Hospice and palliative medicine

Background

The subspecialty of hospice and palliative medicine (HPM) is the medical component of the broad therapeutic model known as palliative care. These subspecialists reduce the burden of life-threatening conditions by supporting the best quality of life throughout the course of an illness and by managing factors that contribute to the suffering of the patient and the patient’s family.

According to the Accreditation Council for Graduate Medical Education (ACGME), HPM specialists can provide the medical aspects of palliative care, in conjunction with the palliative care team, to ensure that:

➤ Pain and symptom control, psychosocial distress, spiritual issues, and practical needs are addressed with patients and families throughout the course of care.
➤ Patients and families obtain the information they need in order to understand their condition and treatment options.
➤ Care is provided within the context of a trusting and respectful physician-patient relationship.
➤ Coordination of care across settings is ensured through regular and high-quality communication among providers at times of transition or changing needs and through effective continuity of care.
➤ Both patient and family are prepared for the dying process and for death, when it is anticipated, insofar as they desire to be prepared. Opportunities for personal growth are supported, and bereavement care is available for the family.

Physicians practicing HPM have typically completed an ACGME- or American Osteopathic Association (AOA)–accredited residency as well as a 12-month ACGME-affiliated fellowship in HPM.

The American Board of Medical Specialties (ABMS) and the AOA recognize HPM as a medical subspecialty, and a large number of boards within the ABMS and the AOA now offer certification in this field, including anesthesiology, emergency medicine, family medicine, internal medicine, OB/GYN, pediatrics, physical medicine and rehabilitation, psychiatry and neurology, radiology, and surgery.

The American Academy of Hospice and Palliative Medicine (AAHPM) is a professional organization for physicians specializing in HPM. AAHPM previously issued certificates through its certifying board, the American Board of Hospice and Palliative Medicine (ABHPM).
Since a parallel certification is offered by cooperating boards within the AOA and the ABMS, ABHPM no longer issues new certificates. However, certificates already issued remain valid for their full eight-year period. During the transition from ABHPM certification to ABMS and AOA certification, the AAHPM will support the certificates previously issued by ABHPM.

### Involved specialties

Internal medicine, anesthesiology, emergency medicine, family medicine, OB/GYN, pediatrics, physical medicine and rehabilitation, psychiatry and neurology, radiology, and surgery

### Positions of specialty boards

**ABMS**

The ABMS member boards, including the American Board of Internal Medicine (ABIM), the American Board of Anesthesiology, the American Board of Emergency Medicine, the American Board of Family Medicine, the American Board of Obstetrics and Gynecology, the American Board of Pediatrics, the American Board of Physical Medicine and Rehabilitation, the American Board of Psychiatry and Neurology, the American Board of Radiology, and the American Board of Surgery, jointly developed subspecialty certification (including certificates of added qualifications) in HPM. The certification exam was first offered in 2008.

To be certified in HPM, candidates must first be certified in one of the medical specialties listed previously. Any additional requirements beyond these uniform standards can be found on each organization’s website, listed at the end of this paper.

To become certified in the subspecialty of HPM by any one of the above-mentioned ABMS-affiliated boards, physicians must meet the following uniform standards:

- Meet the board’s requirements regarding previous certification in the relevant medical specialty
- Satisfactorily complete the requisite graduate medical education fellowship training
- Demonstrate clinical competence in the care of patients
- Complete licensure and procedural requirements
- Pass the certification exam in HPM

Fellowship training taken before completing the requirements for the MD or DO degree, training as a chief medical resident, practice experience, and attendance at postgraduate courses may not be credited toward the requirements for subspecialty certification.
Candidates for certification must meet the board’s requirements for duration of training as well as minimum duration of full-time clinical training.

Clinical training requirements may be met by aggregating full-time clinical training that occurs throughout the entire fellowship training period; clinical training need not be completed in successive months. Time spent in a continuity outpatient clinic, during nonclinical training, is in addition to the requirement for full-time clinical training.

Educational rotations completed during training may not be double-counted to satisfy both internal medicine and subspecialty training requirements. Likewise, training that qualifies a diplomate for admission to one subspecialty exam cannot be double-counted toward certification in another subspecialty, with the exception of formally approved pathways for dual certification.

The training pathway for HPM certification candidates requires satisfactory completion of a 12-month HPM fellowship. HPM fellowship training undertaken after July 1, 2010, must be accredited by the ACGME. HPM fellowship training taken prior to July 1, 2010, must have been conducted within a program affiliated with an ACGME-accredited residency or fellowship program. Training experience must be consistent with guidelines established by the ACGME.

For administration of the first three examinations (2008, 2010, and 2012), diplomates who had not completed 12 months of formal fellowship training in HPM were eligible to apply for the HPM examination if, at the time of application for examination, they could demonstrate they met the requirements of one of the approved pathways:

➤ Practice Pathway A: At least 800 hours of clinical involvement in subspecialty-level practice of HPM during the past five years prior to application for examination, including:
  − At least two years of subspecialty-level practice in HPM
  − At least 100 hours of participation with a hospice or palliative care team that provides active clinical care; holds regular meetings; has regular membership of a physician, nurse, and at least one other professional from a psychosocial discipline; and operates in a context in which a substantial number of the team’s patients are near the end of life
  − Participation in the active care of at least 50 terminally ill patients or patients requiring palliative care

➤ Practice Pathway B: Documentation of certification by the ABHPM. ABHPM certificates expiring on or after December 31, 2007, are acceptable in fulfillment of Practice Pathway B requirements.
AOCCHPM

The American Osteopathic Conjoint Committee of Hospice and Palliative Medicine (AOCCHPM) represents a combined effort of the American Osteopathic Boards of Family Medicine, Internal Medicine, Neurology and Psychiatry, and Rehabilitation Medicine. AOCCHPM developed a certification of added qualifications in HPM. The certification program is designed to recognize excellence among physicians who are specialists in HPM and consists of the following two components:

➤ Satisfactory completion of training
➤ Successful performance on a comprehensive, one-day examination

A valid, unrestricted license to practice medicine in a state of the United States is required of all candidates. A photocopy of the medical license in the state of the current practice must be submitted with the application. Candidates with a restricted, suspended, or revoked license in any jurisdiction at the time of application will not be admitted to the examination or be certified.

The application must also contain substantiation of the diplomate’s satisfactory clinical competence in HPM. This substantiation must be provided by the program director in the HPM fellowship or by two references in a supervisory role over the applicant if the candidate is applying via the clinical practice pathway. One of the references must be by the CEO or director of the hospice unit where the applicant has privileges.

Candidates must be certified by their primary AOA board and must have completed a 12-month AOA-approved fellowship in HPM after July 1, 2009.

Alternately, candidates may apply via the clinical practice pathway, which expires with the 2013 examination. Candidates for the clinical practice pathway must meet the following prerequisites:

➤ 30 hours of CME in HPM over the preceding 24 months prior to application for examination.
➤ Clinical practice for a minimum of two years and ability to demonstrate that a minimum of 25% of that practice has been in the care of the terminally ill. Child neurology and child psychiatry candidates must demonstrate that a minimum of 15% of their practice has been in the care of the terminally ill.
➤ Direct participation in the active care of at least 50 terminally ill patients in the preceding three years, for whom palliative medicine was the predominant goal of care. Candidates who specialize in pediatric patients must have participated in the active care of at least 25 terminally ill and/or severely/chronically ill pediatric patients with life-limiting illness in the preceding three years.
➤ Work as a physician member of an interdisciplinary clinical care team for at least two years, including a minimum of 100 hours of active participation in team meetings that comply with the clinical practice guidelines for quality
palliative care. In lieu of this, the applicant must have served as a hospice medical director in a palliative care practice for one or more years.

➢ Verification by two palliative care medicine authorities that the applicant is an established palliative care provider physician and meets the criteria above (one of the authorities must be the CEO or director of the hospice unit where the physician has privileges).

**ABHPM**

The ABHPM was the only certifying body for HPM from 1996 through 2006. The ABHPM is no longer issuing new certificates, but certificates already issued will remain valid for their full eight-year period. Following the ABMS recognition of HPM as a new medical subspecialty, similar recognition was granted by the AOA in February 2007. As of 2008, cooperating boards within the ABMS began offering a subspecialty certificate in HPM. A parallel certification is also offered by cooperating boards within the AOA.

ABHPM diplomates who wish to continue to be certified after expiration of their ABHPM certificate will need to take the new certification examination offered by ABMS or AOA within the grandfathering period. The grandfathering period for ABMS is from 2008 to 2012, and 2009 to 2013 for AOA.

ABHPM diplomates who also hold primary certification from one of the AOA or ABMS cosponsoring boards will be eligible for the certification exam during the grandfathering period without completing a fellowship.

During the grandfathering period, ABHPM diplomates may seek eligibility to sit for the ABMS or AOA exam through the following practice pathways: Pathway A, which requires at least two years and 800 hours of clinical involvement in subspecialty-level practice of HPM during the five years prior to the application, including at least 100 hours of participation with a hospice or palliative care team and active care of at least 50 terminally ill patients (25 for pediatrics); or Pathway B, which requires prior certification by the ABHPM with an expiration date of December 31, 2008, or later.

After the grandfathering period is over, only those who complete an AOA- or ACGME-accredited HPM fellowship will be eligible to sit for the ABMS or AOA certification exam.

**Positions of societies, academies, colleges, and associations**

**AAHPM**

Through a joint effort, the AAHPM and the ABHPM achieved recognition for the subspecialty of HPM by the ABMS and AOA.
For core competencies, AAHPM refers to ACGME’s Hospice and Palliative Medicine Core Competencies.

**AOA**

According to the Basic Standards for Fellowship Training in Hospice and Palliative Care Medicine, clinical requirements for fellowship must include experience providing care for patients with palliative care medicine, with emphasis on longitudinal care in all settings including the hospital, the nursing home, home hospice, the ambulatory clinic, and the home.

The fellow must serve both as a primary care provider and a palliative care consultant, and must have experience in functioning as a member of an interdisciplinary team. Members of the interdisciplinary team must include a physician, a nurse, a social worker, a psychosocial clinician (such as a psychologist), and a chaplain or pastoral counselor. Longitudinal experiences must be at least six months in duration.

As available, fellows should complete a pediatric rotation for a minimum of one week at the pediatric hospice and palliative care medicine site under the direction of a board-certified palliative care medicine pediatrician, child/adolescent neurologist, and/or child adolescent psychiatrist; the rotation will be supervised by the hospice and palliative care program director or designee. Didactic lectures that cover the main pediatric concerns of palliative care medicine by a pediatrician, child/adolescent neurologist, or child/adolescent psychiatrist with hospice and palliative care medicine experience shall be accepted if there is no pediatric palliative care medicine service available.

Fellows should document supervised clinical experience in bereavement counseling throughout the year of training.

The resident must select one-month electives in any of the following areas: cardiology, child neurology, child psychiatry, ethics, geriatrics, HIV clinic, neurology, oncology/hematology, pediatrics, psychiatry, pulmonary medicine, or radiation oncology. Elective rotations must be a minimum of five consecutive workdays for each week of the elective. The fellow must spend at least 15% of the year providing hospice care in nursing home, home, or inpatient sites.

The fellow must see at least 100 new patients over the course of the year.

The fellow must demonstrate competence with the administration of interventional methods of palliation, including but not limited to application and maintenance of patient-controlled analgesia dosing (PCA or CAD pumps), subcutaneous or intra-articular injections, and supportive osteopathic manual
Hospice and palliative medicine techniques. The fellow must also participate in an outpatient palliative care medicine clinic, with a minimum of at least one half day a week, throughout the entire fellowship. The fellow must assume responsibility for a panel of patients. If an outpatient clinic is not available, experience in a home hospice where the fellow provides ongoing care for a panel of patients throughout the entire fellowship is acceptable.

The HPM fellowship program curriculum must address, at a minimum, the following content and skill areas:
➤ Understanding epidemiology, natural history, and treatment options for patients with serious illness and life-limiting medical conditions.
➤ History of the development of the discipline of hospice and palliative care medicine.
➤ Performance of age-appropriate comprehensive palliative care medicine assessment, including physical exam, cognitive, functional, social, psychological, and spiritual domains, using history, examination, and relevant laboratory evaluation.
➤ Assessment and management of patients in community settings such as the home, assisted living centers, inpatient hospice or respite care, and extended care facilities.
➤ Care of the dying patient, including managing terminal symptoms, patient/family education, bereavement, and organ donation.
➤ Ethical aspects of hospice and palliative care medicine.
➤ Competency in the cultural aspects of palliative care medicine, including geographic location, ethnicity, religious beliefs, and socioeconomic status.
➤ Development of enhanced communication skills, including professional discussion of diagnoses and interaction with patients, families, and colleagues. Clear communication of the treatment plan and prognosis as well as the provision of continued professional assistance and guidance are required.
➤ Scholarship, including familiarity with research methodologies enabling interpretation of the medical literature relevant to end-of-life care.
➤ Skills in quality improvement methodologies applicable to end-of-life care.
➤ Teaching skills relevant to patients, families, and students of all disciplines regarding the practice of hospice and palliative care medicine.

Fellows shall be required to complete a formal research project regarding hospice and palliative care medicine that shall incorporate the elements of research design, including development of a hypothesis, methods, statistical analysis of results, and conclusions.

Fellows must also meet the following requirements:
➤ Satisfactory completion of one of the AOA-approved participating residency training programs, and AOA board certification or eligibility
➤ Submission of an annual report, per the guidelines of the appropriate specialty college, to the specialty college based on the fellow’s primary residency
➤ Submission of a scientific paper and/or research project, suitable for publication by the AOA, pertaining to hospice and palliative care medicine, according to the requirements delineated by the fellow’s specialty college

➤ Membership in the specialty college of the fellow’s primary residency

**ACGME**

According to the *ACGME Program Requirements for Graduate Medical Education in Hospice and Palliative Medicine*, applicants for HPM certification must have completed an ACGME- or AOA-accredited residency program in anesthesiology, emergency medicine, family medicine, internal medicine, neurology, OB/GYN, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, or surgery.

The ACGME states that the duration of a fellowship program in HPM is 12 months.

Fellows must receive clinical training in a minimum of three types of locations, including:

➤ An inpatient acute care site:
  − There must be a minimum of four months or equivalent longitudinal experience in the inpatient setting, which may involve participation on a consultation team or on an inpatient unit, or both. Fellows should have patient care experiences in dedicated palliative care/hospice units.
  − The program must ensure that the inpatient setting provides access to a full range of services usually ascribed to an acute care general hospital, including availability of diagnostic laboratory and imaging services.
  − There must be access to a range of consulting physicians, including those with expertise in interventional pain management.

➤ In the community, through care in patients’ homes and in long-term care facilities:
  − The program must ensure that fellows provide a minimum of 25 hospice home visits during the fellowship year
  − All of these visits must be provided through a Medicare-certified program
  − If the hospice program does not care for children, a portion of the visits may be done through a pediatric homecare program for children with life-limiting conditions
  − The medical director of the hospice homecare program should be certified in HPM
  − Fellows should receive a long-term care experience at a skilled nursing home facility, chronic care hospital, or children’s rehabilitation center
The long-term care experience should comprise a minimum of one month or equivalent and provide access to meaningful longitudinal care of patients either on a consultation team or a hospice or palliative care unit.

Except in the case of federal institutions, the institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each facility must be consistent with those promulgated by The Joint Commission or another entity with reasonably equivalent standards.

**Ambulatory practice setting:**
- Fellows must have a supervised experience(s) in an ambulatory setting, such as an outpatient hospice clinic or day hospital, a dedicated palliative care clinic, or other ambulatory practice providing relevant palliative interventions to patients with life-threatening conditions.
- The ambulatory experience(s) should occur for at least six months of the program. Interdisciplinary care of patients must be available in the setting.

Across the three clinical settings listed above, the participation in a Medicare-certified or veteran administration hospice program must comprise at least 15% of the fellow’s time.

The program must ensure that fellows see at least 100 new patients over the course of the year. Fellows should follow 25 patients longitudinally across settings. In regard to patient care, fellows are expected to:

- **Demonstrate assessment, interdisciplinary care planning, management, coordination, and follow-up of patients with life-threatening illness**
  - The care provided will be patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
  - Fellows will provide palliative care throughout the continuum of illness while addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

- **Coordinate, orchestrate, and facilitate key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation, involving other team members as appropriate**

- **Provide care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum**

- **Recognize signs and symptoms of impending death and appropriately care for the imminently dying patient and his or her family members**

- **Provide treatment and counseling to the bereaved**

Fellows are also expected to learn the scientific method of problem solving and evidence-based decision-making and develop a commitment to lifelong learning and an attitude of caring that is derived from humanistic and professional values.
The companion document to the ACGME’s program requirements for HPM, *Core Competencies for Hospice and Palliative Medicine Fellowship Training*, is separate and distinct from the program requirements. The ACGME states that this document was developed by physician leaders within the HPM community in an effort to assist program directors in demonstrating compliance with the program requirements and to delineate the competent HPM specialist beyond the program requirements.

In the companion document, the ACGME states that fellows should:

➤ Gather comprehensive and accurate information from all pertinent sources, including the patient and his or her family members, healthcare proxies, other healthcare providers, interdisciplinary team members, and medical records

➤ Obtain a comprehensive medical history and physical exam, including:
  - Patient understanding of illness and prognosis
  - Goals of care/advance care planning-proxy decision-making
  - Detailed symptom history, including use of validated scales
  - Psychosocial and coping history, including loss history
  - Spiritual history
  - Functional assessment
  - Quality-of-life assessment
  - Depression evaluation, including stressors and areas of major concern
  - Pharmacologic history, including substance dependency or abuse
  - Detailed neurological exam, including mental status exam

➤ Correctly interpret diagnostic tests/procedures

➤ Perform appropriate diagnostic workup, review primary source information and evaluation, and determine prognosis and appropriate palliative course

➤ Utilize information technology, access online evidence-based medicine resources, and use electronic repositories of information and medical records

➤ Synthesize and apply information in the clinical setting:
  - Develop a prioritized differential diagnosis and problem list
  - Develop recommendations based on patient and family values
  - Routinely obtain additional clinical information (e.g., from other physicians, nurses, pharmacists, social workers, case managers, chaplains, or respiratory therapists) when appropriate

➤ Demonstrate use of the interdisciplinary approach to develop a care plan that optimizes patient and family goals and reduces suffering:
  - Assess and communicate prognosis
  - Appropriately assess and manage patients with the full spectrum of advanced, progressive, life-threatening conditions, including common cancers, common noncancer diagnoses, chronic diseases, and emergencies
  - Appropriately manage physical symptoms, psychological issues, social stressors, and spiritual aspects of the patient and family:
    - Assess pain and non-pain symptoms
    - Use opioid and non-opioid pharmacologic options
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- Use non-pharmacologic symptom interventions
- Manage neuropsychiatric disorders
- Effectively manage physical symptoms and psychosocial and spiritual
distress in the patient and family
- Reassess symptoms frequently and make therapeutic adjustments as
needed

➤ Coordinate, orchestrate, and facilitate key events in patient care, such as
family meetings, consultation around goals of care, advance directive comple-
tion, conflict resolution, withdrawal of life-sustaining therapies, and palliative
sedation, involving other team members as appropriate

➤ Provide care to patients and families that reflects unique characteristics of
different settings along the palliative care spectrum:
  - Perform appropriate palliative care assessment and management for the
    home visit, nursing home visit, inpatient hospice unit visit, outpatient
    clinic visit, and hospital patient visit
  - Address barriers to patient and family access to palliative care in multiple
    settings

➤ Base care on patient’s past history, patient and family preferences, goals of
care, prognostic information, evidence, clinical experience, and judgment

➤ Demonstrate the ability to appropriately respond to suffering through
addressing sources of medical and psychosocial/spiritual distress, bearing with
the patient’s and family’s suffering and distress, and remaining a presence as
desired by the patient and family

➤ Demonstrate care that shows respectful attention to age/developmental stage,
gender, sexual orientation, culture, and religion/spirituality, as well as family
interactions and disability

➤ Seek to maximize patients’ level of function and quality of life for patients
and families

➤ Evaluate functional status over time

➤ Evaluate quality of life over time

➤ Seek to preserve opportunities for individual and family life in the context of
life-threatening illness

➤ Recognize the potential value to patients and their family members of
completing personal affairs/unfinished business

➤ Effectively manage physical symptoms and psychosocial and spiritual distress
in the patient and family

➤ Provide patient and family education

➤ Recognize signs and symptoms of impending death and appropriately care for
the imminently dying patient and his or her family members:
  - Effectively prepare family, other healthcare professionals, and caregivers
    for the patient’s death
  - Provide appropriate assessment and symptom management for the
    imminently dying patient

➤ Provide appropriate information about all settings of the palliative care
continuum (acute and palliative care unit, hospital, home and inpatient
hospice, nursing home, and other community resources) to ensure smooth transitions across settings:
- Deliver timely and accurate information to patients and families about palliative care treatment settings to facilitate choices
- Help patients and families in discharge planning and decision-making
- Work effectively with interdisciplinary team members in formulating the best discharge plan for patients and families

➤ Provide treatment to the bereaved:
- Involve interdisciplinary team members in treating the bereaved
- Appropriately refer family members to bereavement programs
- Recognize the stages of bereavement
- Recognize and differentiate complicated bereavement/prolonged grief reactions from non-complicated bereavement among family members of the deceased
- Identify individuals at high risk of complicated grief
- Appreciate risk of suicide in the bereaved and carry out appropriate assessment for suicide risk in the bereaved

➤ Refer patients and family members to other healthcare professionals to assess, treat, and manage patient and family care issues outside the scope of palliative care practice and collaborate effectively with them

In regard to medical knowledge, HPM fellows should be able to do the following:
➤ Describe the scope and practice of HPM
➤ Recognize the role of the interdisciplinary team in hospice and palliative care
➤ Describe how to assess and communicate prognosis
➤ Identify what elements of the patient’s history and physical examination are critical to formulating prognosis for a given patient
➤ Describe common chronic illnesses with prognostic factors, expected natural course and trajectories, common treatments, and complications
➤ Describe effective strategies to communicate prognostic information to patients, families, and healthcare providers
➤ Recognize the presentation and management of common cancers, including their epidemiology, evaluation, prognosis, treatment, patterns of advanced or metastatic disease, emergencies, complications, associated symptoms, and symptomatic treatments
➤ Recognize the presentation and management of common noncancer life-threatening conditions, including their epidemiology, evaluation, prognosis, treatment, patterns of disease progression, complications, emergencies, associated symptoms, and symptomatic treatments
➤ Explain principles of assessing pain and other common non-pain symptoms

Fellows should be able to describe the following:
➤ Use of opioids in pain and non-pain symptom management
➤ Use of non-opioid analgesics, adjuvant analgesics, and other pharmacologic approaches to the management of both pain and non-pain symptoms
Pharmacologic approaches to the management of common non-pain symptoms

Non-pharmacologic approaches to the management of pain and non-pain symptoms:

Etiology, pathophysiology, diagnosis, and management of common neuropsychiatric disorders encountered in palliative care practice, such as depression, delirium, seizures, and brain injury

The basic science, epidemiology, clinical features, natural course, and management options for normal and pathologic grief

Common issues in the palliative care management of pediatric and geriatric patients and their families that differ from caring for adult patients in regard to physiology, vulnerabilities, and developmental stages

Ethical and legal issues in palliative and end-of-life care and their clinical management

Fellows should be able to recognize, evaluate, and support diverse cultural values and customs with regard to information sharing, decision-making, expression, and treatment of physical and emotional distress, and preferences for sites of care and death. Additionally, fellows should possess the ability to recognize the following situations and circumstances:

Common psychological stressors and disorders experienced by patients and families facing life-threatening conditions, with the ability to describe appropriate clinical assessment and management

Social problems experienced by patients and families facing life-threatening conditions, with the ability to describe appropriate clinical assessment and management

Experiences of distress around spiritual, religious, and existential issues for patients and families facing life-threatening conditions, with the ability to describe elements of appropriate clinical assessment and management

Major contributions from nonmedical disciplines, such as sociology, anthropology, and health psychology, in understanding and managing the patient’s and family’s experience of serious and life-threatening illness

Components of appropriate management for the syndrome of imminent death

Elements of appropriate care of the patient and family at the time of death and immediately thereafter

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for HPM. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”
§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

➤ Individual character  
➤ Individual competence  
➤ Individual training  
➤ Individual experience  
➤ Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners.”

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for HPM. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).
In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.” It goes on to state that this process typically includes:

➤ Developing and approving a procedures list
➤ Processing the application
➤ Evaluating applicant-specific information
➤ Submitting recommendations to the governing body for applicant-specific delineated privileges
➤ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
➤ Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

➤ The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
➤ Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
➤ Consistent application of criteria
➤ A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
➤ Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
➤ A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
➤ Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
➤ A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
➤ A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
➤ A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
➤ Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for HPM. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.
It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual, include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner’s clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialed staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for HPM. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional
liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements

➤ Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status

➤ Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that all individuals provide services only within the scope of privileges granted (MS.12, SR.4).

Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding HPM. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed.

**Minimum threshold criteria for requesting privileges in HPM**

**Basic education**: MD or DO

**Minimal formal training**: Successful completion of an ACGME- or AOA-accredited residency in a primary medical specialty and a 12-month ACGME-affiliated fellowship in HPM or the equivalent in practice experience and/or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification in HPM by the ABMS or the AOA, or current certification in HPM by the ABHPM.

**Required current experience**: Palliative medicine services for at least 50 patients during the past 36 months (with at least 16 in the past 12 months), reflective of the scope of privileges requested, or successful completion of an accredited HPM fellowship program within the past 12 months.
References

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.

Core privileges in HPM

Core privileges for HPM include the ability to admit, evaluate, diagnose, and provide primary care or consultative services to all patients with life-threatening illness who require, or may require, specialist-level palliative care services. Core privileges may include the ability to provide care to patients in the intensive care setting in conformance with unit policies. Candidates must assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges include the procedures listed on the attached privileges list and such other procedures that are extensions of the same techniques and skills.

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.

If the applicant wishes to exclude any procedures, the applicant should strike through the procedures that he or she does not wish to request, and then initial and date.

➤ Performance of history and physical exam
➤ Administration and management of palliative sedation
➤ Assessment of pertinent diagnostic studies
➤ Direct treatment and formation of a treatment plan
➤ Management of common comorbidities and complications and neuropsychiatric comorbidities
➤ Management of palliative care emergencies (e.g., spinal cord compression and suicidal ideation)
➤ Management of psychological, social, and spiritual issues of palliative care patients and their families
➤ Management of symptoms, including various pharmacologic and non-pharmacologic modalities and pharmacodynamics of commonly used agents
➤ Performance of pain-relieving procedures
➤ Provision of appropriate advanced symptom control techniques, such as parenteral infusional techniques
➤ Symptom management, including patient and family education, psychosocial and spiritual support, and appropriate referrals for other modalities, such as invasive procedures
Special noncore privileges in HPM

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence.

Reappointment

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism.

To be eligible to renew privileges in palliative medicine, the applicant must display current demonstrated competence and an adequate volume of experience (32 terminally ill or severely/chronically ill patients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

In addition, continuing education related to HPM should be required.

For more information:

Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654
Telephone: 312-755-5000
Fax: 312-755-7498
Website: www.acgme.org

American Academy of Hospice and Palliative Medicine
4700 W. Lake Avenue
Glenview, IL 60025-1485
Telephone: 847-375-4712
Fax: 847-375-6475
Website: www.aahpm.org

American Board of Anesthesiology
4208 Six Forks Road, Suite 900
Raleigh, NC 27609-5735
Telephone: 866-999-7501
Fax: 866-999-7503
Website: www.theaba.org
American Board of Emergency Medicine
3000 Coolidge Road
East Lansing, MI 48823
Telephone: 517-332-4800
Fax: 517-332-2234
Website: www.abem.org

American Board of Family Medicine
1648 McGrathiana Parkway, Suite 5560
Lexington, KY 40511-1247
Telephone: 859-269-5626
Fax: 859-335-7501
Website: www.theabfm.org

American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106
Telephone: 800-441-2246
Fax: 215-446-3590
Website: www.abim.org

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Telephone: 214-871-1619
Fax: 214-871-1943
Website: www.abog.org

American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514
Telephone: 919-929-0461
Fax: 919-929-9255
Website: www.abp.org

American Board of Physical Medicine and Rehabilitation
3015 Allegro Park Lane SW
Rochester, MN 55902-4139
Telephone: 507-282-1776
Fax: 507-282-9242
Website: www.abpmr.org
American Board of Psychiatry and Neurology
2150 East Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
Telephone: 847-229-6500
Fax: 847-229-6600
Website: www.abpn.com

American Board of Radiology
5441 East Williams Boulevard, Suite 200
Tucson, AZ 85711
Telephone: 520-790-2900
Fax: 520-790-2900
Website: www.theabr.org

American Board of Surgery
1617 John F. Kennedy Boulevard, Suite 860
Philadelphia, PA 19103-1847
Telephone: 215-568-4000
Fax: 215-563-5718
Website: www.absurgery.org

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 800-621-1773
Fax: 312-202-8200
Website: www.osteopathic.org

American Osteopathic Board of Family Physicians
330 East Algonquin Road, Suite 6
Arlington Heights, IL 60005
Telephone: 847-640-8477
Website: www.aobfp.org

American Osteopathic Board of Internal Medicine
1111 West 17th Street
Tulsa, OK 74107-1898
Telephone: 918-561-1267
Website: www.acoi.org
Hospice and palliative medicine

American Osteopathic Board of Neurology and Psychiatry
c/o American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
Telephone: 800-621-1773 or 312-202-8000
Fax: 312-202-8200
Website: www.osteopathic.org

American Osteopathic Board of Physical Medicine and Rehabilitation
142 East Ontario Street, 4th Floor
Chicago, IL 60611
Telephone: 800-621-1773, Ext. 8226
Fax: 312-202-8224
Website: www.aobpmr.org

American Osteopathic Conjoint Committee of Hospice and Palliative Medicine
Website: www.aocchpm.org
Note: For inquiries, the AOCCHPM directs individuals to the primary certification board.

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 877-267-2323
Website: www.cms.hhs.gov

DNV Healthcare, Inc.
400 Techne Center Drive, Suite 350
Milford, OH 45150
Website: www.dnvaccreditation.com
Hospice and palliative medicine

Healthcare Facilities Accreditation Program
142 East Ontario Street
Chicago, IL 60611
Telephone: 312-202-8258
Website: www.hfap.org

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 630-792-5000
Fax: 630-792-5005
Website: www.jointcommission.org

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