



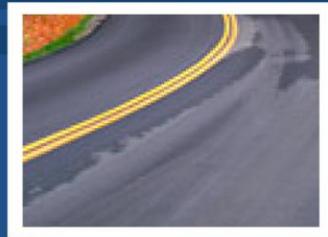
Road Map of Core Competencies for the Direct Service Workforce



Phase I: Direct Service Worker Competency Inventory

(Phase II: Competency Analysis in development)

(Phase III: Synthesis and Validation in development)



May 31st, 2011

PREPARED By the University of Minnesota Research and Training Center on Community Living, with input from The Lewin Group, PHI, The Annapolis Coalition for the Behavioral Health Workforce, and Westchester Consulting

PREPARED For the **CENTERS for MEDICAID & MEDICARE SERVICE**

Purpose

This project supports the federal interagency *Community Living Initiative* in identifying and describing the purpose and use of federally and non-federally funded competency development initiatives for the direct service workforce across long-term services and supports. The direct service workforce is comprised of multiple sectors including behavioral health, intellectual and developmental disabilities, physical disabilities, and aging. A highly competent workforce is critical to the well-being and safety of individuals who need support to live in the community. Several federal agencies play a role in the development, improvement, and oversight of this workforce. This project provides a baseline for exploring how these federal agencies initiatives interact with one another.

Competency-based training is a tool that can be used to ensure that members of the direct service workforce have the skills and knowledge needed to perform the activities of their jobs. While still not common, the number of competency-based training and credentialing programs in this area is growing across the nation. With this growth, it becomes increasingly necessary to identify the competency sets that exist, the relationship between the competency sets in each sector and how well the proposed competencies translate to training programs that result in better trained, more skilled, competent direct service workers.

Nationally recognized and validated competencies that cross the long-term care services and supports sectors promote the development of career ladders and lattices industry-wide. Through these industry-wide efforts, it is envisioned that a more competent, stable workforce will emerge to meet the growing demand of long-term services and supports. This report will inform the process to reach this goal.

This report is Phase I of the *Road Map of Core Competencies for the Direct Service Workforce*, and provides an inventory and overview of competency sets used across and within long-term service and support sectors. The development and application of competency sets within long-term services and support workforce development efforts is identified in Phase I. Phase II of the *Road Map of Core Competencies* will consist of analysis of direct service worker competencies, including further discussion of application.

Method

A comprehensive online literature review was conducted to identify competency sets, and related credentialing and apprenticeship programs that exist within the long-term services and supports sector. This research was conducted across all sectors of the industry that employ direct service workers, including behavioral health, intellectual and developmental disabilities, physical disability and elder services. The research was performed using the following search terms: direct service competencies, direct care competencies, direct support competencies, direct support workforce competencies, human service competencies, long term care competencies, long term care skills, personal care competencies, direct support workforce skills, direct care skills, behavioral health worker competencies, behavioral health worker skills, elderly services competencies and elderly services skills.

This broad inventory presents a comprehensive picture of the competency sets in the direct service workforce and utilization of these competencies. Due the number of competency and competency related initiatives currently underway, this inventory also includes competency sets that are in development. Competency sets designed for direct service workers employed in institutional-based services or services that are strictly medically oriented were ruled out. This inventory is inclusive of

Direct Service Workforce Competency Inventory

competency sets funded by various sources, and the geographic scope of implementation ranges from regional to national.

Once competency sets had been identified through the search process, follow-up phone calls were made to gather further information regarding the current application of the competency sets. A matrix of the competency inventory was drafted and sent to partners of the Direct Service Workforce Resource Center for review by subject matter experts within each sector. The matrix was edited to incorporate any feedback.

Results

Table 1 provides an aggregate count of competency sets by funding source, geographic scope and sector application. Of the 22 identified competency sets, 8 of those are in development, and 6 of the 8 are PHCAST funded projects awarded to states for the development of core competency sets to guide training and workforce development activities within the respective states. Of the 14 developed competency sets, 10 were designed to reach a national audience. Five of the 14 developed competency sets are applicable across at least three sectors.

Brief Inventory Analysis by Funding Source

Number of Competency Sets (Existing and In Development) by Funding Source	
Federal	14 (6 of 14 are PHCAST state projects in development)
State	5
Other	3
Total	22

Brief Inventory Analysis by Intended Sector Application

Number of Existing Competency Sets by Intended Sector Application	
Cross Sector (across 3 <)	5
Aging & PD	1
Aging Specific	2
BH Specific	4
I/DD Specific	2
PD Specific	0
Total	14

The Direct Service Worker Competency Inventory provides the following information about 22 competency sets: 1) title, 2) source of funding and/or support for application in the field, 3) workforce sector, 4) background and development process, 4) application of the competencies, and 5) contact information. The key for workforce sector abbreviations is provided in the bottom left-hand corner of the document.

Direct Service Workforce Competency Inventory

Competency Title	Source of Funding and/or Support for Application	Workforce Sector	Background and Development Process	Application of Competencies and Contact Information
<p>Addiction Counseling Competencies (TAP 21)</p>	<p>Dept. of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Admin. (SAMHSA), Center for Substance Abuse Treatment (CSAT)</p>	<p>BH</p>	<p>In 1998, in cooperation with its Addiction Technology Transfer Center (ATTC) Network, SAMHSA published TAP 21, a comprehensive list of 123 competencies that substance abuse treatment counselors should master in order to do their work effectively.</p> <p>The overarching competencies in this updated version of TAP 21 remain largely unchanged from the original TAP 21. The knowledge, skills, and attitudes (KSAs) have been changed from those in the 1998 edition when necessary, in light of new thinking in the field.</p> <p>The competencies and KSAs that address clinical evaluation and treatment planning have been revised to reflect changes in the field.</p>	<p>The Addiction Counseling Competencies (TAP 21) are recognized both nationally and internationally within the field of substance use disorders treatment. It is purported to be the most developed and broadly disseminated competency set in behavioral health.</p> <p>Used to develop and evaluate addiction counseling curricula, advise students, and assess counseling proficiencies.</p> <p>Center for Substance Abuse Treatment. <i>Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice</i>. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.</p> <p>http://www.kap.samhsa.gov/products/manuals/taps/21.htm</p>
<p>Adult Psychiatric Rehabilitation /Recovery-Oriented Mental Health Services for Adults Competencies</p>	<p>The US Psychiatric Rehabilitation Association (USPRA), formerly IAPSRS</p>	<p>BH</p>	<p>This set is also referred to as the Certification Commission for Psychiatric Rehabilitation Role Delineation Study.</p> <p>There are no nationally recognized core competencies for mental health practice. The competencies in the field of psychiatric rehabilitation are noted to be most relevant for entry-level direct care staff in the mental health field.</p> <p>The USPRA is an organization whose mission is to promote the community readjustment of people with psychiatric disabilities. Formerly known as the International Association of Psychosocial Rehabilitation Services (IAPSRS), the organization conducted a Role Delineation Study, or job analysis, which became the foundation for its subsequent certification process.</p>	<p>State/National Credentialing Program:</p> <ul style="list-style-type: none"> ▶ The Certified Psychiatric Rehabilitation Practitioner (CPRP) credential is a test-based certification based on the seven domains identified in study. ▶ The CPRP is recognized and/or required by Medicaid regulations in 15 states. <p>http://www.uspra.org</p>

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<i>Alaskan Core Competencies</i>	Alaska Mental Health Trust Authority	AG, I/DD, PD, BH	<p>The Alaska Mental Health Trust Authority, in collaboration with the University of AK, Dept. of Health and Social Services, and the Annapolis Coalition on the Behavioral Health Workforce, sponsored this effort by creating the Committee on Workforce Competency (CWC). The CWC is responsible for all activities related to the <i>Alaskan Core Competencies</i>.</p> <p>The <i>Alaskan Core Competencies</i> were created through a process of distilling and integrating the shared competencies from nationally recognized competency sets developed for specific population or disability groups. These were further informed and modified by competencies crafted for practice in Alaska and by the expert opinion of Alaskans who served as project raters. Multiple workforce sectors were represented in the development process.</p>	<p>The competencies have been used by organizations in Alaska to shape or revise training content and performance review processes.</p> <p>The assessment tools were recently released. A comprehensive plan is under development to foster widespread adoption of the competencies within the state.</p> <p>A number of organizations around the country have been granted permission to use the competencies.</p> <p>http://www.annapoliscoalition.org/core_competencies.aspx</p>
<i>Arizona Direct Care Worker Competencies</i>	Arizona Dept. of Economic Security, Division of DD and Dept. of Health Services, Division of Licensing Services	AG, I/DD, PD	<p>Arizona’s Direct Care Workforce Initiative is a public-private partnership that seeks to promote a stable and competent direct care workforce to meet the growing care needs in Arizona and provide support for families as they care for their loved ones at home and in the community.</p> <p>Several committees guided the efforts related to the development of standards for training of direct care workers, developing the model curriculum Principles of Caregiving, and raising public awareness. Participants include home care providers, community colleges, area agencies on aging, community-based organizations, and state agencies.</p>	<p>The Arizona Direct Care Worker Competencies have been developed for use within Arizona. These competencies are the basis of the proposed training and testing requirement for direct care workers employed by provider agencies for ALTCS (Arizona Long-Term Care System) and DES (Arizona Dept. on Economic Security), Area Agencies on Aging.</p> <p>http://www.azdirectcare.org</p>

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<p><i>Community Residential Core Competencies (CRCC)</i></p>	<p>National Institute on Disability and Rehabilitation Research (NIDRR) and Dept. of Education</p>	<p>I/DD</p>	<p>The CRCC were developed as a project of the Research and Training Center on Community Living, University of MN. This study included a replication of the DACUM process to validate the use of the Community Support Skill Standards (CSSS) specifically in community residential services for people with intellectual and developmental disabilities.</p> <p>This validation process yielded results that indicated a strong overlap between CSSS and the KSAs required of direct service workers in community residential services. The identified CRCC provide more specific areas of competence than CSSS within I/DD services and supports.</p>	<p>The CRCC were reviewed and integrated into the National Alliance for Direct Support Professionals (NADSP) Competency Set resulting in the first national credentialing program for professional DSWs.</p> <p>Broadly used in I/DD sector as foundation for competency based training programs, and workforce development and performance management tools.</p> <p>Basis of the College of Direct Support (CDS) national online training program that is used by 180,000 DSWs each day in 32 states.</p> <p>http://rtc.umn.edu/docs/analysis.pdf</p>
<p><i>Community Support Skills Standards (CSSS)</i></p>	<p>Dept. of Labor and Dept. of Education</p>	<p>AG, I/DD, PD, BH</p>	<p>The CSSS Project based out of the Human Services Research Institute (HSRI) conducted an in-depth study of the role of DSWs. This involved a structured DACUM analysis process to study and validate direct service worker roles and to write and validate a set of skill standards. The workers defined their job activities, identified key worker attributes and values, and briefly defined their role. The CSSS use the occupational title of Community Support Human Services Practitioner (CSHSP) to describe direct support work.</p>	<p>The CSSS have been used by numerous community-based human service organizations nationally as competency standards for the training and education of the direct service workforce.</p> <p>Adopted by the NADSP in the development of the NADSP Competency Set. Basis of The College of Direct Support (CDS) national online training program that is used by 180,000 DSWs each day in 32 states.</p> <p>http://rtc.umn.edu/johns/TheCommunitySupportSkillStandards.doc</p>

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<p><i>Competency Standards For Physical Health and Aging:</i></p> <p><i>Certified Nursing Assistant (CNA)</i></p>	<p>Dept. of Labor: ETA grant to the Council for Adult and Experiential Learning (CAEL)</p>	<p>AG</p>	<p>In 2003, CAEL and the Evangelical Lutheran Good Samaritan Society (GSS) developed the CNA apprenticeship with the help of PHI (see below) as a subcontractor. GSS has developed career paths for all clinical occupations and helped employees navigate various paths to move ahead or to specialize in their current job.</p> <p>Technical Assistance to develop this apprenticeship program was provided by the DOL Office of Apprenticeship.</p>	<p>CAEL and GSS developed a four-tiered, competency-based certification process to better qualify staff to meet the needs of long-term care patients. Apprentices receive a wage increase upon completion of each certificate. The CNA apprenticeship offers training in entry-level, advanced and specializations including dementia, restorative care, geriatrics, med aide, hospice and palliative care and peer mentor.</p> <p>http://careerlattice.org/education/advance.asp</p> <p>http://www.doleta.gov/OA/cael.cfm</p>
<p><i>Home Health Aide (HHA)</i></p>	<p>Dept. of Labor: ETA grant to PHI</p>	<p>AG, PD</p>	<p>In 2004, PHI developed the Home Health Aide Registered Apprenticeship based on the Certified Nursing Assistant model (described above) for workers in home settings. PHI provides the development of innovative approaches to training, supporting and developing a highly trained workforce in long-term care. Their work includes the creation of Competency Standards for Physical Health and Aging for Certified Nursing Assistants and Home Health Aides.</p> <p>Technical Assistance to develop this apprenticeship program was provided by the DOL Office of Apprenticeship.</p>	<p>This multi-level apprenticeship allows apprentices to gain basic skills and advance in specialty areas including hospice and palliative care, geriatrics, disabilities, mental illness, dementia and peer mentor. Apprentices are expected to demonstrate competence in basic home care skills and at least two specialties. Apprentices receive interim credentials and wage increases as they complete parts of the program. Entry-level apprentices are supported by experienced home health aides who serve as peer mentors.</p> <p>http://phinational.org/training/resources/apprenticeships/</p> <p>http://phinational.org/wp-content/uploads/2009/05/psc-appendices.pdf</p>

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<p><i>Health Support Specialist (HSS)</i></p>	<p>KS Dept. of Health & Environment; KS Dept. of Commerce; KS Community College</p>	<p>AG</p>	<p>In 2004, Brewster Place Retirement Community partnered with various Kansas state agencies (see list to left) to develop a Registered Apprenticeship program that would address the culture changes taking place in long-term care, particular to provide training for a universal worker.</p> <p>The Health Support Specialist builds and expands upon the Registered Apprenticeship programs for Home Health Aide and Certified Nursing Assistant. PHI was consulted in the development of the apprenticeship.</p>	<p>The HSS apprenticeship was recognized nationally by the US DOL and is used in multiple states.</p> <p>The HSS apprenticeship includes competencies for CNA, Home Health Aide, Activity Director, Certified Medication Aide, Dining Services, Environmental Services, and Rehabilitative Aide.</p> <p>http://www.kansasapprenticeship.org/Pages/Default.aspx</p>
<p><i>Department of Labor (DOL) Long Term Care Supports and Services Competency Model (LTCSS)</i></p>	<p>Dept. of Labor: Education, Training and Learning Admin. (ETA)</p>	<p>AG, I/DD, PD, BH</p>	<p>In February 2011, the U.S. Department of Labor released the Long-Term Care, Supports and Services Competency Model (LTCSS). The Employment and Training Administration (ETA) worked with technical and subject matter experts from education, business, and industry to develop a comprehensive competency model for the long-term care, supports, and services industry.</p> <p>The model is designed as a resource supporting workforce development efforts to prepare DSWs who make it possible for the aging population and those with disabilities to live their lives with independence and dignity.</p>	<p>The Long-Term Care, Supports and Services Competency Model (LTCSS) provides a foundation for the development of industry sector models that reflect more specific competency needs of workers in skilled nursing facilities and assisted living, congregate care, community settings and in-home independent living.</p> <p>http://www.careeronestop.org/competencymodel/pyramid.aspx?LTC=Y</p>
<p><i>Direct Support Professional Competencies of California</i></p>	<p>California Dept. of Developmental Services and Dept. of Education</p>	<p>I/DD</p>	<p>In 1998, the California Legislature established the Direct Support Professional (DSP) Training Program. The program was developed to increase quality of care for people with developmental disabilities living in licensed Community Care Facilities by ensuring core competencies or skills for all Direct Support Professionals.</p>	<p>Effective January 1, 1999, the Department of Developmental Services implemented mandated statewide competency-based training for Direct Support Professionals employed in Regional Center vendored community care facilities.</p> <p>http://www.lausd-dsp.net</p>

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			<p>The DSP competencies, or skill standards, were designed to guide program curricula development and are organized around twelve broad areas for providing direct supports and services to individuals with DD living in community care facilities. These competencies and competency areas were identified through a job analysis process that involved individuals with DD, DSWs, administrators, and regional center service coordinators, quality assurance and clinical staff.</p>	
<p><i>Infant Mental Health Competency Guidelines</i></p>	<p>Michigan Association for Infant Mental Health (MI-AIMH)</p>	<p>BH</p>	<p>The MI-AIMH is an interdisciplinary, professional organization with the mission of promoting the development of infants, toddlers, and families through training and advocacy.</p> <p>The Infant Mental Health Competency Guidelines can be found in MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health: Competency Guidelines.</p>	<p>These competency guidelines were published in 2003 and available for purchase online. The competencies have been articulated for four job levels: infant family associate, infant family specialist, infant mental health specialist, and infant mental health mentor.</p> <p>http://www.miaimh.org/documents/01.30.09_competencies_building_capacity.pdf</p>
<p><i>National Alliance for Direct Support Professionals (NADSP) Competencies</i></p>	<p>NADSP Development support of apprenticeship program and technical assistance provided by the DOL, Office of Apprenticeship.</p>	<p>AG, I/DD, PD, BH</p>	<p>The NADSP Competencies are an integrated set of competencies identified in the Community Support Skill Standards (CSSS) and the Community Residential Core Competencies (CRCC).</p> <p>This set was endorsed by the NADSP Board of Directors and has been used to develop a national, comprehensive credentialing program for direct support professionals working in a variety of community-based human services settings.</p> <p>These competencies were designed to be applicable across sectors. However, the majority of organizations that have adopted these competencies are within the I/DD sector.</p>	<p>DOL Registered Apprenticeship Programs:</p> <ul style="list-style-type: none"> ▶ DSP Apprenticeship Program sponsored by NADSP and ANCOR (American Network of Community Options and Resources). ▶ Active apprenticeship programs in 4 states. <p>National Credentialing Programs:</p> <ul style="list-style-type: none"> ▶ The NADSP Credentialing Program is a national voluntary credentialing program based on the NADSP Competency Set. <p>State Credentialing Programs exist across the US, including:</p> <ul style="list-style-type: none"> ▶ New Jersey DSP Certificate ▶ Indiana State DSP Certificate

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				<ul style="list-style-type: none"> ▶ CDSN DSP Certificate (CA) <p>General Application:</p> <ul style="list-style-type: none"> ▶ Foundation for more than ten competency based training programs across the nation have been developed in accordance with this set and/or have been accredited to meet these competency standards. <p>http://www.nadsp.org</p>
<i>National Association on Dual Diagnosis (NADD) Competency</i>	NADD	I/DD BH	NADD is in the process of completing the development of the NADD Accreditation/Certification Program (ACP), which is composed of three separate but interrelated competency-based quality assurance programs designed to establish standards in the field of mental health care for people who have intellectual disabilities and mental health needs (dual diagnosis). A set of competencies is being developed as part of this process.	<p><i>In development</i></p> <p>NADD is currently developing a voluntary credentialing process built upon the NADD Competency Set.</p> <p>http://www.thenadd.org/pages/about/accred.shtml</p>
<i>Ohio State Workforce Development Initiative</i>	Centers for Medicare and Medicaid Services (CMS), Money Follows the Person (MFP)	AG, I/DD, PD, BH	<p>The Ohio State University (OSU) convened a consortium of experts in the areas of gerontology, developmental disabilities, mental health, alcohol and drug addiction, physical disabilities, economics, human resources, adult education, and workforce to conduct research and guide the development of a stackable “core + specialization” framework.</p> <p>The OSU Center for Education and Training for Employment (CETE) is conducting information-gathering sessions with employers and stakeholders and will perform a DACUM analysis in the next State biennial fiscal year.</p>	<p><i>In development</i></p> <p>The framework is intended to build an academic foundation to an advanced certificate or degree in health and human services. By linking the framework to college credit, Ohio hopes to create a pipeline of direct service workers with experience with persons with disabilities throughout professional health and human service education programs.</p> <p>http://grc.osu.edu/projects/long-termcareworkforceinitiative/</p>

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<p><i>Personal and Home Care Aide State Training Program (PHCAST) Projects:</i></p> <ul style="list-style-type: none"> ▶ California ▶ Iowa ▶ Maine ▶ Massachusetts ▶ Michigan ▶ North Carolina 	<p>Dept. of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA)</p>	<p>AG, PD, I/DD</p>	<p>In 2010, six states were awarded funds to create competency-based curriculum to guide the development of training programs for personal care assistants. States are creating new competency sets or using a hybrid of existing competency sets. States are in the early stages of this project.</p>	<p><i>In development</i></p> <p>http://phcast.linhost1.jbsinternational.com/resources#6</p>

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<p><i>SAMSHA/CSAT TIP 42 Intermediate Competencies</i></p>	<p>Dept. of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT)</p>	<p>BH</p>	<p>Evidence of the frequency with which individuals simultaneously experience mental and addictive disorders has led to a focus on developing “co-occurring” approaches to service delivery and workforce development. While there are evidence-based toolkits for integrated dual disorders treatment and other models and training resources, the competency models for practitioners in this field have not been developed in detail.</p> <p>The expert panel that drafted TIP 42 created this competency model in collaboration with the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services.</p>	<p>The most widely cited resource on co-occurring competencies is the SAMHSA/CSAT TIP 42 Treatment Improvement Protocol, titled <i>Substance Abuse Treatment for Persons with Co-Occurring Disorders</i> (CSAT, 2005).</p> <p>http://www.ncbi.nlm.nih.gov/books/NBK14528/</p>

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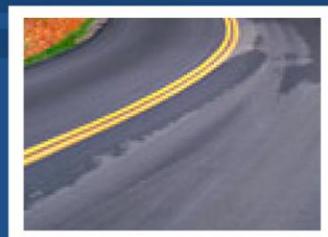
Road Map of Core Competencies for the Direct Service Workforce



Phase II: Direct Service Worker Competency Analysis

*(Phase I: Competency Inventory available in
separate document)*

(Phase III: Synthesis and Validation in development)



December 19, 2011

PREPARED By the University of Minnesota Research and Training Center on Community Living, with input from The Lewin Group, PHI, The Annapolis Coalition for the Behavioral Health Workforce, and Westchester Consulting
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Purpose

This project supports the federal interagency *Community Living Initiative* in identifying and describing the purpose and use of federally and non-federally funded competency development initiatives for the direct service workforce across long-term services and supports. The direct service workforce is comprised of multiple sectors including behavioral health, intellectual and developmental disabilities, physical disabilities, and aging. A highly competent workforce is critical to the well-being and safety of individuals who need support to live in the community. Several federal agencies play a role in the development, improvement, and oversight of this workforce. This project provides a baseline for exploring how these federal agencies initiatives interact with one another.

Introduction and Purpose

This report has been produced as a project of the federal interagency *Community Living Initiative* by the National Direct Service Workforce Resource Center, funded by the Centers for Medicaid & Medicare Services (CMS). It is an objective of the Direct Service Workforce Resource Center to share information and facilitate dialogue among stakeholders regarding workforce challenges and implications for policy and practice across direct service sectors. These sectors include behavioral health, mental health, intellectual and developmental disabilities, physical disabilities, and aging. Numerous departments within government and other human service organizations have played a role in workforce initiatives, such as the development of competency standards for direct service workers. It is a challenge to create and strengthen cross-sector partnerships, as these agencies operate within distinct funding, policy, service, and advocacy systems.

This report responds to the need to develop better understanding of the commonalities and differences across workforce sectors in order to devise a comprehensive resolution to the overall direct service workforce challenges. Competency standards constitute a foundational bearing in key processes of workforce development, including recruitment, curriculum development, training, apprenticeship programs, credentialing and certification systems, performance evaluation, and ongoing staff development. Additionally, they influence the foci of services and supports and therefore quality outcomes. While cross-sector and agency collaboration has been limited, current trends of competency development and implementation reflect fragmented and stunted efforts for national standardization within the direct service workforce. In initiating this effort, CMS and the Community Living Initiative Workforce Work Group recognized that a key first step towards a more unified approach to competency development was to identify and analyze all the existing and established competency standards among sectors of the direct service workforce.

The current report represents Phase II of the *Road Map of Core Competencies for the Direct Service Workforce*. It follows Phase I, which provides an inventory and overview of competency initiatives developed in the United States to improve training and proficiency of the direct support workforce within and across several sectors, including behavioral health, intellectual and developmental disabilities, physical disabilities, and aging. The Phase I report identified fourteen established competency sets that had been implemented within the workforce. It includes eight additional competency sets that were in development during the time of the writing of that report. This profile of twenty-two competency sets demonstrates a significant movement towards advancement and standardization within the direct support workforce. It also contextualizes some challenging trends in these efforts, such as fragmentation and the lack of widespread adoption of competencies.

This Phase II report builds on the Phase I Road Map process. The purpose is to share findings from a comparative analysis and systematic review of the competency sets identified during Phase I. Individual competency sets are applied in a comprehensive content analysis in order to provide a force field analysis and to pinpoint the feasibility of a core competency initiative. Finally, the authors provide some possible next steps that might be

taken to advance the field in the area of competency development and implementation. While the contents of one competency set are applied as a comparative measure within the analysis, the authors do not assert or imply this competency set to be superior or recommend that it be compared to other competency sets within the inventory.

Background

The Direct Service Workforce

The direct service workforce represents a broad category of employees in the health and human service industry. Across several sectors, it is the role of direct service workers (DSWs) to provide hands-on support to individuals based on personal health and human service needs. The range of supports and services delivered by DSWs varies widely, depending on individuals' needs and the type of setting in which services are delivered. Some of the roles and responsibilities that DSWs are generally expected to fulfill involve: assisting with home skills such as meal planning and preparation, housekeeping, and budgeting; assisting with personal care and hygiene; providing employment supports; implementing positive behavior support and crisis intervention; teaching new skills; providing opportunities for community integration; conducting assessments and community referrals; and working with family members.

While many of the roles and responsibilities are common across sectors, there is not a unified occupational title for DSWs. The Bureau of Labor Statistics uses four Standard Occupational Classifications for this field: nurse aid, home health aides, personal care aids and psychiatric aids. However, in the aging and physical disability services sector, common job titles include nurse aide, home health aide, personal care assistant, companion, and attendant. There are many titles used within intellectual and developmental disability services which are often ascribed by employer organizations. The title "direct support professional" is becoming more widely used in this sector. A broadly recognized occupational title for DSWs in the behavioral health sector working in community settings does not exist.

There is limited data on demographics of the direct service workforce due to inconsistent collection of national data and the lack of comprehensiveness across sectors. A synthesis of studies based on the existing data (Hewitt et al., 2008) indicates that DSWs are generally women from 30- to 50-yearsold. Direct service workers in the aging and physical disabilities sector tend to represent more diversity in terms of race and ethnicity throughout the United States, while there is wide variance of such diversity across states within the intellectual and developmental disabilities sector (PHI, 2011). There tends to be higher proportions of DSWs with at least some post-secondary education represented in the behavioral health and intellectual and developmental disability sectors when compared to the aging and physical disabilities sector. Across sectors, there have been increasing amounts of DSWs who have immigrated to the United States and/or speak English as a second language. The existing demographic data demonstrates important trends that inform and influence standardization of competency and training efforts across sectors.

Support and Service Models

The context of support and service models embedded within sectors has influenced the roles, responsibilities, and practice approaches of DSWs. All sectors have historically operated through a medical model of service delivery, with the exception of addiction services in the behavioral health field. The medical model has promoted doctors and medical personnel as primary decision-makers in addressing individuals' health and human service needs. Yet progressive standards of care have emerged in efforts to facilitate the delivery of person-centered supports.

In congruence with person-centeredness, service delivery systems have been gradually moving toward operating in community-based settings rather than institutional settings such as nursing facilities and intermediate care facilities. Nationally, the balance in long term services and supports is shifting toward home and community-based services which requires the establishment of funding mechanisms and service structures that support community living. The shift has been most apparent for people with intellectual and developmental disabilities, for whom the dominant service model has transformed from being based in hospitals and medical institutions to being based in homes, at jobs, and in communities in order to deliver supports that empower people to live fulfilled lives (Hewitt et al., 2008). This trend is mirrored for people aging and people with physical disabilities, although it was later to start, as state Medicaid programs have invested in home and community-based services and infrastructures for these populations. The community support model has not only influenced the settings in which many DSWs provide support; it has influenced the principles and framework of direct services. Within this framework, the facilitation of self-determination, community inclusion, and normalization has become more central to the roles of DSWs.

The sectors are various stages of maturity when it comes to offering participant-directed services, where individual service recipients act as the primary director of their own services, which also has implications for DSWs working in these types of programs. Within this movement, the National Resource Center for Participant-Directed Services has been instituted with the mission to “infuse participant-directed options in all home and community-based services” through technical assistance, training, education, and research (National Resource Center for Participant-Directed Services [NRCPDS], 2011). Researchers from this center report there are over 300 participant-directed, long-term services and supports programs throughout the United States, and the majority of programs have been implemented since 2000 (Sciegaj & Selkow, 2011). Their research indicates that every state has at least one employer authority program that offers participants the opportunity to select and hire their own DSWs and 43 states have at least one program where participants may control their service budgets. Furthermore, the NRCPDS has recently released information regarding efforts with the U. S. Administration on Aging to develop direct service workforce core competencies for the context of person-centeredness and participant-direction in long-term services and supports (Velgose, Sciegaj, & Sanders, 2011). This initiative aligns with the recommendation from sector stakeholders to “keep training and worker support central to all consumer-directed service programs” (Hewitt et al., 2008, p. 31).

The roles and responsibilities of DSWs have become increasingly more complex based on the continued movement toward individualized services in the community and the growing service paradigm placing the participant in the position of directing his or her own services. Community-based services require staff independence in problem solving and decision-making, and less in-person support from coworkers and supervisors. Direct service workers face responsibilities related to maintaining professional roles and boundaries within various contexts. Direct support workers make critical decisions often while working independently with an individual, thus lacking access to support from coworkers or supervisors. This is a significant shift from the expectations of DSWs working in congregate care environments, in which an on-site, team based staff approach is more prevalent. In addition, raising expectations regarding upholding individuals’ freedoms, rights, and choices in all aspects of service delivery presents decisions that require ethical and complex analysis.

Despite the increasing complexities of the job, there is currently no universally accepted code of ethics or guiding principles for DSWs across sectors. Furthermore, there is currently no universally accepted set of core competency standards for DSWs across sectors. Each sector has identified training needs of DSWs, while their application and influence in the direct service field has been limited. With little interdisciplinary research and dialogue, the existing competency sets represent varied practice concepts due to the orthodoxies of service models and sectors. This issue has been reported recently in a synthesis of challenges across sectors in the direct service workforce (Hewitt et al., 2008). Workforce challenges were identified and discussed in the following areas:

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- ▶ The status and image of direct service workers.
- ▶ Supply and demand conditions for DSWs.
- ▶ Recruitment and vacancies.
- ▶ Turnover of DSWs, including measuring turnover rates and determining factors associated with DSW turnover.
- ▶ Wages and benefits, including low DSW wages, low access and utilization of benefits, public assistance, worker injury, and employee assistance.
- ▶ Training and education, including the need for identification and application of DSW competencies.
- ▶ Federal and state training requirements for DSWs.
- ▶ DSW career paths.
- ▶ Supervision of DSWs.
- ▶ Workplace culture and respect for DSWs.
- ▶ Self-directed services.

The areas listed above represent inter-connected challenges that have been perpetuated within trajectories of direct support workforce sectors. In an effort to address and resolve such challenges, a recent report based on the Centers for Medicaid and Medicare Services Leadership Summit on the Direct Service Workforce and Family Caregivers identified an immediate next step as, “Convene stakeholders across populations to reach consensus on a common set of core competencies, and additional competencies beyond the core set depending on the needs of the person they support and types of services they provide” (The Direct Service Workforce Resource Center, 2011, p. vii). In congruence, the authors of the synthesis report on challenges across sectors in the direct service workforce recommend a key strategy to identify core competencies and specialization competencies across sectors. Such a foundational and coordinated approach was deemed “critical to preparing greater numbers of workers for direct service work as well as ensuring the quality of supports and services provided to consumers” (Hewitt et al., 2008, p. 30).

Competencies

Direct service competencies are receiving increased attention and recognition as a critical component of workforce development. A recent literature review has highlighted widespread inadequacies of health and human service delivery due to workers’ failure to demonstrate compliance with practice guidelines (Hoge, McFaul, Calcote, Tallman, et al., 2008). Poor workforce performance across sectors has been attributed to the lack of collaboration among stakeholders regarding the establishment of direct service workforce requirements in contemporary work settings (Taylor, Bradley, & Warren, 1996). Competency-based workforce programs have been largely uncommon based on inadequate funding for DSW training, performance evaluation, and ongoing support (O’Neill & Hewitt, 2005). However, there is consensus within long-term services and supports programs regarding the need for effective workforce standards in order to ensure a high quality of service and support delivery. Despite the wide variety of programs and grants implemented by federal, state, and private organizations targeting the development of competency sets that are detailed in the Phase I inventory, a coordinated process to identify core competencies and specialization competencies across sectors has not yet come to fruition.

There is inconsistency in the definition of the term “competency” and the various elements of competencies in the context of the direct service workforce. This has resulted in a constellation of strategies and processes for competency modeling and development in the field. Competency elements have been identified as KSAPs, which

refer to the knowledge, skills, abilities, and personal characteristics that DSWs demonstrate in delivering effective supports and services. O’Neill and Hewitt (2005) offered a general definition of competence as “having the needed KSAs [knowledge, skills, and abilities] to do something that is designed or required to yield certain outcomes” (p. 131). Hoge, Tondora, and Marielli’s (2005) definition of competency stated that “successful completion of most tasks requires the simultaneous or sequenced demonstration of multiple competencies” (p. 517).

Competencies are considered a foundation for workforce development and standardization. When rigorously developed and effectively implemented, competencies serve the important function of informing DSWs and their supervisors about requirements of job performance. Competencies also provide indicators that are necessary to develop effective curriculum for DSW training, orientation, and continuing staff development. The utilization of competencies in the direct service workforce reinforces shared values of DSWs’ skills and growth (Hoge et al., 2008). Competencies provide guidance within key processes of workforce development, including recruitment, curriculum development, training and staff development, and credentialing. The utilization of competencies within the context of curriculum and training as well as credentialing and certification programs is highlighted in the following sections.

Curriculum and Training

Research indicates that there are several organizational and policy related factors influencing trends of low performance among the direct service workforce (O’Neill & Hewitt, 2005). Service provider organizations report challenges in maintaining high job performance expectations of DSWs while minimizing turnover and balancing demands for needed delivery of supports (ANCOR, 2001). There are various strategies that must be incorporated on multiple levels in order for organizations and systems to address poor performance in the direct support environment. One of the most integral strategies involves development and implementation of high quality, competency-based training programs.

Competency-based training is a systematic skill building approach that targets learners’ achievement of specific outcomes, which are stated competencies. In this context, competencies describe the essential knowledge, skills, and abilities that DSWs are expected to successfully develop, demonstrate, and apply to their jobs as a result of the training. Competency-based training programs are especially applicable and conducive to the direct service workforce because they provide an individualized format for learning. In this format, DSWs may be trained based on competencies relevant to their diverse and ongoing training needs. However, there are several barriers to widespread delivery of effective and individualized competency-based training. Varied federal and state mandated training regulations have been implicated in such barriers. They have influenced service providers to meet only minimum requirements, while further training is necessary to meet standards of person-centered support delivery.

In addition to insufficient training policies, the processes for identifying and verifying DSW competencies are implicated in barriers to delivering effective training. In order for curriculum developers and organizational leaders to understand and measure specific training needs of DSWs, they must have access to recent and accurate information regarding competencies that are required for the delivery of effective daily supports. It is important that competencies are subjected to rigorous testing and piloting processes in order to evaluate their practicality and effectiveness in application to training and other workforce initiatives. However, there is inconsistency in the strategies by which data has been collected and tested in order to check the accuracy of competency sets. Current sets have presented a constellation of development processes and tools, which vary widely in their reliability, validity, and efficiency. Common methods used include job analysis, expert panels and stakeholder involvement, review of literature and existing training programs, and key informant interviews and surveys.

Job analysis involves a structured process focused on what DSWs need to know to perform their jobs and when they need to develop certain skills and abilities (Wiant, 1993). Competencies that have been identified and

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verified through processes of job analyses provide a reliable foundation in the development of curriculum and training programs, as well as job descriptions, performance appraisals, and other workforce improvement strategies. While job analysis is considered a critical step in developing and applying competencies, the process remains uncommon and unstandardized within national, state, and organizational systems that share responsibility in preparing and supporting the direct service workforce.

There is a lack of updated and nationally validated competency sets upon which trainings and workforce processes may be based upon. Due to financial limitations, many competency development projects are not equipped with the means to implement rigorous validation designs. Historically, there has been widespread lack of funding for follow-up evaluations necessary to revise competencies. Many groups have relied on existing competencies as primary sources for developing new competency standards; competencies that may or may not have been sufficiently validated. While national recognition of competency sets serves as a form of validation in practice, it is not a scientifically rigorous method that ensures these competencies are needed for quality direct service provision across sectors and from a national perspective.

Apprenticeship Programs and Credentialing and Certification Systems

A critical base of information on direct support competencies exists in the establishment of apprenticeship programs and systems of credentialing and certification. These programs and systems provide structured pathways for DSWs to achieve competency, focusing on skill attainment through competency-based training and an individual's measured investment in a career.

There have been several credentialing initiatives funded through government agencies, professional associations, and/or private foundations. Due to several factors such as dissemination, accessibility, and quality, these initiatives have varied significantly in their scope and influence of the direct service workforce. A recent report has provided a detailed review of credentialing initiatives in the context of competency development (Hoge et al., 2008). **Table 1** presents competency sets from the inventory that have been applied in nationally recognized apprenticeship programs and systems of credentialing and certification, based on Hoge and colleagues' and the current authors' review.

Table 1: Competency-based Credentialing and Certification Systems

Competency Set	Credentialing/ Certification System	System Description
Addiction Counseling Competencies (TAP 21)	International Certification and Reciprocity Consortium/ Alcohol and Other Drug Abuse (IC&RC)	The IC&RC is a non-profit organization in existence since 1981 that represents 76 member agencies within 44 states, 3 U.S. military branches, 6 Native American territories, and 22 countries worldwide. The member boards have certified over 40,000 professionals in the addiction field. While this program has been widely applied and influential in the professionalization movement, the increasing emphasis on licensure in this field has hindered the credential's impact on DSW career lattices.
	National Association of Alcoholism and Drug Abuse Counselors (NAAADAC) Credentialing System	The NAAADAC is a membership organization in existence since 1972 that represents over 75,000 professionals in the addiction field, with 46 state affiliates. In addition to providing advocacy, the NAAADAC has offered national certification with basic and specialized credentialing tracks since 1990. The NAAADAC Certification Commission manages the credentialing process and over 15,000 professionals have been certified.

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Competency Set	Credentialing/ Certification System	System Description
Adult Psychiatric Rehabilitation/Recovery-Oriented Mental Health Services for Adults Competencies (CPRP)	U. S. Psychiatric Rehabilitation Association (USPRA) Certified Psychiatric Rehabilitation Practitioner (CPRP)	The CPRP Certification has been established since 2001 and the test based Credentialing process is operated by USPRA. The certification is recognized and/or required by state Medicaid regulations in 15 states. More than 2,600 DSWs in the behavioral/mental health sector have received CPRP certification.
Community Support Skills Standards (CSSS)	U. S. Department of Labor (DOL) Employment Training Administration (ETA) Office of Apprenticeships	The DOL ETA Office of Apprenticeship establishes minimum standards and provides technical assistance for these independently managed programs. The credential is nationally recognized and portable. Most long-term service and support (LTSS) apprenticeship programs are based in the aging sector. The impact and accessibility varies across states.
Competency Standards for Physical Health and Aging	Federal Guidelines for CNA, HHA, and HSS Certification Programs	The DOL ETA Office of Apprenticeship establishes minimum standards and provides technical assistance for these independently managed programs. These credentials are nationally recognized and portable. The impact and accessibility varies across states.
Infant Mental Health Competency Guidelines	Michigan Association for Infant Mental Health (MI-AIMH) Endorsement for Culturally Sensitive, Relationship Focused Practice Promoting Infant Mental Health	The MI-AIMH established the “endorsement” program in 2002, which offers a multi-level process for certifying and registering professionals in the infant mental health field. There are 13 state associations that are affiliated with implementing this program in the Endorsement League of States. This process has had a significant impact in the field. Michigan Medicaid policies have been rewritten to require staff endorsement and employers have deemed endorsement as a preferred qualification.
National Alliance for Direct Support Professionals (NADSP) Competencies	National Alliance for Direct Support Professionals (NADSP) Credentialing	The NADSP is a non-profit organization providing advocacy and certification for frontline staff across sectors of the direct service workforce in the US. While still relatively new, this three-tiered voluntary credentialing program is gaining influence and was developed by adoption of the Community Support Skills Standards (CSSS) and Commission on Rehabilitation Counselor Certification (CRCC) competency sets. The Department of Labor (DOL) Registered Apprenticeship program guidelines for DSWs has been based on the NADSP credentialing program, with active apprenticeship programs in four states. Several state service systems have demonstrated formal support of this program through requiring and/or providing incentives for DSW certification.

This cursory review indicates that there is growing attention to and support for programs that verify competencies demonstrated by individual DSWs. Yet the elements of current credentialing and certification systems are confounded, as they are each individually based within the wide range of existing competency sets. Therefore, it is becoming increasingly challenging for national and state policymakers to identify and promote credentialing and certification programs that respond to workforce needs within long-term services and supports.

Stakeholders across sectors have identified the reform of credentialing systems as a promising approach to resolving workforce challenges (Hewitt et al., 2008). This reform is based on the creation of opportunities for DSW advancement through government sanctioned career pathway programs. Stakeholders recommended increasing DSWs' access to continuing education and career path programs.

Methodology

The first phase of this report inventoried competency initiatives developed in the United States to improve training and proficiency of the direct support workforce. It was based on a comprehensive online literature review of established and developing competency sets within and across several sectors, including behavioral health, intellectual and developmental disabilities, physical disabilities, and aging. As a result, the inventory summarized descriptive information on twenty-two competency sets, organized by title, sources of funding and/or support for application, targeted workforce sectors, background and development processes, application of competencies, and contact information. The current Phase II report provides an in-depth discussion of competency sets identified during Phase I through a comparative content analysis and examination of competency descriptions. Methodological approaches applied in the content analysis are detailed in this section.

Within the analysis process, competency sets were compared and contrasted based on their content, focusing on descriptions and meanings within the sets. The content analysis was conducted on a statement level, meaning that all individual statements from each set were examined and compared in the context of statements from other sets. This micro-level approach was necessary in accounting for details within sets, as the structure and categorization within competency sets are widely varied. As a result, the content analysis provides a basis for discussion around evidence based practices, common roles and responsibilities, and relevant themes and terminology across sectors in the application of direct service competencies.

Inclusion Criteria

Given the wide range of focus and different phases of development among competency sets identified during Phase I, standards were established to determine which competency sets were appropriate for content analysis. The inclusion criteria for competency sets were established as: (1) developed and completed competency sets, (2) that apply to the delivery of direct service for adults, and (3) that are nationally recognized. The first criterion was based on the dearth of information available regarding competency sets that were in development. The second criterion was based on findings that competency sets focused on direct care for young children and infants are significantly dissimilar from sets focused on direct service for adults (Hoge et al., 2008). The third criterion was based on findings of comprehensiveness in content and applicability among nationally recognized competency development initiatives.

Based on the criteria, the following seven competency sets were included in the content analysis:

1. Addiction Counseling Competencies (TAP 21; Center for Substance Abuse Treatment, 2006). The eight "Practice Dimensions" were used. The four areas of "Foundations" were not used due to limited applicability among other sets,
2. Adult Psychiatric Rehabilitation/Recovery-Oriented Mental Health Services for Adults Competencies (CPRP; The US Psychiatric Rehabilitation Association [USPRA], 2011).
3. Alaskan Core Competencies (Hoge & McFaul, 2010).
4. Community Residential Core Competencies (CRCC; Hewitt, 1998b).
5. Community Support Skills Standards (CSSS; Taylor et al., 1996).

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6. Competency Standards for Physical Health and Aging (PHI, n. d.). This includes competencies for CNA, HHA, and HSS.
7. National Alliance for Direct Support Professionals (NADSP) Competencies (NADSP, 2011).

Based on the stated inclusion criteria, the following competency sets were excluded from the content analysis (with exclusion criterion applying to each set listed in italics):

- ▶ Arizona Direct Care Worker Competencies (Direct Care, 2010). Not nationally recognized (3).
- ▶ Direct Support Professional Competencies of California (State of California Department of Developmental Services, n. d.). Not nationally recognized (3).
- ▶ Infant Mental Health Competency Guidelines (MI-AIMH; Weatherston & Goldberg, n. d.). Child-focused (2).
- ▶ Long Term Care Supports and Services Competency Model (LTCSS; Employment and Training Administration [ETA], United States Department of Labor [DOL], 2010). In development (1).*
- ▶ National Association on Dual Diagnosis (NADD) Competencies (NADD, n. d.). In development (1).
- ▶ Ohio State Workforce Development Initiative (Ohio Colleges of Medicine Government Resource Center, n. d.). In development (1).
- ▶ Personal and Home Care Aide State Training Program (PHCAST) Projects (Health Resources and Services Administration [HRSA], United States Department of Health and Human Services [DHHS], n. d.). In development (1).
- ▶ Substance Abuse and Mental Health Services Administration (SAMSHA) / Center for Substance Abuse Treatment (CSAT) Intermediate Competencies (TIP 42; CSAT, 2005). In development (1).

* It is important to note that the Department of Labor (DOL), Long Term Care Supports and Services Competency Model (LTCSS) was not included in this study because the model was not fully developed at the time that the content analysis was conducted, as sector specific competencies were not yet created. However, the LTCSS model represents the growing priority of competency driven workforce development strategies within this industry.

Analysis Criteria

The Community Support Skill Standards (CSSS) were used as an anchor for organizing and analyzing statements across sets. The competency areas and skill standards in the CSSS set were established as criteria by which statements were measured and compared (see Appendix C). This set was utilized as an anchor due to its broad focus of application to human service organizations across sectors providing community-based services and supports. The CSSS set was also established in this analysis framework because its contents were developed and implemented with rigorous validation methods and within a national scope (Taylor et al., 1996; Hewitt, 1998a). However, interdisciplinary stakeholders have recently reported that the CSSS is outdated and requires a full revision (Hewitt et al., 2008).

Despite the identification of an anchoring set in analysis criteria, the current authors do not assert or imply the CSSS set to be superior or recommend that these be compared to other competency sets within the inventory. This anchoring approach has been established as a means to collectively analyze information across several sets, rather than evaluating contents of individual sets. The overall goal is to identify strategies for resolving contemporary challenges within the direct service workforce.

Components of the CSSS set are identified throughout the content analysis, based on the functions of providing common descriptors and structuring comparisons among complex competency sets. The remaining competency sets included in the content analysis have been assigned random letters and are referred to more generally as “comparison sets” throughout the discussion of results. This approach, applied in discussion of quantitative comparison results, reinforces the purpose of providing a global view in the evaluation of existing competency sets.

Process of Analysis

Six experts in the area of workforce development at the Research and Training Center on Community Living at the University of Minnesota served as raters to conduct a content analysis of identified competency sets. The raters developed and implemented a systematic process for analyzing competency sets at the skill standard level with inter-rater reliability. To ensure consistency in approach, it was determined that raters would conduct the analysis at the skill standard level rather than competency area, which has also been referred to in sets as “domain,” “category,” and “foundation” or “practice dimensions”. The content of competency areas varied significantly in breadth and depth across the sets. At the competency skill standard level, the breadth and depth of statement content fell within a more similar range.

Inter-rater reliability was established through the following process. First, raters independently compared two randomly identified CSSS competency areas against all skill standards across all competency sets. Each rater worked from the skill standards within each competency area to identify statements of similar content. Then the raters convened and individually reported his or her findings to the research team. At the completion of the reporting process, any statements in which there was not full agreement were discussed and used to identify the parameters to be used in determining “common” elements across statements. The group discussed ways in which the statements may be similar or different based on terminology, content, and concepts, which often varied based on specific sectors and types of service provision. From this, the group formed consensus on parameters in which the statements would be coded consistently among reviewers. Once these parameters were established, one additional competency area was randomly chosen and compared by individual raters to statements across all sets. Findings were individually reported to the team. Again, lack of consensus on any skill standard was discussed, identifying any additional parameters, until consensus was reached. This process was completed one more time, at which time full consensus was reached.

Each rater was assigned competency areas from the CSSS set after inter-rater reliability was established. Using these skill standards as the comparative measure, content was examined across all competency sets to identify statements of similar content. Competency statements were analyzed and compared to determine corresponding statements among seven sets. The group reconvened, reported individual findings, and discussed any inconsistencies to determine status of agreement. If consensus was not reached at this phase, then a similar relationship between statements was not recorded.

The next stage of the process promoted further stability in results of the content analysis. A draft was completed that identified all competency areas from the CSSS set that had at least one skill standard in common among five other sets. In addition, competency statements found in common across at least three sets were identified and highlighted as a common competency regardless of presence in the CSSS set. Raters reviewed the draft individually and reconvened. The group reconsidered the sets of identified common statements and confirmed or disconfirmed each relationship.

This process yielded findings of common and sector specific statements among seven competency sets. During this process of comparing and analyzing competency statements, reviewers maintained a list of similar skill standards that may have been reflected in only two of the sets. These were then reviewed to determine if the

statements reflected best practices in service delivery, and thus were interpreted as a gap in competencies in the context of other sets and/or sectors.

Content Analysis

This section provides results and discussion based on the process of content analysis previously described. The comparison of seven direct service workforce competency sets required detailed examination because the sets represented significant variation in structure and terminology. However, the variation of structure and terminology was found to be arbitrary. The structure and terminology within the CSSS competency set will be applied as a guideline for the purposes of discussion.

Each competency set identified a main competency area (see [Table 2](#)). These ranged from a one word title to a title with a short paragraph of description. The number of areas ranged from seven to 15. Each competency area then listed competency skill standards. The number of competency skill standards within each area across sets ranged from two to 20. The number of total competency skill standards within individual sets ranged from 41 at the lowest, to 123.

Part of the raters' process was determining which statements would be constituted at the skill standard level, as the breadth, structure, and terminology of contents were varied. For example, the Community Residential Core Competencies (CRCC) included further descriptions of duties and tasks associated with competency skill statements (Hewitt, 1998b). The Alaskan Core Competencies included indicators of excellent, satisfactory, and unsatisfactory job performance among skill statements (Hoge & McFaul, 2010). Any additional content represented in the sets, such as the examples mentioned, were utilized to provide context in understanding the competency areas and statements. However, comparisons between set contents were determined and quantitatively recorded on what was determined to most closely fit criteria of a skill standard level.

Identification of Similarities and Strengths

The analysis yielded strong similarities in content at the skill standard level among competency sets. Of the 12 competency areas identified in the CSSS competency set, 11 of the areas contained from one to four competency skill standards that were in common across a total of at least five competency sets (see [Table 3](#)).

Table 3: Areas of the Community Support Skill Standards (Skill standards within each area were applied as the measure in the comparative analysis. See Appendix C for the full listing.)

Table 2: Description of Competency Sets Applied in the Content Analysis

Sector	General Cross-Sector	General Cross-Sector	General Cross-Sector	Behavioral Health	Intellectual and Developmental Disabilities	Mental Health	Physical Health and Aging
<i>Competency Set</i>	Community Support Skill Standards (CSSS)	Alaskan Core Competencies	National Alliance for Direct Support Professionals (NADSP) Competencies	Addiction Counseling Competencies (TAP 21)	Community Residential Core Competencies (CRCC)	Adult Psychiatric Rehabilitation/ Recovery-Oriented Mental Health Services for Adults Competencies (CPRP)	Competency Standards For Physical Health and Aging
<i>Number of Competency Areas / Skill Standards</i>	12/41	10/42	15/64	12/123	14/62	7/75	10/82
<i>Structure of Contents</i>	<p>Areas:</p> <ol style="list-style-type: none"> Participant empowerment Communication Assessment Community and service networking Facilitation of services Community living skills and supports Education, training, and self-development Advocacy Vocational, educational, and career support Crisis intervention Organization participation Documentation 	<p>Categories:</p> <ol style="list-style-type: none"> Working with others Assessing strengths and needs Planning services Providing services Linking to resources Advocating Individualizing care Documenting Behaving professionally and ethically Developing professionally 	<p>Areas:</p> <ol style="list-style-type: none"> Participant empowerment Communication Assessment Community and service networking Facilitation of services Community living skills and supports Education, training, and self-development Advocacy Vocational, educational, and career support Crisis intervention Organization participation Documentation Building and maintaining friendships and relationships Providing person-centered supports Supporting health and wellness 	<p>Foundations:</p> <ol style="list-style-type: none"> Understanding addiction Treatment knowledge Application to practice Professional readiness <p>Practice dimensions:</p> <ol style="list-style-type: none"> Treatment planning Referral Client, family, and community education Documentation Service coordination Professional and ethical responsibilities Counseling Clinical evaluation 	<p>Areas:</p> <ol style="list-style-type: none"> Household management Facilitation of service Health and wellness Organizational participation Documentation Consumer empowerment Assessment Advocacy Community and service networking Building and maintaining friendships and relationships Communication Crisis intervention Professionalism Vocational, education, and career support 	<p>Domains:</p> <ol style="list-style-type: none"> Interpersonal competencies Professional role competencies Community resources Assessment, planning, and outcomes Systems competencies Interventions for goal achievement Diversity and cultural competency 	<p>Areas:</p> <ol style="list-style-type: none"> Role of the direct care worker Consumer rights, ethics and confidentiality Communication, problem-solving and relationship skills Personal care skills Health related tasks In-home and nutritional support Infection control Safety and emergencies Apply knowledge to the needs of specific consumers Self-care

CSSS Competency Areas*

1. **Participant empowerment** — The competent community support human service practitioner (CSHSP) enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.
2. **Communication** — The competent community support human service practitioner (CSHSP) should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.
3. **Assessment** — The competent community support human service practitioner (CSHSP) should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.
4. **Community and service networking** — The competent community support human service practitioner (CSHSP) should be knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.
5. **Facilitation of services** — The competent community support human service practitioner (CSHSP) is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.
6. **Community living skills and supports** — The competent community support human service practitioner (CSHSP) has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.
7. **Education, training, and self-development** — The competent community support human service practitioner (CSHSP) should be able to identify areas for self-improvement, pursue necessary educational/training resources, and share knowledge with others.
8. **Advocacy** — The competent community support human service practitioner (CSHSP) should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.
9. **Vocational, educational, and career support** — The competent community support human service practitioner (CSHSP) should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.
10. **Crisis intervention** — The competent community support human service practitioner (CSHSP) should be knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.
11. **Organization participation** — The competent community support human service practitioner (CSHSP) is familiar with the mission and practices of the support organization and participates in the life of the organization.
12. **Documentation** — The competent community support human service practitioner (CSHSP) is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.

* Dark shading indicates competency areas containing from one to four skill standards that were in common across at least five of seven total competency sets (outlined in [Table 2](#)).

More detailed examination revealed strong similarities in certain areas (see [Table 4](#)). When accounting for the total number of skill standards within each competency area of the CSSS set, there were several competency areas in which all skill standards were represented in five to seven sets. These areas were:

- ▶ Participant Empowerment - The competent community support human service practitioner (CSHSP) enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem and assertiveness and to make decisions.
- ▶ Communication - The competent community support human service practitioner (CSHSP) should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.
- ▶ Assessment - The competent community support human service practitioner (CSHSP) should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires, and interests of the participants.
- ▶ Facilitation of Services - The competent community support human service practitioner (CSHSP) is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.
- ▶ Education, Training, and Self-Development - The competent community support human service practitioner (CSHSP) should be able to identify areas for self-improvement, pursue necessary educational/training resources, and share knowledge with others.
- ▶ Crisis Prevention and Intervention - The competent community support human service practitioner (CSHSP) should be knowledgeable about crisis prevention, intervention, and resolution techniques and should match such techniques to particular circumstances and individuals.

The aforementioned areas may be considered core competencies from which to build workforce development tools, as several sectors have identified skill standards similar in content and meaning. While these may be considered core competencies, the terminology and parameters in which to represent these competencies have not been discussed and embraced across sectors. The Assessment area provides a clear example of how a common competency may be inconsistent across sectors. The skill standards in this area are fully represented in all sets except for the Competency Standards For Physical Health and Aging, as the formal responsibility of assessment is considered the task of licensed or registered nurses working in this sector (P. Powell, personal communication, October 5, 2011).

Across all the competency sets, 30 of 41 total skill standards in the CSSS set were determined to be in common across five to seven competency sets. This constituted a large proportion of CSSS competency skill standards as similar across five to seven sets representing different sectors of the direct service workforce (73.2% of total CSSS skill standards in common, or an average of 74% among competency areas). Refer to Appendix A for further details on this analysis.

Table 4: Skill Standards in Common Within CSSS Competency Areas Across Seven Sets

CSSS Competency Set		Number of Skill Standards in Common Among: (Including CSSS set)			Percent of CSSS Skill Standards
Competency Areas	Total Number of Skill Standards in Area	5 Sets	6 Sets	7 Sets (All in Common)	In Common Among 5 to 7 Sets
Participant Empowerment	4	0	2	2	100%
Communication	3	1	1	1	100%
Assessment	3	0	3	0	100%
Community and Service Networking	4	1	0	2	75%
Facilitation of Services	4	0	2	2	100%
Community Living Skills & Supports	5	1	1	0	20%
Education, Training & Self-Development	2	1	1	0	100%
Advocacy	4	0	3	0	75%
Vocational, Educational, Career Support	3	0	0	0	0%
Crisis Prevention & Intervention	2	0	1	1	100%
Organizational Participation	4	2	0	0	50%
Documentation	3	1	1	0	66.7%
Total:	41	7	15	8	73.2%

Identification of Differences, Weaknesses, and Gaps

As noted in the previous section, there were many similarities found between competency sets at a skill standard level. This represents a movement towards standardization within the direct service workforce. However, it is important to discuss key differences within the sets. This may facilitate a process of identifying gaps and addressing inconsistencies regarding expectations of the direct service workforce.

Differences among competency sets were apparent in one area where there was no CSSS skill standards found *in common across five to seven sets*. This area was:

- ▶ Vocational, Educational, and Career Support—The competent community support human service practitioner (CSHSP) should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.

The competency area of Vocational, Educational, and Career Support contains three skill standards that were found *in common among three to four of competency sets*, which represents a content gap in this study. The team of interdisciplinary stakeholders that developed and validated the CSSS recognized this competency area as a necessary set of skill standards for DSWs across sectors providing community-based services and supports. This is based on the right of all individuals to pursue vocational goals and interests, regardless of age, disability, or retirement status. However, it's possible that the majority of competency sets did not include skill standards in the area of Vocational, Educational, and Career Support because of complex limitations and inaccessibility issues within current employment and vocational service delivery systems.

There were additional areas of CSSS competencies where the majority of similar skill standards were found in only three to four of all sets (see Appendix A). Altogether, these areas included Community Living Skills and Supports; Vocational, Educational, and Career Support; and Organizational Participation. It is important to note that, while a competency set may not have a stand-alone, explicit competency statement within these noted areas, the concept may be present in other competency statements. However, these areas indicate differences in and among direct service competencies sets that deserve further exploration. Dialogue among sector stakeholders is warranted regarding the degree to which these competencies are considered necessary across direct services and/or specializations.

Reflection of Key Practices in Community Support

The results of the content analysis warranted further examination of the extent to which competency sets reflect key practices based on the community support model of service delivery. The authors identified the following concepts as integral within competencies that inform practices of community support:

- ▶ Participant direction.
- ▶ Person-centered planning.
- ▶ Community inclusion.
- ▶ Direct support professionalism.
- ▶ Cultural competency.

The context and representation of each term within the inventory of competency sets will be discussed in this subsection.

Participant direction

Participant direction refers to the choices and options in which people with disabilities, their families, or their allies manage and direct their services and supports. The concept is predicated on the principles of self-determination and normalization, and it allows participants to control and direct processes of recruitment, hiring, and management of support staff (Bogenschutz, Hewitt, Hall-Lande, & LaLiberte, 2010). As discussed in the background section, participant direction is a significant emerging trend and promising approach in models and policies for long-term services and supports delivery.

Within the anchor competency set of the content analysis, the area that most closely aligns with participant-directed services is “Participant Empowerment - The competent community support human service practitioner (CSHSP) enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions” (Taylor et al., 1996). The six competency sets compared to the CSSS set contained similar skill standards in this area, where all seven sets reflected two skill standards, and six sets reflected two skill standards (see [Table 4](#)).

While competency sets in the inventory reflected very high ratings of congruency within the area of Participant Empowerment, it is clear that the anchor area does not contain sufficient information to support direct service competencies in emerging processes of participant direction. Among all competency sets analyzed, there is a gap based on the absence of participant direction terminology and relevant DSW activities. This gap has been confirmed in a recent environmental scan of existing competency efforts provided by the U. S. Administration on Aging (2011). In congruence with the findings from this report, the content analysis indicates that competencies must be developed and established that inform roles and responsibilities of DSWs within the context participant directed services.

Person-centered planning

Person-centered planning is a systematic process involving a collection of tools and approaches that primarily focus on an individual and his or her capacities, values, and interests in order to make collaborative plans and build support networks for his or her future (O’Brien & O’Brien, 2000). It is an especially beneficial process for individuals and their families during the transition through life stages and navigation of complex long-term services and supports (Cotton & Fox, 2011). The anchor competency set of the content analysis does not contain an area that addresses the concept of providing direct services within a model of person-centered planning and supports.

Of the six comparison sets, only one set contained an area with a title that explicitly referenced the term “person-centered.” There were relevant language, themes and practice approaches present among sets regarding DSW collaboration with supported individuals and understanding individuals’ preferences within service provision. However, this representation was minimal. There was a general absence of explicit descriptors regarding person-centered planning and support methods.

This finding indicates a gap and weakness within the current inventory of competency sets. It implicates a compelling need to address the knowledge, skills, and abilities that DSWs must demonstrate in the broadening context of person-centered planning based services. Addressing this gap is imperative based on the demand for each sector to implement a person-centered model of service delivery, especially in the context of community support and participant direction. While a considerable number of DSWs currently function with implicit roles and responsibilities in this context, it is the responsibility of the direct service workforce stakeholders to develop and establish requirements that can guide and inform person-centered practices.

Community inclusion

Community inclusion is a concept that reflects the practice of sharing in community life that involves physical presence in a community setting, cultural integration, implementing valued social roles, engaging in relationships with other individuals, and exercising self-determination. Within the content analysis, this concept is reflected in several areas of the anchor competency set. These areas include Participant Empowerment; Community and Service Networking; Community Living Skills and Supports; and Advocacy.

As mentioned previously in this analysis, the area of Participant Empowerment was reflected highly through competency sets inventoried, with average skill standard representation in this area ranging from 75 to 100% (see [Appendix B](#)). However, this area requires further information in representing key direct support practices involved in participant direction.

The area on Community and Service Networking was rated mainly very high in its average skill standard representation among sets. The six competency sets compared to the CSSS set contained several similar skill standards, where three sets reflected all four skill standards (sets C, D, and E), one set reflected three of four skill standards (set A), and two sets reflected two of four skill standards (sets B and F). Refer to [Appendix B](#).

While practices of Community and Service Networking were well reflected among competency sets, there was low representation of skill standards in the Community Living Skills and Supports area. An examination of skill standards in this area revealed a gap across sets, as the majority of skill standards were common only across three to four sets (see [Appendix A](#)). One of the skill standards was found similar among five sets and one skill standard was found similar across six sets. These results suggest that competency sets require strengthening in the area of Community Living Skills and Supports, especially due to sectors' movement towards implementing services within a community support framework. It is necessary to determine DSWs' roles and responsibilities for implementing services within a community support model. Such standards are required in order for services and sectors to realize this vision. This finding warrants further interdisciplinary dialogue and research activities to ensure that standards for DSWs reflect key practices of community inclusion.

Advocacy represents another important component contributing to practices of community inclusion. This concept was reflected strongly within three sets (B, D, and E). All four skill standards were found to be similar within these sets. However, two of the remaining three sets demonstrated low representation in this area. Two skill standards were found in common within set F and one skill standard was found similar within set C. It was found that the conceptualization and operationalization of advocacy within set C differed in comparison to the CSSS standards. This represents a limitation of the content analysis that is described in the following section.

The group of areas relating to community inclusion point to a larger gap of key practices within the existing direct service competency sets. These areas require further examination and addressing among sector stakeholders in order to prevent the expansion and widening of gaps among competency sets.

Direct service professionalism

Direct service professionalism refers to appropriate and satisfactory actions demonstrated by direct service workers in their daily practice. Key components of direct service professionalism include ethical practice, skill development, and knowledge acquisition (Taylor, Silver, Hewitt, & Nord, 2006). There is a range of activities that have been identified as direct service professionalism. These involve complying with policies and regulations that inform practice guidelines, as well as applying ethical standards of practice and resolving ethical dilemmas. Other activities include establishing appropriate boundaries with individuals being supported, acquiring skills and keeping abreast of information necessary to deliver evidence based practices, completing work in an organized and timely manner, engaging in supervision and eliciting feedback on one's performance, and managing personal health. While many of these activities pertain to an ethical code of practice, there is currently no universally accepted code or set of guiding principles for DSWs across sectors.

The CSSS competency set does not include an area that encompasses direct service professionalism, although it does include an area on the facet of Education, Training, and Self-Development. In contrast, four of the six comparison sets include areas specifically stating a form of the term "professionalism." An additional set addresses relevant themes of professionalism within three competency areas.

While the CSSS Competencies include themes related to direct service professionalism, this set does not address the topic as explicitly as the other sets. Thus, the concept of direct service professionalism was not quantitatively accounted for and compared in this study due to its omission in the anchor competency set. However, there is an evident trend of direct support professionalism that constitutes a significant similarity and strength among existing competency sets across sectors. This common theme should be recognized and built upon in further workforce development activities.

Cultural competency

Cultural competency in the context of direct service practice refers to the DSW's capacity to be knowledgeable, appreciative, and sensitive regarding several facets of diverse cultural groups (O'Neil, 2004). When applying cultural competency in practice, the DSW assesses the supported person's cultural preferences and individualizes service delivery processes and methods with respect to the participant's cultural preferences. The application of cultural competency may be considered continually necessary and relevant within all activities of direct service provision. While there is no consistent framework or definition of cultural competency, a review from researchers of the National Center for Cultural Competence suggests that cultural competence among health care workers impacts a higher quality and effectiveness of service that relates to participants' health outcomes and well-being (Goode, Dunne, & Bronheim, 2006).

Despite the significance of this topic, the CSSS set does not include an area directly addressing cultural competency. Yet this topic is addressed within areas of two comparison competency sets. The remaining competency sets in the comparative analysis contained statements supporting the notion of cultural competency within the workforce. One competency set included 19 statements that referenced the application of cultural competency in several practice areas and activities. Another competency set included five tasks or duties involving cultural competency, while three sets each only contained one statement directly incorporating cultural competency.

Like the topic of direct service professionalism, the concept of cultural competency was not quantitatively accounted and compared in this study due to its omission in the anchor competency set. Despite this, there was a clear presence of cultural competency themes found across sets. Thus, cultural competency may be considered an important key practice across sectors that should be discussed and integrated within further direct service workforce development initiatives. The U. S. Administration on Aging (2011) environmental scan of direct service competency efforts yielded similar findings and conclusions: "While a number of agencies/organizations are focusing on competency for working with diverse populations, identifying how to make these applicable to the range of LTSS workers would be important" (p. 13).

Limitations

The content analysis has limitations. It was conducted as a comparison of competency sets based upon the CSSS set, which was predetermined by the authors as standard criteria for analysis. The CSSS set has been recognized as a rigorously developed competency set that may be applied across sectors and service settings (see Methodology: Analysis criteria section). However, the CSSS set does not reflect the full range of content that is necessary to inform standards of the contemporary and diverse direct service workforce. It is understood that the CSSS set requires updating in order to adequately support the direct service workforce (Hewitt et al., 2008, p. 26). Gaps or omission of relevant content within the CSSS set have been identified in the content analysis (see subsection Reflection of key practices in community support for discussion on person-centered planning, participant direction, cultural competency, and direct service professionalism).

The selection of an anchor competency set in the content analysis also presents a limitation based on the varying structure, language, focus, conceptualization, prioritization, and operationalization of content across different sets. Some differences found in comparison sets may represent a gap or omission of content. Other differences found may be attributed to the variance of structure, language, focus, conceptualization, prioritization, and operationalization of content across sets, as similar content of comparison sets may be addressed in ways that were not captured in the scope of the content analysis. For example, a concept may have permeated throughout a competency set, but not with the strength necessary to be recognized as in common with explicit statements, based on methodological parameters. Conversely, comparison sets may have addressed concepts with more strength or rigor than the CSSS set, but this was not quantitatively accounted for in the content analysis. Thus, there are limitations in the process of comparing complex content among sets that organize and conceptualize content very differently.

Despite challenges in applying an existing competency set as criteria for analysis, it is important to note the overall purpose for comparing competency sets within a content analysis. The purpose is not to highlight one set as dominant or more comprehensive when measured against other sets. The purpose is to gather and examine information based on several sets, and thereby communicate recommendations on how to strategize a resolution to contemporary challenges within the direct service workforce.

Summary of Findings

Background

- ▶ **Support for competency development.** Current funding mechanisms within federal, state, and private systems are fragmented by sector and tend to support short-term, individualized projects around competency development.
- ▶ **Conceptualization.** The sectors are in different stages moving toward providing services within a community support model. The existing competency sets represent varied practice concepts due to the orthodoxies of service models and sectors.
- ▶ **Validation.** Historically, there has been a lack of rigorous validation methods used to support the establishment of competency sets. Many groups have relied on existing competencies as primary sources for developing new competency standards—competencies that may or may not have been sufficiently validated. While national recognition and use of competency sets serves as a form of validation in practice, it is not a scientifically rigorous method that ensures that these are in fact the competencies needed for quality direct service provision across sectors and from a national perspective.
- ▶ **Application.** There is an extensive process and a wide range of ways in which competency sets are utilized and implemented within the direct service workforce. However, the lack of standardization and collaboration in processes of developing and implementing competencies has created an overall trend of weak application of competencies within the workforce.

Content Analysis

- ▶ Comparative analysis at the competency skill standard level showed that there are consistent skills that are essential among these diverse jobs.
- ▶ There were strong similarities found across the competency sets in areas of:
 - Participant Empowerment
 - Communication
 - Assessment
 - Facilitation of Services
 - Education, Training and Self-Development
 - Crisis Prevention and Intervention
- ▶ There were noted differences and gaps found across the competency sets in areas of:
 - Community Living Skills and Supports
 - Vocational, Educational, and Career Support
 - Organizational Participation

These areas indicate differences in and among direct service competency sets that deserve further exploration, based on a low proportion of skill standards found in common across sets. Dialogue among sector stakeholders is warranted regarding the degree to which these competencies are considered necessary across direct services and/or specializations.

- ▶ There is inconsistency in the degree to which competency sets reflect and operationalize key concepts and best practices in the community-based model of service delivery, including:
 - Participant direction
 - Person-centered planning
 - Community inclusion
 - Direct support professionalism
 - Cultural competency

Synthesis

- ▶ This inventory and analysis demonstrates that each sector of the workforce has invested in competency development to a certain degree. However, there is considerable inconsistency across sets.
- ▶ There is growing need for common language, understanding, and expectations of service standards on all levels in different states, sectors, and agencies.
- ▶ Each of the competency sets contains a rich basis of information based on the contexts and efforts in which they were developed. Each competency set represents important perspectives and objectives for guiding direct service workforce development that reflect several factors, including the sector, funding source, geographical scope, and point in time in which it was developed. Therefore, it will be important

to examine and draw upon key concepts within each set in the development of one comprehensive core competency set.

Proposed Next Steps

The analysis and other sources have indicated that an initiative identifying core (generalist) competencies and specialization competencies across sectors would be an effective strategy towards resolving workforce challenges. These competencies would serve as a foundation for policy and practice regarding education, training, and other processes for the direct service workforce. Key points supporting the recommendation of a core set initiative include:

- ▶ There are currently low expectations and lack of widespread application of competencies in current state policies.
- ▶ Evidence based practices for training and employment of direct service workers would be established and supported by a nationally recognized core set.
- ▶ A core set initiative would establish efficient financing for federal and state spending in workforce development, as funding systems could be streamlined to promote national standards.
- ▶ A core set initiative would facilitate interagency collaboration on federal and state levels and help to clarify responsibilities of public agencies in activities related to workforce development.
- ▶ A well-developed national core set of competencies would serve states by creating a basis for states to meet consumers' individual needs and would also establish the funding sources for training reimbursement.

Proposed Process for Development of Core Set of Competencies

1. Convene stakeholders from each sector of physical disabilities, aging, behavioral health, mental health, and intellectual and developmental disabilities to systematically review, discuss, debate, and form consensus on core competencies identified in this analysis. This process would involve the creation and endorsement of skill standard language that would be most meaningful and applicable across sectors. The stakeholders would rigorously examine key concepts from each set, identify general best practices across fields, and address gaps from the current analysis of competency sets. This would inform the Community Living Initiative about the potential for promoting a common set of cross sector competencies across agencies.
2. Strategically collaborate with Federal agencies, notably, the U. S. Administration on Aging and the Department of Labor, and other workgroups that are implementing similar initiatives to identify and define core competencies for systems of long-term services and supports. The Community Living Initiative would engage in a communication network based on information sharing and consultation between collaborative agencies.
3. Conduct a job analysis and role delineation process with direct service workers and individuals who use services, including family members and advocates, in multi-site workshops throughout the United States to address the previously identified gaps. This job analysis process would inform the development of competencies in areas of noted gaps or areas in need of further development. Based on the findings, the core competency set would be modified and re-drafted for use in the next step of the process.
4. Conduct validation studies that include a survey and interview process among a national sample of service users, direct service workers, frontline supervisors, and stakeholders that is representative across all sectors.
5. Establish the core competency set in the public domain and provide technical assistance to promote the development of specializations within each sector.

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Appendix A: Skill Standards in Common Within CSSS Competency Areas Across Seven Sets

CSSS Competency Set		Number of Skill Standards in Common Among: (Including CSSS set)						
Competency Areas	Total Number of Skill Standards in Area	No Sets (None in Common)	2 Sets	3 Sets	4 Sets	5 Sets	6 Sets	7 Sets (All in Common)
Participant Empowerment	4	0	0	0	0	0	2	2
Communication	3	0	0	0	0	1	1	1
Assessment	3	0	0	0	0	0	3	0
Community and Service Networking	4	0	0	0	1	1	0	2
Facilitation of Services	4	0	0	0	0	0	2	2
Community Living Skills & Supports	5	0	0	1	2	1	1	0
Education, Training, & Self-Development	2	0	0	0	0	1	1	0
Advocacy	4	0	0	1	0	0	3	0
Vocational, Educational, Career Support	3	0	0	2	1	0	0	0
Crisis Prevention & Intervention	2	0	0	0	0	0	1	1
Organizational Participation	4	0	0	1	1	2	0	0
Documentation	3	0	0	0	1	1	1	0
Total:	41	0	0	5	6	7	15	8
Percentage in Common with CSSS:	100%	0%	0%	12.2%	14.6%	17.1%	41.5%	19.5%

Appendix B: Skill Standards in Common Within CSSS Competency Areas by Competency Set

CSSS Competency Set		Number of Common CSSS Skill Standards Within Competency Sets:					
Competency Areas	Total Number of Skill Standards in Area	Competency Set A	Competency Set B	Competency Set C	Competency Set D	Competency Set E	Competency Set F
Participant Empowerment	4	3	4	4	4	4	3
Communication	3	3	2	3	3	3	1
Assessment	3	3	3	3	3	3	0
Community and Service Networking	4	3	2	4	4	4	2
Facilitation of Services	4	4	4	4	4	4	4
Community Living Skills & Supports	5	2	1	1	5	5	3
Education, Training, & Self-Development	2	2	2	1	2	2	0
Advocacy	4	3	4	1	4	4	2
Vocational, Educational & Career Support	3	0	1	0	3	3	0
Crisis Prevention & Intervention	2	2	2	2	2	2	1
Organizational Participation	4	2	1	2	4	4	0
Documentation	3	3	0	2	3	3	2
Total:	41	30	26	27	41	41	18
Percentage in Common with CSSS:	100%	73.2%	63.4%	65.9%	100%	100%	43.9%

Appendix C: The Community Support Skill Standards Listing of Skill Standards Used for Comparison in the Content Analysis

Area 1: Participant Empowerment—The competent community support human service practitioner (CSHSP) enhances the ability of the participant to lead a self-determining life by providing the support and information necessary to build self-esteem, and assertiveness; and to make decisions.

Skill Standards:

- ▶ The competent CSHSP assists and supports the participant to develop strategies, make informed choices, follow through on responsibilities, and take risks.
- ▶ The competent CSHSP promotes participant partnership in the design of support services, consulting the person and involving him or her in the support process.
- ▶ The competent CSHSP provides opportunities for the participant to be a self-advocate by increasing awareness of self-advocacy methods and techniques, encouraging and assisting the participant to speak on his or her own behalf, and providing information on peer support and self-advocacy groups.
- ▶ The competent CSHSP provides information about human, legal, civil rights and other resources, facilitates access to such information and assists the participant to use information for self-advocacy and decision making about living, work, and social relationships.

Area 2: Communication—The competent community support human service practitioner (CSHSP) should be knowledgeable about the range of effective communication strategies and skills necessary to establish a collaborative relationship with the participant.

Skill Standards:

- ▶ The competent CSHSP uses effective, sensitive communication skills to build rapport and channels of communication by recognizing and adapting to the range of participant communication styles.
- ▶ The competent CSHSP has knowledge of and uses modes of communication that are appropriate to the communication needs of participants.
- ▶ The skilled DSP learns and uses terminology appropriately, explaining as necessary to ensure participant understanding.

Area 3: Assessment—The competent community support human service practitioner (CSHSP) should be knowledgeable about formal and informal assessment practices in order to respond to the needs, desires and interests of the participants.

Skill Standards:

- ▶ The competent CSHSP initiates or assists in the initiation of an assessment process by gathering information (e.g., participant's self-assessment and history, prior records, test results, additional evaluation) and informing the participant about what to expect throughout the assessment process.
- ▶ The competent CSHSP conducts or arranges for assessments to determine the needs, preferences, and capabilities of the participants using appropriate assessment tools and strategies, reviewing the process for inconsistencies, and making corrections as necessary.
- ▶ The competent CSHSP discusses findings and recommendations with the participant in a clear and understandable manner, following up on results and reevaluating the findings as necessary.

Area 4: Community and Service Networking—The competent community support human service practitioner (CSHSP) should be knowledgeable about the formal and informal supports available in his or her community and skilled in assisting the participant to identify and gain access to such supports.

Skill Standards:

- ▶ The competent CSHSP helps to identify the needs of the participant for community supports, working with the participant's informal support system, and assisting with, or initiating identified community connections.
- ▶ The competent CSHSP researches, develops, and maintains information on community and other resources relevant to the needs of participants.
- ▶ The competent CSHSP ensures participant access to needed and available community resources coordinating supports across agencies.

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- ▶ The competent CSHSP participates in outreach to potential participants.

Area 5: Facilitation of Services—The competent community support human service practitioner (CSHSP) is knowledgeable about a range of participatory planning techniques and is skilled in implementing plans in a collaborative and expeditious manner.

Skill Standards:

- ▶ The competent CSHSP maintains collaborative professional relationships with the participant and all support team members (including family/friends), follows ethical standards of practice (e.g., confidentiality, informed consent, etc.), and recognizes his or her own personal limitations.
- ▶ The competent CSHSP assists and/or facilitates the development of an individualized plan based on participant preferences, needs, and interests.
- ▶ The competent CSHSP assists and/or facilitates the implementation of an individualized plan to achieve specific outcomes derived from participants' preferences, needs and interests.
- ▶ The competent CSHSP assists and/or facilitates the review of the achievement of individual participant outcomes.

Area 6: Community Living Skills & Supports—The competent community support human service practitioner (CSHSP) has the ability to match specific supports and interventions to the unique needs of individual participants and recognizes the importance of friends, family and community relationships.

Skill Standards:

- ▶ The competent CSHSP assists the participant to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs (e.g., human development, human sexuality), by teaching skills, providing supports, and building on individual strengths and capabilities.
- ▶ The competent CSHSP assists the participant with household management (e.g., meal prep, laundry, cleaning, decorating) and with transportation needs to maximize his or her skills, abilities and independence.
- ▶ The competent CSHSP assists with identifying, securing and using needed equipment (e.g., adaptive equipment) and therapies (e.g., physical, occupational and communication).
- ▶ The competent CSHSP supports the participant in the development of friendships and other relationships.
- ▶ •The competent community based support worker assists the participant to recruit and train service providers as needed.

Area 7: Education, Training, & Self-Development—The competent community support human service practitioner (CSHSP) should be able to identify areas for self-improvement, pursue necessary educational/training resources, and share knowledge with others.

Skill Standards:

- ▶ The competent CSHSP completes required training education/certification, continues professional development, and keeps abreast of relevant resources and information.
- ▶ The competent CSHSP educates participants, co-workers and community members about issues by providing information and support and facilitating training.

Area 8: Advocacy—The competent community support human service practitioner (CSHSP) should be knowledgeable about the diverse challenges facing participants (e.g., human rights, legal, administrative and financial) and should be able to identify and use effective advocacy strategies to overcome such challenges.

Skill Standards:

- ▶ The competent CSHSP and the participant identify advocacy issues by gathering information, reviewing and analyzing all aspects of the issue.
- ▶ The competent CSHSP has current knowledge of laws, services, and community resources to assist and educate participants to secure needed supports.
- ▶ The competent CSHSP facilitates, assists, and/or represents the participant when there are barriers to his or her service needs and lobbies decision-makers when appropriate to overcome barriers to services.
- ▶ The competent CSHSP interacts with and educates community members and organizations (e.g., employer, landlord, civic organization) when relevant to participant's needs or services.

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Area 9: Vocational, Educational & Career Support—The competent community support human service practitioner (CSHSP) should be knowledgeable about the career and education related concerns of the participant and should be able to mobilize the resources and support necessary to assist the participant to reach his or her goals.

Skill Standards:

- ▶ The competent CSHSP explores with the participant his/her vocational interests and aptitudes, assists in preparing for job or school entry, and reviews opportunities for continued career growth.
- ▶ The competent CSHSP assists the participant in identifying job/training opportunities and marketing his/her capabilities and services.
- ▶ The competent CSHSP collaborates with employers and school personnel to support the participant, adapting the environment, and providing job retention supports.

Area 10: Crisis Prevention and Intervention—The competent community support human service practitioner (CSHSP) should be knowledgeable about crisis prevention, intervention and resolution techniques and should match such techniques to particular circumstances and individuals.

Skill Standards:

- ▶ The competent CSHSP identifies the crisis, defuses the situation, evaluates and determines an intervention strategy and contacts necessary supports.
- ▶ The competent CSHSP continues to monitor crisis situations, discussing the incident with authorized staff and participant(s), adjusting supports and the environment, and complying with regulations for reporting.

Area 11: Organizational Participation—The competent community support human service practitioner (CSHSP) is familiar with the mission and practices of the support organization and participates in the life of the organization.

Skill Standards:

- ▶ The competent CSHSP contributes to program evaluations, and helps to set organizational priorities to ensure quality.
- ▶ The competent CSHSP incorporates sensitivity to cultural, religious, racial, disability, and gender issues into daily practices and interactions.
- ▶ The competent CSHSP provides and accepts co-worker support, participating in supportive supervision, performance evaluation, and contributing to the screening of potential employees.
- ▶ The competent CSHSP provides input into budget priorities, identifying ways to provide services in a more cost-effective manner.

Area 12: Documentation—The competent community support human service practitioner (CSHSP) is aware of the requirements for documentation in his or her organization and is able to manage these requirements efficiently.

Skill Standards:

- ▶ The competent CSHSP maintains accurate records, collecting, compiling and evaluating data, and submitting records to appropriate sources in a timely fashion.
- ▶ The competent CSHSP maintains standards of confidentiality and ethical practice.
- ▶ The competent CSHSP learns and remains current with appropriate documentation systems, setting priorities and developing a system to manage documentation.