Florida Developmental Disabilities Council, Inc.

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Competencies for Case Management Professionals Supporting People with Intellectual and Developmental Disabilities

Results of an Environmental Scan for the Florida Developmental Disabilities Council, Inc.

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I. Introduction

A. Motivation for this study

Across their life span, children and adults with intellectual and developmental disabilities and their caregivers interact with a variety of providers, depending on their age, their needs, and the service delivery systems that support them. In many service systems, people have access to case managers or service coordinators (hereafter referred to as "case management professionals") to develop a plan of care and coordinate the services identified in those plans. Case management professionals supporting people with intellectual and developmental disabilities can include Early Steps service coordinators, special education staff, home and community-based service (HCBS) waiver support coordinators, vocational rehabilitation (VR) counselors, and hospital or managed care organization care coordinators, among others.

Case management professionals have diverse titles and job functions, and no universal set of responsibilities defines their role or requisite job competencies across all systems (Silverman et al. 2015). Consequently, the quality of service coordination provided to people with intellectual and developmental disabilities and their caregivers is inconsistent across service providers, agencies, and systems (Lukersmith et al. 2016; WellFlorida Council 2021).

In its Five-Year State Plan (2022–2026), the Florida Developmental Disabilities Council, Inc. (FDDC) identified establishing and implementing a high-quality, best-practice case management system as key to improving HCBS in the state. FDDC contracted with Mathematica on the Best Practices in Case Management project to advance this activity.

The project's first objective is to define the shared competencies of case management professionals for people with intellectual and developmental disabilities in a variety of service systems. The second objective is to develop and pilot-test a tool to evaluate these professionals, with the goal of increasing the uniformity and quality of services provided to people with intellectual and developmental disabilities and their caregivers. To advance the first objective, Mathematica conducted an environmental scan which culminated in the development of this report.

This environmental scan provides context for this endeavor in Florida, describes findings from the literature, and addresses next steps. We designed the scan to answer two questions:

1. What is the breadth of competencies for case management professionals supporting people with intellectual and developmental disabilities?
2. What case management competency tools exist, particularly those with strong evidence of positive outcomes for people with intellectual and developmental disabilities?

Mathematica and FDDC will use the competencies and tools identified in this scan to support the delivery of high-quality, consistent case management services in Florida's intellectual and developmental disabilities support systems.

B. Report organization

This report begins with an overview of Florida disability service systems for people with intellectual and developmental disabilities (Chapter I), and then discusses the methods used in the environmental scan to identify case management competencies (Chapter II). Chapter III describes the case management

competencies identified during our scan and stakeholders' input on these competencies. Chapter IV discusses existing case management competency tools we found during our search, including various formats and uses of tools. Finally, Chapter V presents our conclusions, the study limitations, and next steps for the development of a case management competency tool for use by FDDC.

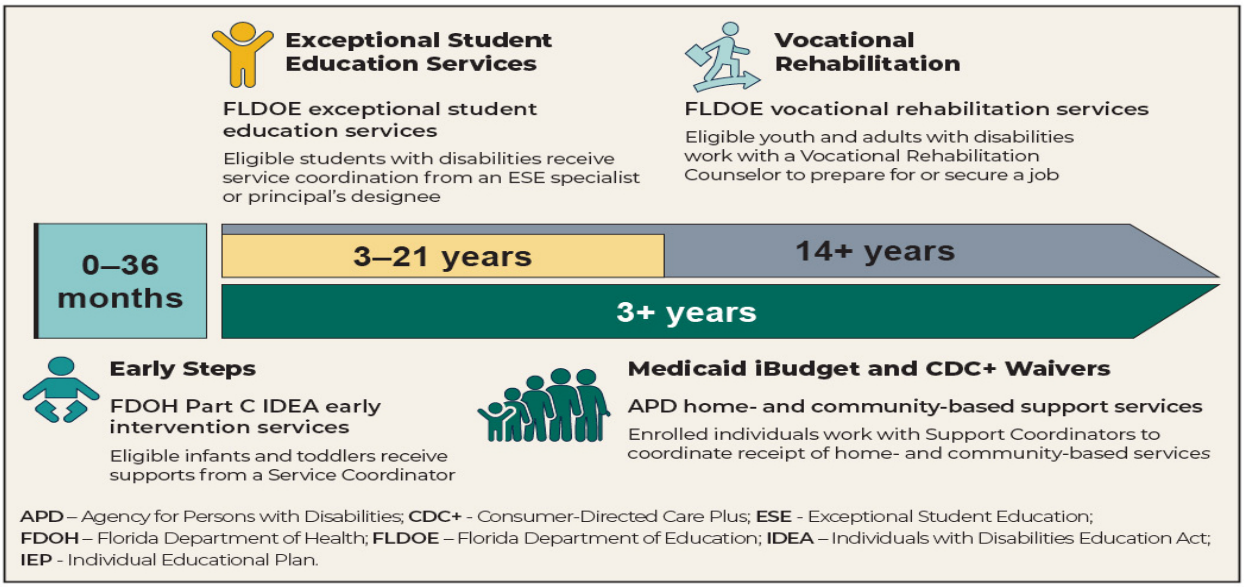
C. Florida service systems for people with intellectual and developmental disabilities

In Florida, case management services for people with intellectual and developmental disabilities are primarily provided through services funded or operated by three agencies: the Agency for Persons with Disabilities, the Florida Department of Health (which includes Early Steps), and the Florida Department of Education (which includes the Division of Vocational Rehabilitation). The focus, scope, and intensity of case management services vary across these systems, reflecting both the goals and authorities of the agencies and individuals' evolving needs over their life span.

According to this project's stakeholder work group, people and their caregivers receiving case management services from several systems at once might receive duplicative services or conflicting information, depending on the system and provider. They might also experience challenges during key transition points. For example, toddlers transition from Early Steps—in which a single point of contact coordinates a wide range of health, education, and developmental services—to Exceptional Student Services when they enter elementary school. In the latter program, the development of individual educational plans (IEPs) is team based and limited to education and support services.

Figure I.1 shows the major service delivery systems for case management in Florida for people with intellectual and developmental disabilities. The sections that follow provide an overview of these systems. The descriptions focus on the different functions of case management professionals depending on their role, their job responsibilities, and the needs of the people they support.

Figure I.1. Florida service delivery systems across the life span



1. Early Steps

Early Steps is Florida's early intervention program, administered by the Florida Department of Health, that supports caregivers with infants and young children (ages birth to 36 months) who have or are at risk for developmental disabilities or delays (Early Steps Program n.d.-a; Florida Health 2022a). Service coordinators in the Early Steps program serve as a single point of contact for eligible families and caregivers and provide individualized support, education, and training based on family resources, priorities, and concerns. The service coordinators work with caregivers to develop individualized family service plans (IFSPs), which include the expected outcomes for a child and family and describe the services required to meet those needs (Early Steps Program n.d.-b). Service coordinators are responsible for implementing the early intervention services in the IFSP and helping caregivers obtain services not provided through Early Steps, such as helping caregivers apply for medical coverage or providing referrals (U.S. Department of Education 2023).

2. Exceptional Student Education

Exceptional Student Education (ESE) services, administered by the Florida Department of Education, offer specially designed instruction, and supports to eligible school-age children across the state. Through the ESE program, all students with disabilities ages 3 to 21 receive an IEP, which describes the educational needs and related services (those enabling a child to benefit from special education) that a student requires (Individuals with Disabilities Education Act of 2004). The IEP is developed and updated collaboratively between parents and a multidisciplinary IEP team, which can include the student's general and special education teachers, school system representatives, and other experts (Florida Health 2022b). The delivery of ESE services varies across districts in Florida, and caregivers might not have a single point of contact on their IEP team responsible for coordinating services. Rather, districts may have ESE specialists, support facilitators, regional staffing specialists, or parent liaisons to help coordinate student services and facilitate communication between parents and schools (Florida Department of Education n.d.).

3. Vocational Rehabilitation

VR services, administered by the Florida Department of Education, help eligible students and adults with disabilities find and maintain meaningful careers (Florida Division of Vocational Rehabilitation n.d.-a). For students ages 14 to 21, VR counselors provide pre-employment transition services to help students explore careers or postsecondary education, encourage self-advocacy, support development of life and work-readiness skills, and help students make informed decisions (Florida Division of Vocational Rehabilitation n.d.-b). For adults, VR counselors work with them to develop an individualized plan for employment (IPE), which describes the services necessary for securing and retaining employment, in line with each person's goals. The counselors then provide guidance and counseling and arrange the services needed to build skills to find and keep a job (Florida Division of Vocational Rehabilitation n.d.-c).

4. Medicaid waiver system (iBudget and CDC+)

Eligible people ages 3 and older with intellectual and developmental disabilities may receive HCBS through one of two Medicaid HCBS waiver programs run by the Agency for Persons with Disabilities. People receiving the Developmental Disabilities Individual Budgeting (iBudget) Waiver receive case management services from a waiver support coordinator (WSC), whereas people in the Consumer-Directed Care Plus (CDC+) Waiver receive more limited support from a CDC+ consultant (Agency for

Persons with Disabilities [APD] n.d.). Both WSCs and CDC+ consultants work with people (and those close to them) to develop a Person-Centered Support Plan, which articulates a vision and future goals for the person. It also describes the supports needed to reach those goals, while addressing health, behavioral, medical, or environmental needs and mitigating risks. WSCs and CDC+ consultants help people access the services and supports in their plan (regardless of the funding source), monitor and update a person's progress and plans, and promote their health and well-being (APD 2021, 2022).

People with intellectual and developmental disabilities may also receive case management services from other programs in Florida, including the foster care system, the publicly funded behavioral health service system, managed care organizations or health plans (such as the Children's Medical Services Health Plan), and individual health care provider organizations.

II. Methods

This chapter describes the methods we used to identify competencies for case management professionals, existing competency models and tools in use across systems, and evidence for the use of these models and tools. It also describes our process for analyzing identified resources and introduces the stakeholder work group convened to inform the environmental scan.

A. Search strategy

This environmental scan sought to identify competencies for case management professionals supporting people with intellectual and developmental disabilities across the life span. The scan also sought to identify current case management competency tools in use, particularly those with evidence of improving outcomes. To achieve these goals, we used a three-tiered strategy to identify resources: an electronic database search for peer-reviewed publications, a targeted search of organizational websites to identify relevant gray literature, and a broader web search to identify existing case management competency tools and address gaps in the evidence.

To start, we searched electronic databases for peer-reviewed publications that appeared to meet our inclusion criteria. The goal of this search was to identify publications that included competencies or standards of practice for case management professionals, as well as evidence for the use of particular competency models. We developed the search terms for this search in consultation with FDDC and a professional librarian. The search terms included provider types, job functions, competencies, service systems, and disability status. See Appendix A for a full list of electronic databases and search terms.

Next, we conducted a targeted search of organizational websites to identify gray literature, such as programmatic materials and publications related to competencies or standards of practice for case management professionals. The organizations fell into three categories: (1) national organizations that represent or provide services and supports to people with intellectual and developmental disabilities and their caregivers; (2) national organizations that represent or support case management professionals; and (3) Florida-based organizations, providers, and other groups in Florida that represent or provide services and supports to people with intellectual and developmental disabilities and their caregivers. See Appendix A for a full list of organizational websites searched.

Lastly, we conducted a broader web search to fill any gaps in the available evidence and identify other resources not found through the targeted searches described above. This broad search focused on identifying existing case management competency tools developed by states or provider organizations. We used Google searches to identify documents using a subset of the terms identified for the database search. See Appendix A for a list of search strings used during this search.

Outside of these search strategies, we received additional resources for analysis from members of the project's stakeholder work group, FDDC, and an external subject matter expert.

Although we were most interested in competencies for case management professionals working with people with intellectual and developmental disabilities, we broadened the search beyond this population due to a dearth of peer-reviewed literature and case management competency models specific to this population. We also conducted narrow searches to identify case management competency models in specific service delivery systems for which we found few results.

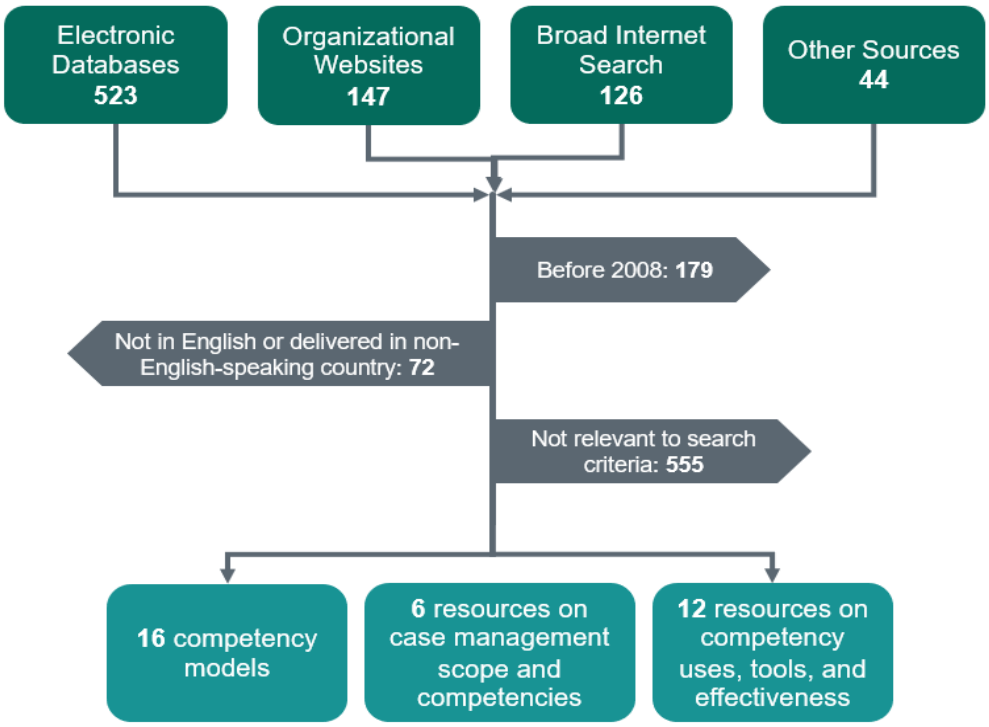
B. Analysis of search results

We filtered the results from the three searches above to identify relevant results, based on the following criteria:

- Written in English and based in the United States, Canada, the United Kingdom, or Australia
- Published after 2008
- Describes competencies, job descriptions or activities, professional requirements, or standards of practice
- Focuses on case managers, service coordinators, or similar roles

We excluded all materials not meeting these criteria from further analysis. Figure II.2 shows the filtering process we used and the number of results included or excluded at each step.

Figure II.2. Number of resources that did and did not meet search criteria



To analyze the search results that met our inclusion criteria, we reviewed each source and imported relevant information into a spreadsheet. We labeled the sources in the spreadsheet by relevant service system, job title, population served, and competencies included, and we added notes on each competency model's format or features (if relevant). Appendix B includes a catalog of the 16 unique competency models identified through the scan. We then analyzed the individual competencies in the competency models for themes and commonalities within and across service systems. We used this analysis, along with analyses of the six additional resources identified on case management scope and competencies, to create the competencies described in Chapter III. We used additional information included in these competency models, along with 12 other resources identified through the environmental scan on

competency uses, tools, and effectiveness, to develop the list of competency tools and uses presented in Chapter IV.

C. Stakeholder work group

In collaboration with FDDC, we convened a stakeholder work group to inform the work of the Best Practices in Case Management project team. The work group includes staff from Florida organizations that oversee or represent providers of support coordination and case management, along with people with intellectual and developmental disabilities and their caregivers. The first work group meeting, held in November 2022, was intended to solicit resources and ideas on how Mathematica can identify best practices or core competencies for support coordinators across service systems.

During the second work group meeting, held in February 2023, Mathematica shared early results from the environmental scan, including case management competencies and definitions; uses of competency models in the field; and potential competency tools and features, usability, and formats. The work group provided feedback on these findings and how shared competencies and tools could advance FDDC's goal of establishing and implementing a high-quality, best-practice case management system for people with intellectual and developmental disabilities. We discuss this input along with our findings in Chapters III and IV.

III. Case Management Competencies

This chapter describes competencies for case management professionals based on our findings from the environmental scan. We present the findings within and across service systems, highlighting those that pertain to people with intellectual and developmental disabilities. Based on the findings, we propose a universal competency model for use in Florida's service systems, and we share the stakeholder work group's feedback on this model.

A. Defining competencies

For this study, we used Marrelli et al.'s (2005) definition of a competency: "a measurable human capability that is required for effective performance." The competencies for a position are distinct from the responsibilities in a position's job description. Whereas a job description focuses on what tasks a person must complete as part of their job, competencies focus on the knowledge, skills, and attitudes or behaviors that enable a person to complete a task effectively and successfully. Competencies can typically be organized into the following categories (adapted from Marrelli et al. [2005]):

- **Knowledge:** awareness and understanding of facts, rules, principles, guidelines, concepts, theories, or processes needed to successfully perform a task
- **Skills:** demonstrated ability to successfully perform a task with a specified outcome or range of outcomes
- **Attitudes:** values, beliefs, and other personal traits that influence behavior and effective performance

Both responsibilities and competencies for case management can be challenging to define because expectations for case management professionals vary significantly across systems (Tahan et al. 2020; Lukersmith et al. 2016). Moreover, these professionals have considerable autonomy and flexibility to perform their jobs based on their professional judgment and the population served. The work group convened for this study voiced the difficulty of describing case management professionals' responsibilities, noting that "support coordinators wear so many hats." Work group members said job functions differ across different agencies, and the nature of supports vary depending on the life stage and individual needs of the person receiving supports. Case management *competencies*, however, are more universally applicable and can capture many of the attributes and intangibles that contribute to effective performance. Work group members were quick to identify attributes that make an effective support coordinator, including active listening, responsiveness, and engagement.

Competencies for a job or job family can be assembled into a **competency model**—a way of organizing the various competencies to facilitate their use (Marrelli et al. 2005). Competency models can have several formats: a simple prioritized list of competencies, a list of competencies sorted into thematic areas, or a multitiered format that presents competencies at different levels of detail within thematic areas. Most of the case management competencies we identified through the environmental scan were presented within competency models; Appendix B shows these models with their high-level competencies included.

B. Findings on case management competencies

The environmental scan identified a wide breadth of competency models for case management professionals organized by the following domains:

- **Service systems.** We identified competency models for professionals across systems (for example, standards established by professional case management societies) and for professionals within service delivery systems (such as early childhood, VR, and health care/Medicaid waivers).
- **Population of interest.** About half of the competency models identified were specific to working with people with intellectual and developmental disabilities or other disabilities. Other models were applicable to other populations, including infants and children.
- **Source.** State agencies, researchers, policymakers, working groups, and professional associations developed and disseminated competency models.

Across these domains, we found high levels of agreement between sources. As expected, most models included elements related to **conducting screenings**, **developing care plans**, and **facilitating connections to services** and supports as key components of the position. Across service systems, effective **communication skills** were nearly universally included, with an emphasis on listening skills. Many models included **empowering people** and their caregivers through skill-building and self-advocacy as a competency. Finally, the use of **person- and family-centered practices** was nearly universally included.

Within specific service systems, we identified several trends in competencies:

- **Early intervention.** Competency models for early intervention were more likely to include knowledge and evaluation of infant and toddler development, effective collaboration with community partners, and management of transitions across systems.
- **Health care.** Competency models for waiver case managers or case managers working with people with special health care needs more frequently included person-centered plan development, resource identification and navigation, and an emphasis on health and safety considerations.
- **Vocational rehabilitation**. Competency models for VR emphasized building relationships with employers and developing a network of community providers.

We also noted trends in models that focused specifically on working with people with intellectual and developmental disabilities. These models stressed the importance of case management professionals upholding **disability values**, such as respect for people's ability to exercise choice and control, where possible, and helping people receive services in the least-restrictive setting possible. These models also emphasized **cultural competency** for professionals, as a person's experience of disability can be shaped through the intersection of race, ethnicity, religion, socioeconomic status, and other identities (The Boggs Center on Developmental Disabilities 2020). A recent public workshop on care systems for people with intellectual and developmental disabilities noted that this group particularly values "care that is sensitive, empathic, and able to account for their communication difficulties" (National Academies of Sciences, Engineering, and Medicine 2022). Our findings in Table III.1 reflect this emphasis on **empathetic practice** and **tailored communication strategies**. Finally, models and research on people with intellectual and developmental disabilities focus on the **role of the family** and the complexities of balancing caregivers' input with decision making by the person with an intellectual disability (Ellem et al. 2018).

Although the environmental scan identified a wealth of competency models and additional resources, we did not find a set of core competencies for case management professionals serving people with intellectual and developmental disabilities that spanned systems and life stages. We therefore used our analysis of existing competency models and additional stakeholder input to develop a universal competency model. This model organizes competencies into two levels: (1) high-level "core competencies," which represent the essential qualities of case management professionals, and (2) more detailed "supporting competencies," which reflect the specific knowledge, skills, and attitudes that case management professionals working with people with intellectual and developmental disabilities should have. Table III.1 describes these core and supporting competencies. We have numbered and presented the core competencies in bold and bulleted the supporting competencies that enable each core competency.

Table III.1. Universal competencies for case management professionals serving people with intellectual and developmental disabilities

1. Communication and meeting facilitation

Case managers demonstrate effective listening and communication skills, tailoring language to individuals and their caregivers to build trust and understanding. They facilitate effective team meetings that prioritize individuals' voices and preferences.

- Uses open-ended questions and engages in active listening with individuals and their caregivers to understand their strengths, values, concerns, preferences, and priorities
- Ensures individuals and their caregivers understand the importance of their contributions and feel understood
- Adjusts language and communication based on individuals' developmental ages, communication styles, linguistic differences, and other considerations
- Uses verbal and nonverbal communication that is honest and not judgmental, stigmatizing, or threatening to build trust
- Facilitates effective team meetings during assessments and planning, ensuring that individuals' and their caregivers' voices are prioritized

2. Continual learning and improvement

Case managers are committed to ongoing professional development and use feedback to improve delivery of services and client outcomes.

- Is a lifelong learner committed to staying current on best practices, pursuing professional development, and maintaining necessary qualifications and education
- Readily seeks and accepts feedback to improve performance
- Maintains self-awareness and recognizes personal biases that could interfere with service delivery
- Is outcome driven—uses feedback from clients and data on outcomes to revise plans and approaches

3. Cultural Competence

Case managers respect and understand cultural diversity and how it affects caregivers' decision making and relationships. They demonstrate an awareness of how social, political, economic, and cultural factors affect individuals and caregivers and provide effective support to individuals of all backgrounds.

- Recognizes how social, political, economic, and cultural factors affect individuals and caregivers, including family dynamics, strengths, barriers, and needed supports
- Solicits, values, and responds appropriately to information about each individual's or caregiver's culture
- Demonstrates the attitude, knowledge, and skills required to provide effective support to individuals and caregivers from any ethnic, racial, sexual orientation, religious, gender, socioeconomic, age, or disability groups
- Recognizes implicit biases and prevents their interference with delivery of care
- Provides universal access to services and supports to all people equally, regardless of background, lifestyle choices, or culture

4. Disability knowledge and values

Case managers incorporate concepts and evidence-based practices related to intellectual and developmental disabilities into their work. They honor the autonomy and inherent rights of people with disabilities.

- Understands and can explain concepts related to intellectual and developmental disabilities, including human development, developmental stages, milestones, and the life cycle, and other relevant knowledge about populations served
- Integrates disability paradigms and values into work (for example, zero exclusion, presuming competence, and the dignity of risk and right to fail)
- Is familiar with the historical treatment and exclusion of people with disabilities and how this informs the modern approach of full inclusion of people with disabilities in the community
- Identifies and incorporates evidence-based practices for the population served into plans and interactions with individuals and caregivers
- Understands and uses person-first or identity-first language, whichever each individual prefers
- Understands how to prevent and recognize abuse, neglect, and exploitation; can articulate a person's rights and provides resources when rights are violated, and correctly follows legal and administrative procedures for mandated reporting and responding, when necessary

5. Empowerment and advocacy

Case managers use strategies to build individuals' and their caregivers' knowledge, self-advocacy skills, and independence. They advocate on behalf of individuals and caregivers to improve outcomes, as appropriate.

- Helps individuals and their caregivers identify and develop a network of social resources, including natural, community, and peer supports
- Provides education and information to ensure individuals and caregivers understand their rights and have the knowledge to advocate for themselves
- Demonstrates strategies to encourage individuals' and their caregivers' confidence, self-determination, and independence, where possible
- Advocates on behalf of individuals to improve outcomes, while demonstrating respect for the processes and people involved

6. Knowledge and facilitation of supports and services

Case managers are knowledgeable about population-specific services and supports and guide individuals and caregivers in accessing services and making transitions between systems.

- Develops and maintains a network of population-specific resources, supports, and services, including a process of what to do when resources are not available
- Helps individuals and their caregivers understand and navigate complex support and service systems
- Provides an array of options and resources to enhance self-direction and informed decision making
- Facilitates referrals and connections to safe, effective, and appropriate supports and services
- Facilitates successful transitions between care settings and life stages to promote positive outcomes for individuals and caregivers

7. Person-centered planning and monitoring

Case managers use person-centered practices to identify an individual's goals, preferences, strengths, and service needs. They use this information to collaboratively develop a comprehensive plan and monitor progress.

- Uses formal and informal assessment tools to gather information about individuals while understanding the conditions of the assessment, including the purpose of the evaluation.
- Uses person- and family-centered techniques to support goal discovery and plan development.
- Demonstrates the ability to identify individual and family strengths, interests, and resources, in addition to their service needs
- Helps individuals navigate differences in their priorities or needs that might not align with those of their family or other support team members
- Uses an array of information to provide options that reflect individuals' or their caregivers' identified needs, strengths, and goals
- Creates a comprehensive plan that encompasses the individual and family context; relevant history; current situation; short- and long-term goals; and perspectives from clients, social networks, and stakeholders where applicable
- Monitors progress toward personal outcomes and individuals' quality of life through regular observation and monitoring, and reassesses and revises plans as needed

8. Problem solving and persistence

Case managers demonstrate characteristics important to client success, including problem solving, creativity, critical thinking, and persistence in the face of challenges.

- Demonstrates problem-solving skills, creativity, and persistence in navigating challenges and developing solutions that meet the needs of individuals and caregivers
- Maintains a solutions-focused mindset and uses critical thinking to sort through information, identify what is important, and make informed decisions
- Maintains flexibility and adaptability while creatively providing solutions to problems

9. Professionalism

Case managers demonstrate professionalism through responsiveness to and reliability with individuals and caregivers; organization and completion of documentation; and ethical, respectful behavior.

- Demonstrates approachability, responsiveness, and reliability in interactions with individuals and caregivers
- Responds to individuals and caregivers in a timely fashion, and is consistent and accountable in follow-up
- Applies organizational and planning skills to meet required timelines and manage documentation
- Accurately and thoroughly completes all documentation related to eligibility, monitoring, and resolution of identified issues, while adequately protecting all confidential health information
- Maintains a code of professional ethics and continuously demonstrates personal integrity, honesty, and sincerity
- Establishes and maintains professional boundaries and demonstrates ethical behavior in the case management relationship

10. Relationship Building

Case managers build trust and rapport, demonstrate empathy, and manage expectations with individuals and caregivers. They are effective at building professional partnerships across systems.

- Shows empathy, respect, and concern for individuals' beliefs, welfare, and future
- Demonstrates the ability to build trust, rapport, and positive relationships with individuals and caregivers
- Clearly explains roles and responsibilities to individuals and caregivers and manages expectations
- Collaborates and builds relationships across systems that are relevant to meeting the needs of individuals and caregivers to facilitate transitions, reduce conflicting information, and enhance available resources

C. Prioritization of competencies by stakeholders

During the February 2023 meeting of the stakeholder work group, Mathematica shared the core competencies identified during the environmental scan. Work group members then rated these competencies by their relative importance to the position of case manager (Figure III.1). Overall, work group members prioritized relationship building as the top core competency, but they scored most of the core competencies as either "very" or "extremely" important. The lowest-rated competency was continuous learning and improvement. Note that two core competencies (professionalism and cultural competence) are not included in this graphic; we elevated them to core competencies after the work group meeting, based on stakeholder feedback.

Figure III.1. Work group's ratings of core competencies

Source: Best Practices in Case Management project Meeting 2, Mentimeter poll conducted February 7, 2023. N = 11.

During the discussion that followed the rating exercise, work group members identified several potential gaps in the competencies. These gaps included empathy, responsiveness, and organizational skills, which we later incorporated into the competency model. When prompted to think about the qualities of a case manager that contribute to relationship building, work group members said communication, transparency, and accountability help them build relationships with people receiving services and their caregivers. Members also said the competencies should capture the challenges of weighing competing responsibilities within the case manager role: balancing caregivers' directives with the rights and preferences of people with intellectual and developmental disabilities; advocating for people while maintaining professional boundaries; and completing required documentation while remaining focused on interpersonal behavior.

For the State of Florida Comprehensive Review and Analysis report, WellFlorida Council, Inc., interviewed and surveyed people with intellectual and developmental disabilities and their caregivers to inform the development of the five-year state plan (WellFlorida Council 2021). One emergent concern was the difficulty families have in navigating service systems and becoming aware of available resources. Thus, self-advocates mentioned a priority that case managers be well-trained in and familiar with all available resources. This provides further evidence to support prioritization of the "knowledge and facilitation of supports and services" core competency in Florida's service systems.

IV. Competency Tools: Uses and Features

This chapter describes how organizations can enhance the usability of competency models and develop tools to evaluate and build capacity around shared competencies. We discuss existing competency tools used in Florida and share feedback from the stakeholder work group on our development of competency tools.

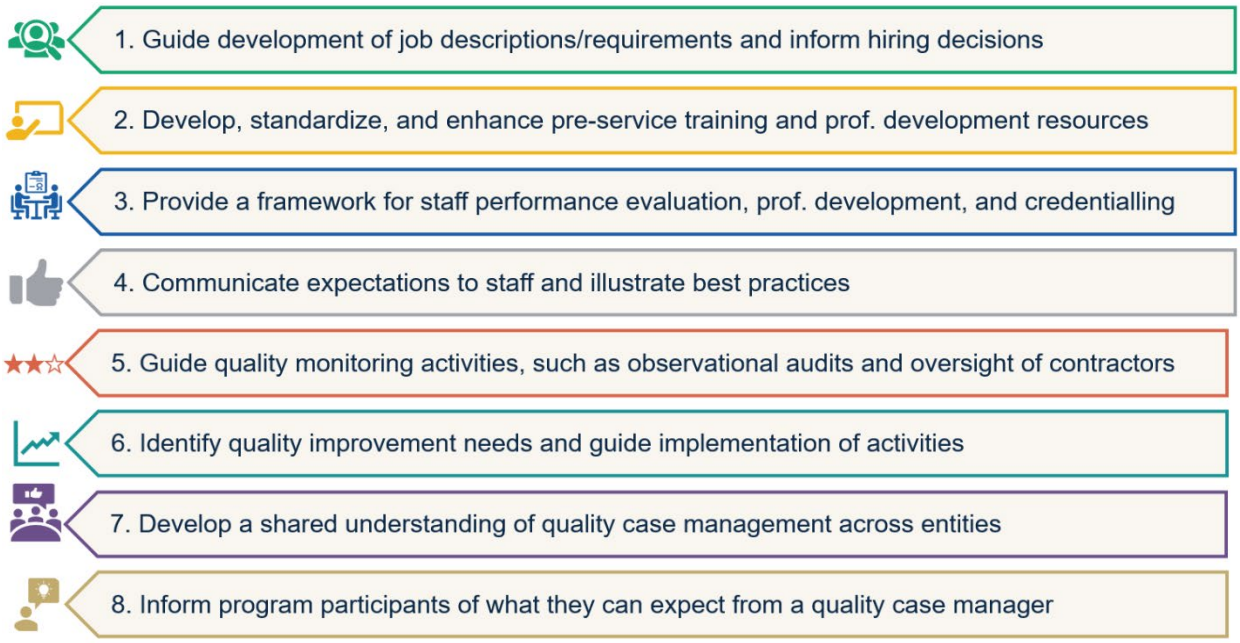
A. Defining competency tools

As described in the previous chapter, competency models provide entities with a way of organizing the individual competencies for a job or job family. **Competency tools** build on these models to enable people in an organization or profession to apply and use competencies for different purposes. This chapter discusses the potential uses of competency tools identified in the environmental scan and the various types and features of competency tools that could contribute to these uses.

B. Uses of competency tools

We assessed the current or intended use of the case management competency tools identified in the environmental scan. These uses generally fell into the categories shown in Figure IV.1.

Figure IV.1. Uses of competency tools in the field



The first four uses listed in Figure IV.1 relate to staffing: **hiring**, **development**, **evaluation** and **credentialing**, and **setting expectations**. These uses are most relevant to case management professionals, their supervisors, and the organization or agency hiring the case management professionals. The next two competencies relate to **quality oversight** and **improvement** at the organization or agency level; agencies contracting with case management organizations—or large organizations themselves—might use the competencies as an organizing framework for oversight and associated quality improvement.

The seventh use, developing a **shared understanding** of quality case management across agencies, is closely related to the purpose of our study. People with intellectual and developmental disabilities and their caregivers have reported inconsistency in case management services across agencies and provider types in Florida. Developing a shared vision of high-quality case management—despite differences in the services provided—can improve alignment and collaboration between different agencies and service provider organizations on shared priorities.

The final use focuses on **program participants** as users of the competency tool. These tools empower people with intellectual and developmental disabilities and their caregivers by increasing their awareness of the skills, knowledge, and attitudes they can expect in a quality case manager.

C. Competency tools and features

We examined the additional features and evaluation tools of the case management competency models we identified in the environmental scan. We summarize several of these features and tools below and discuss how they can be integrated into a unified platform.

1. Proficiency levels and indicators

Competency models can demonstrate expectations at progressive levels of competence (for example, novice, master, and expert) through examples or indicators. Examples can include expected behaviors, knowledge, or skills at various levels of proficiency for a given competency. Indicators can be outcomes or observations that signal high or low proficiency. For essential competencies or those required by law, expected behaviors might be the same regardless of proficiency level (for example, mandatory reporting of abuse). The use of levels and indicators can help professionals and their supervisors gauge competency and identify opportunities to improve (Campion et al. 2011). Figure IV.2 provides an example of proficiency levels and indicators from the British Association of Brain Injury and Complex Case Management competency model.

Figure IV.2. Example of a proficiency demonstration

1c Skills of Communication

Descriptor: Developing the skills to facilitate the exchange of information		
Level 1	Level 2	Level 3
Have the skills required to read individuals and deliver information within own frame of reference	Demonstrate the skills to read individuals and deliver information; requires supervision to fully understand the implications on those involved	Evidence the skills to read the subtle signs of when to probe, question and challenge; delivers information in individual's frame of reference, with an understanding of how they are likely to interpret information

Positive Indicator	Negative Indicator
Clients, families and significant others - understand relevant details of the case management process	Case manager - does not spot the signs when client or significant others are not engaging

Source: British Association of Brain Injury and Complex Case Management (2020).

2. Competency and job requirement crosswalk

Competency models might include a crosswalk between competencies and job requirements, organizational goals, or legislative requirements. These crosswalks can give case managers additional clarity on how the competencies pertain to their daily work. They can also improve the usefulness of the model at the organization or agency level by directly linking staff competencies to organizational goals and obligations (Campion et al. 2011). Figure IV.3 shows an example of a crosswalk between statutory requirements and competencies from the Missouri Division of Developmental Disabilities competency model.

Figure IV.3. Example of a crosswalk

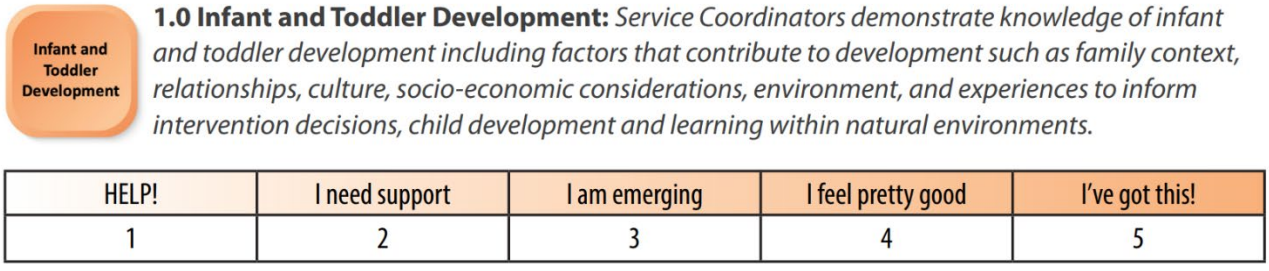
Core Competency: CONNECT TO INTEGRATED SUPPORTS AND SERVICES		
Case Management Requirements	**Sub-Categories**	**Knowledge, Skills, and Attitudes**
42 CFR 440.169 - Case management services *(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the*	**Navigate:** Support the individual to identify and access needed resources, supports, and/or services relevant to the current and upcoming life stage and the cultural context of the individual	• Demonstrates an awareness of a variety of resources available, including eligibility, relevant policies and procedures, the "right" contacts, etc. • Provides multiple options for resources (whenever possible) to ensure individual choice • Models strategies for and supports the individual/family to make informed choices

Source: Missouri Division of Developmental Disabilities (2017).

3. Self-evaluation tools

Self-evaluation tools enable case management professionals to reflect on and rate their proficiencies within the competency model. Professionals can complete self-evaluations either at the core competency level, as shown in Figure IV.4, or for more specific enabling competencies. Self-evaluation tools may support credentialing, performance evaluation, or professional development for staff. If used for professional development, the tools may link to resources or trainings for improvement in specific competency areas. Research shows that professionals are interested in self-evaluation tools that integrate individualized advice and educational pathways for identified growth areas (Trinh et al. 2021). Figure IV.4 provides an example of a self-evaluation tool used along with the National Service Coordination Leadership Institute Group competency model.

Figure IV.4. Example of a self-evaluation tool



Source: National Service Coordination Leadership Institute Group (2020).

4. Supervision tools

Supervisors of case management professionals might use competency tools that build on self-evaluations and/or other sources of performance feedback. Such tools might map competencies to one or more measurement strategies for evaluating the competency—such as observation, self-evaluation, chart review, or feedback from program participants—and include a performance rating. Supervision tools might also document strategies and resources for improving performance on a given competency that expand on the resources provided in self-evaluation tools, such as peer mentorship or coaching. Figure IV.5 shows an example of a supervision tool that North Dakota's early intervention program uses along with its competency model.

Figure IV.5. Example of a supervision tool

Competency: 1- Infant and Toddler Development
A person employed in ND EI Program with competence in infant and toddler development will:

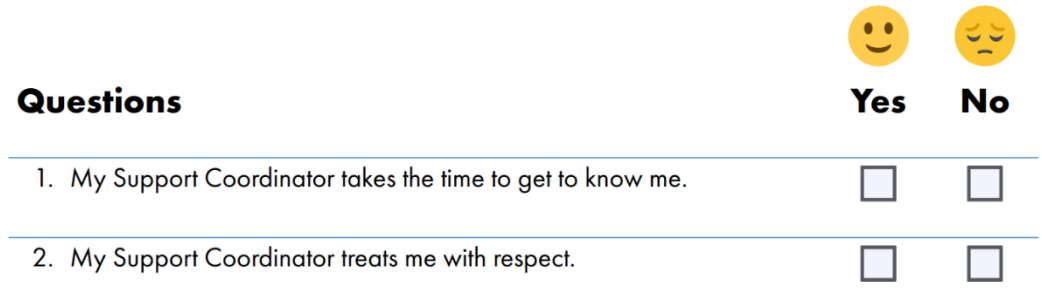
Competency Standards	Measurement Strategies	Performance	Improvement Strategies
1.a Demonstrate knowledge of infant and toddler development, including the principles of growth and development (variability within domains), developmental milestone sequences, early literacy, developmental domains (cognitive, communication, physical, social-emotional, adaptive).	○ _____ ○ _____ ○ _____	○ Exceeds ○ Meets Standard ○ Emerging ○ Novice	○ _____ ○ _____ ○ _____ ○ _____

Source: North Dakota Early Intervention Program (n.d.).

5. Program participant feedback

Participant feedback tools enable individuals and caregivers receiving services to assess the competencies of their case manager. Competencies are limited to those where participants can provide input based on their personal experience of care. Feedback tools should incorporate best practices for communicating with people with intellectual and developmental disabilities, including the use of visual supports, short sentences, definitions, large font sizes, and limited figures of speech (Autistic Self Advocacy Network 2021; W3C 2021). Figure IV.6 provides an example of a feedback tool developed for the New Jersey Department of Human Services. People with intellectual and developmental disabilities use this tool to provide feedback on their service coordinator.

Figure IV.6. Example of a program participant feedback tool



Source: The Boggs Center on Developmental Disabilities (2022).

6. Competency dashboards

Although not identified in the competency models in the environmental scan, emerging research supports the use of competency dashboards for visualizing competency levels for an individual or group (Brown et al. 2015; Elmaleh and Shankararaman 2020). These visual analytic tools can give staff a snapshot of their progress toward acquiring competencies and provide supervisors with a high-level overview of competency levels across staff. Dashboards can integrate data from several sources, such as self-evaluation and participant feedback; research supports the use of multimodal feedback mechanisms for effectively measuring competencies (Ilic 2009; Trinh et al. 2021). Dashboards can help staff track progress over time and inform quality improvement at the organizational level.

D. Tools in use in Florida

During the environmental scan, we investigated what competency models and tools were in use across systems in Florida by case management professionals working with people with intellectual and developmental disabilities and their caregivers. Although most agencies defined clear job responsibilities for case managers, few described competencies for the role. The exception is Florida Early Steps, which defines competencies and has a self-assessment tool for support coordinators. Figure IV.7 shows the format of this competency self-assessment tool.

Figure IV.7. Self-assessment of skills and knowledge for Florida Early Steps service coordinators

SERVICE COORDINATOR SELF-ASSESSMENT OF SKILLS AND KNOWLEDGE

SKILLS AND KNOWLEDGE	ABILITY 1=No Knowledge 4=Very Knowledgeable
Family Practice ***Goal: The Service Coordinator demonstrates respect and mutuality in all interactions with families.***	
8. I recognize and respect the individuality of families (socioeconomic status, available supports, ethnicity and culture, religious affiliation, role in the community, language, goals for a child).	☐ ☐ ☐ ☐ 1 2 3 4
9. I understand the importance of planning and implementing services that respect individual differences and build on family strengths.	☐ ☐ ☐ ☐ 1 2 3 4
10. I acknowledge different definitions of family and work with the family to identify how family members will participate in early intervention services.	☐ ☐ ☐ ☐ 1 2 3 4
11. I understand and acknowledge the influence of my own values and beliefs in my work with families.	☐ ☐ ☐ ☐ 1 2 3 4
12. I understand the importance of using a variety of communication strategies to assure a family's understanding of services and supports (use of translators, coordination with other service providers, home visits, etc.).	☐ ☐ ☐ ☐ 1 2 3 4

Source: Florida Health (2006).

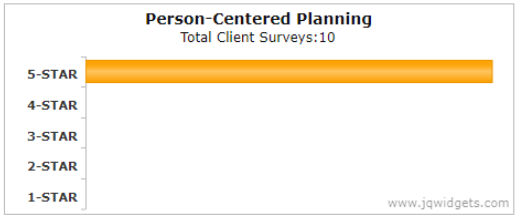
Although not associated with a competency model, the APD Waiver Support Scorecard (Figure IV.8) is a notable example of a program participant feedback tool—and associated dashboard—currently in use in Florida. The scorecard compiles information about waiver support coordinators or CDC+ consultants based on a satisfaction survey fielded with participants, along with reporting on ethical and professional violations, and shares these results in a dashboard.

Figure IV.8. Florida APD Waiver Support Scorecard

Client Satisfaction Scores

	Item	Score
Details	Arranging Needed Supports	5
Details	Availability/Accessibility	4.9
Details	Person-Centered Planning	5
Details	Recommending WSC to Others	5
Details	Respect	5
Details	Sharing Information on Community Resources	4.9

Client Satisfaction Score Details



Source: Florida Agency for Persons with Disabilities (2003).

E. Stakeholder work group feedback

During the second meeting of the stakeholder work group, we solicited input on developing new competency tools to support the use of the universal competency model in Florida service systems. Work group members were optimistic that the universal model and new tools would set expectations for service delivery, create consistency across disciplines, and increase the quality of services. However, the work group cautioned that the fragmentation of the current disability service system—and the many tools and performance metrics already in use in separate agencies—might prevent implementation of new tools. Case managers said they are already overwhelmed with paperwork and high caseloads; any new tools should not add to this burden. Members raised similar concerns for case manager supervisors.

Work group members agreed with the three identified users of new tools (recipients of services and their caregivers, service providers, and supervisors of case management professionals) and added that the tools might help other providers, such as primary care or personal support providers, understand case managers' roles and responsibilities. The members provided focused feedback on the design and implementation of tools for these specific user types, which we will incorporate in the development of the new competency tools.

V. Conclusions and Next Steps

A. Summary and recommendations

This environmental scan summarizes the current state of knowledge about the core competencies for case management professionals supporting people with intellectual and developmental disabilities at different life stages. Drawing on the available literature, existing tools, and stakeholder input, we created a universal competency model for these professionals (Table III.1). Practical knowledge and awareness of available supports and services are essential to this position, but our environmental scan and stakeholder work group also identified soft skills, including relationship building, empathy, and effective communication, as some of the most critical competencies for case management professionals.

This report identifies design features that can be integrated into new competency tools for case management professionals who support people with intellectual and developmental disabilities. In particular, tools that rely on several diverse data sources to assess competency areas (self-assessments, supervisor observation, and participant feedback) could provide more accurate feedback, while proficiency levels and indicators might improve comprehension and utility. Any new competency assessment tools should be accompanied with strategies and resources to help professionals build specific skills and improve their performance.

B. Study limitations

Through the environmental scan, we found broad evidence to support the use of competency models in driving staff performance and organizational quality improvement. However, this evidence was not specific to case management professionals or organizations serving people with intellectual or developmental disabilities. Although many organizations providing case management to this population have adopted competency models, we do not have evidence that adopting these models impacts quality of services or individual outcomes. Moreover, we found limited evidence to support the use of specific competency tools with case management professionals or people with intellectual and developmental disabilities. Future research could focus on the impact of implementing a competency model on case management professionals' performance and outcomes for people with intellectual or developmental disabilities.

C. Next steps

We will use the information in this report to develop a competency tool for case management professionals working with people with intellectual and developmental disabilities in Florida. We anticipate that this competency tool will serve the following purposes:

- Help case managers provide uniform, high-quality, and person-centered services
- Enable employers of case management professionals to review their staff's work and determine their professional development needs
- Help people with intellectual and developmental disabilities, their families, and caregivers know what to expect when receiving case management; select case managers; and share feedback on their experiences with case managers

The competency tool might serve additional purposes, including those listed in Figure IV.1. In particular, the tool could aid in developing a shared vision of quality case management across Florida agencies serving people with intellectual and developmental disabilities, and it could promote improved collaboration on training and quality improvement.

During tool development, we will create separate modules for case management professionals working in different service settings (for example, waiver support coordinators, early intervention support coordinators, and VR counselors). In addition, we will develop evaluation tools for the three user groups identified above: case management professionals, supervisors, and people with intellectual and developmental disabilities and their caregivers. Once the competency tool is developed, we will pilot test it in summer 2023 to identify needed changes before further refinement and widespread adoption.

We will also continue our efforts to gain buy-in for adoption of the tool with agencies providing case management to people with intellectual and developmental disabilities, and we will promote its integration with existing tools. The objective of the competency tool is to add value, rather than burden, for case management professionals, supervisors, and program participants and to improve outcomes.

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Appendix A

Electronic databases of published literature and search terms

Table A.1. Data collection methods

Peer-reviewed literature search	
Electronic databases	
• Academic Search Premier • Agency for Healthcare Research and Quality • APA PsycInfo • Business Source Corporate Plus • CINAHL • Cochrane Database of Systematic Reviews • Education Research Complete	• ERIC • MEDLINE • Policy Commons • ProQuest Dissertations • SAGE • Scopus • SocINDEX

Search terms

Terms related to provider type	Terms related to provider function	Terms related to competencies	Terms related to disability status	Terms related to service systems
• Case manager • Care manager • Care coordinator • Service coordinator • Support coordinator • Transition coordinator • Family support coordinator • Family services coordinator • Early intervention coordinator • Vocational rehabilitation counselor • Waiver support coordinator • Waiver coordinator • Care consultant • Community resource liaison • Non-clinical • CDC + Waiver Consultant	• Case management • Care management • Care coordination • Service coordination • Support coordination • Person-centered planning • Plan of care • Conflict-free case management • Family support planning • Family service planning • Transition coordination • Transitional care • Health plan coordination • Waiver coordination • Care consulting • Early intervention services • Consumer-directed services/care • Self-directed services/care • Behavioral health • Social work	• Service delivery competencies • Service coordination responsibilities • Case management responsibilities • Professional standards • Standards of practice • Standards of care • Service delivery skills • Qualifications • Staff/worker competencies • Professional competencies • Core competencies • Competency domains • Competency framework • Competency tools • Professional development • Competency assessment • Performance standards • Professional practices • Demonstrated abilities	**Primary:*** • Intellectual disability/disorder/impairment • Developmental disability/disorder • Child development disorder • Behavioral disorder/disability • Cognitive disorder/disability • Developmental delay • Behavioral disorder • Individuals with disabilities • People with disabilities • Children with disabilities • Youth with disabilities • Young adults with disabilities • Neurological impairments • Autism/Autism spectrum disorder • Cerebral palsy • Down syndrome • Prader-Willi syndrome • Phelan Mcdermid syndrome • Spina bifida	• Early intervention • Managed care • Medicaid waiver • Home and Community-Based Services/HCBS waiver • Special education • Exceptional education • Vocational rehabilitation • Special needs plan • Worker's compensation • Centers for Independent Living • Aging and Disability Resource Centers • Individual Education Plan • Individual Family Service Plan • Individual Habilitation Plan • Individual Transition Plan • Individualized Plan for Employment • Foster care

Peer-reviewed literature search				
	• Service access	• Expertise	**Secondary:*** • Acquired brain injury • Chronic conditions • Physical disability • Older adults • Chronic conditions • Geriatric • Aging adults • Elders • Traumatic brain injury • Pervasive Developmental Disorder • Asperger Disorder • Autism	• Behavioral health
Organizational website search				
National organizations				
• National Service Coordination Training Work Group • Division for Early Childhood Service Coordination Community of Practice • Administration for Community Living • National Center on Advancing Person-Centered Practices and Systems • American Case Management Association • Case Management Society of America • Certified Disability Management Specialist certification • Commission for Case Manager Certification • Academy of Certified Case Managers			• The Arc • American Association on Intellectual and Developmental Disabilities • The National Association of State Directors of Developmental Disabilities Services • Institute on Community Integration • CDC National Center on Birth Defects and Developmental Disabilities • Rehabilitation Services Administration • National Association of Councils on Developmental Disabilities	
Florida-based organizations				
• Florida Agency for Persons with Disabilities • Early Steps • Florida Department of Health • Florida Agency for Health Care Administration • Florida Medicaid Managed Care • Florida Department of Education • Florida Department of Children and Families • Florida Inclusion Network			• Florida Center for Inclusive Communities • Florida Center for Students with Unique Abilities • Centers for Autism and Related Disabilities • Florida Division of Vocational Rehabilitation • Department of Elder Affairs, State of Florida • Florida Association of Centers for Independent Living • Florida Association of Rehabilitation Facilities • Florida Independent Living Council	

Peer-reviewed literature search Broad internet search
Search strings
• intitle:("care manager|" OR "case manager|" OR "care coordinator|" OR "service coordinator|" OR "patient navigator|" OR "care navigator|" OR "transition coordinator|" OR "transition manager|" OR "support coordinator") AND intitle:(competencies) AND ((intellectual|developmental) AND disability)
• intitle:("care manager|" OR "case manager|" OR "care coordinator|" OR "service coordinator|" OR "patient navigator|" OR "care navigator|" OR "transition coordinator|" OR "transition manager|" OR "support coordinator") AND intitle:(competencies)
• intitle:("care manager|" OR "case manager|" OR "care coordinator|" OR "case coordinator|" OR "patient navigator|" OR "care navigator|" OR "patient progression|" OR "transition coordinator|" OR "transition manager|" OR "care facilitator") AND intitle:(standards) AND ((intellectual|developmental) AND disab*)
• site:.gov ("care manager|" OR "case manager|" OR "care coordinator|" OR "case coordinator|" OR "patient navigator|" OR "care navigator|" OR "patient progression|" OR "transition coordinator|" OR "transition manager|" OR "care facilitator") AND (competencies OR practices)
• intitle:("support coordinator|" OR "early intervention coordinator|" OR "early intervention specialist|" OR "Vocational rehabilitation counselor|" OR "waiver coordinator|") AND intitle:(competencies OR best practices) AND ((intellectual|developmental) AND disability)

*Note: primary terms were prioritized in initial search; secondary terms were to be used in the event the primary results were insufficient.

Appendix B

Competency models identified through environmental scan

Table B.1. Competency models for case management professionals across service systems

Source	Service System	Description	Core Competencies
American Case Management Association (2020)	Health Care	Booklet describing the standards of practice and scope of services for health care delivery system Case Management and Transitions of Care (TOC) Professionals.	**Accountability:** recognizes shared accountability; follows escalation process; contributes to interdisciplinary decision-making **Professionalism:** aligns practice with mission, vision, and values of organization; emulates standards of practices; adhere to ethical standard and code of conduct; recognizes risks and makes referrals; maintains licensure/certification; orients new team members; commits to ongoing learning; demonstrates integrity, commitment, and flexibility; embraces innovation; evaluates own performance using data; communicates effectively **Collaboration:** partners with patients/families/organizations to promote optimal outcomes; respects patients' goals and preferences; builds and maintains relationships **Advocacy:** advocates on behalf of patients and families; provides information on treatment options; promotes self-determination and informed decision-making; provides culturally competent care; reports abuse; promotes professional practice of case management **Resource management:** manages cost of care with patient safety and satisfaction; educates families on financial impact of options; promotes timely progression to appropriate level of care; implements strategies for avoiding unnecessary costs; manages patient and family expectations **Technology:** embraces innovation and technology; uses technology to engage with patients and families; ensures compliance with regulatory requirements when using technology **Certification:** certification validates a case manager's knowledge, competency, and skills
British Association of Brain injury and Complex Case Management (2020)	Cross-system	Resource describing a competency model for case management of people with brain injury and/or other complex conditions. Bridges health and social care professions to describe the necessary behaviors to benchmark case management practice.	**Communication:** rapport, listening, skills of communication, negotiation, and lines of communication **Strategy:** assessment and goal setting, planning, and integration **Coordination and management:** clinical management, implementation, project management, resourcing, and human resources **Monitoring:** analysis, facilitating change, and record keeping **Duty of Care:** Client focused, advocacy, guiding decision making, risk management, and managing expectations **Professionalism:** supervision, consent, capacity and confidentiality, boundaries, and personal development **Personal attributes:** leadership, fostering independence, ingenuity and innovation

Source	Service System	Description	Core Competencies
Mary Beth Bruder et. al (2019)	Early Intervention	Article in peer-reviewed journal funded by the Early Childhood Personnel Center to establish shared competencies across professional disciplines serving infants and young children with disabilities and their families. Not limited to case management professionals.	**Coordination and Collaboration**: knowledge and respect of other disciplines/preparation and skills; ability to develop and implement joint assessment, planning, interventions, and evaluation across disciplines and learning contexts; ability to collaborate with others in the community, including early childhood agencies, programs, and settings **Family-Centered Practice**: Listening to families; respecting family background/structure/culture and choices; sharing information and skills with families; supporting and partnering with families **Data-Based Intervention/Instruction**: Individualized; interaction-based; knowledge of child development and learning theories; application of learning theories; assessment curricula; using learning opportunities through activities and routines; functional curricula; Future orientation and transition **Professionalism**: Advocacy; ethics; accountability; responsibility; orientation to professional service; leadership
Florida Health (2006)	Early Intervention	Document describing the required skills and knowledge for Early Steps Service Coordinators in Florida, including a self-assessment component.	**Mission, Policies, and Procedures:** The Service Coordinator understands and applies the mission, policies, and procedures related to Early Steps. **Family Practice:** The Service Coordinator demonstrates respect and mutuality in all interactions with families. **Promoting Child Development:** The Service Coordinator understands and applies the principles of infant/toddler development as related to early intervention practices. **First Contacts Goal:** The Service Coordinator establishes a positive relationship with the family and conducts first contacts to identify the family's concerns, priorities and resources and to discuss the family's everyday routines, activities and places. The Service Coordinator assists the families in accessing and utilizing all available services, including those available for typically developing infants and toddlers. **Assessment:** The Service Coordinator demonstrates an understanding of the process and procedures of assessment/evaluation as related to early intervention practices. As appropriate for their role, the Service Coordinator assists families in accessing and utilizing assessment/evaluation services, and uses appropriate instruments, measures, and procedures to obtain current information on the child's developmental status. **Developing IFSP's:** The Individualized Family Support Plan (IFSP) is coordinated with all relevant family members, service providers, and agency representatives and conforms to all state and federal requirements. The Service Coordinator participates in a collaborative process for developing and implementing the IFSP. **Planning for Transitions:** The Service Coordinator demonstrates adherence to the IDEA, Part C regulations for the transition process and collaborates with others to ensure that eligible children are enrolled in Part B services by their third birthday or other appropriate early care and education settings. **Collaboration with Others:** The Service Coordinator participates as a collaborative partner in all interactions with early intervention team members, including staff from other agencies and programs, to ensure that a comprehensive, collaborative model of services, without gaps or duplication, is available to Early Steps eligible children and their families. **Professional Practice:** The Service Coordinator conducts all activities in a professional manner. **Completing Administrative Responsibilities:** The Service Coordinator ensures that IFSPs, eligibility documentation, procedural safeguard assurances, correspondence, and progress notes are on file and current.

Source	Service System	Description	Core Competencies
Thomas P. Golden, Andrew J. Karhan, Adene P. Karhan, and Sarah J. Prenovitz (2021)	Vocational Rehabilitation	Article in peer-reviewed journal establishing a taxonomy of case management for youth who receive Supplemental Security Income (SSI) benefits. Focuses on case management services supporting successful postschool outcomes of youth SSI recipients.	**Resource navigation:** Deep knowledge of and ability to navigate various systems that intersect the lives of youth and family members, including but not limited to schools and transition; workforce development; mental health; intellectual/developmental disabilities; health insurance; protection and advocacy; means-tested entitlement programs; and others. **Student- and family-focused planning:** Support the self-determination, self-advocacy and development of youth and families over time based on priorities, desired objectives, preferences, interests, challenges, and support needs. This is accomplished through use of person- and family-centered counseling approaches and motivational interviewing techniques to assist in setting service planning priorities, establishing critical touch points in a youth's and family's life, addressing crises, mitigating obstacles and challenges, and developing individualized service and support plans. **Active understanding:** Understanding and responsivity to unique family dynamics, including provision of services and supports in a culturally and linguistically accessible way; youth and family preferences; and interrelationship and connectivity of individual family members. **Professional qualities and attributes**: Establishment of professional boundaries and ethical behavior within the case management relationship. This also includes effective engagement techniques, confidentiality, future-orientation, innovation and adaptability, and flexible implementation of case management interventions. **Information management and structure:** Comprehensive and systematic collection, archiving and use of data and information, including demographics, intervention tracking, reporting, and management by data practices. **Provider engagement:** Develop, cultivate, maintain, and expand a network of community providers to aid in information and referral in response to the needs of youth and families being served. **Interagency collaboration:** Understand the referral requirements and processes for state, regional, and local agencies and schools, including brokering of meaningful community partnerships, development of shared resources to promote information and referral, and communication strategies across invested stakeholders.
Indiana Bureau of Developmental Disability Services (2022)	Health Care	Quality guide for Case Managers and Case Management organizations developed by Bureau of Developmental Disabilities Services. Section on core competencies is designed to enhance the provision of quality case management throughout the state of Indiana.	**Foundational Values, Beliefs, and Skills**: Case managers are knowledgeable and adaptable professionals, demonstrating ethical behavior and professionalism across all core competency areas. **Engagement**: The case manager develops and maintains a **relationship** with the individual and their IST that facilitates effective communication and collaboration to promote well-being. **Empowerment**: The case manager enhances the individual's capacity for self-direction through ensuring awareness of rights and responsibilities and facilitating access to resources. **Exploration and Planning**: The case manager engages the individual and their IST in a person-centered planning process that results in an integrated and **comprehensive plan** that is reflective of and responsive to the strengths, interests, needs, and desired outcomes of the individual in all areas of their life. **Connecting to Integrated Supports and Services**: The case manager assists the IST to cultivate an array of resources, including paid and non-paid supports that provide the individual opportunities for integrated supports that address both what is important to and important for the individual. **Facilitation of Long-Term Services and Supports**: The case manager facilitates the exploration and acquisition of paid supports from a variety of funding sources and monitors for quality services that maximizes the use of support dollars to meet identified goals and minimize risks.

Source	Service System	Description	Core Competencies
Kentucky Cabinet for Health and Family Services (n.d.)	Early intervention	Document listing Kentucky's Service Coordinator performance standards for early intervention. Includes an accompanying self-assessment for service coordinators based on these performance standard domains.	**Coordinating Intake, Screening and Developmental Evaluations:** Ability to implement the practices that support and empower families, encouraging their role as decisionmakers and assist them in securing supports and services throughout the early intervention process. Includes **Ensuring Procedural Safeguards** **Assessing the Family for Service Planning**: Ability to conduct the family assessment to assist the Individualized Family Service Plan (IFSP) team in identifying the early intervention services necessary to meet the unique needs of the child and family **Developing and Monitoring the Individualized Family Service Plan**: Ability to work effectively and consult with a variety of early intervention team members and community partners for service planning integrated intervention strategies, supports and services for children and their families. **Planning for Transition:** Ability to implement transition planning with the family that identifies the events, activities and processes associated with key changes between environments or programs during the early childhood years.
National Academy for State Health Policy (2022)	Health Care	Report detailing the system-level national care coordination standards for children with special health care needs (CYSHCN). Standards serve as a guide for the establishment of robust, high-quality care coordination programs for CYSHCN and their families.	**Screening, Identification, and Assessment:** Screening, identification, and assessment of a child's needs provides the foundation for effective, high-quality care coordination. Assessment is a continuous process that reflects ongoing conversations with CYSHCN and families about their needs, preferences, and priorities. **Shared Plan of Care:** The shared plan of care provides a roadmap and an accountability system for integrating care based on family needs and priorities identified in the assessment and is used in coordinating a child's care. **Team-Based Communication:** Communication between members of the care team is timely, efficient, respectful, and culturally sensitive. **Child and Family Empowerment and Skills Development:** Care coordination includes education, coaching, and training for CYSHCN, families, and care teams. These activities empower children and families and advance their well-being, while at the same time enabling other members of the care team to gain the understanding and insights needed to serve families effectively. **Care Coordination Workforce:** The care coordination workforce is well trained and prepared to serve CYSHCN and their families. All care team members have opportunities to gain the knowledge and understanding needed to perform their roles effectively. **Care Transitions:** Care transitions refer to the transfer of care between and within medical, behavioral health, social service, education, and justice systems. Particular emphasis is placed on preparing youth for transitions from pediatric to adult care and promoting independence in the transition to adulthood. Advance preparation and careful integration of services following transitions are essential to a successful transition process.

Source	Service System	Description	Core Competencies
National Case Management Network Canada (2012)	Cross-system	Booklet describing the core competencies required by those working in case management in Canada at the beginning and throughout their practice. Encompasses the diverse professional backgrounds and working environments that fall under the case management umbrella.	**Case management expert**: Case management providers demonstrate expertise in complex health and social needs planning. As leaders in coordination and facilitation, case management providers integrate all case management roles to promote and optimize the health and well-being of targeted client populations. **Communicator**: Case management providers use effective communication to develop and enrich the client's health and social networks, to build partnerships and to address barriers at the client and system level using a variety of different communication strategies/methods/techniques. **Collaborator**: Case management providers facilitate the achievement of optimal client and system outcomes by working with the broad health and social networks. Case management providers skillfully engage individuals and groups to reach consensus by providing direct or indirect assistance, guidance or supervision along the continuum of care. **Navigator**: Case management providers help clients navigate health and social systems by working with their networks to identify and address disparities and barriers. **Manager**: Case management providers are integral participants in making decisions about time, resources and priorities that affect the case management plan and contribute to the effectiveness of clients' healthcare plan, social networks and the organizational systems. **Advocate**: Case management providers use their expertise and influence to speak on behalf of their clients, community or population to advance their health and well-being. **Professional**: Case management providers demonstrate professional behaviour in the best interests of clients and society by adhering to the Canadian standards of practice for case management and through ethical and evidence-informed practice
New York State Talent Development Consortium (2014)	Direct support professionals	Document listing core competencies and skills for direct support professionals in New York state working with individuals with intellectual and developmental disabilities. Inclusive of, but not limited to, case managers.	• Supporting a person's unique capacities, personality, and potential • Getting to know the person through assessment/discovery • Promoting advocacy with the individual • Facilitating personal growth and development • Facilitation of supports and services • Building and maintaining relationships • Creating meaningful communication • Developing professional relationships • Exhibiting professional behavior • Showing respect for diversity and inclusion • Creating meaningful documentation records • Education, training and self-development activities • Organizational participation • Exhibiting ethical behavior on the job • Promoting positive behavior and supports • Preventing, recognizing, and reporting abuse • Supporting crisis prevention, intervention, and resolution • Supporting safety

Source	Service System	Description	Core Competencies
			• Ensuring safety of individuals during environmental emergencies • Supporting people to live in the home of their choice • Supporting active participation in the community • Supporting employment, educational and career goal attainment
Glenn Pransky, William S. Shaw, Patrick Loisel, Quan Nha Hong, Bruno Desorcy (2010)	Vocational rehabilitation	Article in peer-reviewed journal enumerating and rating competencies for return-to-work coordinators.	• Respecting and maintaining confidentiality • Having ethical practices as a Return to Work (RTW) coordinator • Having listening skills • Ability to communicate well verbally (phone, in person) and in writing (including email) • Being consistent between what you say and what you do • Being approachable and available • Being committed to the goal of early RTW • Ability to relate well to workers and employers • Ability to respond to others in a timely fashion • Ability to instill trust and confidence in your role as the RTW coordinator • Having organizational and planning skills • Being respectful of other people: their role, their beliefs and their cultures • Ability to sort through data and identify what is important • Being able to communicate in a non-threatening way • Ability to uncover and evaluate underlying problems affecting RTW • Being honest and frank in communications • Ability to adjust communication to a particular situation and individual people • Ability to evaluate and accurately describe job requirements

Source	Service System	Description	Core Competencies
Janis Tondora, Bevin Croft, Yoshi Kardell, Teresita Camacho-Gonsalves, and Miso Kwak (2020)	Cross-system	Resource describing competency domains for staff who facilitate person-centered planning. Applies to a wide range of systems supporting individuals with various types of disabilities, people with behavioral health-related needs, and older adults with long-term service and support needs.	**Strengths-Based, Culturally Informed, Whole Person–Focused**: Person-centered planning recognizes that people grow, change, and can realize personally valued goals. PCP focuses on the universally valued goal of living a good life as defined by the person. All activities focus on the person as a whole (not just their diagnosis or disability) and are informed by the person's unique culture and identity. **Cultivating Connections Inside the System and Out:** Planning facilitates linkages with both paid (professional) and unpaid (natural) supports. This requires understanding of the person's relevant health or disability issues as well as knowledge of the array of systems the person may access. All activities seek to maximize connections to natural community activities and relationships in inclusive settings wherever possible and when consistent with the preferences of the person. **Rights, Choice, and Control:** Relationships and planning activities are based on respect and the assumption that people are presumed competent and have the right to control decisions that impact their lives. Practitioners support people in empowering themselves and discovering their voice in all aspects of plan co-creation and implementation. Practitioners are aware of and able to educate people (when necessary and desired) about the range of legal protections that promote both fundamental safety (i.e., the right to be free from abuse and neglect) and community inclusion (i.e., the right to be free from discrimination and the right to exercise freedoms). **Partnership, Teamwork, Facilitation, and Coordination:** Planning interactions and meetings are facilitated in a respectful, professional manner and in accordance with person-centered principles and the preferences of each individual. Ensures the primary focus remains on the priorities and perspective of the person. Supports the person in expanding their team or circle as desired. Encourages all members to make meaningful contributions and facilitates the process in a way that is transparent and accessible to all parties involved. **Person-Centered Plan Documentation, Implementation, and Monitoring:** The person-centered plan is co-created and captured in writing in a manner that adheres to established expectations around person-centered plan documentation. The plan is valued as a "living document" that is revised as needed based on the person's preferences and evolving situation. There is responsible follow-up and monitoring of the plan's implementation.
Teresa M. Treiger and Ellen Fink-Samnick (2013)	Cross-system	Series of articles in peer-reviewed journal establishing COLLABORATE©: A Universal Competency-Based Paradigm for Professional Case management. Article I establishes the model, Article II provides clarification and information on operationalizing competencies within organizations, and Article III discusses considerations for making the paradigm shift.	**Critical thinking:** Out of the box creativity; analytical; methodical approach **Outcome driven:** Patient outcomes; strategic goal setting; evidence-based practice **Life-long learning:** Valuing: academia and advanced degrees; professional development; evaluation of knowledge requirements for new and emerging trends (e.g. technology, innovation, reimbursement); practicing at top of licensure and or certification; acknowledging that no one case manager can and does know all **Leadership:** Professional identity; self-awareness; professional communication; team coordinator **Advocacy:** Patient; family; professional **Big picture orientation:** Biopsychosocial-spiritual assessment; macro (policy) impact on micro (individual) intervention **Organized:** Efficient; effective **Resource awareness:** Utilization management; condition/population-specific; management of expectations per setting **Anticipatory:** Forward thinking; proactive vs reactive practice; self-directed **Transdisciplinary:** Transcending: professional disciplines; across teams; across the continuum **Ethical-legal:** Licensure; certification; administrative standards; organizational policies and procedures; ethical codes of conduct

Source	Service System	Description	Core Competencies
Virginia Department of Behavioral Health and Development Services (2011)	Health Care	Document recommending competencies for case managers working with individuals with mental illness and those with intellectual disabilities in Virginia. Developed by a case management work group established by the Commissioner of DBHDS.	**General Competencies:** Required competencies for all staff working with consumers needing behavioral health and/or developmental services, including cultural and linguistic competence, safety, ethics, and use of technology. **Job Knowledge**: Foundational information on case management, case management models, and individuals served, specialty areas specific to disability, appropriate terminology, documentation, policies, rules and regulations on case management, and licensure and funding (Medicaid, etc.) requirements. **Assessment Skills:** The ability to identify needs, strengths, capacity, and competency, use of evaluation tools and outcome measurements, ability to gather and summarize information, and assist in identifying personal values, goals and priorities. **Service Planning and Service Access**: The ability to individualize care and supports through ISP development, facilitate service acquisition, service planning and team meetings, intake and discharge planning, linking and coordination, specialty areas by disability, including recovery principles and person-centered planning, wellness recovery plans (WRAP, etc.) and person-centered support plans, and advanced directives, etc. **Advocacy**: The ability to act in the individual's best interest, including the provision of family support and education, knowledge and use of community resources, and promoting the development of other needed services and supports. **Interpersonal and Team Skills**: Advanced abilities in communication, listening, and problem solving, establishing rapport, and effectively working with internal and external teams of services and supports providers. **Judgment and Analytical Ability**: The ability to identify critical issues, act appropriately in high risk situations, assess and reassess appropriate crisis responses, and assist individuals in utilizing creative approaches to problem solving **Adaptability**: The ability to flexibly assume various roles of counselor, advocate, and service broker, and adjust to change to meet the individual's needs in the changing healthcare environment. **Organizational Skills**: The ability to independently manage a diverse caseload, and prioritize both direct service, accountability for recipient records, and other related tasks and activities.

Source	Service System	Description	Core Competencies
Wisconsin Department of Health Services (2021)	Health Care	Document developed by stakeholders in Wisconsin's Children's System of Care. Details competencies and core skills of Service Facilitator/Care Coordinators, aligned around Wisconsin Children's System of Care Principles.	**Family voice and choice:** Family and youth/child perspectives are intentionally elicited and prioritized. **Team-based:** The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships. **Natural supports:** The team, respecting family voice and choice, actively seeks out and encourages the full participation of community, natural and peer supports. **Collaboration:** The intentional choice to co-create solutions, share resources, and share ownership. **Community-based:** Teams implement service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive setting possible. **Cultural and linguistic responsiveness:** Respect and build on the values, preferences, beliefs, culture, experiences, and identity of a child, youth, family, and their community. **Individualized and developmentally informed:** All aspects of the wraparound process are customized around family member's priorities, aspirations, and individualized needs. **Unconditional:** An abiding commitment to the family is not based on circumstantial words or actions but a resolve to better outcome. **Outcome-based:** Cultivating meaningful measures of progress. **Strengths-based:** Through words and actions, a full understanding of how to apply the wraparound principles; Embraces a reflective process of learning about oneself and others.
Workgroup on Recommended Knowledge and Skills for Service Coordinators (2020)	Early Intervention	Document developed by the Workgroup on Recommended Knowledge and Skills for Service Coordinators to provide awareness of the foundational knowledge and skills that are necessary for quality service coordination in early intervention.	**Infant and Toddler Development:** Service Coordinators demonstrate knowledge of infant and toddler development including factors that contribute to development such as family context, relationships, culture, socio-economic considerations, environment, and experiences to inform intervention decisions, child development and learning within natural environments. **Family-Centered Practices:** Service Coordinators demonstrate ability to respect and support the distinctive qualities of each family, recognizing the family as the teacher, support, decision-maker and advocate for their child. **Leadership/Teaming:** Service Coordinators demonstrate ability to be an effective leader by building professional, supportive partnerships with families; collaborating and teaming with IFSP team members to include family members; and engaging/collaborating with a variety of community partners. **Coordination of Services:** Service Coordinators demonstrate ability to coordinate and monitor the timely delivery of identified evidence-based early intervention services. **Transition:** Service Coordinators implement smooth and effective transition plans with the family that identify the events, activities, and processes associated with key changes between environments or programs during the early childhood years. **Professionalism:** Service Coordinators demonstrate professionalism by using personal and professional boundaries, flexibility, resiliency, time management, dependability, and by engaging in ongoing professional development.

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