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August, 2010

Dear Reader,

Attached is a study on housing and service provision for individuals with developmental disabilities prepared for Community Housing of Maine and the Maine Coalition for Housing and Quality Services by Benjamin T. McCall, a student at Bates College who was a summer intern at Community Housing of Maine in 2010.

Ben carefully conducted research on the how housing and services were provided to individuals with developmental disabilities in 10 states around the nation as of this time.

As Ben indicates, “the findings outlined in this report suggest that many states are taking a more independent, community-based approach to care—an approach that more effectively utilizes natural supports, a fluid classification and evaluation of need, and that cedes more control to the individual to whom the funding is tied.”

The report suggests that Maine has some models worthy of examination around the country. It also suggests that the subcommittee of the Maine Coalition for Housing and Quality Services that is working on a continuum of care for individuals with developmental disabilities has some best practices to draw from as it seeks to work with the state to improve the choices, efficiency, and reach of delivery of services and housing options available in Maine.

Again from the report: “...the hopes of the Maine Coalition for Housing and Quality Services are not unreachable, or unheard of. They are in fact being put to use in a number of settings, each conforming to state-specific differences, but still working to promote community inclusion, self-determination, and ease of movement. States are showing themselves willing and able to work with national, state, and local partners in order to meet the increased desire for family input, and program innovation which moves clients out of self-contained facilities and into more involved and fruitful roles in the community.”

Community Housing of Maine is proud to support the Maine Coalition for Housing and Quality Services, a 4000 member parent-led organization that is currently seeking to redefine the array of services and housing available to people with developmental disabilities by designing an efficient continuum of care. At its heart, this continuum of care seeks to utilize natural supports, base needs on functionality, and have the individual be in the driver’s seat.

I hope you find this of value and that you will work with us to fulfill the ideal of true community inclusion, and to support vulnerable special needs populations in living successfully in the community. Many thanks to Ben for his efforts!

For more information about the Maine Coalition for Housing and Quality Services, please email me at cullen@chomhousing.org . For more information about Community Housing of Maine, please go to www.chomhousing.org .

Sincerely,

Cullen Ryan, Executive Director

The State of Services in the United States: A Brief Overview of Housing and Service Provision for Individuals with Developmental Disabilities

Prepared for Community Housing of Maine and the Maine Coalition for Housing and Quality Services by Benjamin T. McCall, Bates College.

August 2010

History

In 1999, the Supreme Court created a landmark precedent by handing down its decision in *Olmstead v. L.C. and E.W.* Until that point in time, placing individuals with developmental disabilities in state-run institutions was the fallback position for most states. While such facilities were efficient mediums for delivering care to a large number of individuals, such living situations were devoid of any sense of community inclusion, treated “patients” as perpetually sick, and afforded them very little in the way of a decent standard of living. Speaking out against such a system, Justice Ruth Bader Ginsburg created what is now known as the ‘integration principle,’ mandating that states provide services “in the most integrated setting appropriate to the needs of qualified individuals...”¹

Since that time, it has been the legally mandated responsibility of states to attempt to integrate individuals into their communities whenever possible. The problem remains, however, that a greater emphasis—whether enforced or voluntary—has not necessarily translated into greater independence, opportunity, and quality of life for America’s DD population. Instead of taking the opportunity to create a truly “community centered” approach to care, states have tended to lock their clients into previously established systems of care which miss this mark. This brief look at such programs will not only touch upon that which could change, but highlights the programs which are looking to more creative and adaptive approaches to provide the best care possible.

Another critical issue for those working with HHS programs across the country is the lack of adaptability to individual needs. The State of New York serves as a clear example. It differentiates its services into distinct categories: *Supportive and Supervised; Independent and Family-Based.*² Intake is conducted by a caseworker that assesses the applicant’s level of need, and the corresponding federal programs and payment streams for which they qualify. Applicants are then either sent to supervised facilities in the cases of those with severe, advanced need, or sent home to receive care and services through local contracted agencies. Need and level of care are assessed and gauged according to very strict and inflexible criteria, often leaving gaps in the care afforded to these individuals.

The use of natural supports, including provisions that allow individuals to venture further away from the home and take advantage of the support that exist within their own communities, varies

¹ “Supreme Court Upholds ADA ‘Integration Mandate’ in *Olmstead* decision.” The Center for an Accessible Society. <http://www.accessiblesociety.org/topics/ada/olmsteadoverview.htm> 30 June 2010.

² <http://www.omr.state.ny.us/servicesindex.jsp>

widely as well. Emphasis seems to be placed on treatments and services which seek to limit damage, rather than improve outcomes. Programs seek either to reimburse providers, or at best allow care-takers to have more control and ability to move funds elsewhere, but do not seek to fund or create options which actively better the lives of those they serve. Little communication seems to exist between HHS (the State agency which most likely controls these funding streams) and other entities that are highly relevant to the client's life (e.g. DOE, county or municipal governments, etc.)

However, there are states that are turning away from the use of rigid definitions and towards a more fluid, flexible, and community centered approach to care. The rest of this report details a total of ten states across the country, all of which—with varying levels of sophistication and scope—seem to be moving in this direction. The next section outlines specific programs of note or areas of interest from each of these states, garnered through a thorough search of their respective websites. This information is only preliminary, especially when learning about the true scope of the programs that exist nationwide, but it does give us a reasonable—if incomplete—overview of the some of the innovative solutions that states are taking in this area.

Various State Overviews

No system is perfect, but Nebraska's moves clearly in a noteworthy direction. It prides itself in using an *integrated approach* to the servicing of the DD community—a system whose goal is service rather than treatment.³ Firstly, this integrated approach has one single point of entry, regardless of the possible level of assistance required. This simple feature allows for ease of entry into a system which is purportedly convoluted and hard to navigate. Secondly, each client is added to a statewide database, which functions similar to many other “matching sites.” The overall goal is to be able to match clients with the most effective service providers (the State contracts with 34 providers, both public and private) which are closer to their homes and provide just the type(s) of services that they appear to seek.

Nebraska also emphasizes the informal, “natural” supports which are often underutilized when providing care for those with developmental disabilities. The State works extensively with its service provider partners through its Community Supports Program (CSP) in order to find the least restrictive and most inclusive treatments for as many clients as possible. The program uses a “self-guided philosophy” which seeks to give as much choice and control to the guardian and client as possible. Finally, the State offers a very flexible reimbursement program, geared at making it as simple as possible for caregivers to change the level of care to more accurately coincide with the level of need. The bottom line of Nebraska's case is that they want to provide the *appropriate* level of care, no more, no less. This philosophy not only controls costs, but also allows for the system to more effectively serve its intended purpose.

Nebraska is not the only notable state. Utah runs a program called “Circle of Support” which puts the client and their guardians at the epicenter of the decision making process. Utah entrusts those most affected by these decisions with far more control and power than most States feel comfortable doing. Clients and guardians together can choose either to pursue the more traditional method of service delivery, focusing on institutions, and other provider organizations.

³ <http://www.hhs.state.ne.us/dip/ded/dedindex.htm>

Or they can choose a more “natural” approach that utilizes natural and community supports to create a more inclusive, integrated outcome for all those involved.

Arizona uses what they refer to as a “qualified vendor system.”⁴ While the state is in control of the funding and the overall coordination, the majority of the decision making power is given to the individual families. Emphasis is placed on finding the right *level* of service; giving the client as much independence as possible and not over-delivering services which are not needed. The use of natural, community-based supports are encouraged, either in lieu of, or in addition to the more traditional “institutionalized” supports. The bottom line in this system, as opposed to many others, is that the personalization of services in this way helps increase efficiency, eliminate waste, and generally improve the overall experience and outcome of each client.

Washington⁵ leaves the coordination of services to a state-wide office. Washington delegates such responsibilities to the individual counties. While this case may be hard to replicate due to the varying strengths of country governments across the country, the point remains that by leaving the work to the smaller, more local units of government, allows for the administration to be run by those who are more familiar with the local array of services, the particular circumstances unique to the region, as well as keep the overall caseloads as small as possible. Arguments could also be made that with the right amount of funding and infrastructure, such responsibilities could even be passed on to local governments. Whichever model is used, the case of Washington suggests that in some cases, the smaller and more local the administration, the better the service delivery *can* be.

Connecticut also maintains a system that allows for a great deal of personal flexibility and coordination. When a person enters the Connecticut system, he or she is paired with a regional caseworker that works extensively with the individual and/or their guardian to create a specific plan that matches need with services available in the particular area, and those which are covered by Medicaid. Yet while the caseworkers help coordinate services and link service providers with clients, they do not hold the final say in terms of particular providers, or final allocation of the funds that the client/guardian is entitled to through Medicaid or other funding streams. Instead—a la the Arizona “qualified vendor” system—the state will pair interested clients with a “support broker” who will help them independently hire staff and other providers. The bottom line in Connecticut is that the people are in control of their own futures and their own care—the State is only there to help ensure that their time and money are well spent.

There are also a great number of national issues with the failure of special education programs in preparing students to enter the “real world.” Programs seem to focus too much on basic life skills, which while necessary, do not help connect the students to more natural community supports that could help make their transition to adulthood easier and more fruitful. Two states have programs that seem to make the transition out of school easier and more beneficial.

The first is Maryland’s *Governor’s Transitioning Youth Initiative (GTYI)*.⁶ Instead of waiting until the student reaches graduation, those participating in GTYI receive assistance in founding

⁴ https://www.azdes.gov/developmental_disabilities/

⁵ <http://www.dshs.wa.gov/ddd/services.shtml>

⁶ http://www.dhmd.maryland.gov/dda_md/transitioning.htm

relevant community contacts, receiving vocational training and other needed services up to two years before leaving school. GTYI is funded as part of the permanent budget of the Maryland Department of Health and Human Services.

The second relevant case is that of Virginia. While it hasn't been used directly with those transitioning from school to work, Virginia does use a "money-follows-the-person" approach for those transition from an institution into the community. Such an approach allows for an easier transition process, without more paperwork and changing of case-workers and programs. This program could, if done so properly, be used to help youth making the transition from school. Already, Virginia assigns "transition managers" who work one-on-one with each student, assessing their strengths and weaknesses, life path preferences and the level and type of care that they may require. Combining the two approaches could lead to many positive consequences, and might warrant particular consideration.

Research Outline

Specific programs are of interest, but what is important is being able to learn the whole story, and be able to trace the relevant processes which these states use to ensure that the persons in their care are taken care of, their needs adequately met, and ultimately that their quality of life is maintained or improved wherever possible. This research also informs the assumptions and statements above, adding first-hand information to the data collected from various state websites.

As such, the next level of this research was carried out by directly contacting each of the States listed above, (as well as Tennessee and Wisconsin), and attempting to have a basic set of questions⁷ answered on the subject of services, housing, natural supports, and (if applicable) student transition⁸. Using these questions as a starting point for a broader conversation on the relevant topics, I tried to ascertain the strengths and weaknesses of each state system, which portions overlapped with the methods of other states, and most importantly, which aspects of these systems worked well with the Continuum of Care devised by the Maine Coalition for Housing and Quality Services.

⁷ See Appendix 1 for the complete set of questions used.

⁸ Student transition, though of overall importance to this research, often fell out of the realm of expertise for a number of my state contacts. The majority of states responded that they transition students from Special Education to adulthood in line with general federal guidelines—beginning the process around the age of 18, varying due to difference in children services' age of termination—and did not have any "special" programs in place. Any states which did employ a different program, or who fell out of the norm, are noted as such in the summary section.

Research Results and Summaries

Table 1-Basic Outline of Research Results

	AZ	CT	MD	ME	NE	NY	TN	UT	VA	WA	WI
Single Point of Entry	X		X	X	X	X	X	X	X	X	
Natural Supports Used	X	X	X		X	X	X	X		X	X
Person-Centered Decision Making	X	X	X	X	X		X		X	X	X
Separation of Housing and Services	X	X	X		X	X	X	X	X	X	X
Community Inclusion Supports Exist	X	X	X		X	X	X			X	X
Multiple Funding Mechanisms Exist (In addition to Medicaid Waivers)		X	X		X			X		X	X
Array of Fluid Services Available	X		X	/	X		X	X	X	X	X

More detailed responses to some of the above answers are included in Appendix 2.

All states had some form of high school to adulthood transition, but all except Arizona and Washington (noted in Appendix 2) had programs that started more than 18 months before graduation. Such programs typically consisted of only printed material, and a few conversations with parents/guardians about the “next steps.”

The most striking feature of the data collected from this research was the amount of similarity across many levels of service-delivery. The majority of states reported having a “single point of entry” for those beginning to receive services. Typically this point of entry is the school system, where the majority of *special needs* and *developmentally disabled* diagnoses are made. But for those who do not begin to receive services at the juvenile stage, most states have a single entry point at the statewide level. At this point, an initial inquiry will be made, and typically the applicant will—when services become available—be paired with a case worker or manager at the state, regional, or county level. It is this person who becomes responsible for the proliferation of services and the coordination and management of funding streams throughout the person’s life. The only exception in my findings was Wisconsin, which maintains a more convoluted entry process, consisting of local, regional, and state contacts, a flurry of intake forms, and a difficult to navigate matrix and aptitude tests.

Natural supports were also emphasized in the majority of conversations that I had—although many states added that they were moving in that direction, rather than currently utilizing natural supports throughout the process. Arizona stood out particularly due to their insistence that natural supports were looked at first when determining the way in which services were going to be delivered. It was made clear that parents, guardians, neighbors, and siblings were always considered to be preferable for providing care—both in terms of relation and proximity to the individual, and the potential monetary savings. Utah also emphasized the use of parents and guardians acting as landlords or administrators of the individual’s funding streams, and were encouraged in many cases to keep their children at home with them, accentuating the ways in which family members can—when willing and able—act as superior caretakers and facilitators.

Person-centered decision-making was also highlighted by most of the states I looked at. The level of involvement by the individual and their family members varied in intensity, but all states stressed that their overall goal was to include the relevant parties in all major decision making. Tennessee stood alone, however, in the domination of this approach in their service provision. Tennessee, like Utah and Wisconsin, uses a system of decision making called “circle of support” which includes family members and other community members in the conversation over the level and scope of a person’s care. This system allows natural supports to be more effectively utilized, for family members to be more familiar with the options available, and for the supports used to be more appropriately tailored to the individual’s specific needs, eliminating possible waste.

All states reported the clear separation of services and housing as well, an important distinction from the case of Maine, which will be visited later on. While various states still maintained larger ICF/MRs, it was clear that community centered living was the priority across the nation, accompanied by various levels of success. Arizona has been a pioneer in this field by operating their qualified vendor system (cited above), allowing individuals to hire and fire their own service providers, and allowing them to find services which matched their housing desires, not the other way around. The emphasis in all cases was placed on allowing the person to find a living option which best suited their needs, targeting options which did the most to promote integration into the community and improve their quality of life.

Various programs existed across the states which attempted to match individuals with vocational interests—especially during high school—and subsequently pair that individual with a local business or training program which could equip the person with the necessary skills they would need to succeed down the road. Efforts are also made to ensure that living situations effectively channel community involvement by being small, comfortable, and adaptable to changing needs.

This leads to another important characteristic shared across state borders: fluidity and flexibility of services. Virginia was the only exception to the rule, admitting that they still maintained very “black and white” categories that were not easily shifted to account for changing levels of need. Yet with this one exception aside, the rest of the states that I looked at exhibited a clear reliance on reevaluation and flexibility. Arizona and Nebraska were the most notable cases, using a “money follows the person” model that allowed individuals and their representatives to shift funding when appropriate. All of these states also offered a wide array of service options, ranging from 24/7 assistance, to partial supervision, to minimal assistance in the form of job coaching, help with basic tasks (e.g. grocery shopping, going to the library, educational tutoring, etc.) It was noted that the level of assistance given did not always meet the level assistance desired, a common problem in the system, but that when possible, the needs and wants of the individual were respected and worked with to the fullest extent. To summarize: all the reviewed states showed flexibility and common sense when providing services. Individuals were often able to live in a myriad of different residence types and have service providers come to them in a number of different settings and situations. While complete freedom of choice does not exist due to statutory constraints, the prerogative is on creating as much flexibility and comfort as possible.

Finally, funding mechanisms were also uniform across most states. Medicaid waivers of varying shapes and sizes (Section 21 especially) dominated the picture. Some states, Utah especially,

relied heavily on Section 8 vouchers to house their DD population, working off the premise that once received, a Section 8 voucher could provide housing assistance for as long as the individual needed it. Other states had secondary funding streams based in state statute, or local/regional preference. Some, like Washington, delegated responsibility to regional disability authorities (similar to the Public Housing Authorities here in Maine) that distributed their own dedicated funds. Other states, like Maryland, had secondary funding streams—often for those who did not qualify for Medicaid support—written into law and distributed at the discretion of HHS. However, whether secondary streams (public or private) were available, all states were bound to some extent to budgetary decision on the national level—leading to widespread cuts, underfunding, and significant waiting lists in the present moment.

Comparison to the Current Situation in Maine

By taking a quick glance at the chart above the preceding section, the current gap in services and approaches between Maine and the rest of the states in this survey is striking.

Natural supports are rarely used in Maine. They may come into use in certain circumstances, but the general rule seems to be that their utilization is solely at the discretion of the individual service providers. Thus, natural, community supports are really only used when a provider feels the need, or possesses the creativity necessary to do so. At the current moment, the use of natural supports on a state-wide policy guiding level is not present. They are used, to a certain extent, by those using a Section 29 (non-residential supports) waiver, but such activity usually comes at the discretion of the particular parent or guardian, because most Section 29 recipients live at home with their families.

In theory, decision-making about the scope and trajectory of services is in the hands of the client and their care-takers. However, the scenario in practice is much different. Due to the continued linking between services and housing, guardians often have maintain a reliance on advice from their provider. This often serves the needs of all of those involved, but since there is a constant interplay between the needs of the provider and both the housing and service needs of the client, it is often the case that State policies will follow the needs of providers more closely than those of the clients. The State of Maine is currently working on proposals that will attempt to sever these ties, and have housing and other services provided separately, with a greater emphasis on independent and community living options. This would involve the relabeling of those with developmental disabilities as another sub-section of “people seeking housing assistance” and thereafter plugging in needed services after housing was obtained. Yet, due to current budget crunches, such changes are on hold for the near future, and until this theory becomes reality, the link between housing and services will continue to pose problems.

Community inclusion supports, by admittance of my State of Maine contact, are relatively weak. They are again at the discretion of the particular provider, who in many cases struggles to find relevant activities to use in this effort. I was told on many occasions that, “community *integration*” would be a more proper term, because most service providers find intermittent activities to involve their clients in—mostly centered around “fun” outings into the community. However, despite the benefit that these outings provide, it is hard to find cases in Maine where clients are pushed to acquire new skills through adulthood. Simply put, integration does exist,

but true “inclusion”—taken in this case to mean participation in full-scale community activities, including groups, clubs, organizations, work, etc.—is hard to come by.

Maine is also in the middle of serious budget issues. As such, multiple funding mechanisms do not exist. The majority of the funding for Maine’s services come from MaineCare (Maine’s Medicaid program) and tap into both the Section 21 and Section 29 waivers. A few small grants and privately funded programs do exist on the local and regional levels, but not enough to warrant the designation of Maine as having “multiple funding mechanisms.”

However, the shortcomings in the system should not distract from its successes. A single point-of-entry does exist for intake. Intake officers exist in all of Maine DHHS’s regional offices. Eligibility denials are handled in a well-established and relatively transparent process. It may not always be easy to access the relevant information, but as can be said of many states, no system is perfect.

And more importantly, Maine does seek to have a flexible and open system for the discernment and proliferation of care. Seek, of course, is the operative term. Like most other states, not every wish can be granted in terms of scope of care, mostly due to Medicaid rules, but Maine seems to be slowly moving towards broadening the reach. Due to funding and staffing shortages, experimentation and flexibility in the provision of care can be lacking. Being creative about care can be hard when the need for the system far exceeds its capacity to provide it, and more of this creative fervor is needed. However, it seems as if a lot of these issues are created by current financial limitations that run through every state agency and program, not only through DHHS.

While this is far from a complete assessment or audit of Maine’s service provision, it is clear that work needs to be done in order for the quality and effectiveness of the system to improve. Natural supports are under-utilized, housing and services continued to be linked, true community inclusion mechanisms are lacking, and the lack of funding in order to improve the system at the current moment is significant. But on the same note, the highlighting of these shortcomings is far from a complete condemnation of Maine’s system. In part, Maine does remarkably well in seeing to the care of those in desperate need of services (Priority 1) and ensuring that a basic level of care is met across the board. This assessment cannot be understood to be a harsh critique of the overall system, only a clear call for a breath of fresh air.⁹

Conclusions and Recommendations

What the research suggests is that the hopes of the Maine Coalition for Housing and Quality Services are not unreachable, or unheard of. They are in fact being put to use in a number of settings, each conforming to state-specific differences, but still working to promote community inclusion, self-determination, and ease of movement. States are showing themselves willing and able to work with national, state, and local partners in order to meet the increased desire for family input, and program innovation which moves clients out of self-contained facilities and into more involved and fruitful roles in the community. Many states are struggling to put such programs in place, both because of current budget gaps, complexity of current services, and lack

⁹ A very big thanks goes to Brian Scanlon at Maine DHHS for his candid and insightful answers to my questions that helped with the drafting of this section.

of cooperation across state agencies. However, advocates and administrators alike are realizing both the cost-saving power natural supports and increased community engagement, but more importantly, they see that using such measures (where and when appropriate) decrease the payload of state workers and eventually pass on a higher quality of life for the clients that they serve.

Of course, the unique nature of Maine does not make it conducive to some of the programs or implementation mechanisms present elsewhere. For instance, a service provider network may be useful in larger urban areas (e.g. Portland, Lewiston/Auburn, Augusta, and Bangor) but may not work as well in more isolated, rural areas. Also, unlike Connecticut and Washington (among others), a coordination effort based on a county level may not function as well due to the weak county governments present in Maine.

However, it is fair to note that the information gathered from this research might invigorate and excite the work of this coalition. Clearly, the needs of people with developmental disabilities, and those who faithfully care for and guide them, are not unique to Maine, nor are they issues which are ignored nationally. The findings outlined in this report suggest that many states are taking a more independent, community-based approach to care—an approach that more effectively utilizes natural supports, a fluid classification and evaluation of need, and that cedes more control to the individual to whom the funding is tied. The bottom line is that change is rapidly occurring across in the country in terms of how states provide services to people with developmental disabilities, change that mirrors the recommendations of this Coalition. Such symmetry should energize and support the work ahead.

As many state employees said to me, no system is perfect. Many options work well for a select group of individuals, but fail to function properly for others. Yet despite some discrepancies, this research strongly suggests that productive steps are being taken in states across the nation, and their examples are highly relevant to the work that this Coalition is undertaking, especially the eventual creation of a Continuum of Care in Maine. What happens next is unclear, but the positive examples of other states have the potential to move Maine forward, and create a more helpful and cost-effective level of service for those who rely on it.

Appendices

1. *Questions Used in State Interviews:*

To what extent is housing: affordable, available, offer the appropriate level of support.

How, and to what extent, are the following services provided?: community inclusion services, support for ADL's, transition from childhood to adulthood, maximization of natural, community supports.

Separation of housing and services--is this done? To what extent?

What funding mechanisms exist to pay for this work?

Choices: who makes the decisions related to level of care? (person vs. agency centered) Are there a variety of models vs. a one-size-fits-all approach?

Availability--what percentage is served? Is there a waitlist, and how large is it?

2. *More detailed responses to Research Questions:*

Arizona:

- Natural Supports are **always** looked at first when assessing the needs and services available to a particular applicant/current client.
- Arizona operates on an “open-ended” Medicaid waiver, meaning that they can offer services to far more applicants than comparable states.
- Extensive use of vocational supports in high school, in order to more effectively transition into the community after graduation. Students are specifically placed in training programs based on vocational interests and coached along by local business owners who act as mentors, references, and at times, job coaches.

Connecticut:

- Some rental supports are offered to clients in lieu of, or in addition to, the traditional Medicaid waivers.

Maryland

- Rental subsidies, Section 8 vouchers, SSI, and HPRP are all used to meet the growing need of housing for the developmentally disabled, especially those who do not qualify for Section 21 vouchers.

Nebraska

- State statutes fund most services across the board.

Tennessee

- Natural supports are considered, but only employed in very specific circumstances. Microboards are used (could be considered to be natural supports) but the success of this and other such mechanisms has varied greatly.
- Circle of Support is used throughout, meaning that the person is always at the center of the decision-making process.
- Community inclusion is currently lacking, but it is encouraged when possible. However despite this setback, services are said to be very “fluid” and moving funding from program to program, or provider to provider, is said to be very simple and done often.

Utah

- What sets Utah apart is their large reliance on Section 8 housing vouchers in order to house the majority of their developmentally disabled population. They have young children put on to their waiting lists so that they reach the top at about the time that they are in need of housing relocation. They also find that setting up a DD individual with a HCV will meet their housing need for life, instead of providing a temporary fix that will have to be reassessed later on down the road.

Virginia

- They do have a single point of entry, but once intake occurs at the state level, the client is immediately referred to a county or local disability authority for further processing and subsequently, service delivery.
- Natural supports are “slowly, but surely” coming into play in Virginia. It was reiterated throughout my conversation that Virginia would be moving towards a more progressive, community-inclusive approach in a few years (as a result of a Legislature initiated report and set of recommendations) but that at present it was still very much behind the times.
- Some state and local funds—often varying by municipality or county—are available in addition to Medicaid waivers.

Washington

- Person-centered decision-making is encouraged but far from prevalent and definitely not mandated.
- Some state funds are available in addition to Medicaid.
- Washington is said to be at the cutting edge of innovation in terms of linking high-school students in special education to internship, apprenticeship, and other vocational supports before they reach adulthood. The hope is to integrate them more effectively into the community.

Wisconsin

- A limited amount of state funds are available in addition to Medicaid.
- Wisconsin is currently experimenting with a number of new, innovative programs including IRIS (Include, Respect, I Self-Direct), Community Integration Program (CIP 1), a state-wide directory of housing and care options, and many supportive employment programs. The full scope of Wisconsin’s programs can be seen at <http://www.dhs.wisconsin.gov/bdds/>.