



MENTAL RETARDATION BULLETIN  
**COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE**

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SUBJECT:

**Subject: Guidelines for Delivery of Supports Coordination Services**

BY:

Kevin T. Casey  
Deputy Secretary for Mental Retardation

**SCOPE:**

County Mental Health/Mental Retardation Administrators  
Administrative Entities  
Supports Coordination Entities

**PURPOSE:**

The purpose of this Bulletin is to establish recommended framework for the consistent statewide delivery of Supports Coordination. County Mental Health/Mental Retardation Programs and designated Supports Coordination Entities are Commonwealth agents for planning, locating, coordinating, and monitoring supports for individuals eligible for Mental Retardation (MR) services.

**BACKGROUND:**

The Mental Health and Mental Retardation Act of 1966, as well as the County Service Regulations, 55 Pa. Code CH. 6201 and CH. 4210, outline intake/eligibility and ongoing support to individuals found eligible for MR services. Since the inception of these regulations, the service system has grown to recognize an individual's right to an "Everyday Life" utilizing "Person Centered" planning and Self-Determination principles. Furthermore, the Office of Mental Retardation (OMR) established the Home and Community Services Information System (HCSIS) to ensure accountability and promote quality in services and supports. The standards outlined in this bulletin will enable the Administrative Entity to ensure that reasonable safeguards exist for the individual's health and well being.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

**The Appropriate Regional Program Office**

## **DISCUSSION:**

In 2003, OMR initiated a work-group of the Planning Advisory Committee (PAC) which developed ten recommendations that called for OMR to provide an adequate number of highly trained Supports Coordinators statewide. The recommendations also called for standardized practices and individual choice of Supports Coordinator and Supports Coordination Entity. OMR shared these recommendations statewide through a series of forums securing feedback, which validated the work-group's direction for Supports Coordination.

## **PROCEDURE:**

### **Statement of Principles**

Individuals and families must have ongoing access to effective, responsive, and reliable individual Supports Coordination. Supports should follow the needs of each individual utilizing formal and informal supports. The Supports Coordinator should represent and advocate for individuals, promoting their independence. Therefore OMR is recommending standard expectations for Supports Coordinators and the following "Code of Ethics."

- **MAKE PEOPLE FEEL VALUED:** Only when you value others, can other people see the value of your efforts.
- **BE CONFIDENT AND POSITIVE:** Confidence and a positive attitude from you will promote a positive attitude towards you.
- **BE FAMILIAR:** People are more willing to trust and try new suggestions from someone with whom they are familiar.
- **BE THERE FOR THEM:** Being accessible for questions/concerns helps to maintain a positive, constructive relationship.
- **DEMONSTRATE CONCERN:** Satisfaction with your efforts comes from the individuals and families feeling that their needs and concerns are heard and understood.
- **DEMONSTRATE GOOD COMMUNICATION SKILLS:** Everyone involved in the communication process must understand each other completely.
- **AGREE TO DISAGREE:** Turn conflict into a constructive exchange of ideas, keep energy focused on the desired outcomes.
- **SHOW COMMITMENT:** The number one expectation of people is that you will do what you say you are going to do.
- **BE HONEST:** Set a realistic picture of what the system can and cannot do and foster a common vision.

## **Administrative Entity/Supports Coordination Entity Structure:**

OMR has established the following recommendations regarding the administration and delivery of Supports Coordination Services

- Each Administrative Entity or Supports Coordination Entity should employ sufficient personnel to meet the standards for service delivery as stated in the Attachment #2 of this bulletin.
- Intake and Eligibility functions should be performed independently of Supports Coordination functions.
- Individuals should have a choice of Supports Coordination Entity. Should an individual elect to receive Supports Coordination from another Administrative Entity, then agreements governing access and choice should be established with the Administrative Entity of choice and the county of registration. Each Entity should document the individual's choice process.
- Individuals should have a choice of Supports Coordinator. Documentation should exist within an Entity to verify that choice has been presented. An Entity may temporarily limit choice due to personnel limitations and geographic distances. The Entity should document the individual's choice process.
- Supports Coordination Entities are required to continually evaluate their structure to promote efficiency. Efforts should be made to explore caseload assignments through weighted caseloads, team approaches, and utilization of case aides/clerical staff. OMR will provide technical assistance to agencies for efficiency.
- Each Entity should become proficient in the use of HCSIS to share information and to promote effective utilization of resources.
- To promote the quality of Supports Coordination, OMR will dialogue with the PAC to evaluate and recommend policy to enhance Supports Coordination Services.

## **Supports Coordinator Roles and Functions**

This Bulletin outlines the recommended minimum standards and expectations for Supports Coordinators. The Supports Coordinator develops and coordinates the implementation of person-centered Individual Support Plans (ISP), and initiates changes as needed. The Supports Coordinator assures that the individual receives the appropriate quality, type, duration, and frequency of services and benefits, and the individual is satisfaction with the manner in which the services or supports are delivered. All Supports Coordinators will be required to coordinate, locate and monitor services in accordance with recommended requirements and timeframes. (See Attachment #1 – *ISP Activities Timeline and Role Clarification.*)

These recommended standards are:

- Completion of ISP's
- Assure team participation in ISP's
- Document contacts with individuals, families, providers, or on their behalf
- Timely recordkeeping
- Locate services
- Plan
- Coordinate

- Monitor services
- Ensure health and safety
- Follow-up and track corrective action

The above roles and functions are detailed in Attachment #2 – *Roles and Functions*.

These activities will be measured through OMR Oversight of Administrative Entities, Independent Monitoring for Quality (IM4Q), HCSIS, and Data Warehouse reports.

### **Quality Improvement**

Quality services require a system that acknowledges its strengths and weaknesses. Supports Coordinators have a critical role in quality management. They are the gatekeepers of information who are usually closest to individuals and families. Through their planning and monitoring, Supports Coordinators have a unique perspective on the quality of services.

The primary function of Supports Coordination should be quality customer service. They must listen to what people need, help them plan for those needs, assist them in choosing services and supports, and ensure implementation of planned services. In order to accomplish this, Supports Coordinators must be accessible to the individuals and their families and they must be provided with the necessary tools and supports to function effectively. Individuals and families report that timely access to their Supports Coordinators is needed, and Supports Coordinators should prioritize responding to individuals and families.

Supports Coordination Entities should develop a system to assure individuals' and families' ability to access Supports Coordinators in a timely manner and assure coverage in the absence of the Supports Coordinator. Administrative and Supports Coordination Entities should implement systems that assure timely response to individuals and families. Attachment #1 includes recommended standards for contacts with individuals and families.

Supports Coordinators must participate in ongoing training and skill development to ensure that they remain current in their knowledge of strategies and philosophies related to their position. Administrative and Supports Coordination Entities should ensure that all Supports Coordinators participate in regular training as recommended by OMR.

Supports Coordinators can be most effective if Administrative Entity staff assure the implementation and utilization of data collecting systems and using information gathered by Supports Coordinators to provide feedback to providers. Supports Coordinators should be encouraged and supported to express their findings and concerns through the monitoring tool, service notes, meetings and the use of HCSIS. Their input needs to be valued and prioritized, especially when there are findings of health and safety risks. Each Administrative Entity should also implement a system for addressing concerns related to Supports Coordination, as described by OMR, to be reviewed by Administrative Entity staff on an annual basis. Their review should include confirmation of resolution of the individual's concerns, requests for change of Supports Coordinator and analysis of aggregated information to identify trends, needed changes, and training

needs. This review should also include development, implementation, and monitoring of appropriate plans of action to address the trends, changes and training needs identified.

Administrative and Supports Coordination Entities should regularly assess the quality of Supports Coordination services. Administrative Entities should encourage individual and family involvement in evaluation of Supports Coordination. Information relevant to the individual from IM4Q on satisfaction, OMR monitoring of Administrative Entities, complaint resolution and other feedback should be incorporated and reviewed annually during the individual's ISP meeting when that information will impact health and safety, services and supports that the individual receives or the individual's ability to have an "Everyday Life." OMR, through the oversight of Administrative Entities will monitor individuals' ISPs for planning outcomes and recommendations outlined in the ISP Bulletin. Administrative Entities should include supports coordination improvement measures in their quality management activities.

### **Supports Coordinator Training and Technical Assistance**

The role of the Supports Coordinator is a professional role that needs to be valued and respected. As professionals, Supports Coordinators should be provided with the necessary tools and assistance to function effectively for the individuals assigned to them. As with all professionals, ongoing training and skill development is necessary to ensure that Supports Coordinators remain proficient in their knowledge of current Support Coordination strategies and philosophies related to their positions.

OMR has established a training curriculum outlining specific trainings for Supports Coordinators. (Attachment #3 – *Supports Coordinator Curriculum Framework* and Attachment #4 – *Draft Supports Coordinator Assessment*.)

### **Support Coordinator Training Recommendations**

Effective January 1, 2007, each Supports Coordinator (and Supports Coordinator Supervisor with an assigned caseload) should complete a minimum of forty hours of annual training. Thirty hours of training should include the standard OMR training requirements as found in the Supports Coordinator Training Curriculum, and ten hours of training could be in the form of Professional Development (i.e., workshops, seminars, conferences) unless the Supports Coordinator and the Supports Coordinator Supervisor has successfully completed all recommended OMR course work. If the Supports Coordinator and the Supports Coordinator Supervisor has completed all recommended OMR course work and if fiscally able, the Administrative Entity may authorize training in the form of Professional Development. To meet the recommendations of Professional Development, the content should be specific to the MR System and/or specific to the role and functions of the Support Coordinator.

Newly hired Supports Coordinators should meet at least 50 percent of this recommendation or twenty hours within the first six months of their employment with the Administrative Entity.

When applicable, trainings received by a Supports Coordinator while employed by another Administrative Entity could be used to fulfill this recommendation, if appropriate documentation is available to substantiate their participation.

The specific method of training delivery used is at the discretion of the individual Administrative Entities, based on the needs of the Supports Coordinator.

To support the training of Supports Coordinators, OMR will offer scheduled Statewide and Regional training through the OMR Consultants, as well as customized trainings through local training and technical assistance plans. OMR will collaborate with Health Care Quality Units (HCQU's), and the Pennsylvania Training Partnership for People with Disabilities and Families in developing training for Supports Coordinators. In addition to the above instructor led training, OMR will support the training curriculum with courses for Supports Coordinators through the College of Direct Support, web based, video or teleconferencing. To supplement the Supports Coordination training effort, a Supports Coordinator handbook, and helpdesk will be readily available.

Each Administrative Entity should develop and implement a process for documenting, tracking and monitoring the fulfillment of training recommendations. Administrative Entity and OMR are responsible for regularly monitoring and ensuring that the training recommendations are appropriately documented and fulfilled by each Supports Coordinator.

### **Certification**

OMR ensures that each Administrative Entity can recognize the ongoing commitment to professional development by Supports Coordinators through the trainings that they complete. Each Administrative Entity will have the opportunity to offer a variety of certifications to Supports Coordinators for skills acquired through participation in trainings. This type of certification could be incorporated in the Administrative Entity Quality Improvement Plan and when included as part of the Supports Coordinator's profile, can be used to assist individuals and their families in their choice of a Support Coordinator.

OMR has developed the attached matrix (*Attachment #5 - Supports Coordinator Certification*) outlining the prerequisites for certification.

### **Attachments:**

- Attachment #1 - ISP Activities Timeline and Role Clarification*
- Attachment #2 - Roles and Functions*
- Attachment #3 - Supports Coordinator Curriculum Framework*
- Attachment #4 - Supports Coordinator Assessment*
- Attachment #5 - Supports Coordinator Certification*

**Attachment #1 - DRAFT**

**ISP Activities Timeline and Role Clarification**

<b>Days Before ISP Due Date</b>	<b>Activity</b>	<b>Supports Coordinator (SC)</b>	<b>Administrative Entity/County</b>	<b>Providers</b>	<b>Individuals and Families</b>
<b>90</b>	<b>Information Gathering</b>	<p>Coordinate information gathering and assessment activity, including the Supports Intensity Scale Plus (SIS Plus)</p> <p>Collaborate with individual/family/provider agency/team to coordinate invitations and ISP/Annual Review meetings dates, times, and locations</p> <p>Coordinate invitations with individual/family, send out invitations, and file copies</p> <p>Record relevant assessment information into ISP in HCSIS</p> <p>Review and share assessment results, monitoring results, and incident reports with individual and family. Include external reviews.</p> <p>Enter information into ISP Draft</p>	<p>If not initial ISP, provide current budget and last year's expenditures before ISP Meeting</p>	<p>If not initial ISP:</p> <p>Receive invitation</p> <p>Complete assessments and send to SC in an ISP-ready format</p>	<p>Respond to communication from SC to coordinate invitations and establish ISP/Annual Review meetings, dates, times, and locations</p> <p>Receive invitation</p> <p>Provide assessment information</p> <p>Review assessment results</p> <p>Choose Services/Provider</p>
<b>60</b>	<b>ISP Meeting/ Annual Review</b>	<p>Conduct ISP meeting/Annual Review with individual/family, and team to adapt or create Outcomes and identify services and supports to address those Outcomes</p>	<p>Attend and participate in ISP Meeting/Annual Review (optional)</p>	<p>Attend and participate in Annual Review</p>	<p>Attend and participate in ISP Meeting/ Annual Review</p> <p>Provide Consent to Share ISP on HCSIS</p>
	<b>Documentation</b>	<p>Complete ISP in HCSIS, contact Administrative Entity/County if total cost of services exceeds current budget, submit completed ISP to Supervisor for review, and respond to revision request</p> <p>Complete/update PUNS with individual/family if OMR services are not available</p> <p>Search Services and Supports Directory and select services for Outcomes based upon individual's/family's choices</p>	<p>If initial ISP or if financial need changes, provide current budget information after Annual Review</p>		
	<b>Approval</b>	<p>Submit ISP to County for approval</p> <p>Receive and respond to alert for approval notice or revision request</p>	<p>Approve ISP in HCSIS or request revisions</p>		
	<b>Financial Authorization</b>	<p>Receive and respond to alert for authorization notice or revision request</p>	<p>Authorize services in HCSIS or request revisions</p> <p>Send authorizations to Providers</p>	<p>Receive authorization</p>	<p>Receive authorization</p>
<b>14</b>	<b>Distribution</b>	<p>Notify Providers plan is approved and available in HCSIS</p> <p>Send approved ISP to team members who cannot access HCSIS</p>		<p>Receive ISP</p>	<p>Receive ISP</p>
<b>0</b>	<b>Service Implementation</b>	<p>Monitor services after implementation</p>		<p>Implement services</p>	<p>Receive services</p>

The purpose of the ISP Activities Timeline and Role Clarification document is to provide families, individual, providers, Administrative Entities/Counties, and Supports Coordination Entities with a guideline for expectations regarding time frames and who will complete various steps in the process. Although there is some latitude in the planning process, the requirement is that the ISP must be completed, approved, and authorized before services are implemented and/or before the current plan expires.

**Attachment # 2 - DRAFT**

**ROLES & FUNCTIONS**

<b>1. Individual Support Plan (ISP)</b>	<b><u>Standards</u></b>
Completion of the ISP.	Assure individual, family and/or team's participation in the ISP process.
	Team members shall be given adequate notice to attend meetings within 30 business days.
	The ISP meeting shall occur between 60-90 business days prior to the expiration of the current Plan.
	ISPs shall be entered into HCSIS within 30 business days prior to the expiration of the Plan.
	Copies of ISPs shall be sent to the team members within 14 business days of the effective date of the Plan.
<b><u>2. Service Notes</u></b>	<b><u>Standards</u></b>
Documenting all contacts with individuals, families, providers, etc.	Service notes shall be entered into HCSIS within 5 business days.
<b><u>3. Supports Coordinator Responsiveness</u></b>	<b><u>Standards</u></b>
Follow-up and track corrective actions.	Supports Coordinators shall respond to emergency inquiries with 24 hours of receipt of a call or e-mail.
	Supports Coordinators shall respond to non-emergency inquiries within 3 days of receipt of a call or e-mail.
	Supports Coordinator shall track appropriate corrective actions relative to: <ul style="list-style-type: none"> <li>✓ concerns resulting from SC Monitoring</li> <li>✓ incident management</li> <li>✓ IM4Q and Office of Mental</li> </ul>

	Retardation Monitoring of Counties (OMOC) Reviews as they relate to the individual
<b>4. Target Service Management (TSM)</b>	<b>Standards</b>
Locate, coordinate and monitor.	Locate: Link, arrange for, and obtain services specified in the ISP including medical, social, habilitation, education, or other community services the individual needs to live at home or in the community.
	Coordinate: Ongoing management of services and support stipulated in the ISP in cooperation with the individual, family and providers of service.
	Monitor: Establish and implement a means to assure that the individual receives the appropriate quality, type, duration and frequency of services and benefits.
<b>5. Monitor Services</b>	<b>Standards</b>
	Monitoring findings shall be entered into HCSIS within 10 business days of the date of monitoring
	Monitoring should occur in accordance with county policy and meet the required standards of funding sources received by the individual
<b>6. Monitoring Process</b>	<b>Standards</b>
Each monitoring contact should promote the spirit of “Everyday Lives” and Self Determination.	Everyone can make choices.
	Everyone has control over his/her life.
	Everyone is different and there is value in difference, therefore supports need to be individualized.
	Each Supports Coordination monitoring activity with the individual will include a review of: Progress towards implementation of the ISP. ✓ Individual’s health and well being.

	<ul style="list-style-type: none"> <li>✓ Incidents</li> <li>✓ Licensing Citations of the residential home if applicable</li> <li>✓ Individual's satisfaction with services/supports.</li> <li>✓ Quality of services/supports and cost effectiveness.</li> <li>✓ Support outcomes and any barriers.</li> </ul>
<b>7. Monitoring Outcome</b>	<b>Standards</b>
The outcome of the monitoring process is to identify, document, and recommend resolution to Issues or Comments regarding the abovementioned standards.	
<b>Issues:</b> any situation that warrants immediate corrective action and timely response by an individual providing supports.	<p>Issues are:</p> <ul style="list-style-type: none"> <li>✓ Circumstances that negatively impact an individual's quality of life.</li> <li>✓ Where an individual is not receiving the appropriate quality, type, duration, and frequency of services as identified in the ISP.</li> <li>✓ If an individual is dissatisfied with the manner in which the services or supports are delivered.</li> </ul>
<b>Comment:</b> Commendations, recommendations, or anything unusual or noteworthy that may necessitate team attention, but not immediate action.	
<b>8. Monitoring Frequency</b>	<b>Standards</b>
Individuals enrolled in the Consolidated Wavier	<p>Except as otherwise approved in the ISP, the county MH/MR program is responsible to ensure that the Supports Coordinator completes three (3) face-to-face meetings with each individual per quarter. These meetings should take place as follows:</p>
	<ul style="list-style-type: none"> <li>✓ At least one meeting at the individual's residence.</li> <li>✓ One meeting at the individual's day program.</li> <li>✓ One meeting at any place agreeable to the individual, i.e., out in their community.</li> <li>✓ The monitoring needs to occur monthly, the documentation in HCSIS need only occur every 90 days.</li> </ul>

	<p>Exceptions and/or differences in the frequency of Supports Coordination services to the monitoring schedule will be due to:</p> <ul style="list-style-type: none"> <li>✓ Individual or family choice to limit Supports Coordination function and activities.</li> <li>✓ Extraordinary needs of the individual for Supports Coordination services.</li> <li>✓ The presence of alternative community safeguards and supports.</li> </ul>
Individuals enrolled in the Person & Family Directed Supports (PFDS) Wavier	For individuals living with their family, the Supports Coordinator should meet with the individual and family at least once every six months, and contact the individual and family at least once every three months.
	Individuals living outside of their family households, the Supports Coordinator should meet with the individual at least once every three months and contact the individual at least once a month, unless otherwise specified in the ISP.
	The Supports Coordinator completes the monitoring as per requirements, the documentation need only occur every 90 days.
Individuals supported through State (base) Funding	An annual monitoring meeting should be conducted as a minimum.

**Supports Coordinator  
Curriculum Framework**

<p><b>Competency Area</b> <i>Knowledge of the MR System</i></p>
<p><u>Skill Standards:</u> Can describe the history of the Mental Retardation System in Pennsylvania and the progressive movement from medical model to community living, the philosophy of Positive Approaches, “Self-Determination”, and “Every Day Lives”. Can describe Pennsylvania’s state and local structure and the way these structures impact the MR System i.e. the MR Waiting List, Waiver Eligibility, MR qualification and MR Funding.</p>
<p><b>Competency Area</b> <i>Philosophy &amp; Ethics</i></p>
<p><u>Skill Standards:</u> Practices the philosophy of “Self-Determination”; uses “Positive Approaches” in helping individuals achieve an “Everyday Life”; demonstrates sensitivity when responding to ethical challenges within the MR System; is aware of personal ethical convictions, beliefs, doubts and uncertainties and does not permit personal values to impact their responsiveness to others; respects alternative views of others; respects intercultural differences.</p>
<p><b>Competency Area</b> <i>Personal Work Skills</i></p>
<p><u>Skill Standards:</u> Creative problem solving and decision making; conflict resolution &amp; negotiation skills; provides professional customer service; utilizes effective time management.</p>
<p><b>Competency Area</b> <i>Documentation</i></p>
<p><u>Skill Standards:</u> Writes ideas completely and accurately in letters, reports, case comments and the Individual Support Plan with proper grammar, spelling and punctuation. Uses computers to communicate information.</p>
<p><b>Competency Area</b> <i>ISP Development, Outcome Development Implementation &amp; Plan Review</i></p>
<p><u>Skill Standards:</u> Develops the Individual Support Plan and includes a summary of planning services and supports taking into account the individual’s preferences, outcomes, health and safety information and medical information.</p>
<p><b>Competency Area</b> <i>HCSIS Home &amp; Community Services Information System</i></p>
<p><u>Skill Standards:</u> Is able to navigate within HCSIS, uses appropriate screens for data entry, enters appropriate data, responds to alerts in a timely fashion, and uses the HELP desk.</p>
<p><b>Competency Area</b> <i>Time Management</i></p>
<p><u>Skill Standards:</u> Uses effective time management tools and methods, meets required deadlines, manages productivity, self manages assignments and tasks, completes tasks and assignments and plans effectively.</p>
<p><b>Competency Area</b> <i>Effective Communication Skills</i></p>
<p><u>Skill Standards:</u> Speaks clearly, selects language, tone of voice, and gestures appropriate to an audience. Listens carefully to what a person says, noting tone of voice and body language and responding in a way that shows understanding of what is said. Shows understanding, friendliness, and respect for feelings of others; asserts oneself when appropriate; takes an interest in what people say and why they think and act as they do.</p>
<p><b>Competency Area</b> <i>Problem Solving &amp; Conflict Resolution</i></p>
<p><u>Skill Standards:</u> Recognizes problems; identifies reason why it is a problem; gathers information about the conflict; generates alternatives; weighs the pros and cons; chooses the best alternative; creates and implements a solution; develops a plan to carry out the solution; watches to see how well solutions work and revises as needed. Successfully implements negotiation techniques, identifies common goals among the individual’s team; clearly presents one’s position; examines possible options; makes reasonable compromises.</p>

**Attachment # 4 – DRAFT**

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#1 Knowledge of the MR System</b>	
1	Can explain the role of the Supports Coordinator to individuals, their family members and others who are part of the person's life.
2	Can explain state and county structures.
3	Can explain eligibility, waiver and funding activities to individuals, their family members and others who are part of the person's life assessment.
4	Can explain PUNS (Prioritization of Urgency of Need for Services) to individuals, their family members and others who are part of the person's life.
5	Can explain Individual Support Plan Development & Outcome Development to individuals, their family members and others who are part of the person's life.
6	Follows the process and requirements of enrolling an individual into the Waiver program.
7	Can explain various funding sources to individuals & families.
8	Can explain eligibility requirements for MR services and supports to individuals & families.
9	Informs individuals and their families of trainings and conferences offered to assist in educating them about the MR system; and local support and advocacy groups.
10	Maintains contact with individuals and families, regardless of funding stream.
11	Coordinates support with medical professionals who treat the individual if appropriate.
12	Assists the individual and others who support the individual in determining how they would like to be involved in the assessment process.
13	Assures completion and review of assessments to determine needs, preferences, and capabilities of the individual and ensures consistency of information.
14	Explains the difference between assessments for eligibility and functional evaluations for intervention and ISP planning.
15	Explains what is meant by assistive technology and the various types of technology available to individual/family.
16	Explains the school transition process for children 14-21years and understanding IEP Process including school transition to individuals and families.
17	Explains family to adult transitions (i.e. school, work, life, provider etc.) to individual and family and what may be needed to make the transition comfortable for the individual.
18	Explains State Center to Community transition and able to explain to individual and family.
19	Explains Community to Nursing Home (OBRA, Personal Care Boarding home) transition and able to explain to individual and family.
20	Explains 24 hour community living arrangement to Semi-independent living to independent living situation, and Explains to individual and family.
21	Explains the procedures to prepare for changes in an individual's service delivery, including steps to assist with the individual's adjustment.
22	Has knowledge of residential options and the eligibility requirements for each.
23	Fulfills requirements of Medical Assistance (MA) Targeted Service Management billing (TSM).
24	Gives individuals and families information about the Mental Retardation (MR) System as it relates to life transitions.
25	Educates and assists individuals and families in making informed choices regarding supports and services, and assists them in applying for needed services.
26	Informs individuals and families of available advocacy services.
27	Fulfills the role of Supports Coordinator in working with transition teams in planning for services and supports related to the individual making life transitions.

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#2 Philosophy &amp; Ethics</b>	
1	Promotes the individual's ability to lead a self-determined life by providing them with the necessary information to build self-esteem, assertiveness and to assist decision making.
2	Assists and supports the individual and family in developing strategies, making informed choices, following through on responsibilities, and making decisions.
3	Promotes partnerships in the design of support services for the individual by consulting with the person and involving him/her in the decision making process.
4	Provides opportunities for the individual to be a self-advocate, encourages and assists the person to speak on his/her own behalf and provides the individual with information regarding peer support and self-advocacy groups.
5	Provides individuals and families with information about human services, legal services, civil rights and other resources that may assist the person with self-advocacy and decision making efforts.
6	Promotes the use of least restrictive and natural options in helping the individual and family to identify needed supports and services.
7	Responds respectfully when it comes to the diverse challenges facing individuals (e.g. human rights, legal, administrative and financial) and identifies and uses effective advocacy strategies to assist individuals to overcome such challenges.
8	Responds to each individual and family's diverse needs in a culturally competent manner.
9	Supports and empowers individuals with disabilities in exercising their choices.
10	Uses Person Centered Thinking and Positive Approaches Principles.
11	Demonstrates the use of Everyday Lives and Self Determination Philosophy when locating, coordinating, planning and monitoring on behalf of the person.
12	Supports the cultural needs and values of the individuals and families.
13	Maintaining standards of confidentiality objectivity and ethical practice.

## DRAFT SUPPORTS COORDINATOR'S Assessment

1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A

### #3 Interpersonal Work Skills

1	Establishes rapport and trust with individual, families and others who are part of the individual's life.
2	Uses observation and active listening skills to help individuals and families identify strengths, needs and priorities of the individual.
3	Respects the individual differences of individuals and their families by modifying actions accordingly, in order to provide Supports Coordination services using a non-judgmental approach.
4	Builds respectful and beneficial relationships between families and professionals on a one-to-one team/agency and interagency basis.
5	Modifies the way support is provided based on the cultural needs of the individual and where the individual lives (i.e. rural or urban).
6	Is accommodating to the individual and family regarding time and location of meetings.
7	Maintains a professional demeanor, asking questions tactfully and is solution oriented.

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#4 Documentation</b>	
1	Meets the requirements for documentation and is able to manage these requirements efficiently (i.e. TSM billable hours/units, monitoring, service notes and ISP).
2	Sets priorities and develops a system to manage documentation requirements efficiently.
3	Maintains accurate records, collects, compiles and evaluates data, submits records to appropriate sources in a timely fashion.
4	Maintains concise case notes, documenting Supports Coordination, family, and provider activities conducted on behalf of and in support of the individual.
5	Uses person centered and respectful language when writing reports, case notes, and other documentation when referring to the individual.
6	Records and maintains information about an individual's concerns, issues and resources, reflecting the relative importance to the individual; includes closure of issues, plan of action and resolution.
7	Remains current with appropriate documentation systems (including HCSIS), and has developed a system to manage documentation.

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#5 ISP Development, Outcome Development, Plan Implementation &amp; Plan Review</b>	
1	Contributes as team member/facilitator during ISP Plan meeting.
2	Supports individuals, their families and team members in identifying priorities, concerns and resources in developing the ISP outcomes
3	Collects and uses information from individuals, families and team members (including direct support staff) on how the person would like their services and supports to be delivered to enhance their everyday lives as reflected in the ISP.
4	Monitors on-going supports and services as identified in the ISP. Assists individuals, family members and team members in assessing if the service provided meets the person's needs.
5	Works with providers to assure documentation of progress crosswalks with the individual's ISP (i.e. Outcomes, Health Promotion, etc.).
6	Assures team involvement in writing and modifying outcomes, services, and/or supports based on the changing circumstances of individual's priorities and needs.
7	Gives individuals the opportunity to indicate their level of satisfaction with progress made when reviewing their ISP outcomes, services and supports.
8	Assists the individual and team in realizing the individual's outcomes.
9	Coordinates the development and implementation of outcomes that meet the individual's needs and balance what is important to the individual as well as what is important for the individual.
10	Supports individuals and families in continually evaluating which services and supports will best address the individual's outcomes.
11	Assists the individual and team in locating and securing community resources and outside funding sources that can be utilized in working toward ISP outcomes.
12	Develops, monitors and revises individualized budgets based on services and supports.
13	Develops cost estimate/budget for needed services included in the ISP
14	Successfully submits a plan for funding approval
15	Identifies and provides information regarding alternative service providers and respective costs
16	Obtains consent from individuals and/or families prior to sharing their ISP with others

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
	1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area 5. N/A
<b>#6 HCSIS</b>	
<b>Home &amp; Community Services Information System</b>	
1	Demonstrates effective use and knowledge of HCSIS.
2	Monitors and maintains accurate data entered in HCSIS to ensure accurate funding and planning for the individual.
3	Uses HCSIS to complete and update the Individual Support Plan (ISP) within established timelines for completion.
4	Uses HCSIS to complete the ISP Monitoring Tool within established timelines for completion.
5	Uses HCSIS to complete case notes within established timelines for completion.
6	Uses HCSIS to complete and update the PUNS within established timelines for completion.
7	Uses HCSIS to complete and update information regarding eligibility for services within established timelines for completion.
8	Uses HCSIS to complete and monitor Incident Management Reports within established timelines for completion.
9	Uses HCSIS to update information regarding eligibility for services within established timelines for completion.
10	Uses HCSIS to report incident as they pertain to individuals' health and safety within established timelines for completion.
11	Makes General Updates to the ISP in HCSIS as needed.
12	Makes Critical Revisions to the ISP in HCSIS as needed.
13	Links services/supports in HCSIS.

<b>DRAFT SUPPORTS COORDINATOR'S Assessment</b>	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#7 Time Management</b>	
1	Meets county specific timelines in developing the ISP.
2	Coordinates meetings in a timely manner.
3	Assures that all team members are kept up-to-date concerning any changes/issues experienced by the individual.
4	Maintains contact with all team members via phone, fax, mail and/or e-mail.
5	Applies methods of organization to streamline tasks.
6	Uses organization and prioritization techniques in order to ensure services, supports and responsibilities are met in a timely manner.
7	Returns phone calls in an appropriate time frame (SC workgroup will ID number of hours) to all key players.
8	Returns e-mails in an appropriate time frame.
9	Uses organization and prioritization techniques in order to ensure services, supports and responsibilities are met in a timely manner.
10	Asks for assistance and uses various resources when falling behind on job duties.
11	Meets timelines related to Waiver Requirements and Monitoring.
12	Meets timelines related to ISP development & review.
13	Meets HCSIS timelines related to: ISP, Case Notes, SC Monitoring Tool, Incident Management, PUNS, and Demographics.
14	Meets timelines related to ISP development, general updates, annual reviews, critical revisions and services and supports.
15	Makes referrals and reports the outcome of the referrals to the team in a timely manner (SC Roles & Responsibilities Work Group is defining "a timely manner").
16	Meets timelines related to completion and updating of information in the PUNS (Prioritization for the Urgency of Need for Services).

DRAFT SUPPORTS COORDINATOR'S Assessment	
1. I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area; 5. N/A	
<b>#8 Effective Communication Skills</b>	
1	Demonstrates a range of effective communication strategies and skills to establish a collaborative relationship with the individual, family and/or team members.
2	Recognizes respects and accommodates various communication styles that are preferred by the individual including individuals who have difficulty communicating their needs to others.
3	Assures individual has access to available assistive technology (i.e. facilitated communication devices).
4	Demonstrates effective written communication skills when documenting information pertaining to the individual.
5	Uses terminology that is easily understood by the individual, family and/or team members.
6	Demonstrates effective communication techniques when listening and responding to the individual, family and/or team members.
7	Facilitates team meetings by working with the individual and his/her team members to set meeting formats and agendas/timeframes.
8	Encourages group and team participation by respecting the dynamics and various roles people play on teams.
9	Addresses the individual's priorities and needs by assuring the individual's desires are addressed first and that they continue to be a priority during team meetings.
10	Effectively demonstrates the use of visual aides when presenting information to the individual, family and/or team members.
11	Demonstrates the ability to address issues with people during challenging situations without being confrontational or disrespectful.

DRAFT SUPPORTS COORDINATOR'S SKILLS INVENTORY	
	1 I perform this skill very well; 2. I perform this skill adequately; 3. I need to improve this skill; 4. I need training in this area 5. N/A
	<b>#9 Problem Solving &amp; Conflict Resolution</b>
1	Utilizes effective strategies (i.e. problem solving, facilitation and negotiation methods) to manage conflict.
2	Respects the roles people play on teams and encourages full participation to minimize conflict.
3	Manages and applies <i>crisis</i> prevention techniques to particular circumstances when working with individuals, families and providers to promote positive outcomes for the individual.
4	Manages and applies <i>crisis</i> intervention techniques to particular circumstances when working with individuals, families and providers to promote positive outcomes for the individual.
5	Manages and applies <i>crisis</i> resolution techniques to particular circumstances when working with individuals, families and providers to promote positive outcomes for the individual.
6	Uses conflict management and resolution techniques to facilitate and negotiate decision making.
7	Addresses and makes responsible decisions related to the individual's personal safety in community/home settings.
8	Demonstrates professional responsiveness to medical emergencies.
9	Monitors, discusses and follows up on incidents and crisis situations with individual, family and authorized staff.
10	Works with the individual, family and team to in adjust supports and when necessary the environment in response to an incident while complying with regulations for reporting.

## **Supports Coordinator Certification**

### **CERTIFICATION: Knowledge of the MR System**

How to use the SIS and Understanding the Relationship to MR Services  
How to Complete the PUNs  
How to Gather Information From Those Who Know the Person Best for the PUNs  
Understanding the PUNs & What the Data Means  
Updating the PUNs  
Service Preference  
Targeted Services Management TSM  
Service Definitions

### **CERTIFICATION: Philosophy & Ethics**

Self-Determination/Everyday Lives  
Balancing Individual Choice and Professional Responsibility  
Positive Approaches  
Person Centered Thinking Day 1 & 2  
Essential Lifestyle Planning Facilitator Day 1 & 2  
Positive Approaches  
Community Inclusion  
Advocacy  
Diversity Training & Cultural Awareness  
Confidentiality  
Code of Ethics

### **CERTIFICATION: Problem Solving Conflict Resolution**

Time Management  
Crisis Prevention  
Conflict Resolution  
Crisis Intervention

### **CERTIFICATION: ISP Development, Outcome Development, Plan Implementation & Plan Review**

ISP Plan Development & Information Gathering  
Understanding the Person Centered Components of the ISP  
Facilitating the Plan Meeting  
Natural Supports  
Supporting People with Challenging Behaviors  
Advanced Positive Approaches

**CERTIFICATION: Outcomes**

Outcomes Basics  
Practice Writing Outcomes Level-I  
Practice Writing Outcomes Level-II  
Developing Outcome Actions  
Linking Outcomes and Services  
Utilizing the Health Promotions Section of the ISP

**CERTIFICATION: Health & Safety**

Understanding Medications  
Side Effects of Medications  
Monitoring Medications  
Assistive Technology  
Adaptive Equipment

**CERTIFICATION: Effective Communication Skills**

Documentation  
Time Management  
Facilitation Skills & Techniques  
Basic-Facilitation Skills & Techniques for Supports Coordinators  
Intermediate-Facilitation Skills & Techniques for Supports Coordinators  
HCSIS Training

**CERTIFICATION: Quality Assurance**

Completing the Monitoring Tool  
Respectful Monitoring  
Incident Management (reporting, closing the loop & follow-up)  
HCQU Health Care Quality Unit  
IM4Q Independent Monitoring for Quality