State Plan for People with Disabilities

FFY 2007-2011

Indiana Governor's Council
for People with Disabilities

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Executive Summary

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EXECUTIVE SUMMARY

Introduction

The federal *Developmental Disabilities Assistance and Bill of Rights Act* (Public Law 106-402) provides states with federal funds to engage in advocacy, capacity building, and systemic change activities on behalf of persons with disabilities. The Indiana Governor's Council for People with Disabilities is the designated state agency established by Indiana Code IC 4-23-29 and is solely responsible for the development of a state disabilities plan and engaging in activities consistent with that enabling legislation and the federal legislation.

The purpose of this plan is to provide a philosophical and practical framework for achieving the vision of accessible inclusive Hoosier communities. The principles set forth in the plan will serve as a blueprint for action as the Council facilitates a dialogue between the public and private sector and people with disabilities in promoting independence, productivity and inclusion throughout the Hoosier community.

The Vision: Hoosier Communities will be accessible, inclusive and respectful of all their members.

The Mission: To advance independence, productivity and inclusion of people with disabilities in all aspects of society.

LONG TERM GOALS:

1. INCLUSION

To strengthen the Hoosier community so that it is more welcoming and accessible, to the end that people with disabilities can fully and equally participate in the life of the their communities:

- have friendships and relationships with individuals and families of their own choice;
- live in typical homes or apartments of their choosing in typical neighborhoods close to community resources, with regular contact with individuals without disabilities in their communities;
- enjoy full access to and active participation in the same community activities and types of employment as individuals without disabilities; and
- take full advantage of their integration into the same community resources as individuals without disabilities, living, learning, working, and enjoying life in regular contact with individuals without disabilities.

2. SELF DETERMINATION

Promote self determination to the end that adults with disabilities and families of children with disabilities have:

- the ability and opportunity to communicate and make personal decisions;
- the ability and opportunity to communicate choices and exercise control over the type and intensity of services, supports, and other assistance the individuals receive;
- the authority to control resources to obtain needed services, supports, and other assistance;
- opportunities to participate in, and contribute to, their communities; and
- support, including financial support, to advocate for themselves and others, to develop leadership skills, through training in self-advocacy, to participate in coalitions, to educate policymakers, and to play a role in the development of public policies that affect individuals with disabilities.

3. PUBLIC AWARENESS

Promote positive attitudes and respect for people with disabilities their rights and contributions including:

- involvement of people with disabilities in policy arenas.
- portrayal of people with disabilities in a positive manner in publications and the media.
- Use of respectful language including “people first language”
- Enforcement of civil rights laws and access standards
- Recognition of the value and strength of a diverse community and workforce

THE OBJECTIVES AND STRATEGIES:

The objectives and strategies of this plan are based on the core strategic Long Term Goals that encompass the areas of emphasis in the *Developmental Disabilities Assistance and Bill of Rights Act - Public Law 106–402.*

While each strategy is associated with a single objective, it is clear that the strategies are interrelated and thus will have impact across multiple objectives.

The success of the following objectives and strategies will depend upon collaborative efforts not only with our partners in the Developmental Disabilities Act but with state agencies, private sector organizations, advocacy organizations and others.

Objective 1

People with disabilities and their families are advocates and organizational leaders throughout the state.

FY 2007

Strategy 1. A

Continue to support Self Advocates of Indiana (SAI).

Contributors
Volunteer time
Arc
Indiana Institute on Disability and Community
Indiana Protection and Advocacy Services
Fund Raising
FSSA Contract (up to $20k – Fort Wayne transition project)
Service Provider Agencies

Success measurement
# of regions developed
# of chapters established
Self Advocates trained
of policy makers educated about Self Advocates

Strategy 1. B

Continue (pending performance) to support the Fifth Freedom project at a level reflecting a significant increase in private support. The Fifth Freedom project includes:

- Initiation, development and support of community cross-disability advocacy groups that carry out:
  - Strategic Planning sessions
  - Research law/policy/regulation on the systems targeted for change.
  - Creation of local Issues agendas and Action Plans
  - Local projects to carry out the Action Plans
  - Legislative or Candidate forums/dialogues in local communities.
  - Disability Awareness Month activities including, but not limited to: distributing GPC Awareness Month materials to schools and churches in their community.
  - Interaction with community policymakers regarding local barriers.
  - Interaction with local organizational representatives to share information about barriers.
- Initiation, development and support of a statewide network of ACT teams that activate local individuals and organizations to respond to timely events and issues of importance to people with disabilities.
- Conduct advanced training sessions for local cross-disability groups on, but not limited to: interacting with policymakers, issues development, preparing strategic action plans, planning and hosting public meetings.
- Maintain an Internet Website offering Fifth Freedom network members advocacy and news alerts, on-line training, real time interactive conferences and forums, a web calendar and other Internet related communications
- Fifth Freedom members include individuals as well as cross disability groups.

Contributors
Fund Raising
Volunteer time
Institute
Local Alliances
Board Members

Success measurement
# of local groups established
# of individual participants added
Actions conducted locally
of actions statewide

Strategy 1. C

Initiate advanced leadership training to enable people with disabilities and families to be effective participants in public commissions, boards of directors and advisory groups. Components may include:

- Organizational development
- Mentoring
- Meeting etiquette
- Effective communication in meetings and organizations
- Speaking in public

Contributors
Indiana Institute on Disability and Community
Community Leadership Training Initiative
Self Advocates

Success measurement
Consumer satisfaction scale
Follow up evaluation

Strategy 1. D

Continue the Consumer Investment Fund to assist people with disabilities and their family members to access training events, conferences and governmental affairs that they otherwise would be unable to attend through:

- Support of educational initiatives of advocacy organizations.
- Support of individuals in acquisition of new information and/or skills.

Contributors
100% match
Volunteer time
Volunteer outcomes

Success measurement
Consumer Satisfaction scale
Follow up outcome forms

FY 2008

Continue Strategy 1. A, Strategy 1. B, Strategy 1. D

STRATEGY 1. E

Initiate a Youth Leadership Forum program for high school juniors and seniors with disabilities. Young people with disabilities will:

- Learn the cultural history of the disabilities movement.
- Learn their rights and responsibilities in securing optimal employment career.
- Learn from successful adults with disabilities.
- Cultivate leadership, citizenship, and social skills necessary to be community leaders role models and mentors..

Contributors
Scholarships
Youth Institute
Boy Scouts
Girl Scouts
Indiana Department of Workforce Development (IDWD)
Other youth oriented groups

Other Resources
National Youth Leadership Forum
Other states who have sponsored Youth Leadership Forum

Success measurement
Consumer satisfaction scale
Follow up evaluation

FY 2009

Continue: Strategy 1. A, Strategy 1. D

FY 2010

Continue: Strategy 1. A, Strategy 1. D, Strategy 1. E

FY 2011

Continue: 1. D, others to be determined

Objective 2

Adults with disabilities and the families of children with disabilities have choice and control over the services they receive.

FY 2007

Strategy 2. A

Conduct the Partners in Policymaking Academy, a leadership-training program for adults with disabilities and parents of children with disabilities. The program teaches best practices, leadership skills, and techniques to develop positive partnerships with elected officials, school personnel and other individuals who make policy decisions about services that you and/or your family use. Session topics may include:

- History-Independent Living, Parent Movement, People First/Self-Advocates Movement
- Education- IDEA, Special Education, Best Practices in Inclusive Education
- State and Local Policy-Services and Legislative Issues, Preparing Testimony
- Best Practices-In Supported Living, Person Centered Planning, Family Supports, Employment, and Assistive Technology
- Federal Policy and Legislative Issues- Americans with Disabilities Act, Federal Disability Laws, Effective Communication with Policymakers
- Community Organizing-Working with Community Groups, Media Relations, Negotiating, Creating Change to Impact Society

Contributors
Indiana Institute on Disability and Community
Indiana Protection and Advocacy Services
FSSA
DOE
State Advocacy organizations
Graduate Volunteers
Fifth Freedom
Self Advocates
Legislators

Success measurement
Consumer satisfaction scale
Life Outcomes scale

Pre and post test
Follow up evaluation

Strategy 2. B

Establish a Self Advocates advanced leadership initiative wherein knowledgeable, self-determined individuals with disabilities will be empowered to understand and enlighten others on the features of good person centered planning, routine life choices, and what it means to be self determined. The initiative will include at least:

- Best practices research.
- Development of a model curriculum and materials.
- Pilot training program.
- Statewide dissemination of the program.

Contributors

Indiana Institute on Disability and Community, Indiana Protection and Advocacy Services, Self Advocates of Indiana

Success measurement

Information from direct management
Consumer satisfaction scale

Strategy 2. C

Support the Back Home in Indiana Alliance in training leaders with disabilities on accessible/affordable housing barriers and effective strategies for increasing the availability of integrated housing. Training may include:

- Assessing whether existing housing is adequately targeted to low income persons with disabilities.
- Strategies to encourage provision of accessible/affordable housing by existing housing programs
- Strategies to obtain future accessible/affordable housing for low income people with disabilities.

Contributors

Indiana Institute on Disability and Community
Indiana Protection and Advocacy Services
Self Advocates of Indiana
Partners in Policymaking
Fifth Freedom

Success measurement

Trainings conducted
Assessments completed

Strategy 2. D

Activate a variety of strategies in order to achieve full implementation of the Americans with Disabilities Act. Some of those actions include:

- Training people with disabilities and their family members
- Partners in Policymaking
- ADA Indiana
- Community projects

Contributors
ADA Steering Committee
Community organizations
Advocacy groups
Self Advocates
Fifth Freedom
Association of Cities and Towns
Independent Living centers
Mayors' Councils
Indiana Protection and Advocacy Services
Indiana Institute on Disability and Community
State agencies
Legal Services Organization
others

Success measurement
Trainings conducted

Strategy 2. E

Collaborate with Indiana Employment First task force and others in the follow up to the Employment Summit completing its action plan and publication of policy recommendations and other information designed to further the full inclusion of people with disabilities.

Contributors
Institute on Disability and Community
INAPSE
SS Administration
INARF
DDVR
OMPP – Medworks
Local Providers

Success measurement
Publication of policy recommendations

STRATEGY 2. F

Create and distribute print and electronic publications that will inform the public about state and national current events, recent studies, best practices, public policy and Council initiatives. Materials may include:

- Newsletters
- Targeted mailings
- Studies
- Flyers
- Brochures
- Position papers
- Fact sheets
- Progress reports
- Annual report

Contributors
Communities
Agencies
Disability organizations
Indiana Institute on Disability and Community
Indiana Protection and Advocacy Services

Other Resources
Information from other organizations and individuals

Success measurement
Reader satisfaction evaluation survey
Focus group
Telephone Survey
Timeliness of issues
E-mail survey

Strategy 2. G

Inform all stakeholders about services, rights and responsibilities under the Home and Community Based Services waiver through:

- Publication of the updated Medicaid Waiver Guide.
- Workshops and training events.
- On Target and the Council E-Newsletter.

Contributors
FSSA

Case Managers
Arc
DOE
Consumers
IPIN
Others

Success measurement
Reader satisfaction survey

FY 2008

Continue: Strategy 2. B, Strategy 2. C, Strategy 2. D, Strategy 2. E, Strategy 2. F, Strategy 2. G, Strategy 2. H,

Strategy 2. H

Promote expanded participation in Self Directed Care through training and advocacy for expansion of the program.

Contributors
CPAS contracting

Success measurement
trained
#participating in SDC

Strategy 2. I

Promote the inclusion model throughout the education system. Initiatives may include:

- Sponsoring conferences
- Sponsoring training
- Coalition building
- Publications

Contributors
Department of Public Instruction
IPIN
INSOURCE

Success measurement
TBD

FY 2009

Continue: Strategy 2. A, Strategy 2. B, Strategy 2. C, Strategy 2. D, Strategy 2. E, Strategy 2. F, Strategy 2. G, Strategy 2. H, Strategy 2. I

FY 2010

Continue: Strategy 2. B, Strategy 2. E, Strategy 2. F, Strategy 2. G, Strategy 2. H, Strategy 2. I

FY 2011

Continue: Strategy 2. A, Strategy 2. B, Strategy 2. E, Strategy 2. F, Strategy 2. G, Strategy 2. H, Strategy 2. I

Objective 3

State and local coalitions effectively address key social issues that affect people with disabilities.

FY 2007

Strategy 3. A

Conduct a statewide conference that focuses on the disability prospective regarding current topics and events, and incorporates the following:

- Showcase best practices
- Highlight model public policy
- Explore issues that impact people with disabilities
- Engage people in discussion
- Provide tools, knowledge and skills building techniques
- Provide networking opportunities
- Offer of CEUs

Contributors
Volunteers
Exhibitors
Indiana Department of Workforce Development (IDWD)
Indiana Protection and Advocacy Services
FSSA
Hotel cost reduction
Donations
Some Speakers

Success measurement
Participant evaluation
Attendance

STRATEGY 3. B

Support a statewide consortium focused on health care for vulnerable populations. The Consortium will:

- Develop policy recommendations.
- Develop a variety of publications that will have multiple applications in shaping the health care debate..
- Host focus groups, town hall meetings and other opportunities for discussion of health care issues.

Contributors
Arc
Providers
Mental Health Association
COVOH
Cit Act
Paul Chase
ICHHI
IPIN
USA
AARP
Church organizations

Success measurement
Participation
Items produced
Issues elevated to policy level

FY 2008

Continue Strategy 3. A,

STRATEGY 3. C

Explore the potential for establishing a Community Mutual Support Network of families of people with disabilities wherein families network at the community level to potentially utilize a co-op model to provide each other with some supports currently unavailable from other sources. Exploration may involve:

- Conducting research / cost benefit analyses
- Conducting seminar(s)
- Developing and publishing materials on Community Mutual Support Networks

Contributors
Family Support Council

Success measurement
Participation
Consumer satisfaction scale

# of networks initiated /established

Strategy 3. D

Work in conjunction with the Generations Project to achieve full implementation of Senate Enrolled Act 493 on Long Term Care.

- Conducting research / cost benefit analysis.
- Conducting seminar(s), forums and other venues for discussion.
- Developing and publishing materials on SE493 and related Long Term Care topics.

Contributors
Generations Project

Success measurement
TBD

Benchmark

FY 2009

Continue: Strategy 3. A

FY 2010

Continue: Strategy 3. A

FY 2011

Continue: Strategy 3. A

Objective 4

Public policy that advances the rights of people with disabilities, integration and best practices is embraced throughout the state.

FY 2007

Strategy 4. A

Conduct a feasibility and fiscal impact study on the potential implementation of the Family Opportunity Act.

Contributors
IPIN
Arc
Indiana Institute on Disability and Community
Riley Child Development Center
Family Support Council

Success measurement
Study completed and published

Strategy 4. B

Promote best practice policies through Council participation in state level policy making initiatives including but not limited to:

- State Use Law committee.
- Family Support Council.
- Other initiatives to be determined

Contributors
TBD

Success measurement
TBD

STRATEGY 4. C

Promote National Disability Employment Awareness Month Disability Mentoring Day to:

- empower students and job seekers with disabilities,
- promote an inclusive workplace,
- highlight the contributions workers with disabilities can make, and
- match job shadowing and hands-on career exploration opportunities for people with disabilities. DMD celebrations sponsored by the U.S. Department of Labor.

Contributors
Indiana Department of Workforce Development (IDWD)
Indiana State Personnel Department
Mayor's Councils
Indiana Protection and Advocacy Services
Indiana Institute on Disability and Community
Independent Living Centers

Success measurement
Trainings conducted

STRATEGY 4. D

Train people with disabilities in all aspects of the electoral process. Training may include:

- Implementation of the Help America Vote Act
- Get Out the Vote methods
- Rights and responsibilities in the election process
- Becoming poll workers

Contributors
Indiana Secretary Of State
Indiana Protection and Advocacy Services
Indiana State Election Board
Local election officials
Self Advocates
Advocacy groups
League of women voters
NAACP
Entities covered under the Motor Voter Act
Area Agencies on Aging
Services providers
Independent Living Centers
American Association of People with Disabilities

Case Management

Success measurement
Trainings conducted

FY 2008

Continue: Strategy 4. A, Strategy 4. B, Strategy 4. C

FY 2009

Continue: Strategy 4. A, Strategy 4. B, Strategy 4. C

FY 2010

Continue: Strategy 4. A, Strategy 4. B, Strategy 4. C

FY 2011

To be determined

Objective 5

People with disabilities, their contributions and rights are valued and respected by all aspects of society.

FY 2007

STRATEGY 5. A

Continue to sponsor March Awareness Month to fully engage the public and private sectors in conducting an array of activities. Activities may include:

- Mayors' proclamations
- Recognition events
- Essay contest
- Community celebrations
- Art contest

Contributors

Volunteer advocates
Fifth Freedom
United Cerebral Palsy of Greater Indiana
Schools

Universities
Faith based communities
Public media
Law enforcement agencies
Corporate enterprises
Government entities
Indiana Institute on Disability and Community
Indiana Protection and Advocacy Services
Independent Living Centers

Success measurement
Consumer satisfaction scale
Perceived community change

STRATEGY 5. B

Sponsor the Community Spirit Awards to recognize the efforts of those individuals and organizations that make a difference, through their advocacy efforts, to insure that people with disabilities and children with disabilities have the opportunity, supports, and access they need to become fully included in society. The process may include:

- Nominations for the Distinguished Leadership and the Disability Awareness Campaign Awards
- Selection of honorees
- Recognition event

Contributors
Volunteer advocates and organizations

Success measurement
Awards presented
Attendance at luncheon
Media coverage
participant evaluation

FY 2008

Continue Strategy 5. A, Strategy 5. B

Strategy 5. C

Create a series of multimedia products depicting the history of the disability movement in Indiana for various venues and distribution. Products may include:

- DVD
- Booklets
- CD

- Slides
- Powerpoint
- Brochures
- Personal illustrations
- Play/Film
- A permanent display at the State Museum
- Internet / world wide web presence

Contributors
Indiana Arts Commission
State Museum
Indiana Oral History Project
Self Advocates
Hoosier Heartland Festival
Historical Society
VSA
Public Radio/TV
Independent Living Centers
Indiana Institute on Disability and Community
Advocacy groups and individuals
and others

Success measurement
Creation of multimedia products
Museum commitment to support the project and maintain a display/installation/
Website establishment

Strategy 5. D

Train local groups and individuals to conduct March Awareness Activities in their communities. Trainees will be prepared to reach out to local:

- Schools,
- faith based communities,
- law enforcement agencies,
- corporate enterprises,
- government entities and
- other local decision makers

Contributors
Indiana Protection and Advocacy Services
Indiana Institute on Disability and Community

Riley Child Development Center
IPIN
Self Advocates

Success measurement
People Trained
Local activities conducted

FY 2009

Continue: Strategy 5. A, Strategy 5. B, Strategy 5. C

Strategy 5. E

Develop and cultivate a partnership with non disability focused entities in order to increase opportunities that will result in sponsorships of collaborative efforts and enhance the participation of people with disabilities as a valuable untapped resource on economic, community, civic and social issues.

Contributors
Economic Development Council
Indiana Humanities Council
Aging Network
Universities
Community organizations
Philanthropic organizations
Transportation policy bodies
Housing policy bodies
Media
Others to be determined

Success measurement
Joint action, project, or co-sponsorship of an effort between the Council and other organizations.
Greater participation of people with disabilities in initiatives that are not disability focused.

FY 2010

Continue: Strategy 5. A, Strategy 5. B, Strategy 5. C

FY 2011

Continue: Strategy 5. A, Strategy 5. B, Strategy 5. C

STATE PLAN EVALUATION

For this plan to fulfill its potential value it is vital that an evaluation component be implemented. The Council board and staff will deploy a variety of techniques to assess the effectiveness of its actions over the coming five year period. Performance targets are associated with each Goal, Objective and Strategy. These will be utilized to determine the success of each effort and to assist in any necessary modifications. These results and the results of consumer satisfaction surveys as well as other indicators will be employed in developing annual reports and annual updates to this plan.

STATE PLAN DISSEMINATION

This plan will be posted on the Council website, and made available in accessible printed and alternative electronic formats.

POLICY REVIEW AND ANALYSIS AND DIRECT CONSUMER INPUT

The Council has chosen to reach beyond the requirement in conducting a comprehensive review that describes the availability and extent of services, supports, and other assistance, the extent of unmet needs for those individuals with disabilities and their families in the State as well as issues, influences and views beyond the typical human services perspective.

Consumer Survey

A consumer survey gathered responses regarding degree of satisfaction, importance, and progress in Indiana's service system and consumer preferences for areas that need significant improvement. There were 842 respondents, from 82 of Indiana's 91 counties

Approximately 16% of respondents were partners graduates.

A significant number of respondents chose to use the items that requested narrative responses to describe "Other" to express their concerns that were not specifically covered in the survey. A large portion of these related to public school issues. This could be indicative of families feeling more empowered and less compliant.

The Top 3 barriers to community participation indicated by respondents were cost, attitudes and transportation. However, the top priorities for improvement among respondents were Education, Medical and Health and Employment. Equally interesting is the fact that Education, Medical and Health were rated number 1 and number 3 highest satisfaction with current systems.

Satisfaction with Services

To assess satisfaction with services, respondents who has used a particular service were asked to rate their satisfaction on a scale of 1-5 (where "1" = Not Satisfied and "5" =Very Satisfied). Satisfaction rates of service users were particularly high (more than 60% rated the service "3" or higher) for education, service coordination and case management, and medical and health services.

Medicaid waivers, services to resolve disputes and discrimination, respite services, and family support services received the lowest percentages of satisfaction (less than 40% rated the service above "1" or "2").

Sources of News and Information

Respondents were asked to indicate the extent they used various sources of news and information, on a scale of 1-7, with "1" = not used at all to "5" = used very much. Television

and the Internet/World Wide Web are the most frequently used sources. Least used sources (less than 50%) were radio, public libraries and news magazines like Time, Newsweek, etc.

Voting

The survey yielded results about the growing rates of people with disabilities exercises their civic responsibilities. More than 80% of the people with disabilities of voting age were registered and had picture IDs. Nearly 75% voted in the last election, and only 12% of these used absentee ballots. They experienced very little need for assistance (only 12% indicated the need) and 82% found the poll workers knowledgeable, helpful, and non-discriminatory. Of those that did not vote, most were prevented from doing so because they did not care to vote, had difficulties with transportation, or could not because of physical accessibility, either with the machines or the polling place itself. Poll workers are generally considered helpful but there are still incidences of people turned away and issues of access to polls and voting machines.

Community Participation

Several questions attempted to ascertain the extent and type of community participation people with disabilities engage in. The most popular community venues where people with disabilities participate include church (85%), restaurants (80%), and community events like fairs, parades, and festivals (66%). People with disabilities participate least frequently in civic events such as town or school board meetings and government hearings (24%), volunteer activities (40%), and recreational sporting events (44%). The most significant barriers to increased participation in community activities and events that the respondents cited were cost, transportation, and community attitudes.

Community Attitudes

Several questions were presented to the respondents to ascertain information about community attitudes. Respondents were asked to rate attitudes of various community groups on a scale of 1-5, with “1” = poor attitudes to “5” = very good attitudes. Ratings were quite high in this area, with faith-related groups and health and medical professionals reported as having good attitudes by more than 75% of the respondents. Respondents were least happy with the attitudes found in the news, and those of elected officials and staff of government programs.

Sources of News and Information

Respondents were asked to indicate the extent they used various sources of news and information, on a scale of 1-7, with “1” = not used at all to “5” = used very much. Television and the Internet/World Wide Web are the most frequently used sources. Least used sources (less than 50%) were radio, public libraries and news magazines like Time, Newsweek, etc.

Focus Groups

14 Focus Group sessions involving people with disabilities and other representatives of nonprofit organizations, advocacy groups, state and local governments, service providers, media and others met to identify issues and related policy recommendations.

The focus groups were Facilitated and results compiled by Ms. Vicki Pappas PhD, Mr. Jeffrey Chait, and Mr. Matthew Norris of the Collaborative Work Lab Indiana Institute on Disability and Community— Indiana University Center for Planning and Policy Studies

The focus groups covered the following topics:

- Education - staff training, staff retention, career visioning, transition, School to Work, higher education, Disability Student Services, curriculum, IEPs, assistive technology, ISTEP,ISTAR
- Community Living Supports - waivers, case management, personal assistance, respite
- Transportation
- Housing
- Health and Safety - access to health care, health insurance, emergency evacuation
- Civil Rights - the ADA, voting, criminal justice
- Accessible Technologies - assistive technology, websites, computers, Section 508
- Employment - recruitment, pay, benefits, supports, Social Security career development, entrepreneurship,
- Values - media, ethics, public attitudes
- Preschool, Early Intervention, and Child Care
- Community Participation & Leadership - board member-ship, civic participation, recreation and leisure, worship, arts

In each session key stakeholders identified primary issues and recommendations to address the issues identified. The resulting 370 issues statements and 388 recommendations can be regarded in 5 basic categories; funding, quality assurance, coordination, attitudes and empowerment/power sharing.

FUNDING

Funding was an issue across all of the topics. Participants provided a clear message that the whole statewide “Hoosier family” is not utilizing resources in ways that respect it’s members who have disabilities.

There were expressed need for funding for expansion of personal services, better pay for teachers, aides, school psychologists, maintenance and expansion of services, better and expanded higher education preparing professionals to serve people with disabilities, transportation, technology, health care/insurance, housing, etc.

Recommendations have more to do with what to do with additional funding rather than how to acquire it. There was one highly ranked recommendation to enact a state tax credit to offset the costs above $200 for providing assistive technology necessary to employ individuals with disabilities.

QUALITY ASSURANCE

Standards, qualifications, supports and accountability are terms that appeared in nearly every session. Stakeholders indicated a desire for stronger education and training of personnel in all areas of service to people with disabilities, stronger enforcement of law and regulations protecting people with disabilities from bad service, exploitation and abuse and levels of service and support that assure a good quality of life.

COORDINATION

Coordination is closely related and linked to Quality assurance. Participants identified coordination and communication as a major factor across topics. They indicate that there is fragmentation in approaches, to serving people with disabilities between and even within entities intended to serve. The fragmentation in approaches is one of the factors resulting in lack of common definitions, cohesive unified leadership and conflicting policies and limiting cooperation and coordination.

While the current implementation of the “one stop” approach was deemed significantly inadequate there seemed to be considerable support for making it work properly and expanding it into a wider arena of service access.

Further recommendations to address coordination centered around methods, establishing better communications, including people with disabilities and families at ever higher level of decision making, consortiums of providers, and consolidation of different programs.

ATTITUDES

The general public, the media, the legislature, business, service providers, medical personnel, state agency personnel, school personnel, etc. all came in for rather sharp criticism regarding attitudes about people with disabilities. While it was acknowledged that there has been some progress in recognizing the value and dignity of people with disabilities, the lives of many are still limited by antiquated attitudes that impact all aspects of daily life.

More information, public awareness campaigns and education were generally put forth as recommendations for changing the impact of attitudes on people with disabilities.

There has been some indication in the political arena in recent years that providing information and explanations may not be the most effective method. Approaches that utilize highly charged terms such as “family”, “security”, etc. to trigger deeply ingrained patterns of belief may yield better results.

EMPOWERMENT/POWER SHARING

Participants indicated that a great deal still is lacking in empowerment of people with disabilities to control their own destinies. There was a call for stronger supports for participation of people with disabilities and family members in IEPs, local advocacy leadership, voting, control of services and providers and policy development at state and

local levels. There continues to be a need for better representation of people with disabilities in all forms of communication media.

Extensive Research was conducted by Health Strategies Inc. A summary of that research is attached. In addition Staff researched an extensive collection of state plans, policy statements, progress reports, surveys, etc.

These three components and the core priorities were employed to develop the goals, objectives and strategies related to advocacy, capacity building, and systemic change that are subsequently undertaken by the Council to contribute to the achievement of the purposes of the State Plan.

Research Summary Report

Purpose

The Council has expanded on the basic requirements for policy and system review in order to provide a greater understanding of the issues and a comprehensive description of the entire picture, the context within which the Council must operate. First and foremost the Council must be cognizant, have an intuitive understanding, and appreciation about the economic, political, and social climate that is in play. Without this broader context, change has very little chance of occurring, planning is void without this essential knowledge. Successful strategies can only be formulated when these elements are taken into consideration.

It is also important to note that the majority of the data in this report is a snapshot within the time frame of on and before December 2005. Since the collection of data, the service delivery system has been in a state of flux. There have been numerous changes in personnel, in overall operating procedures, and most significantly, philosophy in how and who delivers services vis-à-vis, privatization, consolidation with the question to whom, and at what cost. Because these changes are still evolving, it is not possible to capture the future impact they may have on the system. However; when ever possible, the plan has reflected the state of the state.

Introduction

As part of the larger context , data was collected and analyzed from the following sources:

- The Indiana state budget
- The federal budgets
- The Indiana Consolidated Plan
- The Workforce Investment Act
- Law and policy governing:
  - Services to people with disabilities and people who are aging
  - Health care services
  - Assistive Technology

- Education
- Early Intervention
- Independent living services
- Protection & Advocacy services
- Vocational Rehabilitation
- Housing
- Medicare and Medicaid
- Social Security
- Temporary Assistance For Needy Families
- Mental health Services
- Child supports
- Homeless services

- Reports published by
  - United States Government Accountability Office
  - Indiana Family and Social Services Administration
  - Indiana Housing Finance Authority
  - Indiana Business Review
  - RAND Corporation research reports
  - The Consortium for Children and Youth with Disabilities and Special Health Care Needs
  - Center On Budget And Policy Priorities
  - Business Research Center Kelley School of Business Indiana University
  - Center for American Progress
  - Project HOPE, Health Affairs
  - U.S. Department of Health and Human Services Agency
  - Council For Exceptional Children
  - Bureau of Labor Statistics
  - Community Transportation Association of America
  - Indiana department of Transportation
  - Harris Survey
  - Coordinating Council on Access and Mobility
  - World Bank
  - The Economist
  - Economic Policy Institute
  - The Cato Institute
  - National Council on Disability
  - Manpower Corporation
  - Business Week
  - Society of Industrial & Office Realtors
  - National Coalition for the Homeless
  - National Low Income Housing Coalition
  - National Association of Home Builders
- State of the States in Developmental Disabilities (The Braddock report)

and numerous other sources of information pertinent to this plan.

In 2005, the GAO reported that there were more than 20 federal agencies and nearly 200 programs providing a wide array of assistance to persons with disabilities with monetary, medical care, and employment-related services among others. These programs are complex and the regulations governing them even more so. Some serve people with disabilities exclusively; others serve both persons with and those without disabilities. Over eight of every $10 dollars out of the $120 billion in federal support for persons with disabilities in FY 2003 went for monetary support.[1]

In light of that information we must ask how well are the people with disabilities in Indiana served? Do we have the kind of system we need now and in the future? What are the factors that are important in assessing the need for and the nature of the changes necessary to transform the system we have? Since Indiana participates in most federal-assistance for persons with disabilities, its service system will reflect to a large degree the characteristics, for good or ill, of the federal system

THE INDIANA SERVICE SYSTEM FOR PERSONS WITH DISABILITIES

Assistive Technology Policies, Funding, and Legislation

1. AT is central to independent living. The 2004 Harris Survey indicated that Americans with disabilities rely on assistive technology, and over a third said they would lose their independence without this technology.
2. Current Federal Strategy is to fund alternative financing. Funding for assistive technology has moved from funding indirect support in the form of education, information, referral, and technical assistance to funding devices and services through current programs or loan programs. [2]
3. Local Communities can develop recycling programs. [3] Promoting AT recycling efforts is a viable strategy for making AT more available and affordable.
4. Several Barriers Remain. In its 2000 report to the President and Congress, the National Council on Disability listed a number of federal policy barriers to assistive technology and made recommendations for their removal. Several

[1] United States Government Accountability Office. Federal Disability Assistance: Wide Array of Programs Needs to be Examined in Light of 21st Century Challenges. Report to Congressional Committees. (GAO-05-626). June 2005.

[2] Taken from descriptions provided by the Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration. http://www.ed.gov/programs/atsg/index.html (Accessed Sep 2005).

[3] "Assessing the Assistive Technology Act of 1998," **http://edworkforce.house.gov/hearings/107th/21st/assistivetech32102/novak.htm** (Accessed Sep '05).

of these areas have been and continue to be addressed; some are being neglected; all seem relevant today.

5. A number of challenges in Indiana remain:
   a. The ATTAIN project will no longer receive funding under the old Tech Act.
   b. There is a lack of home modification services, and services are not equally available to all consumers throughout the state.
   c. Accessible electronic and information technology is needed in the schools
   d. Lack of Community-Based Funding. While some people are able to access assistive technology and other services through programs such as Medicaid or Medicaid waivers, there continues to be a waiting list for these services that can be up to six years long. In addition there are many people who do not qualify for services through these programs due to a higher income or limits set by programs such as Vocational Rehabilitation.

      The majority (58%) of people who used an assistive device received assistance in paying for it, while 35% paid for their device on their own.

      From those who received assistance paying for their device,
      - 62% reported that their health insurance paid for it;
      - 19% said a public program other than insurance;
      - 16% indicated that a family member or friend fund it;
      - 9% received support from a current or former employer; and,
      - 7% said that workers' compensation paid for it.[4]

Education

Early Intervention Program for Infants and Toddlers Under IDEA
Purpose: This program provides formula grants to states to assist in implementing and maintaining statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs of early intervention services for infants and toddlers with disabilities and their families. Allocations are based on the number of children in the general population in the state from birth through age 2. States are responsible for making services available to eligible children and their families, and may also elect to provide services to infants and toddlers who are at risk of having substantial developmental delays if appropriate early intervention services are not provided.

Over the period 1999 through 2003, Indiana showed a per annum growth rate in the number of infants and toddlers served of 6.4 percent.

[4] National Organization on Disability, *N.O.D./Harris Survey of Americans with Disabilities*, 2004. http://www.nod.org/index.cfm?fuseaction=page.viewPage&pageID=1430&nodeID=1&FeatureID=1422&redirected=1&CFID=3907504&CFTOKEN=16562697 (Accessed Sep '05). Specifics on this survey are available at: http://aidtac.ruralinstitute.umt.edu/harris2004_pres.pdf (Accessed Sep '05)

In **Indiana, for the year ending in 2004, the most common services provided (in addition to "Service Coordination" were: (1) speech therapy; (2) developmental therapy (3) physical therapy; (4) occupational therapy; and (5) audiology**

The 2006 Indiana legislature Created the bureau of child development services within the division of disability, aging, and rehabilitative services and placed the infants and toddlers with disabilities program (first steps) under the bureau of child development services.

The Part C early intervention Program

Over the past five years, total funding for the early intervention efforts in Indiana have increased 15 percent per annum. The federal grant for infants and families was estimated to decline 2 percent for FY 2005 and FY 2006.

Table 4 : Funding for Infant and Toddler Programs, Indiana SFY 2004.

Source	Services/Activities Supported	Amount
Federal		**$26,275,836**
Federal Part C	All Services and Activities	$7,818,892
Medicaid Federal	EI Medical Services, Intake, Eligibility Claims, Personnel Development & Training, Quality Assurance, Child Find, System Coordination	$7,734,780
TANF Federal	EI Non-Medical Services	$11,349,107
State		**$38,546,794**
Early Intervention	All Services and Activities	$17,778,588
Medicaid State	EI Medical Services, Intake, Eligibility Claims, Personnel Development & Training, Quality Assurance, Child Find, System Coordination	$3,335,268
SSBG State Supplemental	All Services	$5,000,000
TANF State	EI Medical Services	$12,122,340
MCH/CHCS State	Intake and Eligibility	$138,684
Local		
Private, Insurance, Fees *		
Other(s), Non-Federal		
Voluntary Family Co-payments	All Services	**220,637**
Total Early Intervention Support		**$65,498,296**

* Cost Participation collection for families exceeding 350% of poverty level began on April 1, 2003

Source: Indiana First Steps Annual Performance Review, 2004, Attachment 1.

Preschool Program, IDEA, Part B

While the Early Intervention Program for Infants and Toddlers with Disabilities (Part C) promotes a comprehensive approach to meeting the needs of children with disabilities from birth through age 2, the Preschool Grants Program is authorized to provide services to children with disabilities ages 3-5.

In the U.S. over the past 5 years (2000-2004,) the number of children served under the IDEA Preschool Grants Program rose from 588,300 to 680,142 for an increase of 16 percent. This growth has slowed when compared to the previous five-year period. Indiana's enrollment increased even more dramatically – up 23 percent for the period.

In light of declining federal revenues and increases in the number served, States have had to do more with less federal grant support. The federal Section 619 per pupil allocations have dropped from $663 in FFY 2000 to $570 in 2004 (-14%); in Indiana, the amounts declined from $627 to $487 (-22%).

According to U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS) in 2003 in Indiana about 23 percent of preschoolers are served in typical early childhood settings or at home and the remainder (77%) was served in environments designed for children with disabilities. The U.S. rate in 2003 was 37 and 63 percent respectively.

Students Ages 6 Through 21 Served Under IDEA

Purpose: The program provides formula grants to states to assist them all in meeting the costs of providing special education and related services to children with disabilities. Funds to states are distributed based on the amounts each state received for FY 1999 and the relative numbers of children in their general populations and in poverty in the age ranges for which they mandate services. Most of the funds must be distributed to local education agencies directly serving children; States may retain the remaining funds for state-level activities including administration of, support of, and direct services to children with disabilities.

Table 23: Number of Children Served Under IDEA, Part B, Ages 6-21. Indiana and in the 50 States and D.C., 1999-2003 and percent change.

Year	Indiana	U.S.
1999	137,100	5,608,237
2000	141,219	5,703,372
2001	145,172	5,789,626
2002	150,136	5,884,875
2003	153,457	5,963,496
2004	155,132	NA
Change 1999-2003	12%	6%

Source: ideadata.org
2004 data from 2004-05 Special Education Statistical Report, Indiana Dept of Education

Issues: Data from the 2004 *Quality Counts* report for Indiana suggests some area of excellence and some in need of improvement.

a. Most states – except California and Indiana - counted students with disabilities who took alternate assessments when calculating participation rates.
b. In 2003-04, Indiana did not report participation rates, performance on alternative testing, drop-out or graduation rates separately for student with disabilities.
c. Indiana does not consider any fiscal factors (e.g., district wealth, student poverty, or students with high educational costs) in allocating money to schools in its special education funding formula.

Employment and Vocational Rehabilitation

Vocational Rehabilitation Services

Vocational/Habilitation Services (VRS) - provides services needed by eligible individuals with disabilities through the Division of Disability and Rehabilitative Services (DDRS), Vocational Rehabilitation Services (VRS) assists people with disabilities to obtain essential services "to prepare for, enter, engage in and retain employment."

Some of the services that VRS provides include: counseling and guidance, referrals to vocational/community supported employment agencies, training, restoration services, job placement assistance, Randolph Shepard Blind Vending Program, Independent Living Services and Assistive Technology Services. Services are initiated in the individual's home community whenever possible through partnerships with local agencies, rehabilitation programs, and employers.

Blind and Visually Impaired Services
Blind and Visually Impaired services is a bureau within the FSSA's Division of Disability, and Rehabilitative Services (DARS). Blind and Visually Impaired Services (BVIS) provides state-wide assistance and services to enable the achievement of vocational and personal independence to the citizens of Indiana with blindness and visual impairment. Individuals may be referred by Vocational Rehabilitation or can be self referred to the following programs. The Randolph Sheppard Business Enterprise Program" (BEP). The BEP program is managed through this bureau. The Randolph-Sheppard Act of 1936, as amended in 1954 and 1974, was enacted to provide blind persons with remunerative employment, enlarge their economic opportunities, and encourage their self-support through the operation of vending facilities in federal buildings.

Workforce Investment Act

The Workforce Investment Act of 1998 (P.L. 105-220) was designed to "consolidate, coordinate, and improve employment, training, literacy, and vocational rehabilitation programs in the United States." The Act establishes a coordinated system of federal aid programs for vocational education, adult education, and job training at State and local levels.

- Title I: Workforce Investment Systems - Replaced the Job Training Partnership Act (JTPA) and certain other Federal job training law with new workforce investment systems.
- Title II: Adult Education and Literacy - Adult Education and Family Literacy Act - Replaced the Adult Education Act (AEA), the National Literacy Act of 1991, and other adult education and literacy programs.
- Title III: Workforce Investment-Related Activities - Subtitle A: Wagner-Peyser Act - Amended the Wagner-Peyser Act that directed: (1) assistance in the coordination and development of a nationwide system of public labor exchange services, provided as part of the "one-stop customer service systems" of the States; (2) assistance in the development of continuous improvement models for such a nationwide system that would ensure private sector satisfaction and meet the demands of jobseekers; and (3) the provision of reemployment services and other activities for individuals otherwise eligible for unemployment compensation in which they must participate to receive the compensation.
- Title IV: Rehabilitation Act Amendments of 1998 - Rehabilitation Act Amendments of 1998 - revised and extended the Rehabilitation Act of 1973 and made minor changes.

The Workforce Investment Act was intended to revitalize the Nation's job training system to provide workers with the information, advice, job search assistance, and training they need to get and keep good jobs, and to provide employers with skilled workers. The Budget for 2005 for the Department of Labor regarding WIA includes:

- Adult employment and training activities—Grants to provide financial assistance to States and territories to design and operate training and employment assistance programs for adults, including low-income individuals and public assistance recipients.
- Dislocated worker employment and training activities— Grants to provide reemployment services and retraining assistance to individuals dislocated from their employment.
- Youth activities—Grants to support a wide range of activities and services to prepare low-income youth for academic and employment success, including summer jobs. The program links academic and occupational learning with youth development activities.
- Job corps—a system of primarily residential centers offering basic education, training, work experience, and other support, typically to economically disadvantaged youth.

- Prisoner Re-Entry Initiative—Supports activities to help individuals exiting prison make a successful transition to community life and long-term employment. The 2005 Budget proposes a four-year Prisoner Re-Entry Initiative, involving the Departments of Justice, Labor, and Housing and Urban Development, which will fund grants to faith-based and community organizations to help reduce recidivism among ex-offenders through mentorships, job training, and other critical services.
- Native Americans—Grants to Indian tribes and other Native American groups to provide training, work experience, and other employment-related services to Native Americans.
- National programs—Provides program support for WIA activities and nationally administered programs for segments of the population that have special disadvantages in the labor market.
- Community College Initiative—a new grant program to provide training through community colleges that will be focused on industries with demonstrated labor shortages.
- Personal Re-employment Accounts—a new pilot program to offer personal re-employment accounts for unemployment insurance recipients.

Legislation was expected to be proposed for 2005 to reauthorize the Workforce Investment Act (WIA), but that has not yet occurred. According to the DOL, "The reauthorization proposal will increase State flexibility and target resources more effectively. For adults, the proposal will consolidate the Adult, Dislocated Worker and Employment Service State Grants into a single block grant to facilitate coordination and eliminate duplication in the provision of services to adults. For youth, the proposal will minimize overlap between the Departments of Labor (DOL) and Education by targeting all of DOL's formula resources to out-of-school youth programs and national grant resources to non-school and out-of-school youth programs that have proven effective." What this implies is a budget reduction or, in some cases, program terminations.

Other Department of Labor Services

- Employment service—The public employment service is a nationwide system providing no-fee employment services to individuals who are seeking employment and employers who are seeking workers. State employment service activities are financed by allotments to States distributed under a demographically based funding formula established under the Wagner-Peyser Act, as amended. Employment service allotments are funded on a program year basis running from July 1 through June 30 of the following year.
- One-stop career centers—These funds are used to support the joint Federal-State efforts to improve the comprehensive One-Stop system created under the Workforce Investment Act (WIA). This system provides workers and employers with quick and easy access to a wide array of enhanced career development and labor market information services. In this activity, funds will be used to implement the emerging egovernment strategy for the WIA workforce system, which will improve accessibility, update the one-stop

technology infrastructure, and improve the efficiency of the labor exchange and other services.

- Work incentive grants—These funds provide competitive grants to improve access to and coordination of information, benefits, and services to enable individuals with disabilities to return to work.

Other Employment Programs for Persons with Disabilities

Supported Employment - Education
The purpose of the Supported Employment program through the Department of Education is for states to develop collaborative programs with appropriate public and private nonprofit organizations to provide supported employment services for individuals with the most significant disabilities. "Supported employment" includes both individuals in competitive work and individuals working in an integrated setting toward competitive work.

Bureau of Developmental Disabilities Services
The Bureau of Developmental Disabilities Services, a part of the Division of Disability and Rehabilitation Services (DDRS) of the Indiana Family and Social Services Administration, funds long-term vocational/employment support services and developmental/rehabilitation services, and support services after an eligible individual's time-limited services through Vocational Rehabilitation have concluded. Employment services include Supported Employment and Sheltered Employment.

Challenges

1. Where do people with disabilities spend the majority of their time? The most recent "Day and Employment Services Outcomes System Report" gives a picture of those kinds of activities in 58 of 65 of Indiana's Community Rehabilitation Programs (CRP). For 10,559 respondents in May 2005, one third (33%) spend their time in sheltered employment, one third (31%) in integrated employment, and one third (36%) in non-work or "alternatives to work" environments. This distribution has not changed over the past five reporting periods. Of the 1,869 individuals in Alternatives to Employment, 67% were "looking for a job." Only 2 percent said it was their choice.
2. Funding for Supported Employment. Funding of the VR program has been flat, and, in light of inflation, has declined. Supported Employment for individuals with the most severe disabilities that are placed in competitive jobs has no federal appropriations for FY 2006.
3. Workforce Development Services Inadequate for Persons with Disabilities. There is insufficient capacity of the workforce development system to provide meaningful opportunities to people with disabilities, including people with significant disabilities and high support needs who are

transitioning to the community from institutional settings or are at risk of segregation.

4. Indiana's *FY 2005-2007 WIA Plan* does not seem to recognize persons with disabilities as an important resource in serving the State's need to grow jobs, employment, and personal income. Indiana has a critical shortage of workers in jobs requiring education and training. Persons with disabilities represent a non-traditional source of labor with skills and work habits that can serve the needs of the State. By dint of performance measures alone, persons with disabilities meet or exceed those exiters in the WIA Indiana system that are not disabled.
5. The reconstitution of the Indiana State Workforce Investment Board (former State Human Resource Investment Council) should include representation of Vocational Rehabilitation. According to the current WIA State Plan, Indiana's State Workforce Investment Board has been dysfunctional for over three of the past four years and was not involved in the formulation of the State Plan. It is not clear whether any agency representing the needs and priorities of persons with disabilities was among those consulted, or whether any past work of the State Workforce Board was available for use in development of the current plan.
6. Geographic Service Areas for WIA. It is unclear what the merits are of the State's request for a waiver to Section 116 of the WIA Act to designate a two-workforce service area for the State. Under the proposal, the State Human Resources Investment Council (SHRIC) would serve as the board for all of the State except Marion County, which would have its own local Workforce Investment Board. This would, in effect, nullify the scope of the SHRIC.
7. Priorities for Regional Boards. Although guidance for Regional Boards regarding the establishment of priorities for funding core services when funds are limited includes criteria for including certain targeted groups, including persons with disabilities as a priority group, each Region has the ability to establish its own criteria, and each Region may establish more stringent criteria than spelled out in the plan – which may trump any statewide priorities.
8. Indiana's VR Spending Patterns. Over the recent past four years, the VR program has expended about $76.5 million on average, 75 percent of which has gone to direct employment services for clients. Guidance and counseling comprised 17 percent and nearly 5 percent on administrative costs. This pattern differs from states in Region 5 when nearly nine percent of expenditures went toward administrative expenses, 30 percent for counseling/guidance, and 56 percent for services. Compared to the distribution of service expenditures in FY 2004 in Region 5, Indiana spent less on eligibility determination/needs assessment and relatively more on physical and mental restoration and rehabilitation technology services.
9. Per Client VR Service Expenditures. The absolute amount of service expenditures per client in Indiana has declined about 11 percent over the FY 2001-2004 period. During that same period, the difference in mean

cost of services expended per client between Indiana and the national mean has declined significantly – about 34 percent.

10. VR Administrative Staff. VR Administrative staff accounted for 6.7 percent of total staff in FY 2004. Nationally, and for agencies of Indiana's type, administrative staff comprised 14 percent of total staff. In Region 5, they accounted for 17 percent. Compared to national rates in total and rates for agencies of Indiana's type, the State's rate of administrative funding is the lowest.
11. VR Counseling and Rehab Tech. Indiana VRS differs among its peer group of all general and combined agency types most notably in the (smaller) proportion of participants receiving Vocational Rehabilitation Counseling and Guidance, Job Readiness Training, Job Search and Job Placement Assistance, Transportation, and Maintenance services. On the other hand, Indiana bettered its peers in the provision of Rehabilitation Technology Services by nearly 44 percentage points.
12. VR Referral Sources. The majority of referrals to VRS are self-referrals or referrals from the medical system. Referrals in Indiana's VR program from the medical system in 2004 were nearly twice the U.S. or Region 5 rates, while referrals from elementary and secondary schools were half the U.S. or Region 5 rates.
13. Client outcomes. Over the recent past, Indiana's VRS has exceeded benchmark measures on six of seven indicators of employment and access standards. The State has failed on only one indicator – a measure of growth in personal income after program completion.
14. VR Risk Review. A diagnostic review of the FSSA designed to identify risk areas to which the organization was vulnerable with regard to vocational rehabilitation services cited 17 risks in the audit, 10 of which were deemed "high" risks.
15. Community Rehabilitation Program Changes. Day and Employment Services Outcomes System reports in Indiana's Community Rehabilitation Programs (CRP) show that about one third spend their time in sheltered employment, one third in integrated employment, and one third in non-work or "alternatives to work" environments. This distribution has not changed over the past five reporting periods.
16. The Future of Independent Living Centers. The Centers for Independent Living program makes competitive grants to support a network of consumer-controlled, nonresidential, community-based centers that provide a broad range of independent living services. Federal funding of Independent Living Centers in Indiana has remained basically unchanged over the past five years, and the program is now *current funded.*

Housing

Indiana has a fairly wide array of housing options that may serve people with disabilities. The following chart shows the Federally funded housing programs targeted to persons with disabilities.

Table 1: Federally funded housing programs targeted to persons with disabilities.

Federal Agency	Program	Assistance to PWD	Targeted to PWD
Agriculture	Rural Rental Assistance Payments	Indirect	Partially
Agriculture	Rural Rental Housing Loans	Indirect	Partially
Agriculture	Section 538 Rural Rental Housing Guaranteed Loans	Indirect	Partially
HUD	Assisted Living Conversion for Eligible Multifamily Housing Projects	Indirect	Partially
HUD	Housing Opportunities for Persons with AIDS	Indirect	Wholly
HUD	Lower Income Housing Assistance - Section 8 Moderate Rehabilitation	Indirect	Partially
HUD	Public and Indian Housing	Indirect	Partially
HUD	Section 202 Housing	Indirect	Partially
HUD	Shelter Plus Care	Indirect	Wholly
HUD	Supportive Housing for Persons with Disabilities	Indirect	Wholly
HUD	Supportive Housing Program	Indirect	Partially
VA	Specially Adapted Housing for Disabled Veterans	Direct	Wholly

Source: GAO-05-626, as presented in Health Strategies report State and Federal Housing Policies, Funding, and Legislation

The Consolidated Plan prepared by the Indiana Department of Commerce (now the Indiana Economic Development Corporation), Indiana Housing Finance Authority, and the Indiana Family and Social Services Administration guides the use of Community Development Block Grants (CDBG), Emergency Shelter Grants (ESG), the HOME Investment Partnerships Program (HOME) and Housing Opportunities for People with AIDS (HOPWA) funding, and replaces the Comprehensive Housing and Affordability Strategy (CHAS) Community Development Block Grants activities include many different programs that provide assistance to a wide variety of grantees. The following table shows the diversity of applications and the 2005 Proposed Allocations

Table 2:Indiana Housing Finance Authority 2005 Proposed CDBG, HOME, and ADDI Allocations

Community Development Block Grant (CDBG)	Allocation
Foundations	**500,000**
-Housing Needs Assessments	400,000
-Site-Specific Feasibility Studies	100,000
Housing from Shelters to Homeownership	**4,500,000**
-Emergency Shelters	500,000
-Youth Shelters	300,000
-Transitional Housing	300,000
-Migrant/Seasonal Farmworker Housing	300,000
-Permanent Supportive Housing	300,000
-Rental Housing	300,000
-Owner-Occupied Units	2,300,000
-Voluntary Acquisition/Demolition	200,000
Total [2]	**5,000,000**

HOME Investment Partnerships Program (HOME)	
Foundations	$400,000
-CHDO Predevelopment Loans	
-CHDO Seed Money Loans	
Housing from Shelters to Homeownership	$4,569,820
-Transitional Housing	
-Permanent Supportive Housing	
-Rental Housing	

-Homebuyer Units	
-Owner-Occupied Units	
-Homeownership Counseling/Downpayment Assistance	
HOME/RHTC/Bond	$2,400,000
-Transitional Housing	
-Permanent Supportive Housing	
-Rental Housing	
CHDO Works - CHDO Operating Grants	$652,806
First Home Down payment Assistance Programs 2	$1,665,509
INTR City Program	$0
Homeownership Counseling	$0
HOME Owner-Occupied Rehabilitation Program	$5,000,000
Administration 3	$1,632,014
-IHFA Administrative Expenses and Professional Contracts	
-Administrative Subrecipient Agreements	
Total	**$16,320,149**
American Dream Down Payment Assistance (ADDI)	
First Home Downpayment Assistance Programs 3	**$634,491**
Housing Opportunities for Persons with AIDS (HOPWA)	
Rental Assistance	$403,549
Short-term Rent, Mortgage and Utility Assistance	$214,653
Supportive Services	$120,206
Housing Information	$34,345
Project Sponsor Administration 1	$53,621
Resource Identification	$242
Operating Costs Technical Assistance	$7,818
IHFA Administration 2	$0
Acquisition, Rehabilitation and Conversion 3	$24,180
Total	**$858,614**
Grand Total	**$22,813,254**

Source: *Consolidated State Plan*, Section III, p. 11

The Home Choice program was created by Fannie Mae to provide affordable housing for low- to moderate-income individuals that are disabled, or who have disabled dependents living with them. The availability of this program in Indiana is the result of a team effort among Indiana Housing Finance Authority (IHFA), Fannie Mae and the Back Home in Indiana Alliance. The program is tailored to meet the unique needs of people with disabilities by offering lower down payment requirements; flexible qualifying and underwriting standards; and use of non-traditional credit histories. IHFA has earmarked $1 million in revenues from its non-taxable mortgage revenue bonds (MRBs) to finance the first mortgages. Additionally, borrowers receive HOME/ADDI funded down payment assistance of 10% of the sales price or the appraised value of the property, whichever is less, up to $14,999.

Challenges

The consumer surveys conducted in developing the Consolidated Plan seem to indicate that while a significant proportion of the special needs population continue to feel that their needs are not met, that percentage is shrinking slightly as indicated by the table below.

Table 3: Percent of Consolidated Plan survey respondents stating needs are not being met by special needs group. Indiana, 2002-2005

	2002	2003	2004	2005
Homeless	57%	57%	55%	59%
Mental Illness	51%	54%	55%	52%
Physical Disability	50%	44%	47%	47%
Development Disability	55%	43%	45%	42%
Elderly	43%	39%	40%	39%
HIV/AIDS	38%	38%	37%	36%
Seasonal Farm Workers	37%	31%	30%	25%

Source: Consolidated State Housing Plan, Section III, p. 21., as presented in Health Strategies report State and Federal Housing Policies, Funding, and Legislation

1. Waiting Lists for Section 8 and Public Housing. It is estimated that about 2,825 families with disabilities are on waiting lists in 34 of the State's city and county public housing authorities (PHA). An examination of the 2004 and 2005 approved PHA plans among 51 authorities showed that no waiting lists were maintained by 17 or one-third (typically smaller PHAs). Among those 34 that did, 24 or 71 percent reported data on Section 8 waiting lists, 51 percent on public housing, and 21 percent on a combination of both.
2. Decline in Funding for Supported Housing and Section 8 Choice Vouchers. The HUD (President's) budget would cut Section 811 in half, dropping funding down to $120 million from its FY 2005 level of $238 million. In addition, the budget would eliminate funding for new unit production in FY 2006 by zeroing out the capital advance/project-based side of the program.
3. Multi-family Units for Persons with Disabilities. It appears that many properties for which persons with disabilities would be eligible do not have units designated for them. Having an "accessible feature" in a unit does not necessarily mean that a unit is fully accessible to persons who use wheelchairs or that it contains accessible features for persons with vision and hearing impairments. According to disability advocacy groups, there does not appear to be any HUD monitoring of Section 811 vouchers to ensure that they are being issued to people with disabilities in need of supportive housing.
4. Allocation of Community Development Block Grant (CDBG) Funds According to Need. Continued use of the current allocation formula has created several anomalies. An increasing number of housing jurisdictions with the same need receive substantially different grants, the amount of funds going to the neediest on a per capita basis has decreased, while the amount of funds going to the least needy on a per capita basis has increased. As a result, among the entitlement communities, on a per capita basis, the neediest 10 percent of communities receive four times as much as the least needy 10 percent of jurisdictions.
5. Private Housing Providers. HUD's Section 504 regulations treat private housing providers participating in the Section 8 housing voucher program as "contractors" rather than as "recipients" of federal financial assistance. As a result of this designation, these housing providers are not required to meet all requirements for assuring accessibility of their programs, services and

activities, thereby further limiting the housing choices available to persons with disabilities.

6. Consumer Education and Outreach. There are no consumer-friendly public documents or counseling programs staffed with persons familiar with fair housing laws like Section 504, the ADA and the Fair Housing Act. This is especially detrimental for persons with disabilities attempting to move out of institutions into the community. ***(This is based on the information available to the researcher as of December 2005)***
7. 7. Planning and Design of Public Housing. Provisions of accessible and adaptable residences for residents with physical disabilities under Section 504 of the Rehabilitation Act of 1973 and the Fair Housing Act of 1988 at the design review stage of construction of new public housing requirements are not enforced, so non-compliance is usually discovered after the public housing project is built.
8. Data and Reporting. HUD's Family Report does not capture data related to the accessibility of units in privately-owned apartment buildings. Without this information, HUD will not know to what extent families' needs for accessible units under the disabilities voucher system are being met in this program. Further, there is no requirement that a PHA report on the number of "general purpose" vouchers that have been provided to disabled families.
9. Discrimination. Many public housing authorities are not in compliance with the nondiscrimination requirements of the FHA and Section 504 of the Rehabilitation Act regarding access to public and/or Section 8 housing for persons with disabilities. In communities where accessible housing does exist, some housing providers still have policies that exclude or place discriminatory conditions of residence on persons with disabilities. In many communities across the country, there continues to be strong opposition by citizens and their elected officials to the location of group homes, assisted living facilities, and other facilities for persons with disabilities in residential settings.

Health and Long Term Care

Maternal and Children's Special Health Care Services.

The Indiana State Department of Health administers the Title V grant through Maternal and Children's Special Health Care Services (MCSHC), a division of the Community Health Development Services Commission (CHCSC). Federal law mandates that at least 30% of Title V grants to states be spent on preventative and primary care services for children and at least 30% of the grant be spent on services for children with special health care needs. Indiana's FY 2005 Title V Block Grant allocation is estimated at $12,500,265.

Children with special health care needs (CSHCN) often require more extensive services than children without special needs. The State Children's

Health Insurance Program (SCHIP) in many states typically provides less extensive benefits and services than do state Medicaid programs.

Researchers examined the characteristics or pre-enrollment experience of the CSHCN population in four states, including Indiana, who enroll in SCHIP.

In their 2003 study, data from the Child Health Insurance Research Initiative to measure the prevalence of CSHCN in SCHIP described their demographic and health care features at enrollment, and compared their sociodemographic characteristics, health status, prior health care experiences, and unmet needs versus children without special health care needs.

The findings indicated that –

- Demographic characteristics of CSHCN were similar to those of children without special needs.
- Although CSHCN were more likely than children without special needs to have been insured before SCHIP, a large proportion of CSHCN were nevertheless uninsured for at least 12 months before SCHIP (New York, 56%; Florida, 68%; Kansas, 24%; Indiana, 25%).
- A high proportion of all SCHIP enrollees, including >30% to 40% of CSHCN, were reported to have unmet health care needs at enrollment in SCHIP. The most prominent reason for unmet needs in Indiana were financial ones.
- The vast majority of CSHCN as well as children without special needs rated the quality of their medical care before SCHIP highly on several specific quality measures.
- Findings confirmed prior studies that CSHCN children have higher use of care and more unmet health care needs before enrollment.

The researchers suggested a number of areas for monitoring and improving SCHIP for CSHCN enrollees, including:
Benefit packages that adequately cover services required such as prescription medications and specialty, mental health, developmental, and home services; alternative financing because utilization of care will be high among this large group of children; coordination of care across programs - such as between SCHIP and the state Title V Maternal and Child Health Services program, a component of which serves CSHCN).

Medicare/Medicaid

Medicaid is the largest public health care program in Indiana, and is the key source of funding for long-term care services and supports for persons with disabilities. In SFY 2003, Medicaid served 12.4 percent of Indiana's population and claimed 14.6 percent of all State General Funds with total state and federal expenditures of $4.3 billion

Persons with disabilities are more likely to be enrolled in Medicaid and less likely to have private health care coverage than the general population. Persons with disabilities in Indiana represented about 12 percent of all Medicaid recipients. Because of their extensive health care needs, however, they account for a much higher proportion of total Medicaid spending (38%).
Persons with disabilities generally qualify for Medicaid through their eligibility for cash assistance through Supplemental Security Income (SSI) program, or because their high medical expenses enable them to qualify for Medicaid as a "medically needy" individual. Indiana is a "209(b) state" with financial (asset) criteria for aged, blind, and disabled enrollees that are more restrictive than the standards for the federal SSI program

a. As a result, in part, of Indiana's more stringent criteria as a 209(b) state, it has proportionately fewer Medicaid beneficiaries in its Medicaid program. The proportion of the Indiana population under age 65 estimated to be eligible for Medicaid assistance was 16 percent in 2002, compared to the national rate of 21 percent. In fact, 209(b) states as a whole have lower rates of eligible persons and lower rates of beneficiaries.
b. The average per beneficiary Medicaid payment was nearly $900 more in 209(b) states compared to non-209(b) states (2002 data). Indiana, however, appeared to be the exception.

Indiana currently has eight Home and Community-based waivers (1915(c), a managed care waiver (1915(b)), and two Section 1115 experimental or pilot programs for prescription drugs and hospice service. Indiana is experiencing explosive growth in waivered community-based services with recent recipient increases of 11-12 percent. Among all states Indiana had the highest increase in HCBS expenditures for persons with MR/DD over the 1994-2004 period

Table 4:. Number served in HCBS waivers. Indiana, SFY2003-2005 (Interpolated)

HCBS Waiver	SFY 2003	SFY 2004	3Q SFY 2005	Interpol. SFY2005	2003-05 % Chng
Aged and Disabled					
Aged & Disabled	3,962	4,637	3,639	3,798	-4.1
Assisted Living	49	106	121	143	190.8
MR/DD					
Autism	331	346	336	335	1.1
Developmental Disabilities	4,655	5,303	5,362	5,409	16.2

Support Services	2,997	3,658	3,681	3,738	24.7
Physical Disabilities					
Traumatic Brain Injury	141	176	148	150	6.0
Children					
Medically Fragile Children	127	131	105	107	-15.7
ALL	12,262	14,357	13,392	13,678	11.5

Source: http://www.in.gov/fssa/statistics/

Table 5: HCBS expenditures in HCBS waivers. Indiana, SFY2003-2005 (Interpolated)

HCBS Waiver	SFY 2003	SFY 2004	YTD 3Qs SFY 2005	Interpol. SFY2005	2003-05 % Chng
Aged and Disabled					
Aged & Disabled	$28,727,559	$33,476,841	$24,662,832	$25,740,433	-10.4
Assisted Living	73,806	317,793	452,787	533,241	622.5
MR/DD					
Autism	10,322,746	12,197,679	8,776,274	8,737,094	-15.4
Developmental Disabilities	246,427,140	329,382,439	252,837,086	255,029,724	3.5
Support Services	10,858,346	26,348,008	20,740,731	21,061,900	94.0
Physically Disabled					
Traumatic Brain Injury	3,478,914	3,382,743	2,947,413	2,977,285	-14.4
Children					
Medically Fragile Children	1,596,876	1,593,011	1,023,036	1,042,522	-34.7
TOTAL	$301,485,387	$406,698,514	$311,440,159	318,091,285	5.5

Source: http://www.in.gov/fssa/statistics/

Table 6: Number of persons on waiting lists for HCBS waiver services. Indiana, SFY2003-2005 (3Q)

HCBS Waiver	SFY 2003	SFY 2004	3Q SFY 2005
Aged and Disabled			
Aged & Disabled	400	1,740	2,164
Assisted Living	0	45	42
MR/DD			
Autism	2,145	2,430	2,756
Developmental Disabilities	6,000	12,569	13,795
Support Services	6,800	7,996	9,149
Physically Disabled			
Traumatic Brain Injury	201	294	342
Children			
Medically Fragile Children	765	892	847
ALL	16,311	25,966	29,095

Source: http://www.in.gov/fssa/statistics/

Table 7: Number of recipients and expenditures for HCBS for persons with MR/DD. Indiana, 1994-2004.

Year	Recipients	Expenditures		
		Total	Per Recipient	Per Capita
1994	529	$4,016.2	$7,592	$0.70
1995	594	16,863.3	$28,389	2.90
1996	816	23,461.3	$28,752	4.00
1997	1,067	33,300.6	$31,210	5.59
1998	1,405	34,323.8	$24,430	5.82
1999	1,554	73,133.6	$47,062	12.31
2000	2,081	73,046.10	$35,101	14.57
2001	2,646	107,430.90	$40,601	17.57
2002	3,802	198,630.00	$52,244	32.25
2003	7,983	267,608.20	$33,522	43.33
2004	9,307	395,771.20	$42,524	63.45
Growth Rate				
1995-99	27.2%	44.3%	13.5%	43.6%
2000-04	45.4%	52.6%	4.9%	44.5%
1994-2004	33.2%	58.3%	18.8%	56.9%

Source: Residential services for persons with developmental disabilities: Status and trends. Reports 1994-2004.

In addition to Medicaid HCBS, states have the option of providing home health and personal care services. Indiana does not offer personal care services. About half of Medicaid-supported home health beneficiaries are persons with disabilities. Recent growth in home health has been explosive both in terms of recipients and expenditures.

The annual cost, on average, to support persons with MR/DD in Medicaid-certified, ICF-MR facilities was $75,500, or about $212 per day. Large, state facilities were over twice that rate at $569 per day. Total per capita expenditures in Indiana have been considerably higher than the U.S. taken as a whole. Indiana has spent about 1.4 times the U.S. per capita rate for its ICFs-MR over the past 10 years. In the recent past there have been notable shifts toward non-state residential services, toward smaller units, and away from ICF-MR certified facilities. The proportion of residents in ICF/MR facilities in Indiana has declined sharply over the past five years, and the influence of state facilities has all but ended.

Nationally, Nursing Facility (NF) residents as a percent of ICF-MR, HCBS, and NF residents combined declined sharply over the five-year period – from 20.5 percent in 2000 to 11.2 percent in 2004 - in effect showing the displacement of settings by HCBS recipients. In Indiana, the decline was less dramatic – from 18.1 percent in 2000 to 15 percent in 2004. Still, there are over 1,700 persons with MR/DD in nursing homes in Indiana.

At the end of SFY 2004, there were an estimated 5,629 persons not presently receiving MD/DD residential services outside their family homes and on waiting lists for such services. It would require an estimated 57 percent growth in available residential service capacity in the State to provide residential services to all of the persons currently waiting.

The managed care waiver was amended in 2003 to include the Aged, Blind, and Disabled population, as well as people receiving both Medicare and Medicaid, people who get room and board assistance, people on MEDWorks, and children receiving adoptive services. This program (Medicaid Select) operates through a primary care case management system on a fee-for-service basis.

The proportion of children that self-select in Indiana's SCHIP is greater than 95 percent, and from 70 to 80 percent have seen their provider at least once during the previous two years. The number of well-child or preventive visits by children under 15 months is below expectations.

Challenges for Home and Community-based Services.

The home and community-based services component of Indiana's long-term care system continues to face challenges regarding collaboration with stakeholder groups, case management, a growing waiting list, quality assurance and enhancement, and direct support workforce issues. An extraordinary number of councils and commissions have weighed in on Indiana's long-term care system over the years up to and including the Government Efficiency Commission. Each in turn would build community capacity, eliminate barriers, and develop partnerships and systems to support consumer choice in the belief that their work would finally "tip the scales away from traditional modes of care and toward more responsive, consumer-driven, outcomes-oriented community care."

1. Direct support workforce issues. One critically important challenge facing the Indiana HCBS program is the ability of provider agencies to find, keep and train qualified people to provide supports to people who receive HCBS. The current reimbursement rate for services results in many providers paying wages that are slightly higher than minimum wage and many direct support staff having few paid benefits, especially if they are working part-time.
2. Bias in Eligibility and Benefits. Medicaid rules for coverage, eligibility and administration favor spending on institutional care often resulting in institutionalization of children, adults and seniors even when community care is less expensive and more appropriate for the individual. Of particular concern is the gap in home and community-based services for adults and children with mental illness and emotional disturbance.
3. Department of Justice (DOJ) Authority under CRIPA is limited. DOJ has no jurisdiction to investigate individual Olmstead complaints, is dependent on the cooperation of local authorities, cannot investigate privately-run institutions, and cannot follow individuals in the post-institutional phase.

4. Fragmentation and Lack of Coordination. Individuals with disabilities face barriers to community living because the right "mix" of services and supports is rarely provided in one package. Instead, individuals with disabilities, their families and caregivers frequently must put together services and supports from multiple service programs, each of which may have its own funding streams, eligibility requirements, policies, procedures, and service sites.
5. Case management. People who receive HCBS services in Indiana do have choice regarding their case manager. This ability to choose a service coordinator was important and appreciated by all of the individuals, family members and stakeholders that the site visitors interviewed. However, even when people do choose an independent case manager, they still have an AAA case manager and a BDDS service coordinator. This was very confusing to many consumers and was reported to be too complex and unnecessarily burdensome by many stakeholder groups. **(Since the State of The States Report efforts to simplify this process and to identify procedures for accountability and authority regarding the role of case management have culminated in a determination by FSSA to contract with a single case management entity. This will tend to remove the ability of the people receiving services to chose their case manager.)**

Fiscal Problems Target Medicaid. Medicaid spending grew by 57 percent nationally between fiscal years 1999 and 2004. In Indiana, the growth was even more explosive with the State showing a 72 percent increase from $2.9 billion to $5.1 billion. This has caused fiscal problems at the state level and threats at the federal level to curtail Medicaid spending.

1. Growth in spending in Indiana over the SFY 1999 to 2003 of 10 percent per annum matched by a growth rate of 10 percent for enrollees indicated that growth in spending was due to the effect of increased enrollments, due in part to economic downturns that made more persons eligible. Additional pressures in enrollment have come from increasing enrollments of children under CHIP.
2. Growth in spending (SFY 1999-2003) was unevenly spread across various services. For those services that claimed a large share of total spending, rapid increases were evident for prescription drugs (15.3% per annum), prepaid/managed care programs (28.1%), and waiver services (36.3%)
3. Growth in enrollment for persons with disabilities and the elderly were much slower than for adults or children, but notable nonetheless, especially for persons with disabilities. This could be due to the State's more aggressive shift to community-based services and HCBS waivers under Medicaid. Despite the moderate growth in enrollment, persons with disabilities claimed nearly half the total spending growth over 1999 – 2003.
4. Growth in long-term care Medicaid expenditures was slower than overall Medicaid spending between 1999 and 2004. Home care services, however, claimed about 58 percent of all spending growth for LTC services. When viewed by eligibility groups, persons with MR/DD were more likely to show a

balance in community-based programs versus institutional ones when compared to persons that are aged or physically disabled.

5. OMPP's FY 2007 forecast would put expenditures at $5.2 billion, with a state share of $1.9 billion. This would represent a 2003-07 growth rate of 7 percent per annum – below the prior year growth of 9.7 percent. Enrollment under this forecast is estimated to increase 4.8 percent – down from previous year's rate of 9.8 percent. The category of persons with disabilities is expected to grow 5.1 percent.

Social Services and Other Community Supports

Social Security

SSI and SSDI

1. The overall participation rate in SSI, taken as a proportion of the total population, has been notably lower in Indiana compared to surrounding states and the U.S. as a whole. And while Indiana's rate or proportion of the population participating in SSI has been increasing at a faster rate that of the U.S., the State remains at nearly one percentage point away from the national average.
2. Recent Increases in SSI Participants. Over the past five years (2000-2004), the total number of SSI recipients in Indiana increased by 9.3 percent, driven by the larger proportion and increase in the number of persons with blindness or disabilities (up 11.6 percent). Children under 18 years of age were the fastest growing group compared to those 18 and older. Overall, about 32 percent of all SSI recipients are also receiving OASDI (Old-Age, Survivors, and Disability Insurance). Payments have risen faster than the number of recipients – up nearly 27 percent over the past five years – from $33.3 million in 2000 to $42.1 million in 2004.
3. SSI Payments to Persons with Disabilities. While the number of persons that are disabled and receiving SSI payments increased 12 percent over the five-year period, the total payments to these individuals increased 28 percent. Accordingly, the per-person amount received in December of each of the five years rose 14.5 percent, from $395 in 2000 to $452 in 2004. SSI recipients under 18 were paid over 20 percent more than the average SSI recipient.
4. SSI Supplementary Payments. In Indiana, there are no mandatory SSI supplementary payment recipients.
   a. The State does provide optional payments to SSI and Medicaid recipients that are residents of room and board facilities (RBAs). The Room and Board Assistance (RBA) is intended to supplement SSI or other income where the recipient is not in need of ongoing residential medical care, but is in need of financial assistance to reside in a room and board setting.
   b. Indiana also began providing in 2002 a monthly personal allowance of $52 for aged, blind, and disabled adult residents of Medicaid-certified facilities. SSI recipients living in these facilities that are entitled to a $30 SSI payment also receive a State-administered supplemental payment of $22.
   c. Over 69 percent of recipients of Indiana's optional supplementation payments were persons with disabilities on January 2004. Over 70 percent of these were living in Medicaid facilities.
5. Indiana's '209(b) Status. In Indiana, the SSI determination does not drive the Medicaid determination. Currently by law, Indiana is a 209(b) state, which means that Indiana's Medicaid definition of disability is more restrictive than the SSI definition.

6. Self-Sufficiency Opportunities. A number of provisions added to the Social Security Act improve opportunities for self-sufficiency for persons with disabilities.
   a. In Indiana, PASS plans (plans that permits an SSI recipient that is disabled to set aside earned or unearned income and resources for a work goal) are not recognized except for persons that are blind or for individuals that have their Medicare premiums paid for by Medicaid. If individuals have more than $1,500 in resources, including amounts in a PASS plan, they will lose their Medicaid benefits. It has been estimated that this has excluded over 1,000 people in Indiana. Over the recent past, the number of PASS plans in Indiana has remained flat at a range of three to six. In 2004, the number jumped more than double to 15. In contrast to the State's experience in the 1990s, however, when it was more common to have 100 to 200 plans in effect, the current number of PASSs is paltry.
   b. While the number of persons on SSI continues to increase, the number of working SSI recipients continues to decrease, and the percent of SSI disabled that are working is declining. In December 2000, there were 82,592 persons with disabilities in Indiana on SSI and about 8.2 percent of those were working. By December 2004, the number on SSI increased 11 percent to 91,519 while the number of working SSI recipients declined 15 percent.
   c. Over the 2000-2004 period, Indiana's rate of PASS/IRWE (Impairment-related Work Expenses) /BWE (Blind Work Expenses) participants was below the U.S. average of participants as a proportion of total SSI working recipients, and has fallen below the national average of PASS/IRWE/BWE participants as a proportion of working SSI individuals.
   d. Over the 2000-2004 period, there was a notable decline in the number of 1619(a) and 1619(b) recipients. In Indiana, the former group was down about 49 percent; in the U.S. the decline was 38 percent. This category comprised about 16 percent of all 1619 recipients. For the 1619(b) group (those that can continue to be eligible for Medicaid) the decline was less dramatic, with Indiana showing a 24 percent drop and the U.S. down nearly 12 percent.
7. Indiana's Medicaid Buy-in program's eligibility rules and policies apply to the Basic Coverage only and does not include persons that are 'medically improved.' Persons eligible are those age 16-64 with annual incomes less that 350 percent of federal poverty limits. Up to $2,000 in assets for individuals and $3,000 for couples are disregarded. Premiums apply for those that earn over 150 percent of poverty. The average monthly expenditure for Medicaid Buy-in participants was less than $1,000 nationally for 21 states, and in 11 states the figure was under $750. However, in Indiana the average expenditure was $2,260 – nearly 10 times the lowest state figure. Over 20 percent of Indiana's participants spent in excess of $5,000.
8. SSDI Population. The total number of SSDI persons in Indiana in 2003 was 165,740, up by 17.5 percent from 1999, and slightly higher than the U.S.

growth of 16.4 percent. The proportion of all Social Security beneficiaries (OASDI) represented by the SSDI group grew in Indiana from 14.4 percent in 1999 to 16.2 percent in 2003 – the same as the U.S. rate. Total benefits grew faster for SSDI persons than OASI recipients as a whole. The annual per person average benefit was about 89 percent of the OASDI amount, below the proportion for the U.S. (93%).

Temporary Assistance for Needy Families (TANF)

1. TANF Benefit Level. Indiana, as with other states, is free to set the benefit levels that apply under its TANF program. Indiana has not increased benefit levels since 1995.
2. Diversion Programs. Most States offer applicant diversion assistance to families as an alternative to ongoing TANF assistance. This assistance can provide benefit payments to families for short-term financial assistance to meet critical needs in order to secure or retain employment. A number of diversion programs provide applicant job search, other services, and/or referral to alternative assistance programs. Indiana has no cash diversion provision.
3. Benefit Limits. States generally may use Federal TANF funds to provide assistance to a family that has received assistance up to 60 months (whether or not consecutively), and may extend federally funded assistance beyond 60 months to 20 percent of the caseload, without penalty, based on hardship or domestic violence. Indiana sets the lifetime limit for assistance at 24 months. Benefits continue to children after the lifetime limit. There are no intermittent time limits.
4. Changing Demographics.
   a. Nearly three fourths (73%) of Indiana's TANF families are single-parent families while the remainder lacked parents. The latter group has grown dramatically – up 5-fold since FY 2000 – while the former has declined about 8 percent.
   b. Children comprised 74 percent of all Indiana's TANF recipients over the five-year period FY 2000-2004. Their numbers increased much more rapidly than those for adults – rising 40 percent compared to adults at 11 percent – in a period when the total number of recipients rose 32.4 percent. For the U.S., on the other hand, total recipients declined nearly 20 percent, with the rate for children declining 17 percent.
5. Changing Service Mix. In FY 2004, Indiana spent 39 percent of its total Federal TANF and State Maintenance of Effort (MOE) funds on cash assistance. This represented a decrease from 45 percent in FY 2002. Spending on services increased 33 percent over the FY2002-2004 period, and the proportion of total expenditures for services went from 35 percent to 48 percent – a jump of 13 percentage points in three years.

6. Total spending
   a. Total spending for TANF has declined about 11 percent over the past three years. Federal contributions were down 10 percent and State MOE match was off 20 percent. Supplemental State Programs (SSP) increases of 54 percent provided some stability and protection.
   b. States spent $2.1 billion in combined funds, or 8.3 percent, on work activities in FY 2004, which includes work subsidies, education and training, and other job readiness activities. Indiana reported spending $9.3 million, or 3 percent, in this area. In all states, child care spending totaled 2.2 percent of all spending in FY 2004, an increase of 0.6 percent from FY 2002 spending levels. Indiana spent no federal or state TANF funds on child care.
7. Post-Service Enrollment. Preliminary findings suggest that Indiana does a very good job of enrolling TANF participants in Medicaid or SCHIP after they leave the program, but the proportion of low-income working families receiving food stamps in Indiana has declined. Indiana ranked 19 among the states in its ability to provide access to child care, but the State was near the bottom of states in the proportion of children eligible for child care based on federal eligibility standards.
8. Promoting Two-Parent Families. The ratio of total number of out-of-wedlock births in TANF families to the total number of births in TANF families is used as a measure for the effectiveness of promoting two-parent families. The percent of births to unmarried women in Indiana in 1999-2000 was 34.5 percent, and by 2001-2002 had risen to 35.9 percent. Based on the change in percent between these two time periods, Indiana ranked 41 out of 50 states.
9. TANF Participants with Impairments. A national study of TANF recipients by the General Accounting Office found that 44 percent of TANF recipients had at least one physical or mental health impairment, nearly three times higher than the rate of such impairments among adults not receiving TANF benefits, and that 38 percent of TANF recipients reported impairments severe enough to require assistance in activities of daily living. Yet, the report indicated no change in the proportion of TANF recipients with disabilities prior to welfare reform in 1996 and afterwards despite declining caseloads – indicating a possible access problem. In addition –
   a. About 20 percent of those reporting impairments also indicated working full or part-time, compared to 44 percent of TANF recipients without impairments. However, the GAO also found that once barriers were identified, recipients often did not receive services designed to address those barriers and help them secure employment.
   b. In areas where TANF recipients with barriers were exempted from work requirements, they were much less likely to receive any services to assist them to address these impairments and take steps toward employment.

c. Most formal instruments used to screen TANF applicants for physical and mental health impairments have not been examined for reliability and validity.

10. Few characteristics of TANF recipients with disabilities in Indiana are publicly reported.
11. Risk Review of TANF. The diagnostic review of the FSSA conducted by KPMG (2005) to identify and prioritize the risks of the organization noted several areas affecting the TANF program. All risks related to the TANF program were rated "high" and needed immediate attention. They included:
    a. Governance and Administration. In its interviews with key management and staff at central and local offices, KPMG could not identify a "quality assurance program or program evaluation process in place for the TANF program, which could result in unidentified issues within TANF."
    b. Eligibility: Determination. KPMG found that, in general, clients "may not be properly assessed for a variety of reasons, including high caseloads, subjective eligibility criteria, and inconsistencies between offices and locations." Investigators found that a combination of factors might lead caseworks to make inaccurate assessments, including highly detailed eligibility guidelines, high caseloads, and time pressures to complete assessments.
    c. Eligibility: Re-determination. KPMG identified different procedures and standards for different programs within local DFR offices (e.g., TANF, food stamps, child care) that made the processes that affect similar clients inefficient for the organization and inconvenient for the clients.
    d. Information Technology Controls. Caseworkers are overriding the computer-based eligibility system in order to accommodate clients eligible across several programs (see Re-determination issue above).

Transportation

1. A large number of persons with disabilities have difficulty obtaining the transportation they need. The 2004 N.O.D./Harris Survey found that people with disabilities are twice as likely to have inadequate transportation (31 percent versus 13 percent) compared to those without disabilities.
2. Gaps in ADA compliance. There are many gaps in ADA compliance with fixed route transit systems. Many fail to announce bus stops, and automatic stop announcement systems have their problems; Problems persist with the maintenance of accessibility equipment; and, wheelchair and scooter attachments are often inadequate.
3. Problems with Paratransit. While Paratransit ridership has increased dramatically along with its costs, riders continue to experience problems using local paratransit systems. Some agencies have tightened eligibility procedures, causing problems when service is denied. Some systems

experience inordinate trip denials, causing failure of next-day guaranteed rides. And, lack of timeliness continues to plague the paratransit system.

4. Lack of Enforceable ADA Standards. Accessible public rights-of-way – streets, sidewalks, and public infrastructures – are critical to practicable transportation for persons with disabilities. Some communities tolerate inaccessible bus stops, intersections without (or with improperly constructed) curb ramps, pedestrian signals inaccessible to people with visual impairments, and barriers blocking sidewalks. Although curb cuts have been required in projects and programs that receive federal financial assistance since 1973, hundreds of thousands have not been built. Additionally, many curb cuts that have been built have not been properly maintained or were not built correctly. The ADA only makes existing transportation accessible; it does not address the many transportation gaps that exist.
5. Private transportation is often inaccessible for those persons with service animals or in wheelchairs
6. Flex and other alternative services often fail to provide services comparable to fixed route with paratransit capability.
7. Rural Transportation. A significant discrepancy in funding to rural areas means that public transit in general and transit service for persons with disabilities in particular will be in short supply.
8. Meeting Indiana's Demand for Transportation. Using the previous needs assessment figures in conjunction with 2004 service use, it is estimated that the State now meets about 27 percent of total demand – 28 percent of urban and 19 percent of rural demand. The State's current *Long-Range Plan* does not appear to address implications of this gap.

Indiana's State of the States Report.

The "State of the States in Developmental Disabilities" is a research project of National Significance administered by the University of Colorado and authorized by the Federal Government's Developmental Disabilities Act as amended. It is funded by the Administration on Developmental Disabilities, United States Department of Health and Human Services. ADD describes the project as "a comparative nationwide longitudinal study of public financial commitments and programmatic trends in developmental disabilities services and supports. The Project is a "benchmarking" study of states performance as they work to implement President Bush's New Freedom Initiative and the U.S. Supreme Court's Olmstead decision, both of which promote community living and greater independence."[5]

In 2004, David Braddock, Ph.D., Project Director of the State of the States in Developmental Disabilities delivered a 2004 progress report on developmental disabilities services in Indiana.[6] The purposes of the report were to analyze the State's performance over the 2000 – 2004 period; compare Indiana's performance to surrounding states; and, provide recommendations for the future direction of DD services in the State. Two previous reports had been prepared by the researchers in 1996 and 2000 and a subsequent nationwide State of the States in Developmental Disabilities 2005 has been completed. The following information updates the Braddock reports with more recent data where available.

■ **Substantial Progress 2000 – 2004.** Indiana's 317 Plan was credited with the "substantial progress" made over the past four years (2000-2004) in the developmental disabilities (DD) services system. As a result of this plan, $157 million in new funding was allocated for DD services to reduce waiting lists and provide services and supports to those unserved and those leaving the institutions that were closing. Fewer persons were being admitted to institutions while more were being supported in their communities in more home-like environments.[7]

Among the several markers of success - the institutional placement rate in Indiana was below national levels, Medicaid spending for waivers to institutional care increased while spending for ICFs/MR dropped. "Today," wrote the researchers, "the HCBS [Home and Community-based Services] Waiver is the

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[5] Administration on Developmental Disabilities, Administration for Families and Children, U.S. Department of Health and Human Services. "The State of the States in Developmental Disabilities." http://www.acf.hhs.gov/programs/add/pns/pns11.html (Accessed Oct '05).

[6] Braddock D and Hemp R. Developmental Disabilities Services in Indiana: 2004 Progress Report. Prepared for the Association of Rehabilitation Facilities in Indiana, Arc of Indiana, Indiana Governor's Planning Council for People with Disabilities, and Indiana Institute on Disability and Community (Indiana University). 2004.

[7] Senate Enrolled Act 317, signed by the Governor in 1997. See report on the 317 Plan by Steve Cook, Director of DDARS, before the MR/DD Commission. http://www.in.gov/fssa/servicedisabl/ddars/mrddreport.html (Accessed Jul '05).

primary federal funding source for Indiana community services programs. This is an important achievement, and the Waiver has underwritten the 80% adjusted community spending growth from 2000 to 2004."

■ **Reduced Reliance on Institutions.** The number of residents at Indiana's state-operated State Developmental Disabilities Centers and in units within state mental illness institutions declined from 797 to 559 by 2004. In addition, there were 835 persons residing in large (i.e., 16 beds or more) private ICFs/MR in FY 2000; by 2004 there were 321. Overall, the decline in the number of residents in large facilities (mostly ICFs/MR), both state-operated and private, for the 2000-2004 period was 14.3 percent per year.[8] Currently, Indiana leads all other states in the surrounding area with the exception of Michigan in the rate of persons in large state and nonstate facilities in 2004.

Table 4: Rate per 100,000 population of persons in large residential facilities. Indiana and Surrounding States, June 30, 2004.

State	Pop (100,000)	Number in Large Settings	Rate per 100k
Illinois	127.14	6,959	54.7
Indiana	62.38	880	14.1
Michigan	101.13	129	1.3
Minnesota	24.01	893	37.2
Ohio	114.59	4,890	42.7
Wisconsin	55.09	2,041	37.0
U.S. Total	2,936.55	69,148	23.5

Source: Coucouvanis K, Prouty RW and Lakin KC. (2005). "Services provided by state and nonstate agencies in 2004." in R.W. Prouty, Gary Smith & K.C Lakin (eds.), Residential services for persons with developmental disabilities: Status and trends through 2004. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

■ **Reliance on Nonspecialized Nursing Facilities.** There were 1,739 individuals with intellectual disabilities and related developmental disabilities (ID/DD) residing in Indiana nonspecialized nursing facilities on June 30, 2004. Expressed as a rate per 100,000 state population, Indiana's rate was higher than that of the U.S. as a whole and of each of its surrounding states. Over the 200-2004 period, there was a 2.6 percent per annum decline of ID/DD residents in nursing homes.

[8] Calculated on the number present on June 30 of the fiscal year, not on the average daily population.

Table 5: Rate per 100,000 of persons with developmental disabilities in nonspecialized nursing facilities. Indiana and surrounding states, June 30, 2004.

State	Pop (100,000)	Number in Nonspecialized Nursing Facilities	Rate per 100k
Illinois	127.14	707	5.6
Indiana	62.38	1,739	27.9
Michigan	101.13	589	5.8
Minnesota	24.01	320	13.3
Ohio	114.59	2,429[a]	21.2
Wisconsin	55.09	112	2.0
U.S.	2,936.55	32,899	11.2

[a] FY 2003 figure

Source: Coucouvanis K, Prouty RW and Lakin KC. (2005). "Utilization of and expenditures for Medicaid Institutional and Home and Community Based Services." in R.W. Prouty, Gary Smith & K.C Lakin (eds.), Residential services for persons with developmental disabilities: Status and trends through 2004. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

■ **Growth in Community Residential Services.** The number of individuals served in out-of-home settings in Indiana increased by 46% between 2000 and 2004, from 10,076 to 14,683. The number of persons with disabilities that owned or leased their living arrangement or that lived in the home of a family member increased 2.3 and 2.5 times respectively. An increasingly larger proportion of those in residential facilities were living in smaller settings. In FY 2000, 19 percent lived in large facilities of 16 or more beds while half (50%) lived in smaller (six beds or less); by FY 2004, only 9 percent lived in the larger facilities while 64 percent resided in small homes.

Table 6: Residents by Setting. Indiana, June 30, 2000-2004.

				Receiving services		
Year	Congregate (ICF/MR)	Host/Foster Care Family	Owned/Leased by Person w/MR-DD	All Residents	in home of family member	Family + Residential
2000	5,423	490	1,447	8,718	1,358	10,076
2001	5,295	517	2,471	8,283	DNF	10,076
2002	4,981	782	2,256	7,989	2,256	10,245
2003	4,729	782	4,586	10,097	4,587	14,684
2004	4,510	543	4,815	9,868	4,815	14,683
Pct Change	-16.8	10.8	232.8	13.2	254.6	45.7

Source: Residential services for persons with developmental disabilities: Status and trends. Reports 2000 - 2004.

The proportion of residents in settings for 6 or fewer persons was higher in three of the five comparison states in 2004 than in Indiana. Michigan was highest with 88 percent, followed by Minnesota (82%) and Wisconsin (76%). The U.S. average was 70 percent in FY 2004.

■ **Growth in Community Spending.** Braddock and Hemp reported that over the 1998-2004 period, "combined institutional and community spending in real terms advanced 64% to a total spending level of $834.2 million in 2004. During 1998-2004, community spending grew 113% and institutional spending plummeted by 27% as the New Castle and Northern Indiana State Developmental Centers and six large private ICFs/MR were closed, and Muscatatuck State Developmental Center and the Madison MR/DD unit continued to be downsized."

- In 2004, it cost $346.1 million to support Indiana's ICFs-MR, 65.27 percent, or $225.9 million, of which was the federal cost share.
- While the number of residents of ICFs-MR had declined 4.9 percent during the 2000-2004 period, total expenditures increased 7.6 percent. The daily costs of State institutions rose 12.4 percent.
- The annual cost, on average, to support persons with MR/DD in these Medicaid-certified facilities was $75,500, or about $212 per day. Large, state facilities were over twice that rate at $569 per day. Total per capita expenditures in Indiana have been considerably higher than the U.S. taken as a whole. Indiana has spent about 1.4 times the U.S. per capita rate for its ICFs-MR over the past 10 years.
- Indiana spent nearly half (48.3%) of all long-term care MR/DD Medicaid dollars in the institutional sector compared to the overall U.S. rate of 42.2 percent.

■ **Growth in Individual and Family Supports**. Individual and family support, consisting of family support, supported employment and supported living and personal assistance, grew exponentially during the period. Family support, consisting mostly of respite care services in the early years, grew from $1 million in 2000 (inflation adjusted) to $26 million in 2004, with only a slight increase in families served from 2,400 to 2,500. Supported employment resources increased 108% in inflation-adjusted terms from 2000-04, from $6.6 million (adjusted) to $13.7 million, with an increase in participants from 1,824 to 4,778. Supported living was estimated by the researchers to total $272 million in 2004 for 8,008 participants, due mostly to the expansion of Home and Community-based waiver services.

- In 2002, Indiana ranked 37th among the states in per capita spending for family support, behind all surrounding states, save Ohio. Supported employment spending per capita was equal to the level in Illinois but well below the levels of all other surrounding states. The State's spending in 2004 at $2.17 was still below the U.S. 2002 level of $2.30. Supported living on a per capita basis in Indiana of $1.37 was well below Ohio, Michigan, Wisconsin, Illinois, and U.S. In 2004, per capita spending of $43.31 exceeded the U.S. level and those of all surrounding states.

■ **Role of Home and Community-Based Waivers in Support Services.** The HCBS Waiver has become the principal financial source for individual and family support spending in the U.S. and in Indiana. Total federal-state Waiver spending in 2002 constituted 47% of family support spending, 29% of supported employment spending, and 68% of spending for supported living and personal assistance. Family support spending in Indiana in 2003 and 2004 consisted almost entirely (98%) of HCBS Waiver funds, and the Indiana Waiver share of supported living spending, 88%, also exceeded the U.S. average in 2002. However, the Indiana Waiver financed only 15% of the State's supported employment services, one-half the U.S. average. Overall, Indiana has been very aggressive in using waiver dollars for individual and family support services. Among all states Indiana had the highest increase in HCBS expenditures for persons with MR/DD over the 1994-2004 period.

Table 7: Percent of supports funded by Medicaid Home and Community-Based Waivers.

	U.S. 2002	Indiana 2003-04
Family Support	47	98
Individual Support		
Supported Employment	29	15
Supported Living	68	88

Source: Braddock and Hemp, p. 23.

■ **Quality Assurance.** A number of initiatives in Indiana's long-term care system have effected a climate of improvement in the quality of services to persons with disabilities:

- **Person-centered Planning. "**Rule 460 IAC 7 was fully promulgated in May 2003. The Rule mandated the use of the person centered planning process for all individuals receiving services authorized by the Bureau of Developmental Disabilities Services (BDDS), including supported living, group home services, and large private (16+) ICFs/MR. As of November 2003 nearly 300 community provider personnel throughout Indiana were approved to facilitate person centered planning."
- **Community Services Standards. "**Indiana Rule 460 IAC 6 promulgated standards for supported living services and supports, including provider qualifications, defining the roles of providers (including case managers), and establishing the processes of provider approval, consumer rights, monitoring and sanctioning of providers, staff training, incident reports, and other mandated health and safety policies and procedures."
- **Individual Support Plans. "**Rule 460 IAC 7 promulgated the individualized support plan . . . including systems to track data from surveys of residential and vocational/habilitation programs. As individuals with DD transition from state-operated facilities, nursing facilities or large private ICFs/MR, BDDS and BQIS staff conduct pre-transition surveys,

post transition surveys at 7 and 30 days, and they continue to follow the individual in her or his new home."

- **Other QA Activities.** "Quality assurance and quality improvement also includes a complaint process, an incident reporting policy and procedure, a risk management committee, and a mortality review committee. Indiana joined the National Core Indicators Project in 1997 (a joint effort of the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute).[9] Indiana scored at or above the national average in most areas. Indiana ranked relatively low in "individual case management recognition" and Indiana and virtually all states had high direct care staff turnover."[10]

■ **Fiscal Effort.** Fiscal effort in Indiana, or the ratio of expenditures on behalf of persons with developmental disabilities to total personal income, expanded substantially between 2000 and 2004 by 43% increase from $3.15 to $4.52. In 2002, Indiana had ranked 32nd in fiscal effort ahead of Michigan (38th), and Illinois (40th). Fiscal effort in 2004 was projected to be 11 percent higher than the projected U.S. level when the State should contribute $4.52 to MR/DD services for every $1,000 in personal income.

■ **Overall Comparisons to Other States.**

- **Family Support - Cash Subsidy.** "Michigan's cash subsidy and family support programs have had a direct impact on the state's mental retardation service system. Michigan places proportionately fewer individuals with mental retardation in out-of-home placements than do Indiana, and all comparison states but Illinois. Illinois, with its family support cash subsidy legislation, and Minnesota have also developed strong family support programs that are good examples for Indiana."
- **Alternatives to Institutions.** "Michigan and Minnesota have made the most progress in the development of community service alternatives to state institutions. Minnesota closed its last remaining state MR/DD institution in October 2000 (now serving only 37 persons in a state MH Center MR/DD unit) and Michigan serves 181 institutional residents in one remaining facility."
- **Nursing Home Reductions.** "Michigan, Wisconsin, Minnesota and Illinois have made the most progress in reducing the numbers of persons with mental retardation and related conditions in nursing homes, with nursing facility utilization rates of 6, 7, 8, and 8, respectively. The U.S. average was 11 and the rate in Indiana was the nation's highest, 30 per 100,000. Although Indiana nursing facility utilization declined to 27 in 2004, it was still more than double the U.S. average for 2002."

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[9] For Indiana's participant in the National Core Indicators Project. See: http://www.in.gov/fssa/servicedisabl/ddars/cip.html; and http://www.hsri.org/nci/ (Accessed Oct '05).
[10] Braddock and Hemp, pp. 23-25.

- **Growth in HCBS**. "Growth in the HCBS Waiver in Indiana in the last four years is impressive, and the State is moving in the direction of Michigan, Minnesota and Wisconsin in reduced reliance on ICF/MR spending, especially for state institutions."
- **Local Government Funding for Services**. "There is local government funding for community MR/DD services in all comparison states, but not in Indiana."

■ **Wages and Benefits for Direct Care Staff.** "Direct support staff wages in privately operated community-based long-term care programs in Indiana are well below the wages of all workers covered by unemployment insurance … below wages for state-operated direct care … just above nursing aides …and the 2002 poverty level for a family of four …" The demand for direct support staff will be strong – up 63 percent through 2010. States are liable for litigation based on low wages since turnover and inability to recruit staff are detrimental to the quality of services. Research has shown that average wages for full-time direct support workers and direct service staff vacancy rates account for about a third of the turnover in facilities.[11]

■ **Aging Caregivers.** Persons with developmental disabilities are living longer and will require caregivers for a longer time. Family caregivers, along with the rest of the population, are aging and approaching an age when they are no longer able to care for their family members with disabilities. Based upon an estimated 99,305 children and adults with developmental disabilities in Indiana, well over half (59%) were calculated to reside with caregivers. Of those, one quarter or about 14, 500 are residing with caregivers ages 60 and older.

■ **Waiting Lists.** "Major factors that have contributed to growing waiting lists in Indiana and other states, in addition to the growing number of aging caregivers, include the large proportion of nursing home residents who could benefit from receiving services in community alternatives, and students exiting special education programs." Estimates on the number on waiting lists include:

- 6,000 awaiting services (317 Task Force, 1998)
- 6,000 waiting for residential services in 2002 (Prouty et al., 2003)
- 11,004 waiting services from DD Waiver (2003)

The FY2005 Program Performance Report from the Council to the Administration on Developmental Disabilities reported the following:

Waiting List Name	Number in Plan or previous PPR	Number in FY2005
Aged and Disabled	1740	2164

[11] Coucouvanis K, Prouty RW, Larson SA, and Byun S. (2005). "Staffing patterns, characteristics and outcomes in large state residential facilities in 2004" in R.W. Prouty, Gary Smith & K.C Lakin (eds.), Residential services for persons with developmental disabilities: Status and trends through 2004. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

Assisted Living	45	42
TBI	294	336
Autism/ Developmental Disabilities	15275	16551
Medically Fragile	892	847
Support Services	7996	9149
Choice	2592	0

■ **Future Priorities.** While Indiana can be justifiably proud of its accomplishments in meeting the needs of persons with developmental disabilities in the State, a number of challenges remain. The researchers recommended that Indiana –

- Continue development of community-based alternatives for nursing facility residents
- Continue expansion of the HCBS Waiver and reduce reliance on ICFs/MR
- Address needs of 10,000 + on Waiver waiting lists
- Steadily expand resources for family support and supported employment
- Increase wages and benefits for direct support staff
- Refine and expand quality assurance and quality improvement and Strengthen DDARS staff to manage expansion and quality improvement of service system
- Launch strategic cross-disability initiative in long-term care

National Core Indicators: Indiana's Performance.

The National Core Indicators (NCI) project was initiated in 1996 by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) "to support state developmental disabilities authorities (SDDAs) in developing and implementing performance/outcome indicators and related data collection strategies that would enable them to measure service delivery system performance."

Phase I began in January 1997with a set of 61 performance/outcome indicators with six states agreeing to conduct a field test of these indicators, including administering the project's consumer and family surveys and compiling other data.

NCI Phase II began in 1999 with revised indicators and improved project data collection tools and methods. The version 2.0 indicator set consisted of 60 performance and outcome indicators and expanded its scope to include services for children with developmental disabilities and their families, and recruited additional states to

participate in the project. Phase II data is considered baseline project data with 12 participating states.

Four additional states joined the project during the following year (2000), and Indiana and six other states joined in 2001. As of 2005, 22 states are actively participating in NCI, plus a local DD authority in California, although not all participated in every year.[12]

Core Concepts
The NCI measures performance in domains that are important values in the performance of systems providing services to persons with disabilities. The Consumer survey uses about half of the set of 60 indicators grouped into clusters that express those values. The clusters relate to Consumer Outcomes and System Performance outcomes:

Consumer Outcomes

- **Community Inclusion**
- **Choice and Decision-Making**
- **Relationships**
- **Satisfaction**

System Performance

- **Service Coordination**
- **Access**
- **Health, Welfare, and Rights:**
  - **Safety**
  - **Health**
  - **Medications**
  - **Respect / Rights**

Survey Results in Indiana. The table following lists the core indicators by domain and includes the scale score for three domains of Community Inclusion, Choice and Decision-Making, and Service Coordination, the adjusted mean scores for items related to scale scores, as well as the mean score for the other domain items.

Readers are cautioned in making comparisons from year to year since the mix of states differs each year and may affect sample results, and each state drew different samples each year rather than following the same group of individuals.

Highlights from this survey indicate that Indiana compared to 16 other states –

- scored "average" on *Community Inclusion* for 2002, 2003, and 2004 - that is, as not statistically different from all other states combined - on the proportion

[12] National Core Indicators. http://www.hsri.org/nci/ (Accessed Oct '05). Indiana is no longer participating after 2005.

of people who participate in everyday integrated activities in their communities.[13]

- was not statistically different from all other states combined for all three years on *support-related choices*, that is, on the proportion of people who make choices about their everyday lives.
- scored "average" on *personal choices* for 2002 and 2003, and "above average" for 2003 for the proportion of people who report having been provided options about where to live and work.
- Scored "below average" on two out of three years and "above average" in one year for *Service Coordination*, that is, for accessible, responsive, and supportive services coordinators.

Other Differences. One notable difference between Indiana and the other states on the Consumer Survey was the relatively higher percentage of Indiana respondents that indicated having visited more than one home before moving into their current homes. Somewhat similar differences were evident for looking for a job or visiting a day activity center.

Hoosiers were more likely to report that they could visit friends whenever they wanted [Relationships]. They were less likely to say that services they needed were not available to them, at least in the first two years of the survey [Access]. Most remarkably, Indiana respondents were much more likely to report having had a physical exam within the past year, visited the dentist within the past six months, and, for female respondents, having had a gynecological exam within the past year.

A greater proportion of Indiana participants indicated taking psychotropic medications for mood, anxiety, or behavioral problems.

A larger proportion of Indian respondents said they have an advocate or someone that can speak on their behalf.

Trends. Since different samples were drawn each year in the states, discussion of trends can only be suggestive. While tentatively, the following items were selected as 'trends' if there was a percentage point difference greater of 5 or more or a difference of -5 or less.

Improving Support-Related Choice. On this basis, all support-related choices can be considered to have improved over the 2002 – 2004 period. For example, in 2002, 37 percent of respondents indicated they had some say on the choice of their case manager. By 2004, over half (51%) said they had that choice or some input into that choice. Equally strong improvements can be said for choice of staff that help at home and at work.

[13] Of course, Indiana was different from *some* states. For example, in 2002, Indiana was significantly from Washington State and Vermont. The former was below and the latter above Indiana.

More modest improvements were seen for personal choices, especially related to what to buy with spending money.

Improving Relationships in some areas. Improvement was evident in two areas: having a close friend to share personal matters, and ability to see family when desired.

Decline in Satisfaction. There was a seven percentage point decline in the proportion indicating overall satisfaction with their living arrangements, and a small decline in satisfaction with work.

Improving Service Coordination. Despite below average scale score in the System outcome area of service coordination, respondents appear to be showing more positive responses about service coordinators in helping participants get what they need and in paying attention to their preferences.

Decreased utilization of OB/GYN services. The gap is narrowing for females indicating having had a GYN exam within the past year.

Increased prevalence of medication use. In 2002, 39 percent reported taking psychotropic medications; by 2004, that proportion had risen to 51 percent.

In addition to using these indicators as performance measures to track improvement and to identify areas in need of improvement whether externally by way of comparison with other states or internally within a single state, additional analyses are possible. For example, how does the population of persons with disabilities compare to the general population of persons without disabilities, or what factors affect performance on which domains?[14]

For example, what factors affect access to health care? In an NCI report, researchers examined a number of likely factors influencing access to primary care, dental care, and specialized care. Findings are suggestive, based on the 2003-2004 data collected by the states from 9,192 persons, that there were "significant differences in health outcomes between consumers who are white and non-white, among those who live in structured settings and those who live at home, those who do and do not have access to transportation, and between those who have a mental health diagnosis and those who do not."[15] In short, minorities, persons that live at home with a parent or relative, and those without transportation show reduced numbers of physical exams, dental exams, and (for females) gynecological exams. Persons with cognitive impairments compared to

[14] For a sample of the several presentations made over the past three or four years using NCI, see: http://www.hsri.org/nci/index.asp?id=presentations

[15] Human Services Research Institute, "Data Brief: Factors Influencing Access to Health Care," *Core Reports*, Vol. 4:1, February 15, 2005. http://www.hsri.org/docs/786_Core_Report_4.1_Health_Access.pdf (Accessed Oct '05).

those with dual diagnoses are much more likely not to take any psychotropic medication.

On the other hand, persons with disabilities in this survey and with respect to these general measures on health care access are gaining access to the system at the same level as the general population.

ORGANIZATION OF SERVICES

In addition to issues relating to the design of programs, the costs of making program changes and the affordability to do so, and the feasibility of making needed changes in light of available human resources and technology, there is the consideration of the organization of services and whether they achieve the integration, efficiency and effectiveness to serve their constituents.

Indiana Family and Social Services Administration (FSSA)

In Indiana, the Family and Social Services Administration (FSSA) was created in 1991 by the Indiana General Assembly to integrate and coordinate the delivery of human services. It has approximately 9,700 employees, located in offices throughout Indiana's 92 counties as well as in its Central Office in Indianapolis and is organized into four major divisions: Division of Disability, Aging and Rehabilitative Services; Division of Mental Health and Addiction, Division of Family Resources, and Office of Medicaid Policy and Planning.[16] FSSA administers Federal programs such as Medicaid, Vocational Rehabilitation, Food Stamps, Temporary Assistance for Needy Families (TANF), Social Security and Disability Insurance (SSDI), Supplemental Security Income (SSI), First Steps (early childhood intervention), and Children's Health Insurance Program (CHIP), among several others. It also provides State mandated programs and provides health and related services to children, the elderly, persons with mental illness, with addictions, and with physical and developmental disabilities.[17]

The FSSA was established to improve the efficiency and management of human services in the State thereby addressing the problems of fragmentation and duplication. In 1991 Indiana's human services agencies were reorganized from independent departments into divisions under the umbrella of a 'super agency,' centralized and consolidated by the Office of the Secretary of Family and Social Services.

Programs overlap to some degree if they serve similar populations (e.g., the homeless are served by the Department of Mental Health and Addictions - since many persons that are homeless suffer from mental disabilities – as well as the Division of Family Resources) or if they have conditions that span several domains (such as persons that are dually diagnosed).

The Division and programs provided by them are listed on Table 1.

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[16] The Division of Disability, Aging and Rehabilitative Services has been subdivided recently into the Division of Disability and Rehabilitative Services and the Division of Aging. See: FSSA, "Our Functional FSSA" http://www.in.gov/fssa/about/ (Accessed Oct '05).

[17] FSSA's website: http://www.in.gov/fssa/events/fastfacts.html (Accessed Oct '05).

Table 1: Divisions of the Indiana Family and Social Services Administration

Division[a]	Budget FY2004-05	FY2006 (in Millions)	FY2007 (in Millions)	Pct. State	Population Served	Program Areas
Family & Children: Family Resources; Child Services[a]	$1,023,950,955	$195	$195	26.1	Economically disadvantaged and vulnerable children and families	TANF Food Stamps Housing Child support[a] Child protection[a] Child care Adoption Energy assistance Homeless services Medical services eligibility Nutrition assistance Job programs
Child Services		$98	$106			
Mental Health and Addiction	$207,734,216 ($144,048,167)[b]	$252	$252	62.8	Economically disadvantaged in need of mental health or	Hoosier Assurance Plan managed care

[a] Child protection and support functions were moved into a new Department of Child Services (DCS) by executive order in 2005.

					chemical addictions services	providers State Mental Illness institutions Prevention services Homeless services
Disability, Aging[c], and Rehabilitative Services:	$320,164,515 ($86,374,018) [b]	$24	$24	62.8	Persons with disabilities or the elderly, primarily economically disadvantaged	In-home services Community services Vocational rehabilitation Supported employment Independent living Nutrition Hard-of-hearing services Blind and visually impaired services Social Security Disability eligibility Assistive Technology Senior employment Protection & Advocacy
Aging and Disability		$65	$65			
Developmental Disabilities		$126	$142			
Office of Medicaid Policy and Planning	$4,391,818,059	1,455	1,525	30	Economically disadvantaged children and families; persons with disabilities; the elderly	Health care services under Title XIX (Medicaid)

[b] Institutional expenditures.
[c] Aging services were separated from the Division of disability, Aging, and Rehabilitative Services.

Priorities of FSSA. FSSA has developed a performance plan including agency performance standards and methods for measuring performance against the standards. The standards are "priorities" for directing resources and support systems within the agency to improve the provision of services. The standards have become part of the budget process and are incorporated in the agency's biennial budget presentation. The following priorities were established for the FY2004-05 biennium:

1. **Community- and Home-Based Services**
   A. Increase the community- and home-based services for troubled children by 550.
   B. Continue to increase community- and home-based service capacity for people with developmental disabilities and people with severe mental illness.
   C. Increase community- and home-based service capacity for the elderly by 1,000.
2. **Prevention**
   A. Conduct screenings for 90% of Hoosier births, offering services to 100% of at-risk families, with 99% of participants with no substantiated abuse or neglect annually.
   B. Offer First Step services to 100% of eligible children, with 95% of children leaving First Steps with verified increased functional abilities.
   C. Increase earnings and savings of TANF recipients by 15%.
   D. FSSA will meet or exceed the national average for people with disabilities competitively employed and increase the number of individuals with severe mental illness and/or addictions placed in supported employment.
   E. Help 15,000 Hoosiers acquire new long-term care insurance policies.
3. **Healthy and Safe**
   A. Increase the number of children on Hoosier Healthwise receiving well visits. Standards are 5 visits from birth to 15 months; 2 annual visits between ages 2-5; and 1 annual visit between ages 6-10.
   B. In four critical diseases, achieve specific clinically measurable improvements annually for Medicaid population: Asthma, Congestive Heart Failure, Diabetes, and HIV/AIDS.
   C. Increase the number of seniors receiving prescription drug benefits under Hoosier Rx to 30,000.
4. **Accountability**
   A. FSSA will publish, implement, and operate with measurable standards to assess quality of services provided.
   B. FSSA will be rated in the top five nationally for efficient use of information technology in a social services agency.

BUDGET OF THE U.S. – 2006

Findings

1. The philosophy of the Administration has been and will continue to be to spend on defense and security and grow the economy through budgetary reductions in non-defense spending and tax relief.
2. Total FY 2006 receipts were estimated (mid-year) to be $2.272 trillion. Total spending was estimated to be $2.613 trillion, for a deficit of $341 billion.
3. While non-security discretionary spending had grown by 15 percent in the last budget of the previous administration, in 2005, such spending was expected to rise only about 1 percent and in the 2006 budget decline by 1 percent.
4. The Congress passed a budget resolution that holds discretionary spending to less than the inflation rate of 2.4 percent. The President's 2006 budget called for a reduction in mandatory spending of $85 billion. Congress agreed to a reduction of $35 billion in its resolution.
5. The Budget proposes more than 150 reductions and eliminations in non defense discretionary programs, saving about $20 billion in 2006, and an additional set of reforms in mandatory programs, saving about $137 billion over the next 10 years.
6. Selected program concerns and <u>restraints</u> are those in the major entitlement programs – Medicare, Medicaid, and Social Security. Concerning the first two:
   a. **Medicare**: Realizing the provisions of the 2003 Medicare Modernization Act would include a drug benefit and expanded prevention benefit for seniors and other eligible populations, increased beneficiary choices, injecting more of a market-based approach to the program (e.g., Health Savings Accounts, modernizing information systems through the promotion of electronic medical records, and liability reform).
   b. **Medicaid**: Medicaid's open ended finance structure encourages efforts by States to draw down Federal matching funds, sometimes inappropriately. These financing practices undermine the Federal State partnership required by the Medicaid statute and jeopardize the financial stability of the program. The 2006 Budget proposes several program measures to reduce inappropriate use of Federal commitments under Medicaid and gives States more flexibility to provide needed care to larger numbers of the uninsured, while reducing needless overhead and waste. This reform will focus on increasing health insurance coverage for low income families while also promoting more efficient and rational ways of delivering care, such as community based care alternatives for persons with disabilities.
7. Support of families and communities comes by way of competitive grants for States to develop innovative approaches to promote healthy marriages, and money for research, demonstration projects, and technical assistance, primarily focusing on family formation and healthy marriage activities. Funds would be taken from the TANF program. With heavy involvement from faith-based organizations, the government seeks to increase maternity homes, support non-custodial fathers, continue abstinence-only programs for teens, and help those in foster care develop work-related skills.
8. The Administration seeks to promote **accessible health care** by
   a. increasing enrollment in Medicaid and SCHIP;

b. re-inventing tax credits to help lower-income individuals purchase insurance with more choices and options;
c. allocating funds to the States to set up insurance purchasing pools;
d. expanding the number of health center sites including 40 in high-poverty counties that lack health centers.
e. increasing access to medications for seniors and persons with disabilities under Medicare's Drug Discount cards.
f. The 2006 Budget includes several proposals that promote home- and community- based care options for people with disabilities. These proposals follow the President's *New Freedom Initiative*, which is part of a nationwide effort to integrate people with disabilities more fully into society. Under a five-year demonstration project, the Budget would pay for Medicaid services for individuals moving from institutions to the community to encourage home- and community-based care that is both less expensive and more effective than the care provided in institutions.

9. **Providing shelter –**
   a. The Budget for the Department of Housing and Urban Development (HUD) includes $1.4 billion for Homeless Assistance Grants, $200 million more than in 2005.
   b. The Budget provides $231 million to support the Department of Veterans' Affairs' (VA) efforts to combat homelessness among the Nation's veterans-and an additional $1.5 billion for medical care to homeless veterans.
   c. The 2006 Budget includes "The Samaritan Initiative" that will provide up to $200 million in 2006 for housing and social services to treat the chronically homeless properly.
10. Programs and services related especially to persons with disabilities will change under the FY 2006 budget.

    Education -
    a. The discretionary budget will decline 1 percent
    b. The Administration supports reforms in special education that improve services to students with disabilities, namely:
       1. The $12.2 billion budget for all IDEA programs includes $11.1 billion for IDEA Grants to States - a 75-percent increase since 2001. The request for Special Education programs includes increased support for programs to improve educational and early intervention outcomes for children 3 to 21 with disabilities. The budget will maintain the level of support for the Infants and Families program and the Preschool Grants program at their 2005 levels.
       2. A small amount would support a Transition Initiative that would help States improve high school graduation rates and post-school outcomes for students with disabilities.
       3. Personnel Preparation and Parent Information Centers would be funded at their 2005 levels.
       4. For Rehabilitation Services and Disability Research, the budget provides $3.1 billion to support comprehensive and coordinated

vocational rehabilitation and independent living services for individuals with disabilities through research, training, demonstration, technical assistance, evaluation, and direct service programs. The request includes $2.7 billion for Vocational Rehabilitation (VR) State Grants to help over 215,000 individuals with disabilities obtain or maintain employment. Funds are not requested for three vocational rehabilitation programs in this account: Supported Employment State Grants, Projects with Industry, and the Migrant and Seasonal Farm workers program. Other discretionary funding would be at 2005 levels.

5. The request includes $15 million for the Alternative Financing Program (AFP), authorized under the Assistive Technology Act, for loan programs that help individuals with disabilities purchase assistive technology devices and services. The original grant program to states under the Tech Act would be terminated.

c. Program Terminations, Reductions, and Transfers within the Department of Education, including the termination of 48 programs that have been shown to be ineffective (Even Start, Safe and Drug-Free Schools State Grants, and Vocational Education) and many that were unable to demonstrate results. In addition, funding for 16 programs will be reduced. As a result, $4.7 billion will be redirected toward such programs as Title I, IDEA, the High School Intervention Initiative, and improving teacher quality.

Health and Human Services

a. Most of the HHS budget is consumed by mandatory programs, particularly Medicaid and Medicare, which serve the elderly, disabled and the poor. And these are up 9.9 percent over FY 2005.
b. The Centers for Disease Control and Prevention, the world's premier public health agency, would lose about $500 million from last year's $4.5 billion budget. CDC would slash preventive health grants and bioterrorism preparedness grants to state and local health departments.
c. Medicaid spending would be cut $45 billion over the next decade from negotiating lower drug prices, cracking down on fraud, and caring for the elderly in their own homes rather than more costly nursing homes.
d. NIH would remain veritably flat and the FDA would increase 4.5 percent. Any additional funding would go toward biodefense or counter-terrorism programs.
e. The 2006 budget gives greater attention to persons with disabilities with additional promotions for home care options, but mainly through demonstration projects. States will enjoy the option to continue Medicaid eligibility for spouses of individuals with disabilities that return to work, and to provide Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community.

Housing

a. The budget for HUD would shrink due to a transfer of program responsibility of the Community Development Block Grants to the Department of Commerce.
b. Housing for persons with disabilities would be cut nearly in half along with housing assistance for persons with AIDS, Native Americans, and for public housing rehabilitation and the lead abatement program.
c. Housing programs would increase for some forms of rental assistance, for anti-homeless programs, and for down payment assistance programs.

Labor

a. This department's budget would shrink 4.4 percent from 2005 outlays.
b. Workforce Investment Act programs would be combined into one program with a reduction of $61.5 million. The elimination of the Migrant and Seasonal Farmworker job-training program and the Responsible Reintegration for Young Offenders program would reduce the total Employment and Training discretionary budget by $358.2 million.

Veterans Administration

Overall, the department's budget would rise to $70.8 billion, including $37.4 billion in mandatory funding on entitlements, such as disability payments, pensions and education and rehabilitation programs for veterans.

Transportation

a. Overall, this agency's budget would increase slightly – from $58.7 to $59.5 billion.
b. Any decrease in discretionary funding would come from Amtrak where the government is attempting to get the railroad to become financially self-supporting. The budget calls for the elimination of the Railroad Rehabilitation and Improvement Financing program.
c. Additional monies are included to fund surface transportation under the Safe Accountable Flexible and Efficient Transportation Equity Act (SAFETEA).

Agriculture

a. Agriculture would be trimmed by about $2 billion or 9.6 percent less than fiscal years 2005.
b. Cuts would be made to the Food stamp program. The Budget proposes to tighten overly broad waivers from the program's eligibility criteria. Households that receive SSI or TANF cash assistance would continue to be automatically eligible for food stamps, while all other individuals would apply under regular program rules.

1. The total amount appropriated for the 2005-2007 biennial budget in Indiana was $43 billion for operations and construction. Nearly 40 percent were to come from general (state) funds, 30 percent from dedicated sources, and 31 percent from federal grants. Less than 1 percent (0.3%) was to be derived from local sources.
   a. **Education:** The second largest budget item was education at $13.9 billion, 77 percent of which was targeted to elementary and secondary education. $256 million in each fiscal year went to 'handicapped education,' mostly (88%) from federal grants.
   b. **Health & Human Services** claimed the largest share of the biennial budget but the second largest share of general funds. This fund is comprised mostly of the budget of the Indiana Family and Social Services Administration. Over the two years, $14.3 billion will be spent with roughly two-thirds coming from federal sources and one-third from states sources. Over the five-year period, FY 2003-2007, appropriations for Health and Human Services has grown at a rate of 5.2 percent per annum – from $5.9 to 7.3 billion. The largest increases for the current biennial FY2005-07 budget will be in the areas of Medicaid Assistance, home and community based services for persons with developmental disabilities, and child protection services.

      The State Budget Agency subcategorizes the Health and Human Services group into five subdivisions: (The figures in parentheses are the share of total (i.e., $14.3 billion) biennial appropriations)
      - Family, Children, and Social Services (94.5%)
      - Public Health (4.7%)
      - Other Health (0.7%)
      - Veterans Affairs (0.0%), and
      - Social Services Advocacy (0.1%)

      FCSS. The Family, Children, and Social Services subdivision includes appropriations for the Family and Social Services Administration - (including the Office of Medicaid Policy and Planning), Division of Mental Health and Addictions including the State Facilities, Division of Family Resources, Division of Aging, Division of Disability and Rehabilitation Services, Developmental Centers – and the Department of Child Services. (including the Social Services Block Grant (Title XX)).

      Public Health. Public Health includes the State Department of Health and its 76 odd programs, and Special Institutions (Silvercrest Children's Developmental Center among two others).

      Other Health programs include Indiana Prescription Drug Program, the Tobacco Use Prevention and Cessation Board, and Indiana Schools for the Blind and for the Deaf.

Veterans Affairs consists mainly of the Department of Veterans Affairs. The mission of the Indiana Department of Veterans Affairs is to assist Hoosier Veterans, service personnel, their dependents and/or survivors in obtaining every benefit and advantage due them under the laws of the State of Indiana and the United States. The Department works with a network of certified County Veteran Service Officers.

Social Services Advocacy comprises the Indiana Protection and Advocacy Services and the Governor's Council for Developmental Disabilities.

Organizationally, the Family and Social Services Administration's former Division of Disability, Aging, and Rehabilitation Services was divided into the Division of Aging and the Division of Disability and Rehabilitation Services. Appropriations for Residential Services for Developmentally Disabled Persons increased $36.6 million over the FY 2005 appropriation.

A new Department of Child Services was created by moving child protection services, foster care, adoption, independent living, child support, and other programs from FSSA. This cabinet level agency will receive almost $8 million annually in additional state appropriations in FY 2006 and FY 2007 in order to hire additional caseworkers to strengthen the state's child protection system.

The mix of funding for Public Health has changed over the last biennium where there was a greater reliance on General and Local funding. The current budget shows a significant reliance on Dedicated and Federal funding. The Indiana State Department of Health (ISDH) will use $59 million from the Tobacco Master Settlement Agreement to help fund 19 health programs as well as $12.7 million in state General Funds in both FY 2006 and FY 2007. State appropriations are increasing by $1.6 million in the biennium to allow the Department to continue providing public health services such as childhood vaccinations, certification of nursing homes, and programs for children with special health needs.

The special institutions, which include Silvercrest Children's Developmental Center, the Indiana Soldiers' and Sailors' Children's Home, and the Indiana Veterans Home received state appropriations in the amount of $31.8 million annually in the FY 2006-FY 2007 biennium. Funding for the special institutions has increased slightly.

c. The 2006-2007 biennium budgets for **transportation** include $3.5 billion, or 8.2 percent of the total biennial budget, but a decrease of 7.1% from the previous biennium. The reduction was due to uncertainty about federal appropriations under the new transportation act. About two-thirds of Transportation expenditures are expected to derive from dedicated funding

sources (e.g., motor fuel tax), while the remaining one-third will come from federal grants.

2. If the economy avoids a downturn during this biennium, or if one-time revenue sources continue to be available, and if expenditures do not rise higher than expected, Indiana may achieve financial stability.
3. In the past, Indiana used all of the typical measures to realize a balance budget. It increased taxes and increased tax collection enforcement; exhausted rainy day funds; relied on one-time windfall revenue; carried forward balances in the general fund; conducted non-routine transfers from other funds; sold assets; increased and/or added fees or charges; and did debt refinancing.
4. The Government Performance Project, the nation's only source for comprehensive and independent information about state management performance, and funded by the Pew Charitable Trust, gave Indiana a C+ for its fiscal efforts in its FY2005, "Grading the States. Perhaps most telling among the State's weaknesses was its lack of strategic and long-range planning.
5. The Center on Budget and Policy Priorities puts Indiana into the "significant risk" category, based on scores in ten criteria. On a scale of 3 to 10, Indiana received a 7 for the number of factors that would contribute to a 'structural gap' or structural budget problems.
6. The Center on Budget and Policy Priorities estimated that federal policies have cost Indiana $3.09 billion over the 2002-2005 periods.
7. The growing burden of Medicaid in Indiana as in other states has brought about a spate of studies and proposals to discipline spending. According to the State Budget Agency, "With historic growth rates for Medicaid exceeding 5%, the Family and Social Services Agency (FSSA) will be undertaking several initiatives to contain the growth rate to 5%. Some of these initiatives include the expansion of managed care, increasing the efficiency of Medicaid waiver programs, decreasing the dispensing fee for pharmaceuticals, and reducing rate increases for nursing homes and other institutional settings."

APPENDIX A

The Context of Program Transformation

There are a number of forces and trends currently shaping the United States. In addition to the large and growing fiscal imbalance, policymakers confront a host of emerging forces and trends, which GAO highlighted in its 2004-2009 strategic plan for serving the Congress and the Nation.[18]

> *National boundaries are becoming less relevant in addressing a range of economic, security, social, public health, energy, and environmental issues. The shift to a knowledge-based economy and additional productivity gains are having significant impacts on the job market. Scientific research and technological developments are improving and even extending life, but they are also raising profound ethical questions for society. Accompanying these changes are new expectations about the quality of life for Americans and how we should measure the nation's position and progress.*[19]

Governance structures must evolve to contend with these new forces and the accelerating pace of changes in security threats, global interconnectedness, the economy, an aging and more diverse population, science and technology, concern for quality of life, and the challenges and opportunities to meet public needs and wants.

Of the 12 areas examined in the GAO report, several are relevant to persons with disabilities: education and employment; housing; health care; disability policy; and governance.

Education and Employment

If we are to compete effectively in a growing, knowledge-based economy, our educational system must equip children with appropriate skills to meet high standards and provide means for adults to continue to learn new skills and enhance their existing abilities. This will require ensuring that diverse populations have access to postsecondary, vocational, and adult education.

Early Intervention. The large achievement gap between students of different backgrounds, including students with disabilities, has persisted for decades despite a significant federal investment in educating disadvantaged students during that time. Many disadvantaged children start school with fewer skills than their more

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[18] U.S. Government Accounting Office. GAO's Strategic Plan for Serving the Congress and the Nation, 2004-2009. GAO-04-534SP. http://www.**gao**.gov/new.items/d04534sp.pdf (Accessed Oct '05).

[19] GAO. 21st Century Challenges Transforming Government to Meet Current and Emerging Challenges. Testimony of D.M. Walker, Comptroller General of the United States before the Before the Subcommittee on the Federal Workforce and Agency Organization, Committee on Government Reform, House of Representatives. July 13, 2005. GAO-05-830T

advantaged peers. Research shows that early intervention helps children succeed in school and is particularly effective for the most disadvantaged students. It is less clear whether current levels of coordination among the myriad federal and state programs efficiently produce desired results for particular subgroups of children.

Accountability. There is no comprehensive assessment of how fully the combination of federal and state programs addresses preschoolers' needs. Recent legislative initiatives, such as the *No Child Left Behind Act* with its emphasis on accountability, may help change this trend and could be aided by retargeting federal investments. The Elementary and Secondary Education Act was passed in 1965 to provide assistance to states in educating disadvantaged students through Title I, the largest federal program for elementary and secondary education. However, since about 90 percent of school districts receive these Title I funds to improve the education of disadvantaged students, including a growing number with limited English proficiency, an opportunity exists to improve targeting of funds to school districts having the greatest number and percentage of disadvantaged children.

- Reexamine the investment for early childhood programs (e.g., funds provided under the Child Care and Development Block grant and certain expenditures under Title I) to better coordinate them and ensure they support state and local efforts to prepare disadvantaged children to succeed in school.
- In light of the increasing diversity of the nation's school age population, the Department of Education should reexamine whether there are opportunities to better target limited resources such as Title I funds so that the needs of disadvantaged students including those with limited English proficiency are better addressed.

Housing

A number of programs provided by the Department of Housing and Urban Development (HUD) and USDA's Rural Housing Service (RHS) and other agencies,
as well as other tools and incentives, are designed to provide decent rental housing affordable to target populations. Over the years, the emphasis of these incentives has shifted from the supply side (production subsidies) to the demand side (vouchers).

Most construction of federally financed affordable rental housing has resulted from tax provisions. That market will tighten as a number of federally assisted units become eligible to leave some older subsidy programs in the next two decades. The costs of HUD's housing choice voucher program continue to grow, driven in part by the difference between the eligible population's income growth and the cost of privately owned rental housing, and this gap is increasing rapidly in certain markets. The struggle will be to balance the competing demands of maintaining

assistance for a specified number of households while controlling the increasing costs of doing so.

Health Care

Between 1992 and 2002, overall health care spending rose from $827 billion to about $1.6 trillion; it is projected to nearly double to $3.1 trillion in the following decade. This price tag results, in part, from advances in expensive medical technology, including new drug therapies, and the increased use of high-cost services and procedures. Many policymakers, industry experts, and medical practitioners contend that the U.S. health care system—in both the public and private sectors—is in crisis.

Of special interest to States is the growing burden of Medicaid spending. Today, Medicare and Medicaid combined share of the federal budget – 20 percent – has more than doubled in the past 20 years. Long-term care continues as a growing challenge with aging of the population and increasing levels of disability.

Disability Policy

The challenges facing retirement and disability programs are long-term, severe, and structural in nature. A successful policy response to these challenges will require a fundamental and comprehensive reassessment of each of the key components of our national retirement and disability system.

Federal disability programs have experienced significant growth over the past decade and are expected to grow even more as increasing numbers of baby boomers reach their disability-prone years. The composition of the disability rolls has changed significantly, with a larger proportion of beneficiaries with mental impairments receiving benefits today than in the past. At the same time, recent scientific advances as well as economic and social changes have redefined the relationship between impairments and work.
Advances in medicine and technology have reduced the severity of some medical conditions and have allowed individuals to live with greater independence and function in work settings. Moreover, the nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment. Given the projected slowdown in the growth of the nation's labor force, it is imperative that those who can work are supported in their efforts to do so.

Yet federal disability programs remain mired in concepts from the past and are poorly positioned to provide meaningful and timely support for workers with disabilities.

Governance

To respond to these trends and challenges, government must have the institutional capacity to plan more strategically, identify and react more expediently, and focus on achieving results.

Key Performance Indicators. Ensuring that public constituents have objective, current, and scientifically grounded information that is widely accessible and useable can go a long way toward ensuring that problems are well-framed, that decisions are good ones, and that solutions are effective. To make this happen requires a system of key indicators – measures of the performance of government across the spectrum of programs and services. These systems focus on providing a public good: a single, freely available source for key indicators of a jurisdiction's position and progress that is disseminated to broad audiences.

'Stovepiped' and 'Siloed.' **"**Most major outcomes of federal activities are supported by multiple programs and tools that, in turn, are often sponsored by many different federal agencies. Although these individual programs address common or similar performance goals, they result in an overly fragmented delivery network and at times work at cross purposes."

APPENDIX B:

ADDITIONAL FACTORS IMPACTING SERVICES TO PEOPLE WITH DISABILITIES

In addition to the laws, regulations, budgets and characteristics of the service systems and needs for service there are other factors that have significant impact on the condition and future of the quality of life for people with disabilities. Some of those factors statewide and others are national in scope. Below are items for consideration as we plan our courses of action for 2006 thru 2011.

Economy and employment

1. Following very strong growth of 3.8 percent in 2004, the world economy is slowing.

Output increased particularly quickly in the first half of 2004, driven by solid U.S. performance and a torrid export-led expansion in China. But higher oil prices and the effects of exchange-rate appreciation caused quarterly output in a number of high-income countries to decline in the second half, notably in Germany, Italy, and Japan.

Developing economies outgrew high-income countries, with aggregate GDP rising by some 6.6 percent for the year as a whole – a record expansion. In addition to China, India and Russia also grew very quickly. But all developing regions grew faster in 2004 than they did during the past decade.
Prospects For The Global Economy
World Bank

2. Data in "Rising Personal Bankruptcies: A Sign of Economic Strains on America's Middle Class" published by the Center for American Progress Indiana ranked 6th highest in personal bankruptcies in 2003. The report stated

> Personal bankruptcies appear to be linked to lack of health insurance and personal disposable income, but not to unemployment. States with higher bankruptcy rates also tended to have a larger share of their population without health insurance. For the ten states with the highest bankruptcy rates, the share of the population without health insurance averages 17.9 percent. This compares to an average of 10.7 percent of the population in the ten states with the lowest bankruptcy rates (table 1). An even stronger link seems to exist between per capita income and bankruptcy rates. Specifically, per capita disposable income seems on average to rise to the middle of the distribution of bankruptcy rates and then level off around $28,000. In comparison, there does not appear to be a clear link across

states between the unemployment rate and the bankruptcy rate, at least not in 2003.

3. For the last 10 years Indiana real personal income has increased but it has not kept up with the rest of the nation. Thus Hoosier income has effectively declined.

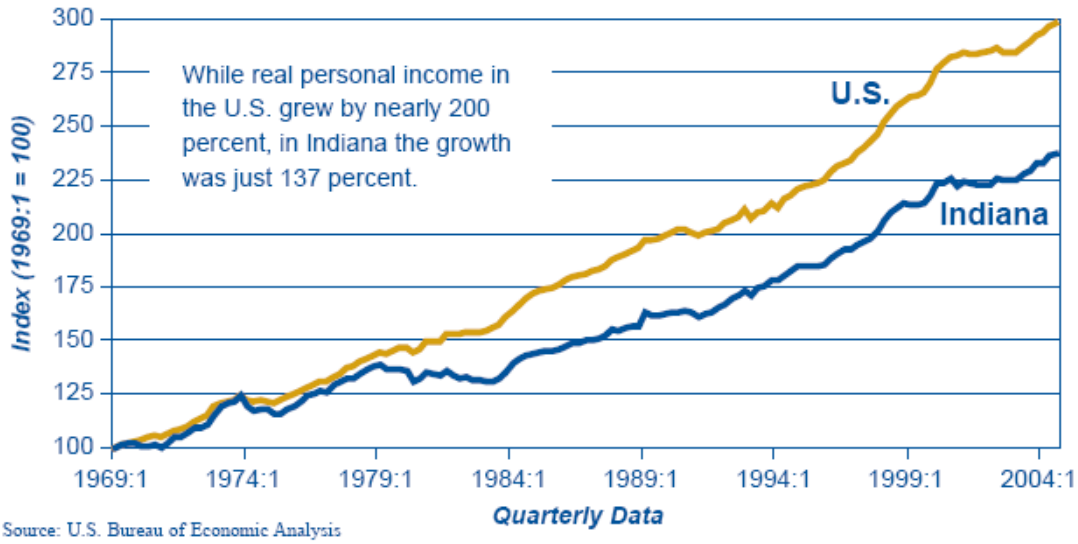
The Long and Short of Indiana's Economy
Morton J. Marcus
Director Emeritus, Indiana Business Research Center,
Kelley School of Business, Indiana University

Our measure of economic performance is the most basic data: real personal income, that is, the total money the people of Indiana make as a result of working for themselves or someone else, plus all the dividends, interest and rent they collect, plus any Social Security, unemployment compensation or other payments from the federal government. When we say real, we mean adjusted for price changes to year 2000 levels.

Figure 1 compares Indiana's record of growth in real personal income with that of the nation. Both economies are set equal to 100 in the first quarter of 1969 and then the chart follows them through 143 quarters to the third quarter of 2004.

Figure 1: Thirty-Five Year Index of Real Personal Income through 2004:3

Since 1969, Indiana has not kept pace with the national average growth



Source: U.S. Bureau of Economic Analysis

At the start of 1969, Indiana ranked as the 11th largest economy in the United States. By the third quarter of 2004, Indiana ranked 16th in the nation, passed by Georgia, Maryland, North Carolina, Virginia and Washington (see sidebar). The state's share of the nation's personal income

slipped from 2.5 percent to 2 percent. This drop was the sixth worst record in the country.

INCONTEXT January-February 2005, Vol. 6, No. 1

Projected Number of U.S. Jobs to Move Overseas

Management: Number of jobs moving overseas by 2015:	288,281
Business: Number of jobs moving overseas by 2015:	348,028
Computer: Number of jobs moving overseas by 2015:	472,632
Architecture: Number of jobs moving overseas by 2015:	184,347
Life sciences: Number of jobs moving overseas by 2015:	36,770
Legal: Number of jobs moving overseas by 2015:	76,642
Art, design: Number of jobs moving overseas by 2015:	29,564
Sales: Number of jobs moving overseas by 2015:	226,564
Office: Number of jobs moving overseas by 2015:	1,659,310

Source: Forrester Research, Inc. November, 2002

4. There is much disagreement about the actual number and percentage of unemployed people in the US and for good reason.

The US census and the Department of labor use the following definition of unemployment:

Unemployed Persons

All civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness. Source: www.census.gov/dmd/www/glossary/glossary_e.html

The official definitions of unemployment exclude significant numbers of people who would work if jobs were available such as those without employment who have stopped looking for work and people who want to work but are discouraged about job opportunities and so have given up an active job search.

On the other hand part-time workers who want full-time jobs are counted as fully employed. People working as little as one day a week are categorized as employed including Substitute teachers and other on-call workers who are called to work as needed.

5. One approach to employment problems is implemented in Ohio:
If (an) employer is willing to sell to the employees and if the employees are interested in buying the operation, the next step is to have a professional conduct a preliminary feasibility study to determine if the plant in question can survive competitively, under what conditions and whether employee ownership is a workable alternative.

The federal Workforce Investment Act of 1998 (WIA) continues the prefeasibility study grant program originally authorized by the Job Training Partnership Act (JTPA), to provide monies for such studies. The Ohio Department of Job & Family Services (ODJFS) has contracted with the Ohio Employee Ownership Center (OEOC) at Kent State University to administer prefeasibility study grants in the State of Ohio.

The size of the prefeasibility study grant is typically in the $10,000 to $20,000 range, but larger grants are possible when there is particular justification.

In the last two decades, there has been an explosive growth in employee ownership of businesses in North America. There has been a modest growth in production cooperatives, a considerable growth in widely distributed stock options, and a spectacular growth in the United States in employee ownership through ESOPs. It is estimated that about 15 million Americans, or about 12% of the work force, share in ownership of the company which employs them through one of these mechanisms. Today, some 11,000 companies employing about 10 million people, or about 8% of the American work force, are partially or wholly owned by their employees through ESOPs….

Participatory employee-owned firms appear, in fact, to systematically outperform conventionally owned companies. There is considerable evidence that they have both higher rates of reinvestment than competitors, and also higher rates of total employee compensation.
This experience suggests three lessons:

1. Firms which are substantially employee owned, and which involve their employees in decisions, systematically outperform their conventional competitors.

2. Employee ownership is part of a successful strategy to anchor capital in high wage areas.
3. Employee-owned firms tend to secure jobs, both because they prioritize jobs and because they appear to have higher rates of reinvestment than comparable conventional firms.

THE ROLE AND HISTORY OF EMPLOYEE OWNERSHIP COMPANIES, THE WORKER-OWNERSHIP INSTITUTE

… the number of people working for the 11,000 employee-owned firms in the U.S. exceeds the number of unionized employees, according to Noemi Giszpenc with Cambridge, Mass.-based Ownership Associates.

Fuel Prices and Transportation

6. Fuel prices continue to rise. People in the U.S. may soon find themselves paying fuel prices for transportation, heating, cooling, cooking, etc. equal to those in Europe and other parts of the world. This will be one of the most significant factors in shaping the environment for inclusion of people with disabilities. On the negative side is the impact on access to services (especially in rural areas). On the positive side is the potential for creating consensus and the will to truly functional public transportation for all.

A recent National Summit on Transportation For People with Disabilities in Rural Settings hosted by the Council in Indianapolis identified a significant number of issues that impact Indiana as well as across the nation. Some of those issues include.

a. There is a need for cultural change in thinking, rhetoric and vision of transportation. There is a cultural negative and/or apathetic attitude toward transportation. The general public does not realize the importance of transportation or that it is a rural issue as well as urban. Operational expenses are perceived as a burden on the taxpayer.

b. While the automobile receives major subsides transit has been unable to meet needs due to lack of equity in funding. In spite of the many different sources of funds, the total is insufficient.

c. This in turn relates to the set of issues associated with those many sources - accounting, billing, authorization, eligibility and payment variations across programs, inability to transport among rural, urban, and suburban geographic locations, inability to assist passengers between a vehicle and the building they are entering or leaving,

d. Insurance premiums in our litigious society are so high that some providers have nearly had to close. Additionally Insurance companies are placing harsh limitations on how and where vehicles can be used.

e. There are few incentives for collaboration so territorialism of clientele, geography and capital assets continues.

f. In rural areas problems are exacerbated by the absence of the planning capacity and authority for planning in terms of regional RPOs (Regional Planning Organizations).

HEALTH INSURANCE

7. According to Rand corporation publications at least 45 million Americans are uninsured. Most are employed, but can't afford, or are not offered, employer-sponsored coverage. RAND researchers examined how the individual health insurance market could help to close the coverage gap. They concluded that the future of this market may depend in large measure on public policies.

8. HOUSE ENROLLED ACT No. 1075 passed in the 2005 Indiana Legislative session provides that an individual policy of accident and sickness insurance that is issued after June 30, 2005, may contain a waiver of coverage for a specified condition for up to 10 years.

9. Key findings of the Rand Corporation publication The First National Report Card on Quality of Health Care in America were

• Overall, participants in the study received 55 percent of recommended care.
• Underuse of care was a greater problem than overuse. For example, patients failed to receive recommended care about 46 percent of the time, compared with 11 percent of the time when they received care that was not recommended and potentially harmful (see Figure 2).
• Overall performance was strikingly similar in all of the communities studied. Overall quality ranged from 59 percent in Seattle to 51 percent in Little Rock (see Figure 3).
The researchers found the same basic level of performance for chronic, acute, and preventive care.

EDUCATION

10. The National Committee of Parents and Advocates Organized to Protect IDEA states that… "two days after Congress passed the IDEA Conference Report with its "glide path to full funding" it appropriated significantly less funding for special education than it had just promised."

HOUSING

11. In Indiana, an extremely low income household (earning $17,546, 30% of the Area Median Income of $58,486) can afford monthly rent of no more than $439, while the Fair Market Rent for a two bedroom unit is $612.
A minimum wage earner (earning $5.15 per hour) can afford monthly rent of no more than $268.
An SSI recipient (receiving $564 monthly) can afford monthly rent of no more than $169, while the Fair Market Rent for a one-bedroom unit is $502.
In Indiana, a worker earning the Minimum Wage ($5.15 per hour) must work 91 hours per week in order to afford a two-bedroom unit at the area's Fair Market rent.
The Housing Wage in Indiana is $11.77. This is the amount a full time (40 hours per week) worker must earn per hour in order to afford a two-bedroom unit at the area's Fair Market rent.
National Low Income Housing Coalition 2004

PUBLIC REVIEW AND INPUT

The Goals and objectives of the plan were published for public review in survey format on the Internet at http://www.in.gov/surveytool2/public/survey.php?name=GPCPD_State_Plan_input from May 8, 2006 thru June 26, 2006.

There were 47 responses. Most respondents agreed that the goals and objectives are appropriate and feasible. Most of those who commented negatively about the feasibility of the objectives seemed to be reacting to the current economic conditions and the state of state and federal support budgets and programs.