# American Academy of Home Care Medicine
# Clinical Competencies

**The clinician caring for patients at home should have the following attitudes, knowledge and skills to be able to practice effective and safe care:**

**CARE FOR THE COMPLEX PATIENT AT HOME (PEDIATRIC, ADULT AND GERIATRIC)**

1. Explain and use evidence-based approaches to screening, immunization, health promotion and disease prevention taking into consideration patient and family preferences, goals of care, and anticipated life expectancy.
2. Define the components of a comprehensive assessment, the disciplines involved, and instruments used to assess cognition, mood, physical function (mobility, ADLs, IADLs), vision, hearing, nutrition, pain, caregiver competency/training, caregiver burden/support, social and spiritual issues, and finances.
3. Diagnose and manage patients with common and advancing chronic conditions and multi-morbidity, such as heart disease, diabetes, lung disease, and arthritis.
4. Diagnose and manage patients with neuromuscular conditions such as cerebral palsy, spinal cord injury, ALS, and multiple sclerosis.
5. Diagnose and manage patients with common geriatric syndromes and conditions, including falls, wound care, sleep disturbance, urinary incontinence, chronic pain, weight loss, constipation, frailty, and self-care deficits.
6. Competently and appropriately use diagnostic and therapeutic technology in the home. Know available ancillary services in the community and refer appropriately.
7. Apply concepts of prognostication to inform patients and families about estimated life expectancy and provide quality end-of-life care.
8. Develop, document and oversee patient-centered plans of care with patients related to their health and condition(s) and expected or realistic trajectory with emphasis on personal health goals, such as prolonging life, function, and achieving rehabilitative and/or palliative aims.
9. Develop plans of care collaboratively with the patient, family, caregivers, and other health and community professionals involved in the patient's care that include all aspects that effect the patient's overall well-being: medical management including medication management, behavioral health, family health and relationships, functional impairments and environmental adaptations, financial problems including housing and nutrition; and steps in each area, and responsible person.
10. Apply knowledge of the biological, physical, cognitive, psychological and social changes commonly associated with aging when developing a plan of care.
11. For Pediatric patients, in addition to the above concepts, have a knowledge of normal development and developmental assessments, pediatric nutrition, education needs and socialization needs.

**MEDICATION MANAGEMENT**

1. Accurately review a patient's pharmacotherapy (including those prescribed by all other physicians and clinicians, over-the-counter medications and preparations, expired medications, and complementary and supplemental nutritional preparations) and prepare a comprehensive reconciled medication list for the patient.
2. Use evidence-based practices to maximize medication adherence, identify undesired medication effects and adverse drug reactions, eliminate medications that are no longer effective, are duplicative, carry a greater burden than benefit, and/or no longer have an indication, and to offer all medically-indicated, appropriate medications.

**FUNCTIONAL IMPAIRMENT AND REHABILITATION**

1. Describe the indications and contraindications for referring patients to physical, occupational, speech, or other rehabilitative therapies, and refer if appropriate.
2. Appropriately evaluate for, document the medical necessity, and prescribe durable medical equipment.
3. Recognize and manage the care of functionally impaired patients at high risk for poor outcomes, including those with

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| | falls, deconditioning, skin breakdown, hip fracture, stroke, frailty, and dysphagia. |
| 4. | For Pediatric patients appropriately use durable medical equipment such as apnea monitoring, home mechanical ventilation, oxygen tents, phototherapy for jaundice and total parenteral nutrition and enteral feeds. Appropriately use rehabilitation services for both fine and gross motor skills and sensory processing problems. |
| 5. | For Pediatric patients recognize that developmental disabilities are often medically underserved and are at higher risk for secondary health conditions such as seizures, obesity, falls, dental disease, dysphagia and constipation and appropriately manage these problems. |
| **COGNITIVE, AFFECTIVE AND BEHAVIORAL HEALTH** | |
| 1. | Diagnose and manage common cognitive, affective and behavioral health conditions, including dementia, depression and other serious mental illnesses. |
| 2. | Describe key issues in the management of patients with dementia in the home setting, including patient and family safety, quality of life, driving, firearms, caregiver stress, and medical comorbidities. |
| 3. | Describe key issues in the management of patients with depression in the home setting, including medication management and safety. |
| 4. | For Pediatric patients have knowledge of early intervention programs and school based educational/developmental programs. |
| **CAREGIVER ASSESSMENT AND SUPPORT** | |
| 1. | Assess and incorporate family/caregiver needs and limitations, including caregiver stress into management plans. |
| 2. | Describe community resources available to provide support for caregivers. |
| 3. | For Pediatric patients recognize and manage the family/marital stress due to parenting a child with special needs and the impact on siblings. |
| **PATIENT AND STAFF SAFETY** | |
| 1. | Assess specific risks and barriers to patient home safety, including the general environment, falls, fire hazards, elder mistreatment and other risks in the home (e.g., heating/air conditioning), be able to use home safety checklists and describe interventions to maximize safety. |
| 2. | Recognize mistreatment (abuse/neglect) for patients of all ages, and develop a plan of care to maximize patient safety and quality of life, including knowledge of the reporting responsibilities of staff/clinicians of suspected abuse/neglect. |
| 3. | Consistently demonstrate infection control practices in the home. |
| 4. | Describe approaches to personal safety of the clinician and other staff while traveling and during home visits. |
| 5. | For Pediatric patients know that children with disabilities are at increase risk for abuse. Know the signs of child abuse and how to report suspected abuse. |
| **ACUTE/EMERGENT CARE** | |
| 1. | Be able to accurately and effectively triage patients with acute issues to appropriate timing and setting of face-to-face assessment and provide guidance to patients and caregivers for reporting changes in condition in a timely manner. |
| 2. | Recognize, diagnose and manage common acute conditions such as fever, delirium, falls, acute pain, and shortness of breath both in person and by reports from formal and informal caregivers by phone. |
| 3. | Develop and implement urgent/emergent management strategies to provide support for patients and families and reduce unnecessary ED visits and hospitalizations, in alignment with patient/family goals, values and preferences. |
| **PALLIATIVE AND END OF LIFE CARE** | |
| 1. | Effectively manage pain and other physical and psychosocial symptoms in the home for patients with advancing chronic conditions and those near the end of life. |
| 2. | Sensitively communicate prognosis and guide planning for future medical care by leading conversations regarding Advance Directives, resuscitation guidelines, surrogate decision-makers, location of care, and limitation of additional therapies with patient and family. |
| 3. | Employ palliative and hospice care principles when making a treatment plan; engage relevant organizations as |

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| appropriate. |
| **INTERPROFESSIONAL CARE** |
| 1. Work effectively with patients, informal caregivers and interprofessional health care team professionals across care settings when making treatment plans. |
| 2. Describe the roles and responsibilities of commonly encountered team members in home care, including OT, PT, and Social Work. |
| **COMMUNICATION AND PROFESSIONALISM** |
| 1. Demonstrate the ability to teach patients, caregivers and others about their health conditions. |
| 2. Act with professionalism in all settings. |
| 3. Recognize and manage ethical issues that arise in the home setting, such as who should make decisions, when to change living arrangements (autonomy vs. safety), how to handle conflicts and how to maintain boundaries. |
| 4. Practice culturally sensitive shared decision making with patients and families/caregivers in the context of their health literacy, desired level of participation, and goals of care. |
| **COMMUNITY AND SYSTEMS BASED RESOURCES AND SUPPORTIVE CARE AND SERVICES** |
| 1. Identify the need for, refer to and collaborate with community service providers, such as support groups and those that aid with housing, personal care services, home oxygen and other durable medical equipment, meals, and transportation. |
| 2. Describe, navigate and use the different sites of care that can best manage specific patient needs, refer patients to appropriate home health and community support services to maximize ability to remain in their homes, and advocate for patients' needs when appropriate. |
| 3. Demonstrate expertise in effective transitions of care by communicating verbally or with a timely discharge summary the following: medication reconciliation, patient's cognition and function, pending medical results, advance care plans, and follow-up needs including home services. |
| 4. Describe tele-health and other e-technologies that may enable remote monitoring and assessment of patients in the home setting. |
| 5. For Pediatric patients know available community resources such as group homes, day programs, workshops and vocational training. |
| **PRACTICE MANAGEMENT** |
| 1. Specify how home care medicine is financed, including the roles of fee-for-service payments, managed care, Veterans Health Administration and Medicare/Medicaid, where applicable. |
| 2. Appropriately document and bill for visits, care plan oversight, care management, certifications, and procedures. |
| 3. Detail important elements of a house call program business plan including the role of a mission/ vision statement, the product(s)/services delivered (e.g. urgent, chronic, transitional, or concierge care), regulatory requirements, market analysis, management team/staffing and finances. |
| 4. Describe models of care and ongoing demonstration projects exploring the organization of home care services to improve outcomes, including those in the Department of Veterans Affairs, Accountable Care Organizations, and private insurers. |
| 5. Demonstrate knowledge of commonly accepted quality measures and explain the importance of reporting. |
| 6. Describe the elements of a corporate compliance program. |
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