Missouri Support Coordination Core Competencies

The MO SC Core Competencies were developed from a variety of resources in partnership between UMKC-IHD, the Division of Developmental Disabilities, and the Support Coordination Capacity Building Advisory Group representing individuals with I/DD, families, support providers, and targeted case management entities. The competencies were developed to ensure person-centered, consistent and quality support coordination across the state. The DDD uses the competencies as overall guidance when working with entities that are contracted to provide support coordination, as well as training state employed support coordinators.

Missouri SC Core Competencies

Core Competency: FOUNDATIONAL VALUES, BELIEFS, AND SKILLS

Support Coordinators are knowledgeable and adaptable professionals, demonstrating ethical behavior and professionalism across all core competency areas.

Case Management Requirements	Sub-Categories	Knowledge, Skills, and Attitudes
DDD TCM Manual: The single most important element of quality support coordination is building relationships. When strong relationships are developed and trust exists between all people involved with the individual supported, the quality of supports and services improves. Yet, building relationships is not a separate and distinct activity; it is integral to each function the support coordinator performs.	**Disability Values and Knowledge:** Understand and articulate the philosophies and practices related to supporting individuals with disabilities, *and* the various systems that establish and ensure services and supports align with these paradigms **Self-Awareness:** Recognize and respond to any personal or professional values or behavior that may interfere with the ability to provide supports in an ethical, unbiased, and culturally competent manner **Professionalism:** Continually develop and utilize personal and professional skills in a responsible and responsive manner to meet both regular and unexpected work tasks	• **Disability Values/Paradigms:** Integrate the philosophical values related to supporting persons with disabilities into all core competency areas • **Disability Service Infrastructure:** Understand the formal services and service structures at federal, state, and local levels, including both internal agency and external service delivery practices and standards • **Best Practice:** Identify and implement evidence based intervention approaches to promote well-being in all life domains • **Ethics:** Behave and practice ethically, adhering to all relevant laws and regulations and respecting the rights of the individual supported • **Cultural-Competence:** Respect the cultural needs and preferences of each individual, to include the use of verbal and written communication that is understandable to all • **Self-Awareness:** Recognize personal biases and prevent them from interfering with work tasks or relationships • **Professional Judgment and Critical Thinking:** Utilize personal strengths and decision-making skills to prioritize work tasks, seeking feedback and assistance from appropriate others when needed • **Professional Development:** Maintain qualifications and develop additional capacities through accessing opportunities for personal and professional growth • **Personal Professionalism:** Demonstrate the qualities of a responsive and responsible employee in personal appearance, work behavior, task completion, and team collaboration

Core Competency: ENGAGEMENT Support Coordinator develops and maintains a relationship with the individual and their team that facilitates effective communication and collaboration to promote well-being		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services (1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following: (i) Taking client history. (ii) Identifying the needs of the individual, and completing related documentation. *(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.*	**Relationship-Building:** Establish collaborative, professional relationships that are built on mutual respect and trust with the individual and others on the support team **Communication:** Use positive and respectful verbal, non-verbal, and written communication in a way that can be understood and facilitates coordination between all members of the team **Holistic Perspective of Person:** Identify and address the physical, social, emotional, behavioral, and spiritual well-being of the individual across all life stages and quality of life areas	• Understands and effectively communicates with the individual and support team the roles and responsibilities of the team • Shows genuine concern for the individual's welfare and future • Continuously demonstrates personal integrity, honesty, and sincerity • Demonstrates respect for individual's perceptions, learning style, personal being, and culture • Possesses confidence in working with strong emotions and the ability to self-manage to facilitate a collaborative team and mediate potential disagreements • Accurately interprets and utilizes tone of voice and body language • Uses language appropriate and respectful to the individual and team (non-technical, non-jargon) • Demonstrates effective communication skills, including active listening (summarizing, paraphrasing, reiterating, etc.) and conveying accurate information in a manner that can be understood • Demonstrates basic professionalism and courtesy – such as timeliness, responsiveness, and follow through • Utilizes basic team facilitation skills, including problem solving, action planning, and leading a meeting • Utilizes technology to accommodate individual needs and ensure efficiency • Facilitates meaningful conversation through awareness and utilization of a variety of tools and strategies and relevant language supports (accessible language, adaptive communication, use of interpreter, etc.) • Understands and uses People First language in all interactions
Core Competency: EMPOWER Support Coordinator enhances the individual's capacity for self-direction through ensuring awareness of rights and responsibilities, and facilitating access to resources.		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services (2) Development (and periodic revision) of a specific care plan based	**Advocacy**: Support the individual to continually increase self-direction by equipping him/her to speak for him/herself with providers, family members,	• Identifies and builds upon the strengths and resources of the individual and/or support team • Possess a basic understanding of various systems, and applicable policies and procedures

on the information collected through the assessment, that includes the following: (i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. *(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.* (iii) Identifies a course of action to respond to the assessed needs of the eligible individual.	community, and others *and* by promoting systems change that removes barriers to self-determination **Education:** Educate the individual and all support team members regarding individual rights and responsibilities *and* resources and options, including their related benefits and risks **Capacity Building:** Increase individual autonomy, resiliency, and skill sets by identifying and providing the appropriate level of support in each circumstance	• Understands developmental stages and the life cycle, and applies knowledge to normalize experiences and educate regarding life possibilities • Bridges and connects to resources across all life stages and quality of life areas • Advocates on behalf of the individual with the support team or other stakeholders when necessary • Facilitates self-exploration and self-advocacy to enhance skills of self-determination • Assesses the specific information needed, and provides education that is culturally and developmentally appropriate and sensitive to learning style • Understands and clearly articulates individual rights and takes action when rights are infringed upon • Understands and clearly articulates resources a person has when rights are violated or a person is dissatisfied with the quality of services (complaints and appeals) • Provides impartial information about the array of options and ensures informed choice • Identifies social, political, economic, and cultural factors that affect the individual, and assists the individual to identify external barriers that may affect their ability to live a self-directed, self-determined life and/or access needed resources • Promotes the individual's self-advocacy skills and links to opportunities for enhancement • Develops alliances with groups working for change
Core Competency: EXPLORE AND PLAN Support Coordinator engages the team in a person-centered planning process that results in an integrated and comprehensive plan that is reflective of and responsive to the strengths, interests, needs, and desired outcomes of the individual in all areas of their life.		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services (2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following: (i) Specifies the goals and actions to address the medical, social, educational, and other	**Exploration and Assessment:** Facilitate identification and articulation of personal goals, as well as supports and services that will assist the individual to achieve those goals **Plan Development:** Collaboratively develop a person-centered plan that is a comprehensive reflection of the individual with a related plan for services and supports	• Facilitates collaboration and discussion • Identifies trends in observations and conversation • Utilizes informal assessment techniques, such as asking open-ended questions, reviewing case notes, etc. to gather meaningful information • Utilizes formal assessment tools to gather information • Identifies strengths, interests, needs, areas for learning and growth • Consolidates collected information and collaboratively establishes a plan that addresses major concerns and major areas for learning and development • Facilitates the planning process so that an integrated plan that encompasses the family context, relevant history, current situation, future goals, etc. results • Facilitates planning for both the long-term and the short-term

services needed by the eligible individual. (ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals. (iii) Identifies a course of action to respond to the assessed needs of the eligible individual.	**Implementation:** Assist the individual to set goals, and to identify and make informed choices regarding strategies to achieve his/her goals	• Designs plans that meet regulatory requirements but remain relevant and sensitive to the individual • Utilizes and reflects the person's voice when articulating meaningful, attainable, measurable, and specific goals and outcomes • Identifies integrated resources, supports, and/or services and facilitates the development of goals to help the individual to achieve identified outcomes • Monitors for progress, reassessing and responding as necessary • Understands awareness of circumstances necessitating revisions to the plan, such as changes in client's condition, lack of response to the plan, preference changes, transitions across setting, etc. • Presents anticipatory guidance by facilitating a proactive conversation related to the potential experiences and related expectations, needs and desired outcomes at each stage of life
Core Competency: CONNECT TO INTEGRATED SUPPORTS AND SERVICES Support Coordinator assists the support team to cultivate an array of resources that meet the needs of the person, including paid and non-paid supports.		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services (3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.	**Navigate:** Support the individual to identify and access needed resources, supports, and/or services relevant to the current and upcoming life stage and the cultural context of the individual **Inform:** Explain services and service terms to the individual being supported and the support team **Network:** Develop and leverage personal and professional knowledge and relationships that will facilitate opportunities for the individual to make connections and access integrated supports **Negotiate:** Assist the individual to overcome barriers to receive needed services	• Demonstrates an awareness of a variety of resources available, including eligibility, relevant policies and procedures, the "right" contacts, etc. • Provides multiple options for resources (whenever possible) to ensure individual choice • Models strategies for and supports the individual/family to make informed choices • Assess the level of support needed and enhances the capacity of the individual (or family) to avoid creating dependence • Demonstrates the ability to look forward and prepare for transitions by anticipating and identifying expectations, needs, and desired outcomes during each stage of life and during transitions • Researches, locates, and refers to resources • Connects the individual and stakeholders to other organizations and groups • Develop a system for remaining aware of changing resources • Encourage and assist individual in connecting with others in a valued social role • Support the individual to identify, connect to and access recreational, social, and learning opportunities valued in his/her culture • Support the individual to connect to friends and live included in the community of their choice • Acts as mediator or liaison when necessary • Demonstrates an ability to problem solve and resolve conflict

		• Demonstrates an awareness of technological supports • Demonstrates networking skills and builds relationships in the community that can be leveraged to enhance the resources available to (or experiences of) individuals and families • Leverages and facilitates access to an array of identified resources and supports to meet the individual's needs and personal outcomes, prioritizing the use of resources available to any individual in the community prior to state and federal disability specific funding
Core Competency: FACILITATE LONG-TERM SERVICES AND SUPPORTS Support Coordinator facilitates the exploration and acquisition of paid supports from a variety of funding sources, and monitors for quality services that maximizes the use of support dollars to meet identified goals and minimize risks.		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services (4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met: (i) Services are being furnished in accordance with the individual's care plan. (ii) Services in the care plan are adequate. (iii) There are changes in the needs or status of the	**Gather and Assess Information:** Formally and informally gather, review, and analyze information from a variety of sources, utilizing the results to track progress and collaboratively guide support work **Monitor and Manage Risk:** Objectively identify potential for positive and negative outcomes, working to maximize individual progress and satisfaction and minimize/prevent abuse, neglect, exploitation, or other negative outcomes **Resource Management and Stewardship:** Facilitate the utilization of available support dollars from a variety of funding sources to allow for timeliness of service delivery in accordance with an individual's justified needs and identified goals	• Understands and explains disability specific funding mechanisms and eligibility for federal, state, and local resources and how to integrate with other community supports • Understands and explains types of long term service and supports, and the role of providers in supporting a person throughout the lifespan • Explains roles, expectations, rights/regulations, and responsibilities governing the relationship between the disability service providers and the persons receiving supports and ensures understanding between parties • Interprets information from formal and informal assessments to justify services and supports needed to reach identified outcomes • Demonstrates objectivity and discernment that facilitates unbiased provider relationships to facilitate informed choice regarding services and supports received and from whom • Monitors progress toward personal outcomes and person's quality of life in all domains, quality of service, and environments/settings through regular observation, conversation, documentation review, and formal monitoring • Identifies, communicates, documents and responds appropriately to issues found during monitoring and/or reported by the individual or team members • Recognizes the signs of abuse, neglect, and/or exploitation, report incidents according to applicable regulations and procedures, and completes appropriate actions to ensure immediate health and safety • Identifies serious events and complete appropriate follow-up action

eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.		• Accurately and thoroughly completes all documentation, to include (but not limited to) eligibility, monitoring, resolution of identified issues, etc. • Facilitates authorization of paid services according to specified time frames • Ensures availability of service provision through completion of authorization processes according to specified time frames

Development of the MO Support Coordinator Core Competencies

Need:

- Support Coordinators need skills and knowledge to support person with DD and their families that are consistent with state and national policies and practices.
- Persons with DD and their family rely on knowledgeable and informed support coordination to assist with person centered planning, linking to needed resources, as well as supports and services that lead to a quality life.
- Support Coordination entities need a consistent set of performance standards to develop and implement training and coaching that is customizable to meet the needs, strengths and culture of their specific region and enhance the capacity of the support coordinators.
- Division of DD needs a set of performance standards for support coordinators to ensure consistency and quality across the state of Missouri.
- TCM entities need a clearinghouse to access and share best practice resources for developing policies, procedures, trainings, etc.

Contributors: These competencies were developed from a variety of resources in partnership between UMKC-IHD, the Division of Developmental Disabilities, and the Support Coordination Capacity Building Advisory Group representing individuals with I/DD, families, support providers, and targeted case management entities. The following resources were used throughout development:

- Michigan State University (2000). Best Practice Briefs: From Case Management to Service Coordination.
- Cohen, M., Nemec, P., Farkas, M., Forbess, R. (1993). Service Coordination Reference Handbook. Center for Psychiatric Rehabilitation: Boston University
- US Department of Labor (2014). National Direct Service Workforce Resource Center Final Competency Set
- Division of Developmental Disabilities (2017). Support Coordination Manual. Department of Mental Health: Division of Developmental Disabilities: Missouri.
- Division of Developmental Disabilities (2017). Support Coordination Training. Department of Mental Health: Division of Developmental Disabilities: Missouri.
- Division of Developmental Disabilities (2017). Targeted Case Management Contract. Department of Mental Health: Division of Developmental Disabilities: Missouri.
- UMKC-Institute for Human Development (2016). Missouri Support Coordination Capacity and Innovation Project Survey and Focus Group Data. UMKC-IHD: Missouri.

Uses: The support coordination core competencies can be used in a variety of ways. First, they provide overall guidance for DDD when working with state employed support coordinators as well as entities contracted to provide support coordination. They also provide a standard for aligning training and performance measures for support coordinators, serving as a resource for TCM entities to identify areas in which their practices may be enhanced. The Support Coordinator Performance Standards will further be used to organize a clearinghouse, through which TCM entities can access training resources and other best practice materials for providing Support Coordination. The use of this clearinghouse be offered as a resource – not a requirement – to assist TCM entities in developing training and/or policies and procedures when areas for improvement are identified through self-assessment, current TCM TAC reviews or other evaluations.