr. Rosegrant called for a motion for the meeting be adjourned. Ms. McCommon made a motion the meeting be adjourned. Ms. Hardin seconded the motion. Motion passed unanimously.

Meeting adjourned at 3:35 p.m.

ATTEST:

Executive Secretary

Mr. David Rosegrant, Chair
Board of Developmental Disabilities Services

Attachment 1:1

DDS Plan for Systems Change

January 2011

Overview

The closure of the Alexander Human Development Center (HDC) and the ongoing U.S. Department of Justice lawsuits garner most of the attention currently but there are good things happening at DDS as well. Our five remaining HDCs are all nationally accredited at the highest level and are all certified by the Centers for Medicare and Medicaid. The DDS Home and Community Based Waiver has increased capacity by 60% in the past seven years and our Day Treatment Clinic Services have increased 29% in the past five years.

Although we feel as if the overall direction of the agency is positive, there are issues that need addressing in the coming years if we are to continue to improve our service to Arkansans with developmental disabilities. Staff at DDS have met and consulted with local and national experts as well as numerous local stakeholder groups to develop the strategic plan outlined in this document. While many important issues are addressed in this plan, there are several that are noteworthy:

- The need to update and upgrade our practices at our public Intermediate Care Facilities.
- The growing waiting list for the Home and Community Based Waiver.
- Service needs of people who are dually diagnosed with a developmental disability and a mental illness.
- The need to incentivize private providers to care for children with all levels of need.
- Addressing the unique needs of people diagnosed with Autism Spectrum Disorders.
- We must do a better job of gathering and managing data throughout our entire system.

Addressing some of the issues noted in this plan will not increase our costs. However there are needs that will require significant funding increases. Regardless of available resources, DDS will continue to strive to improve services for people in Arkansas with developmental disabilities.

HDCs

1. Increase staff-client ratios and clinical services at Arkadelphia, Booneville, Warren, and Jonesboro. Increased services will include, but are not limited to:
   - Primary Care Physicians
   - Quality Assurance/Improvement
   - Occupational, Physical, Speech and Language Therapy

   *Projected Cost: $ -0- (Redistribution of Alexander funding)

   See Appendix A for further information

2. Increase retention of direct care staff on evening and midnight shifts at all HDCs by:
   - Examining impact of staggered shift duration utilizing 10-12 hour shifts.
   - Better utilization of shift differential pay for shifts with high turnover rates.

   Projected Cost: $1.3m GR Needed: $380,000

3. Develop a comprehensive data management system that includes, but is not limited to:
   - Electronic Medical Records
   - Habilitation/Treatment Planning
   - Trending Analysis Capability
   - Interactive Pharmacy Component

   *Projected Cost: $1m GR Needed: $280,000

   *one-time cost

4. Develop more appropriate guidelines for admission in order to ensure the HDCs are addressing the needs of the public.

   Projected Cost: $ -0-

   See Appendix B for further information

5. Restructure housing opportunities on the BHDC campus to eliminate use of large dormitory living situations. This can be accomplished with the construction of 10 new living units, renovation of the 10 Curtis Circle Cottages, and reducing the capacity of the center from 149 to 128 beds.

   *Projected Costs: $2.5m FY 12
   $2.5m FY 13
   $2.5m FY 14
   $2.5m FY 15

   *These are one-time costs. No federal matching funds can be used for construction or renovation.

6. Hire a DDS Assistant Director for Residential Services to coordinate service provision across the five HDCs.

   Projected Cost: $121,356 GR Needed: $33,979

7. Hire clinical personnel to assist in maintaining Evidence Based Best Practices at all HDCs.

   Projected Cost: $804,846 GR Needed: $225,357

   See Appendix C for further information

8. Contract with an outside agency to conduct Independent Training Surveys annually at all HDCs.

   Projected Cost: $135,000 GR Needed: $37,800

Home and Community Based Waiver (HCBW)

1. Develop a comprehensive data management system that includes, but is not limited to:
   - Applicant Tracking
   - Expenditure Tracking
   - Trending Analysis Capability
   - Electronic Prior Authorization Capability

   Projected Cost: $ -0- (ARRA is already funding this project)

2. Develop a Group Home/Apartment Program Waiver designed specifically for existing congregate settings that would allow for maximum use of current facilities.

   Projected Cost: $ -0- (These costs are currently absorbed in the HCBW)

   See Appendix D for further information

3. Amend the current HCBW to allow it to be more responsive to client and family needs. Changes should include, but not be limited to:
   - Retainer payments for client absentee days (hospital stays, etc.)
   - Provision of nursing services to adults
   - Restructure billing system for annual limits rather than daily limits (cost neutral)
   - Conversion to "Host Homes" for adults (cost neutral)

   Projected Cost: $6,490,385 GR Needed: $1,858,197

4. Develop Waiver Cooperatives similar to Educational Cooperatives to support waiver clients with challenging issues such as dual diagnoses. Services provided include, but not limited to:
   - Crisis Prevention and Intervention
   - Behavior Plan Development
   - Medication Management Consultation
   - Staff Training

Projected Cost:	$1.2m	FY 12	GR Needed:	$539,600	FY 12
	$1.8m	FY 13		$809,400	FY 13

The figures represent forming two cooperatives in FY 12 and the remaining three in FY 13

See Appendix E for further information

5. Cultivate providers of community based mental health services to enroll as HCBW providers in order to increase provider network capacity to serve people with the dual diagnoses of a developmental disability and a mental illness.

   Projected Cost: $-0-

6. Increase the capacity of the HCBW in order to reduce the wait time of people currently on the waiting list to 2 years by adding 80 slots monthly in FY 12 & 13 and 25 monthly in FY 14 & 15.

Projected Cost:	$18.5m	FY 12	GR Needed:	$5.4m	FY 12
	$34.3m	FY 13		$10.1m	FY 13
	$21.5m	FY 14		$6.3m	FY 14
	$10.7m	FY 15		$3.1m	FY 15

The above costs are predicated on the previous year's amount being in the base.

See Appendix F for further information

7. Increase the capacity for residential services in community based settings by approximately 25% (250 slots) by utilizing HCBW Group Home/Apartment model.

   Projected Cost: $9m GR Needed: $2.5m (spread over FYs 13-15)
   The cost would be $-0- if the waiver wait list is reduced as outlined in #6 above

   See Appendix D for further information

Children's Services

1. Revise the First Connections Early Intervention (EI) Program to be more responsive to requirements of the funding agency (Office of Special Education Programs).

   University of North Carolina personnel are currently conducting a comprehensive review of the program and will issue recommendations by 6/30/2011.

   *Projected Cost: $ -0- (ARRA is already funding this project)

   See Appendix G for further information

2. Develop a comprehensive data management system for use with the EI program. The system will include, but is not limited to:
   - Applicant Tracking
   - Expenditure Tracking
   - Outcomes Reporting Capability
   - Electronic Prior Authorization Capability

   *Projected Cost: $ -0- (ARRA is already funding this project)

3. Engage the Arkansas Department of Education and the Special Education Cooperatives throughout the state in mutually beneficial arrangements with regards to the provision of Early Childhood Special Education Services in conjunction with Developmental Day Treatment Clinic Services.

   *Projected Cost: $ -0-

4. Establish additional private Pediatric Intermediate Care Facility (ICF) services for children. These facilities would replace services to the approximately 50 children currently served at the Conway HDC. Shifting these services to the private sector would allow the Conway HDC to concentrate on providing services to adults.

   *Projected Cost: $ 6,750,000 GR Needed: $280,000**
   **Majority of funding would come from CHDC budget

   See Appendix H for further information

Autism Spectrum

Recommendations regarding services to people with Autism Spectrum Disorders (ASD) are part of more extensive recommendations generated by the Legislative Task Force on Autism.

1. Develop and Implement an Early Intervention Autism Waiver program to provide intensive therapy for children identified as having an Autism Spectrum Disorder.

   Projected Cost: $ 5.4 m GR Needed: None ($1.5 m already in base from tobacco tax)

   This will provide services to approximately 100 children age 3-11.

   See Appendix I for further information

2. Provide opportunities for training of physicians and other pediatric health care professionals to assess children for ASDs.

   Projected Cost: $ 150,000 GR Needed: None (ARRA is funding this project)

   See Appendix J for further information

3. Increase the capacity of Developmental Disabilities Pre-School provider organizations to serve children with ASDs by providing training in Autism specific curriculums such as STAR (Strategies for Teaching based on Autism Research) curriculum.

   Projected Cost: $ 250,000 GR Needed: $250,000

   See Appendix K for further information

All

1. Hire an Information Technology Coordinator to assist all DDS sections and facilities with data management functions

   Projected Cost: $ 91,000 GR Needed: $45,500

DDS Systems Change Proposal Summary - January 2011

	Additional General Revenue Needed			
	FY 12	FY 13	FY 14	FY 15
HDCs				
Upgrade ratios and clinical services at HDCs	$ -			
Increase retention on evening/midnight shifts	$ 380,000			
Develop more appropriate admission guidelines	$ -			
Assistant Director for Residential Services	$ 33,979			
HDC Best Practices Team	$ 225,357			
Independent HDC Surveys	$ 37,800			
Home and Community Based Waiver				
Comprehensive Data Management System	$ -			
Group Home and Apartment Waiver	$ -			
Family Friendly revisions	$ 1,858,197			
Waiver Support Cooperatives	$ 539,600	$ 809,400		
Cultivate Mental Health Providers to serve DD population	$ -			
Reduce time on waiting list to 2 years	$ 5,478,571	$ 10,114,286	$ 6,347,768	$ 3,160,714
* Increase Community Based Residential Capacity 25%		$ 1,000,000	$ 1,000,000	$ 500,000
Children's Services				
Restructure EI Program	$ -			
Comprehensive Data Management System	$ -			
Revise Cooperative Agreement with ADE	$ -			
Privatize Pediatric ICF services	$ 280,000			
Autism				
Early Intervention Waiver	$ -			
Physician/Clinician Screening Training	$ -			
Pre-School Training	$ 250,000			
All				
Information Technology Coordinator	$ 45,500			
Total New Revenue	$ 9,129,004	$ 11,923,686	$ 7,347,768	$ 3,660,714

* Cost for this item would be $-0- if the reduction of the wait list was funded

One-Time Expenditures				
New units and renovation at BHDC	$ 2,500,000	$ 2,500,000	$ 2,500,000	$ 2,500,000
Comprehensive Data Management System for HDCs	$ 140,000	$ 140,000		

Attachment 1:2

Current, Completed and ARRA Projects Report
November 01,2013

Current Projects

HDC	MOF	Project	Amount	BHDC
BHDC	2349	Admin and Nyberg Roofing	$ 120,000	$ 120,000
		Project has bid. Waiting on construction contract.		
CHDC	2349	3 Cedar, 1825 Popular	$ 151,522	
		Work in progress		
CHDC	3364	Chiller	$ 300,000	
		Work lin progress		
ArkHDC	3365	Chiller	$ 275,000	
		Work in progress waiting on final		
CHDC	3366	Windows	$ 205,000	
		Work in progress. Approximately 75% complete		
SEAHDC	3429	Kitchen Equipment	$ 40,000	
		Equipment ordered		
BHDC	3430	Davidson Showers	$ 75,000	$ 75,000
		Architect & engineer are designing		
JHDC	3431	Bldg 200 Bath Renovation	$ 20,000	
		Owner is collecting quote bids.		
ArkHDC	3432	Rec Building	$ 400,000	
		Project has been submitted to ABA for design review		
BHDC	3433	Rec Building	$ 300,000	$ 300,000
		Project is in the last stages of design		
SEAHDC	3487	Repair Supt. House	$ 20,000	
		Owner is collecting quote bids.		
SEAHDC	3488	Paint Interior Buildings	$ 20,000	
		Owner is collecting quote bids.		
ArkHDC	3367	Lighting Retrofit	$ 170,000	
		Work in progress. Waiting on final		
Total			$ 2,096,522	$ 495,000 24%

ARRA Projects Completed
2009 - 2012 (calendar)

	Project Cost	BHDC	
ArkHDC Re-Roof S1, S2, S3, S4, S11, Maint., Laund, Auto Shop,			
ArkHDC Re-roof CCRC 3 Bldg, Porches, Pool Bldg, Staff 1, 2, & 3			
CHDC Re-Roof Assistant Superintendent's Residence			
CHDC Re-Roof TA 58,59,60,61,62 and Cedar, Birch, and Maple Bldgs	Roof Total		
JHDC Re-roof Buildings 100, 400, & 700	$1,500,000		
JHDC Re-roof Buildings 1100, 1200, 1400, 1500, 1700			
SEAHDC Re-Roof 14, 15, 16, 17			
BHDC Rock Apt Emergency Generator	$ 100,000.00	$ 100,000.00	
BHDC Cottage Renovation To Alex, Clients	$ 318,839.00	$ 318,839.00	
BHDC Chiller Replacement Davison House	$ 296,057.00	$ 296,057.00	
CHDC Cooling Tower	$ 481,803.00		
ArkHDC Asbestos removal-ceilings/Floors	$ 1,341,801.00		
BHDC Davison House Showers	$ 20,000.00	$ 20,000.00	
BHDC Residence HVAC Renovation	$ 1,597,937.00	$ 1,597,937.00	
CHDC Central Plant Chillers Replacement	$ 750,000.00		
SEAHDC Boiler Replacement	$ 192,050.00		
JHDC Storeroom/Kitchen expansion	$ 1,404,539.00		
JHDC Kitchen expansion (15 Ton Carrier PKG Unit)	$ 20,000.00		
Total	**$8,023,026**	**$2,332,833**	29%

1DE Completed Projects 2010 -2012 (calendar)	Project Cost	BHDC	
JHDC Telephone Lines	$ 387,937		
JHDC Door Replacement	$ 100,300		
CHDC Repairs to 20 Birch	$ 132,895		
JHDC Renovate Medical Clinic	$ 41,673		
CHDC Network Expansion	$ 398,350		
ArkHDC Sewer Plant Repairs	$ 186,539		
CHDC Asbestos Abatement & Testing			
ArkHDC Asbestos Abatement & Testing	Total Asbestos		
JHDC Asbestos Abatement & Testing	$ 230,605		
BHDC Asbestos Abatement & Testing		$ 29,979	
SEAHDC Parking Lot	$ 307,934		
All HDCs Capitol Equipment	$ 798,026	$ 103,743	
JHDC Pavilion	$ 52,683		
SEAHDC Pavilion & Rec Area	$ 202,845		
ArkHDC Sidewalk Repair	$ 201,163		
BHDC Water Tank	$ 942,928	$ 942,928	
BHDC Davidson Showers	$ 14,000	$ 14,000	
BHDC Roof on Hampton Hall	$ 94,820	$ 94,820	
SEAHDC Kitchen Renovation	$ 433,676		
SEAHDC Generator Replacement	$ 87,107		
JHDC Parking Lots	$ 63,759		
CHDC Hot Water Renovations	$ 106,133		
BHDC Fan Coils and Piping	$ 244,677	$ 244,677	
BHDC Re roof Commons Building	$ 306,613	$ 306,613	
CHDC Re roof Admin	$ 137,107		
SEAHDC Re roof cottages	$ 250,000		
Total	**$ 5,721,770**	**$ 1,736,760**	30%

Attachment 1:9

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of the Director

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September 12, 2012

The Honorable Tom Harkin
United States Senate
Washington, D.C. 20510-6300

Dear Senator Harkin:

The Arkansas Department of Human Services (DHS) is submitting this report to the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) to describe Arkansas's progress in administering services to individuals with disabilities in the most integrated settings appropriate for their needs. As such, the accompanying report provides data and information on the current status of efforts to meet the requirements of the United States Supreme Court's *Olmstead* decision.

Since convening the initial Olmstead working group in 2001 and producing the *Arkansas Olmstead Plan* in 2003, the state has made steady progress in addressing barriers to integrated care in home and community settings for individuals with disabilities and expanding access to these services and supports. DHS's major accomplishments and initiatives include, but are not limited to:

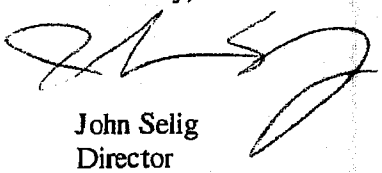
- The Money Follows the Person program successfully began transitioning adults out of skilled care facilities and into home and community based service (HCBS) settings.
- A long-term-care systems transformation grant enabled the state to establish the Choices in Living Aging and Disability Resource Center (ADRC), which is responsible for informally screening applicants for Medicaid eligibility and HCBS, and helping them initiate the formal application process.
- The number of HCBS waiver participants has increased steadily for ElderChoices, Alternatives for Adults with Physical Disabilities, and IndependentChoices.
- Wraparound services are available statewide to children with moderate to severe behavioral health needs and their families. Wraparound provides services and supports that allow children to remain in their home and communities.

Additionally, Arkansas is currently working to design and implement an innovative multi-payer model, Arkansas Health Care Payment Improvement Initiative, and an intensive care coordination model, Health Homes. This is coupled with pursuing several options to increase access to community-based services including the Community First Choice option, 1915(i) option, and Balancing Incentives Payment Program. This broad effort will help the state build a

health care system with enhanced personal choice, improved client experiences and better health outcomes. It will also support cost reduction resulting from alignment of an individual's treatment needs with the appropriate level and setting of care and the elimination of unnecessary spending due to improved care coordination.

In Arkansas, we envision a health care system that supports high quality, integrated treatment while also enhancing access to services and supports in home and community-based settings. DHS has made a commitment to partnering with other stakeholders to achieve this vision for an improved health care system for all Arkansans.

Sincerely,



John Selig
Director

Arkansas Department of Human Services
Report on the American Disabilities Act and Olmstead Plan
September 2012

The purpose of the following report is to provide information on the Arkansas Department of Human Services effort to implement *The Olmstead Plan in Arkansas*. This data was compiled in response to the request from the United States Senate Committee on Health, Education, Labor, and Pensions. This report provides a snapshot of the progress made in the state since 2008 to transition individuals with disabilities into more integrated home and community based services.

Transitions to Home and Community Settings

The figures included in this section address the number of people for each year from 2008 to the present moved from nursing homes, intermediate care facilities for individuals with intellectual disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult day care homes or residential health care facilities), to living in their own home, including through a supportive housing program.

The Alternative Community Service (ACS) waiver under the 1915(c) option is available to a limited number of individuals with disabilities, based on the waiver limit, to provide home and community based services (HCBS). In order to receive ACS waiver services an individual must meet the institutional level of care. The waiver is an alternative to institutionalization and allows individuals with developmental disabilities to live as independently as possible in the community, in the least restrictive setting, with the necessary services and other supports. In a later section of the report, additional information is available on the expansion in waiver slots since 2008. The table below reports on transitions that have occurred since 2008 through the ACS waiver:

Transitions to More Integrated Settings (ACS Waiver) 2008 – Present

	State Hospital	Human Development Center	Intermediate Care Facility	Nursing Facility	Total
2008	3	15	15	10	**43**
2009	7	17	27	4	**55**
2010	10	14	15	4	**43**
2011	15	31	31	4	**81**
2012- Present[1]	11	16	14	2	**43**
Total	**46**	**93**	**102**	**24**	**265**

The adult population receiving behavioral health services is a high priority for AR DHS due to many of the challenges in successfully transitioning these individuals into the least restrictive setting of care; plans are currently underway to expand access to home and community based services HCBS for this population. Additional information regarding plans to pursue the Health Homes and 1915(i) options are detailed later in the report, which would specifically benefit individuals with persistent, chronic mental illnesses and co-morbid conditions.

[1] This column does not represent a full year, but provides totals through September 2012.

Arkansas community mental health centers (CMHCs) serve as the single point of entry into a state inpatient psychiatric facility by providing initial screenings. The screening for appropriate admission is based on continuity of care and treatment which provides the least restrictive setting. CMHCs must also determine if appropriate alternatives to inpatient treatment are clinically appropriate and available, and arrange for the provision of alternative outpatient services if inpatient or crisis residential services are not recommended.
In addition to overseeing a psychiatric skilled nursing facility and funding local acute care beds, the Division of Behavioral Health Services (DBHS) also operates the Arkansas State Hospital (ASH), a psychiatric inpatient facility and certifies specialty clinics focused on serving adults with severe and persistent mental illness. After individuals have received the maximum benefit of acute inpatient psychiatric treatment, community placements must be identified with the appropriate level of supervision, monitoring and intervention. At any one time there are typically 10 to 12 such adult patients at ASH awaiting discharge. As such, increasing access to specialty clinics allows for appropriate treatment in the least restrictive setting.

The figures in the chart below includes discharges from any state psychiatric facility and readmissions rates at any state operated psychiatric facility at 30 days and 180 days from discharge.[2] There have been well over 500 discharges from state psychiatric facilities each year during this period. When compared to the readmissions targets, actual readmissions were under the target threshold for 2008-2010. Also, the number of individuals transitioned to the least restrictive and more integrated environment, a certified specialty clinic, increased by 14% between 2008 and 2011.

Psychiatric Inpatient and Specialty Clinics 2008-2011

	Psychiatric Facility Inpatient Discharges	Readmissions Target 30 days	Actual Readmissions 30 days	Readmissions Target 180 days	Actual Readmissions 180 days	Specialty Clinics Clients Served
2008	650	10%	3%	25%	16%	594
2009	764	5.5%	3.1%	15%	10.2%	604
2010	689	5.25%	5.2%	9.5%	9.4%	642
2011[4]	573	-	-	-	-	679

[2] Discharges and readmission targets are provided as reported in the Community Mental Health Block Grant Application. Readmission targets were not required in the 2012 report which explains the lack of data for 2011.

State Expenditures in Current Year

The following figures represent the amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

Arkansas Medicaid Projections SFY 2013

	State (Medicaid Only)	Federal	Other[3]	Total
Private Nursing Home	$81,057,044	$449,427,572	$108,723,992	$639,208,608
Public Nursing Home	-	$31,656,301	$13,367,594	$45,023,895
Infant Infirmary	$4,761,417	$16,866,998	$2,361,057	$23,989,472
Human Development Centers	-	$87,975,323	$37,149,585	$125,124,908
10 Bed ICF/MR[4]	$3,141,788	$16,329,817	$3,753,850	$23,225,455
Inpatient Psychiatric *	$48,155,466	$114,038,761	-	$162,194,227
			TOTAL	$1,018,766,565

Home and Community Based Waivers *				
Alternative Community Services (ACS) Waiver	$55,138,062	$130,574,509	-	$185,712,571
ElderChoices	$21,481,885	$50,872,056	-	$72,353,941
Adults with Physical Disabilities	$13,009,951	$30,809,353	-	$43,819,304
Living Choices Assisted Living	$4,442,866	$10,521,318	-	$14,964,184
Non-Waiver Home and Community Based Programs*				
Independent Choices	$8,724,201	$20,660,106	-	$29,384,307
Developmental Day Treatment Clinic Services (DDTCS)	$48,890,519	$115,779,467		$164,669,986
			TOTAL	$510,904,293

* Includes projected expenditure for all Medicaid population.

[3] Other funds may be from a non-federal source or state funds from divisions or agencies besides Arkansas Medicaid.
[4] Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)

Expansion in State Capacity

This section reports on the extent to which Arkansas has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program. This includes the amount of state dollars spent on the expansion and the specific nature of the capacity added each year from 2008 to the present. These figures are reported for populations served by the DHS Divisions of Behavioral Health Services, Developmental Disabilities Services, and Aging and Adult Services.

DHS Division of Behavioral Health Services (DBHS)

Wraparound Services – In an effort to support transitions out of residential treatment centers (RTC) and to maintain children in the community, led by the Arkansas Children's Behavioral Health Care Commission, AR DHS launched a cross-divisional System of Care (SOC) transformation effort in 2007. In October 2009, DBHS initiated the Wraparound Demonstration Projects to provide a family driven and youth guided, team based approach that wraps services and supports around a family whose child is at risk of removal from their home, school and community due to behavioral health issues. Wraparound is a coordinated planning process that leads to an individualized care plan and development of a child and family team. The targeted population is children with severe to moderate behavioral health care needs. Wraparound funds are available to provide services and supports to prevent family crises. These services include respite, mentoring, or other nontraditional supports to prevent disruptions in the home environment. Funds were distributed to 14 sites located across the state within the mental health service areas, and the projects have moved from the demonstration phase to permanent integration in the System of Care since initial implementation. The figures below summarize expenditures since the inception of the program. Since implementing wraparound services across the state, 4002 children have received services.

Arkansas Wraparound Program SFY 2010-2012

SFY	Children Served	Federal (Social Services Block Grant)	State	Total Expenditures
2010[5]	506	$228,181	$36,919	$265,100
2011	1789	$363,013	$616,064	$979,078
2012	1707	$330,994	$427,014	$758,008
Total	**4002**			**$2,002,186**

DHS Division of Aging and Adult Services (DAAS)

DHS DAAS administers several programs to provide services and supports to individuals with long term care needs including ElderChoices, Alternatives for Adults with Physical Disabilities, Independent Choices, and Living Choices. Additional information is summarized below about these programs and the expansions in capacity since 2008.

ElderChoices - ElderChoices is a 1915(c) Medicaid home and community-based waiver program that provides in home services to individuals 65 and over. This program is an alternative to nursing home care for those who meet nursing home eligibility criteria for an intermediate level of care, as assessed by state registered nurses across the state. In April 2008, cash and counseling (Independent Choices) was added to the ElderChoices program under the 1915(j) option to allow program participants to self-direct homemaker and companion services. The waiver cap for ElderChoices has been 7950 for the reported time period.

[5] This data represents a partial year due to the implementation of the project in October 2009. In subsequent years, figures are reported from July 1 through June 30.

ElderChoices Program SFY 2008-2011

SFY	Client Count	Program Expenditures
2008	7,153	$43,309,102
2009	7,197	$51,948,631
2010	7,380	$62,778,795
2011	7,836	$66,054,358
Total		**$224,090,886**

Independent Choices - The Independent Choices program allows Medicaid individuals age 18 and older to self-direct personal care and several waiver attendant care services. The program supports in home care by providing a monthly allowance in place of personal care services. It provides participants with the autonomy to hire and supervise their personal attendants of choice through both employer and budget authority. Independent Choices Program was converted from an 1115 demonstration waiver to a 1915(j) state plan service in April 2008.

The Independent Choices Program expenditures totaled more than $71 million between 2008 and 2012. Since 2008, the number of individuals receiving services has increased by 40%.

Independent Choices Program SFY 2008-2011

SFY	Client Count	Program Expenditures
2008	2,804	$10,620,606
2009	3,004	$15,632,149
2010	3,497	$21,081,374
2011	3,934	$24,024,130
Total		**$71,358,259**

Nursing Home Alternative – Arkansas has one state-funded program that provides home and community based services to older adults and/or adults with physical disabilities through the Area Agencies on Aging (AAA), including adults referred by Adult Protective Services. There are no income eligibility requirements or asset limits; the intent is to target adults over the age of 60 or adults with some type of limiting disability. The program is funded exclusively with state general revenue and it provides services in the amount of $4,765,025 per year. The total program expenditures for SFY 2008 through 2012 are $23,825,125. The current system reports aggregate data on clients served for this program and several others. A system upgrade will be implemented soon to allow DAAS to separately track the client count for the Nursing Home Alternative program.

Alternatives for Adults with Physical Disabilities (AAPD) Program – AAPD is a home and community-based program that provides attendant care and environmental modification services to individuals age 21 through 64 who meet the criteria for intermediate nursing home care. The individual's income should be less than 300% of the SSI Federal Benefit Rate and meet the resource limits for Medicaid.

Since 2008, the capacity of the AAPD waiver program has expanded by 50%, adding new slots each year. For each year that the waiver cap increased, the program client count was at maximum capacity. The waiver cap for SFY 2013 has not yet been reached.

Alternatives for Adults with Physical Disabilities SFY2008-2013

State Fiscal Year	Client Count	Program Expenditures
2008	2,000	$33,964,665
2009	2,250	$39,653,701
2010	2,550	$41,838,590
2011	2,600	$41,943,273
2012	2,800	$42,584,358
2013	3,000	-

Living Choices - Assisted living facilities (ALF) provide 24 hour supervision and supportive services including limited nursing services in a congregate setting to persons aged 65 and older or to persons 21 years of age and above that are blind or disabled. Assisted living is a Medicaid and community based waiver program. The capacity of the Living Choices Assisted Living waiver has been expanded.

Assisted living facility (ALF) caps have increased as indicated below. The capacity of the ALF waiver program has increased each year, having tripled since 2008. For each year that the waiver cap increased, the program client count was at maximum capacity.

Time Period	Waiver Cap
Dec 2007 – November 2008	415
Dec 2008 – November 2009	515
Dec 2009 – November 2010	615
Dec 2010 – November 2011	800
Dec 2010 – present	1,300

SFY	Program Expenditures
2008	$3,387,215
2009	$5,950,708
2010	$8,580,547
2011	$10,074,858
2012	$12,428,725
Total	$40,422,053

Choices in Living - In 2008, Arkansas was awarded a $2 million Systems Transformation Grant. As a result of this grant, Arkansas developed an Aging and Disability Resource Center (ADRC), *Choices in Living*. This resource center has a physical location, but is also accessible by a toll free phone number and individuals are directed to the appropriate services. This single point of entry model provides options counseling to individuals and families that are in need of long term care services and supports. Additionally, individuals can complete an informal screening for Medicaid and HCBS eligibility through the ADRC. In SFY2012, the resource center received over 6,100 calls.

Division of Developmental Disabilities Services (DDS)

DHS DDS administers the Alternative Community Services (ACS) program under the 1915(c) Medicaid waiver. This waiver provides a variety of community-based services to eligible individuals, including services such as Case Management, Waiver Coordination, Supported Living Services, Non-Medical Transportation, Adaptive Equipment, Environmental Modifications, Supplemental Support Services, Consultation Services, and Crisis Intervention Services, through DDS licensed community providers.

DDS expanded the capacity of the DDS Home and Community Based Waiver by 65% in the past 10 years from 2500 program slots in 2002 to 4100 program slots in 2012. Program expenditures from SFY2008-2012 are included below. Additionally, DDS lowered public ICF average census by 15% in the past 10 years with more individuals being served in the community based settings. For each year that the waiver cap increased, the program client count was at maximum capacity. The current waiver waiting list is approximately 2200.

SFY	Client Count	Program Expenditures
2008	3827	$111,785,275
2009	3970	$128,276,687
2010	4025	$139,067,231
2011	4055	$158,217,942
2012	4100	$167,346,313
Total		**$704,693,448**

In addition to expanding the number of waiver program slots each year, DDS has implemented a number of measures to expand HCBS for individuals with intensive needs and to reduce the waiting list to receive these services. These policy and program changes are summarized below:

- DDS established a reserved capacity on the DDS Home and Community Based Waiver for children in state custody, thus diverting unnecessary institutionalization.

- DDS established the "pervasive" level of care on the waiver that allowed pre-authorized expenditures up to $392 per day which was double the previous "extensive" level of care cap. The increase allowed an opportunity to provide more intense level of services to individuals with complex needs.

- In order to address the needs of many individuals on the waiting list, DDS established the priority system as well as reserved capacity that allowed people in intermediate care facilities (ICF), Arkansas State Hospital (ASH), and nursing homes to receive home and community based waiver funding immediately, upon request, to allow a move to a community setting.

- DDS implemented the Supplemental Support service category within its waiver program to assist with expenses when exiting institutional settings or in response to crisis, emergency or life threatening situations. The supplemental support service helps improve or enable the continuance of community living and includes funding for items such as deposits, essential furnishings, essential miscellaneous household appliances, etc.

- DDS created the "Transition Coordinator" position at each Human Development Center (HDC) and Arkansas State Hospital (ASH) in order to facilitate more efficient transitions from institutional to home and community based settings.

- DDS launched the Provider Electronic Solutions (PES) system to allow providers to request prior authorizations for waiver services. This significantly reduces the time needed for DDS to approve requests.

- DDS has recently requested funding to further the work of a provider cooperative for crisis planning, intervention, and respite services. Systematic Therapeutic Assessment Respite and Treatment (START), an evidence based practice, will enable people who have both a developmental disability and a mental illness to remain in the community during a behavioral crisis instead of seeking institutional services.

Arkansas Olmstead Plan

This section includes: the contents of Arkansas's Olmstead Plan for increasing community integration; a description of the strategic planning process used to create it; revisions that have been made since its creation; the extent to which it incorporates the new tools created by the federal government to support home and community-based services; and the extent to which Arkansas has been successful in meeting quantifiable goals identified within its Olmstead Plan. Please see attached document, *The Olmstead Plan in Arkansas*, which was developed in March 2003 for contents of the state's plan.

Development of Olmstead Plan

The Governor's Integrated Services Taskforce (GIST), created in 2001 to assist DHS with the development of the Olmstead Plan, met between 2001 and early 2003 to produce the Olmstead Plan for Arkansas. The diverse group included consumers, advocates, providers, and representatives from several state agencies. The GIST made several recommendations that target four key areas of needs: (1) additional resources to support system improvements; (2) increased community capacity; (3) new approaches to service provision; and (4) increased consumer-directed care. In 2008, the outlined goals and action steps were reviewed to assess progress and identify remaining objectives (see attachment *Arkansas Olmstead Plan 2008 Revision*).

Significant progress has been made in Arkansas since 2008. DHS has made a continuous commitment to implementing systems changes needed to achieve the vision conveyed in the Arkansas Olmstead plan. This is reflected in the reported increases in capacity and current investments in improving care for behavioral health, long term care, and developmental disabled populations, as outlined above.

Money Follows the Person (MFP)

Many individuals in the state were able to successfully transition to the least restrictive setting through the Money Follows the Person (MFP) program. MFP has been a key tool is expanding access to HCBS for individuals with disabilities in Arkansas. The Arkansas Money Follows the Person (MFP) program transitions individuals who have resided in institutions 90 days or longer into qualified home and community-based programs. The chart below reports the number of individuals transitioned to home and community settings as a result of the MFP program in Arkansas. The following information summarizes program highlights since 2008:

- Between FY2008 and 2011, 247 individuals were moved to home and community settings.
- The number of individuals transitioned to home and community settings in 2011 was more than five times higher than in 2008, with a steady increase each year.
- The MFP Rebalancing Program expenditures were $2.1 million for this four year period.

Money Follows the Person SFY2008 – 2011

SFY	Aged[6]	Physically Disabled	ID/DD[7]	Adults with MI[8]	Total
2008	5	2	14	0	**21**
2009	13	16	12	2	**43**
2010	20	29	15	2	**66**
2011	6	83	27	1	**117**
Total	**44**	**130**	**68**	**5**	**247**

[6] The aged population includes adults aged 65 years old and over. The remaining categories refer to individuals that are 19-64 years old.

[7] ID/DD is an abbreviation for intellectual disabilities and developmental disabilities.

[8] MI refers to adults with a mental illness diagnosis.

Current HCBS Expansion Efforts
Arkansas is currently pursuing several of the opportunities afforded to states under the Affordable Care Act to support HCBS expansion, including the Community First Choice Option (CFCO), State Balancing Incentive Payment Programs (BIPP), and the 1915(i) option. DHS has developed work groups to analyze the impact and proposed state models for potential implementation of CFCO, BIPP, and 1915(i). The programs will expand access to lower cost community based services while strengthening the person-centered nature of the long term care system by providing a broad range of options and enhanced community integration.

Health System Transformation Initiatives
In the face of rising health care costs and a slow growing economy, Arkansas has embarked on a broad health systems transformation initiative to support the health and well-being of all Arkansans, especially those with low household incomes and serious health conditions. A significant focus of this effort is Arkansas Health Care Payment Improvement Initiative (payment improvement), which will bring together Medicaid and private insurance companies to design and build a new payment system that will drive the shift to a higher-quality and more cost-efficient system of care. The CFCO and BIPP complement the payment improvement initiative. The primary goal of these two options is to align the level of need with the most appropriate level of services in the least restrictive care setting. This provides a framework for the episode-based payment improvement approach for community based services which will be reinforced by robust quality tracking and outcomes measures. The CFCO also provides additional resources and a mechanism to eliminate the Alternative Community Services (ACS) waiting list of over 2000 people with developmental disabilities and offers long-awaited services to those who need them.

The 1915(i) option is also being pursued as a mechanism for creating access to new home and community-based services for targeted populations of individuals with disabilities. As noted in a previous section, the reported data indicates that expanding access to home and community based services for the mentally ill population has not grown at the same pace as other populations. Many of the behavioral health services in Arkansas are currently provided under the Rehabilitation Services for Persons With Mental Illness (RSPMI) program and some desirable services, such as supported employment and peer services, are not provided under RSPMI, but could be provided under a 1915(i) state plan amendment. This model would support a recovery oriented approach for individuals with severe and persistent mental illness and enhance independent functioning and improve quality of life.

Finally, Arkansas is planning to build a health care system that complements implementation of innovative care coordination models such as Health Homes, which will be made available to many of the highest needs people in the state. In an effort to provide enhanced care coordination for individuals with chronic conditions, a health homes model will be developed to improve care coordination, patient experience, and health outcomes. Planning efforts are underway to address the fragmented health care delivery system and improve access to services for individuals with developmental disabilities, mental health issues, and elderly individuals receiving home and community-based services or receiving care in long-term care facilities. While subject to change, projected implementation for the DD health home will begin in 2013. To help guide the development of the health homes model for the identified targeted populations, the following guiding principles will ensure health home planning efforts support the intent of the provision and align with the payment improvement initiative:

- Health homes must address the comprehensive needs of individuals by utilizing a "whole-person" and "person-centered" approach while ensuring personal choice assurances throughout service planning and service delivery.
- Health homes will provide services that address issues of access to care, accountability and active participation on behalf of both providers and individuals/families receiving services, continuity of care across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services.
- Health homes will provide services that seek to align a fragmented system of needs assessment, service planning, care coordination, transitional care , and direct care service delivery.

- Health homes must demonstrate the use of health information technology as a means to improve service delivery and health outcomes of the individuals served.

In order to support Arkansas in accomplishing the vision of this model for our health care system, an application will be submitted to the Center for Medicare and Medicaid Innovation for the State Innovation Model (SIM) grant in September 2012. The SIM funding opportunity was created to help states design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance.

This broad effort supports integrated care planning, patient centered treatment options, and access to appropriate services to meet the specific needs for each population. It will provide seamless navigation of medical, behavioral, long term care, and other areas of services for those who have complex needs or require additional layers of support. The expected outcomes of these reforms are enhanced personal choice, improved client experience and health outcomes, as well as cost reduction due to alignment of need with the appropriate level and setting of care, and elimination of unnecessary spending due to better care coordination.

Successful Strategies

This section addresses successful strategies that Arkansas has employed to effectively implement Olmstead, highlighting particular strategies that could be replicated by another state or on a national scale.

Regarding the strategic planning process, it has been most effective to develop cross-divisional work groups or task forces to assess the needs of individuals with disabilities across systems that include AR DHS Divisions of Behavioral Health Services, Developmental Disabilities Services, and Aging and Adult Services. This approach has been successful in supporting a broad analysis of needs and gaps in the system. It has also been key in identifying policy or program barriers that impede the provision of integrated care for individuals with disabilities (i.e., the need for a single, person-centered care plan). Providers and consumers must also be included in the strategic planning process in order to provide feedback on the impact of program and policy changes in the community. Stakeholder engagement has been a vital part of the Arkansas effort to transform the health care system by involving them in each phase including: (1) needs assessment; (2) program design; (3) program implementation; and (4) program evaluation.

Multiple opportunities and new programs have been afforded to states to expand capacity to provide services for people in the most integrated settings. In addition to expanding the capacity of current programs, Arkansas is currently pursuing the Community First Choice Option, State Balancing Incentive Payment Program, Health Homes, and the 1915(i) option. As outlined in the previous section, Arkansas is working to effectively leverage these tools in order to build a robust, sustainable home and community-based care model in the State. The impact of these tools is yet to be seen, but Arkansas anticipates significant improvements in the health care system in the state that provides individual with disabilities with a full continuum of treatment options and supportive services.