Transplant hepatology

Background

Transplant hepatology is the study of liver diseases and liver transplantation. Transplant hepatologists manage patients before and after transplantation and work in conjunction with transplant surgeons. They have specialized training in the management of patients with end-stage liver disease, pre- and postoperative care of transplant patients, and the use of immunosuppressive therapy.

The American Board of Internal Medicine (ABIM) offers subspecialty certification in transplant hepatology, and requires that at the time of application for certification the candidate hold certification in gastroenterology, since the subspecialty encompasses all phases of liver transplantation. After medical school, transplant hepatologists complete an internal medicine training program, a fellowship in gastroenterology, and a transplant hepatology fellowship.

The American Board of Pediatrics (ABP), in collaboration with the ABIM, offers a certificate of added qualifications in pediatric transplant hepatology. After medical school, pediatric hepatologists complete a training program in pediatrics, a fellowship in pediatric gastroenterology, and a pediatric transplant hepatology fellowship.

The American Association for the Study of Liver Diseases (AASLD) announced that it, in conjunction with the ABIM, has launched a pilot program competency-based medical education curriculum in gastroenterology-transplant hepatology training. Five pilot programs began July 1, 2012. These programs are approved by the Accreditation Council for Graduate Medical Education (ACGME).

Involved specialties

Transplant hepatologists, pediatric transplant hepatologists, internal medicine physicians, gastroenterologists, and pediatricians

Positions of specialty boards

**ABIM**

Certification in transplant hepatology was jointly developed by the ABIM and the ABP for candidates certified in gastroenterology.

At the time of application, physicians must maintain current, valid certification in gastroenterology, must satisfactorily complete the formal training
requirements, and must demonstrate clinical competence, procedural skills, and moral and ethical behavior in the clinical setting.

Practice pathways for admission to the transplant hepatology certification examination were available for the 2006, 2008, and 2010 administrations of the examination, but were discontinued after the 2010 administration of the examination. All candidates must now fulfill the requirements of the training pathway.

The training pathway requires candidates to satisfactorily complete 12 months of accredited clinical transplant hepatology training. According to the ABIM, transplant hepatology fellowship training that was credited toward the 36 months of required gastroenterology fellowship training cannot be used to fulfill requirements for admission to the transplant hepatology certification examination.

Training experience must include meaningful responsibility for perioperative care of 20 liver transplant patients in a United Network for Organ Sharing (UNOS)–approved transplant center. Training should also include performance of at least 30 percutaneous liver biopsies, including allograft; interpretation of 200 native and allograft liver biopsies; and knowledge of indications, contraindications, and complications of allograft biopsies.

**ABP**

The ABP, in collaboration with the ABIM, offers certification in pediatric transplant hepatology. Applicants must be certified in pediatric gastroenterology to be eligible to apply for the pediatric transplant hepatology certifying examination.

Fellows who entered transplant hepatology training on or after January 1, 2011, are required to complete 12 months of training in a program accredited for training in transplant hepatology by the Review Committee for Pediatrics in the United States or the Royal College of Physicians and Surgeons of Canada (RCPSC).

An applicant who entered training prior to January 1, 2011, in a nonaccredited training program must have completed a minimum of 12 months in a transplant hepatology program associated with a pediatric gastroenterology fellowship program accredited by the ACGME or RCPSC. The nonaccredited training must have been broad-based and, in general, be consistent with the clinical components outlined in the “Guidelines for Training in Pediatric Gastroenterology” developed by the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (Journal of Pediatric Gastroenterology and Nutrition 29:S1–26, 1999, or the most recent version) as they specifically relate to advanced training for the expert in pediatric hepatology, according to the ABP.

According to those guidelines, training experience must be gained at a UNOS-approved center with a qualified pediatric liver transplantation specialist and a
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qualified liver transplantation surgeon. The trainee should spend a minimum of six months on the clinical inpatient liver service, with a weekly continuity clinic for 12 months. The remaining months should consist of other hepatology or transplant-related experience, including involvement in basic or clinical transplant research. The trainee should have direct involvement in pre-, peri-, and postoperative care of at least 10 pediatric liver transplantation patients, and should have direct involvement in outpatient management of at least 20 pediatric liver transplant recipients. Fewer may be adequate or more may be necessary depending on the structure of the program and the involvement of the trainee.

Training completed as part of the fellowship program in pediatric gastroenterology cannot be used to qualify for the certification examination in pediatric transplant hepatology.

**AOBIM**

The American Osteopathic Board of Internal Medicine (AOBIM) does not publish guidelines specific to transplant hepatology. However, the AOBIM does publish information for the subspecialty certification program in gastroenterology, which can lead into transplant hepatology training and covers disorders and infections of the liver as well as liver transplantation.

According to the AOBIM, certification in gastroenterology requires satisfactory completion of three years of an American Osteopathic Association (AOA)–approved fellowship program in gastroenterology and successful performance on a written and clinical examination.

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

**AASLD**

The AASLD has announced that it, in conjunction with the ABIM, has launched a pilot program competency-based medical education curriculum in gastroenterology-transplant hepatology training. Five pilot programs began July 1, 2012. These programs are ACGME-approved.

According to the AASLD, the pilot program will assume a trainee has achieved competence in gastroenterology (which can take place in two or three years) by traditional standards. The pilot program is available to all currently ACGME-certified transplant hepatology centers.

ABIM requires that contact information for all trainees enrolled in this pilot program be submitted to the Board. Each of these candidates will be informed by the board of their enrollment in the pilot and will receive documentation that they are being granted an exception to existing ABIM training requirements that
will allow them to sit for certification in both gastroenterology and transplant hepatology upon successful completion of the pilot.

**AST**

The American Society of Transplantation (AST) does not publish any privileging guidelines for transplant hepatology.

**AOA**

According to *Specific Basic Standards for Osteopathic Fellowship Training in Transplant Hepatology*, which are an addition to *Common Basic Standards for Fellowship Training in Internal Medicine Subspecialties*, the site of training must:

➤ Be affiliated with an AOA-accredited fellowship in gastroenterology
➤ Provide the program director with adequate support for the administrative activities of the transplant hepatology subspecialty program fellowship
➤ Demonstrate that there is a culture of continuous quality improvement in the areas of patient care, patient safety, and education
➤ Demonstrate a commitment to quality patient-centered care and safety, education, research, and scholarship sufficient to support the fellowship program and share appropriate inpatient and outpatient faculty performance data with the program director
➤ Have services available from other healthcare professionals, including dietitians, language interpreters, occupational therapists, physical therapists, and social workers
➤ Provide interventional radiology facilities capable of performing balloon angioplasty and transjugular intrahepatic portal systemic shunt
➤ Have a liver transplant program that is a member in good standing of the UNOS and is affiliated with an AOA-accredited gastroenterology fellowship program
➤ Treat a population with a variety of clinical problems and stages of disease, broad age range, and sufficient number of patients available to achieve the required educational outcomes
➤ Allow for the performance of 20 liver transplantations per year for each fellow in the program

The fellowship program in transplant hepatology program must be 12 months in duration. Prior to entry into the transplant hepatology fellowship, fellows must have satisfactorily completed a three-year AOA-approved residency in internal medicine followed by a three-year AOA-approved gastroenterology fellowship.

Fellows must participate in learning activities in the following areas:

➤ Anatomy, physiology, pharmacology, pathology, and molecular virology related to the liver and biliary tract
➤ Drug hepatotoxicity and the interaction of drugs with the liver
➤ The impact of various modes of therapy and the appropriate use of laboratory tests and procedures
Transplant hepatology

- The natural history of chronic liver disease
- Factors involved in nutrition and malnutrition and their management
- Organizational and logistic aspects of liver transplantation, including the role of nurse coordinators and other support staff, organ procurement, and UNOS policies, including those regarding organ allocation
- Principles and application of artificial liver support
- Principles of donor selection and rejection
- Principles of living donor selection, including appropriate surgical, psychosocial, and ethical considerations
- Principles and practice of pediatric liver transplantation
- Transplant immunology, including blood group matching, histocompatibility, tissue typing, infection and malignant complications of immunosuppression, and indications for, contraindications for, and complications of allograft biopsies

With regards to patient care, fellows must have experience and training in the following:
- Comprehensive management of patients high on the transplant list and in the intensive care setting with complications of end-stage liver disease, including refractory ascites, hepatic hydrothorax, hepatorenal syndrome, hepatopulmonary and portal pulmonary syndromes, and refractory portal hypertensive bleeding
- Diagnosis and management of hepatocellular carcinoma and cholangiocarcinoma, including transplantation, non-transplantation, surgical, and nonsurgical approaches
- Ethical considerations relating to liver transplant donors
- Evaluation and management of both inpatients and outpatients with acute and chronic end-stage liver disease
- Management of chronic viral hepatitis in the pre-transplantation, peri-transplantation, and post-transplantation settings
- Management of fulminant liver failure
- Nutritional support of patients with chronic liver disease
- Performance of at least 30 percutaneous liver biopsies, including allograft
- Prevention of acute and chronic end-stage liver disease
- Psychosocial evaluation of all transplant candidates, particularly those with a history of substance abuse
- The use of interventional radiology in the diagnosis and management of portal hypertension, as well as biliary and vascular implications

Clinical practice in an ambulatory clinic must be incorporated within the training program, according to the AOA. The duration and time spent in the ambulatory clinic will be determined by each institution.

In regards to clinical and practical experience, the fellow must:
- Participate in primary evaluation, presentation, and discussion at selection conferences of at least 10 potential transplant candidates.
- Provide follow-up treatment for at least 20 new liver transplant recipients for a minimum of three months from the time of their transplantation.
Gain familiarity and expertise with the management of common long-term problems such as cardiovascular disease, acute and chronic kidney injury, screening for malignancies, and diagnosis and treatment of recurrent disease.

Participate in the follow-up of 20 or more liver transplant recipients who have survived more than one year after transplantation. There must be a minimum six-month follow-up period for each patient to ensure longitudinal care of transplant recipients.

Actively participate in the transplant recipients’ medical care, including management of acute cellular rejection, recurrent disease, infectious diseases, and biliary tract complications. The fellow must serve as a primary member of the transplantation team and participate in making decisions about immunosuppression.

Share with faculty patient comanagement responsibilities with transplant surgeons from the preoperative phase to the outpatient period.

Have close interactions and education with an experienced liver transplant pathologist.

Observe in one cadaveric liver procurement and three liver transplant surgeries.

Have formal instruction and clinical experience in interpretation of the following diagnostic and therapeutic techniques and procedures:
- Review of 200 native and allograft liver biopsies
- Appropriate use of ultrasound localized, laparoscopy guided, and transjugular liver biopsies

Receive formal didactic instruction in the pathogenesis, manifestations, and complications of end-stage liver disease and hepatic transplantation, including the behavioral adjustments of patients to their problems.

Participate in a multidisciplinary team to approach issues in donor selection and evaluation, and in recipient criteria.

ACGME

According to ACGME Program Requirements for Graduate Medical Education in Transplant Hepatology (Internal Medicine), the educational program in transplant hepatology must be 12 months in length.

The transplant hepatology fellowship must function as an integral part of an ACGME-accredited fellowship in gastroenterology.

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows must demonstrate competence in the following:
- Practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness
- Comprehensive management of patients high on the transplant list and in the intensive care setting with complications of end-stage liver disease, including
refractory ascites, hepatic hydrothorax, hepatorenal syndrome, hepatopulmonary and portal pulmonary syndromes, and refractory portal hypertensive bleeding

- Diagnosis and management of hepatocellular carcinoma and cholangiocarcinoma, including transplantation and non-transplantation, and surgical and nonsurgical approaches
- Ethical considerations relating to liver transplant donors, including questions related to living donors, non-heart beating donors, criteria for brain death, and appropriate selection of recipients; the evaluation and management of both inpatients and outpatients with acute and chronic end-stage liver disease
- Management of chronic viral hepatitis in the pre-transplantation, peri-transplantation, and post-transplantation settings; the management of fulminant liver failure; nutritional support of patients with chronic liver disease
- Performance of percutaneous liver biopsies, including allograft (each fellow must perform at least 30)
- Prevention of acute and chronic end-stage liver disease
- Psychosocial evaluation of all transplant candidates, in particular those with a history of substance abuse
- Use of interventional radiology in the diagnosis and management of portal hypertension, as well as biliary and vascular complications

Fellows should be knowledgeable of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. Fellows must demonstrate knowledge of the following:

- Scientific method of problem solving and evidence-based decision-making
- Indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, including the appropriate indication for and use of screening tests/procedures
- Anatomy, physiology, pharmacology, pathology, and molecular virology related to the liver and biliary tract
- Drug hepatotoxicity and the interaction of drugs with the liver
- Impact of various modes of therapy and the appropriate use of laboratory tests and procedures
- Natural history of chronic liver disease
- Factors involved in nutrition and malnutrition and their management
- Organizational and logistic aspects of liver transplantation, including the role of nurse coordinators and other support staff (including social work), organ procurement, and UNOS policies, including those regarding organ allocation
- Principles and application of artificial liver support
- Principles of donor selection and rejection (e.g., hemodynamic management, donor organ steatosis, and indication for liver biopsy)
- Principles of living donor selection, including appropriate surgical, psychosocial, and ethical considerations
➤ Principles and practice of pediatric liver transplantation  
➤ Transplant immunology, including blood group matching, histocompatibility, tissue typing, and infectious and malignant complications related to immunosuppression  
➤ Indications for, contraindications for, and complications of allograft biopsies

All 12 months must include clinical experiences and appropriate protected (block or concurrent) time for research. Fellows must participate in training using simulation. The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend.

Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. Fellows must be instructed in practice management relevant to transplant hepatology. Each fellow must participate in primary evaluation, presentation, and discussion at selection conferences of at least 10 potential transplant candidates.

Each fellow must provide follow-up for at least 20 new liver transplant recipients for a minimum of three months from the time of their transplantation, and must participate in the follow-up of 20 or more liver transplant recipients who have survived more than one year after transplantation.

Fellows must gain familiarity and expertise with the management of common long-term problems such as cardiovascular disease, acute and chronic kidney injury, screening for malignancies, and diagnosis and treatment of recurrent disease.

There must be a minimum six-month follow-up period for each patient to ensure longitudinal care of transplant recipients. Each fellow must actively participate in transplant recipients’ medical care, including management of acute cellular rejection, recurrent disease, infectious diseases, and biliary tract complications, and must serve as a primary member of the transplantation team and participate in making decisions about immunosuppression.

The fellows and faculty in the program must share patient comanagement responsibilities with transplant surgeons from the preoperative phase to the outpatient period.

The program must ensure close interactions and education with an experienced liver transplant pathologist.

Fellows must observe in one cadaveric liver procurement and three liver transplant surgeries.
Fellows must review 200 native and allograft liver biopsies, and must have formal instruction and experience in the appropriate use of ultrasound localized, laparoscopy guided, and transjugular liver biopsies.

Fellows must have formal didactic instruction in the pathogenesis, manifestations, and complications of end-stage liver disease and hepatic transplantation, including the behavioral adjustments of patients to their problems.

According to *ACGME Program Requirements for Graduate Medical Education in Pediatric Transplant Hepatology*, specific competencies include teaching and supervising liver biopsies as well as diagnostic and therapeutic endoscopy and paracentesis; managing post-transplant immunosuppression; and leading daily rounds with the liver transplant team.

Fellows must know how to care for patients that receive technical variant grafts such as living donor grafts and must demonstrate knowledge and clinical competence in:

- Management of children with chronic cholestasis, cirrhosis, and end-stage liver disease
- Management of acute liver failure including critical care management
- Diagnosis and management of metabolic liver disease, viral hepatitis, autoimmune hepatitis and sclerosing cholangitis, and drug hepatotoxicities
- The impact of chronic liver disease on growth and development in children
- Nutritional support of patients with chronic liver disease
- Knowledge of indications and strategies for liver transplantation
- Recognition of absolute and relative contraindications for liver transplantation
- Psychosocial evaluation of candidates and recipients and their families
- Primary evaluation, presentation, and discussion of potential liver transplant candidates for consideration by a multidisciplinary board
- Ethical considerations relating to liver transplant donors, including questions related to living donors, donation after cardiac death, criteria for brain death, and appropriate recipients
- Evaluation of indications for emergent reoperation or re-transplantation
- Management of opportunistic infection in the transplant recipient, including cytomegalovirus, adenovirus, fungal infection, and the spectrum of disease related to the Epstein-Barr virus, including post-transplant lymphoproliferative disease
- Prevention and management of recurrent viral hepatitis in the allograft
- Development of a knowledge base in transplant immunology, including blood group matching, histocompatibility, and tissue typing
- Recognition, evaluation, diagnosis, and treatment of acute and chronic allograft rejection
- Recognition and intervention for complications of immunosuppressive therapy
- Recognition, evaluation, and management of long-term complications of liver transplantation
Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Particularly, fellows must be able to interpret liver transplant biopsy specimens with an experienced liver transplant pathologist; must demonstrate knowledge of the indications, contraindications, complications, and interpretation of allograft biopsies; and must perform at least 15 percutaneous liver biopsies during education.

In institutions where liver biopsies are performed only by interventional radiology, arrangements should be made for fellows to work with the radiologists in order to perform the required number of biopsies under the direction of the radiologist.

In addition, the fellow should be familiar with the appropriate indications for ultrasound guided biopsies. He or she must demonstrate the ability to learn the principles of donor selection and management (e.g., hemodynamic management, indications for donor biopsy, and donor factors that increase the risk of poor graft function) through observation of at least three deceased donor liver procurements.

The fellow will evaluate living related donor (LRD) candidates and observe/participate in LRD donor/recipient procedures.

Fellows must acquire a current working knowledge of liver transplantation, including the management of pediatric patients with end-stage liver disease and management of major complications, such as nutritional complications of cholestasis and chronic liver disease, upper gastrointestinal hemorrhage, refractory ascites, hepatorenal syndrome, and hepatic encephalopathy.

Knowledge of the different methods of vascular and biliary reconstruction, the outcomes of prolonged warm and cold ischemia times, as well as familiarity with the risks and associated complications of the different operative phases, including the anhepatic phase and reperfusion, by observing at least three liver transplant procedures is required.

Fellows must also demonstrate an understanding of the organizational principles of a multidisciplinary transplant program, including the training and responsibilities of nurse coordinators, procurement coordinators, and other support staff; and must demonstrate knowledge of the current UNOS organ allocation policies and the history of the evolution of the process.

Fellows are required to complete a minimum of six months on the clinical inpatient liver service. The remaining months should consist of other hepatology or transplant-related experience, including involvement in liver transplantation research.
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There must be 12 months of weekly transplant clinic to provide continuity care to patients with liver failure or postoperative transplant patients, as well as formal instruction on the pathogenesis, manifestations, and complications of chronic liver disease, end-stage liver disease, and hepatic transplantation, including the behavioral adjustments of patients to their problems.

Positions of accreditation bodies

CMS

CMS has no formal position concerning the delineation of privileges for transplant hepatology. 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 transplant hepatology. 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 transplant hepatology. 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 transplant hepatology. 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 this transplant hepatology. 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. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.
Minimum threshold criteria for requesting privileges in transplant hepatology

Basic education: MD or DO
Minimal formal training: Successful completion of an ACGME-/AOA-accredited training program in internal medicine or pediatrics, plus successful completion of an ACGME-accredited fellowship program in gastroenterology or pediatric gastroenterology, followed by successful completion of a transplant hepatology or pediatric transplant hepatology fellowship and/or current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in transplant hepatology by the ABIM or a certificate of added qualifications by the ABP.
Required current experience: Applicants for initial appointment should demonstrate that they have provided transplant hepatology or pediatric transplant hepatology services for at least 50 patients in the previous 12 months or demonstrate successful completion of a hospital-affiliated accredited residency, clinical fellowship, or research within the previous 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 transplant hepatology

Core privileges for transplant hepatology include the ability to admit, evaluate, diagnose, consult, and manage patients of all ages with liver dysfunction or end-stage liver disease requiring liver transplantation, including participation in the selection of appropriate recipients for transplantation and donor selection, histocompatibility and tissue typing, pre- and postoperative and continuing inpatient care, the use of immunosuppressive therapy, histologic interpretation of allograft biopsies, interpretation of ancillary tests for liver dysfunction, percutaneous liver biopsy, and long-term patient care.

Reappointment

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

Applicants must demonstrate that they have maintained competence by showing evidence that they have successfully provided transplant hepatology or pediatric transplant hepatology services for at least 50 patients annually over the reappointment cycle based on the results of ongoing professional practice evaluation and outcomes. In addition, continuing medical education
related to transplant hepatology or pediatric transplant hepatology should be required.

For more information

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Telephone: 856-439-9986
Fax: 856-439-9982
Website: www.a-s-t.org

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: 800-633-4227
Website: www.cms.gov

DNV Healthcare, Inc.
1400 Ravello Drive
Katy, TX 77440
Telephone: 281-396-1000
Website: www.dnvaccreditation.com

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
Website: www.jointcommission.org

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