



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Hospice and Palliative Medicine Entrustable Professional Activities

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HPM Curricular Milestones/EPAs Workgroup

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Preamble

The Accreditation Council for Graduate Medical Education (ACGME) strives to advance the quality of resident and fellow training. With its Next Accreditation System (NAS), ACGME emphasizes a focus on practical training outcomes and introduces Entrustable Professional Activities (EPAs). EPAs are observable and measurable tasks (activities) that characterize core physician practice within a given specialty or subspecialty, entrusted to a trainee to perform without direct supervision after he or she has attained sufficient specific competence.¹

EPAs

- define physician work in a field such as Hospice and Palliative Medicine (HPM)
- require knowledge, skills, and attitudes to execute the activity
- cover one or more ACGME core competencies
- are time-limited and executable by the trainee
- offer a framework for future trainee assessments and curriculum improvement
- may result in increased curricular consistency across fellowship training programs
- are intended to help clinical supervisors with a more pragmatic training approach by defining the field-specific tasks expected of trainees.²

The American Academy of Hospice and Palliative Medicine (AAHPM) convened the HPM Curricular Milestones/EPAs Workgroup—comprising 10 practicing HPM physicians and fellowship directors representing hospice, palliative medicine, academic, community-based, adult, and pediatric perspectives from across the country—to develop EPAs. After drafting 16 initial EPAs, the workgroup employed a multiphase, iterative review process to extensively deliberate and edit each one. The workgroup solicited input about the draft EPAs from recent HPM fellowship graduates, HPM program directors during a live workshop, attendees to a general vetting session at the 2015 AAHPM & HPNA Annual Assembly, and AAHPM physician members through a survey to the field. All feedback data were systematically reviewed by the workgroup, resulting in additional revisions and addition of a 17th EPA.

Because graduate medical education, healthcare, and the field of hospice and palliative medicine continue to change and evolve, the workgroup anticipates the need for future EPA revisions. In addition, the workgroup envisions future work phases to include development of HPM curricular milestones and specific tools and strategies for assessment and evaluation.

References

1. ten Cate O. Nuts and bolts of entrustable professional activities. *J Grad Med Educ.* 2013;5(1):157-158.
2. ten Cate O, Scheele F. Competency-based postgraduate training: can we bridge the gap between theory and clinical practice? *Acad Med.* 2007;82(6):542-547.

FAQs

Why are there 17 EPAs (not more or less)?

A challenge the EPA workgroup faced was to define EPAs that were discrete enough to make them useful without creating an unmanageable number of EPAs for educators. EPAs should be observable and measurable; operationalizing this remains a challenge for the future work phases of the workgroup and for the field.

Why aren't there EPAs focused on pediatrics?

The workgroup included pediatric HPM physicians and sought to delineate EPAs that are broadly applicable to both pediatric and adult HPM-focused trainees. HPM concepts were not separated into distinct pediatric EPAs because the activities reflect fundamental learning tasks within the subspecialty regardless of the age of patients. Core pediatric concepts including developmental stages and the importance of the family in the care of the patient are incorporated into the EPAs. A comprehensive set of EPAs can serve both pediatric and adult HPM fellowship programs by ensuring that the essential aspects of caring for pediatric patients are included in the educational outcomes of all trainees.

Why isn't there an EPA focused on ethics?

An understanding of the principles and practices of clinical bioethics is essential to HPM curricula and practice. However, the workgroup presupposes that medical ethics education has been included at the undergraduate and residency level for all trainees and that bioethical training is not unique to HPM providers. Clinical bioethics is arguably an element of all 17 HPM EPAs but may be most prominent in EPAs 7, Prevent and mediate conflict and distress over complex medical decisions; 8, Manage withdrawal of advanced life-sustaining therapies; and 10, Address requests for hastened death. Although EPA 10 may be the most focused EPA, it has the potential for even broader considerations in states that allow physician assisted death. The workgroup wishes to point out that EPA 10 is specific to 'addressing the request' and should not be misinterpreted as 'hastening dying'.

Why is the term "hospice medical director" used in EPA 15?

The workgroup recognizes that HPM fellowship graduates should be competent to act as hospice medical directors by providing clinical care to and meeting the regulatory needs of a group of patients in a Medicare-certified hospice. Terminology can be confusing because individual hospice agencies may use different terms for their top or lead physician role (eg, Hospice Medical Director, Chief Medical Officer). Nevertheless, a physician providing clinical care and employed by a hospice agency is technically considered a "hospice medical director" regardless of his or her leadership status within the agency. While graduating fellows may or may not have the leadership skills required to be the lead physician of a hospice agency, they should be able to fulfill the role of a hospice medical director.

Couldn't some EPAs be combined (specifically EPAs 11 and 12)?

After consideration, the workgroup elected to keep EPAs 11, Support patients and families in the psychosocial domain, and 12, Support patients and families in the spiritual and existential domain, separate because the skills, responses, and team members' roles are typically distinct. The workgroup

highly values the role of the interdisciplinary team and the expertise brought forth by psychosocial, bereavement, and spiritual care colleagues. HPM fellow graduates should have a basic level of familiarity with the roles and expertise of interprofessional team members because it affords better interdisciplinary collaboration. Moreover, graduates should have a basic level of competence in these domains to address patient and family needs in emergency situations or when interprofessional colleagues are not available.

Why isn't there a "family meeting" EPA?

Through careful consideration and consensus, the workgroup opted to forgo an EPA specifically focused on family meetings for two main reasons. First, a family meeting EPA currently exists for other fields (eg, Geriatrics and Internal Medicine) and is not unique to HPM. The workgroup agrees that facilitating family meetings should be a basic palliative care skill set for all healthcare providers. Second, the workgroup concluded that the family meeting is a tool or a means to achieve a more specific entrustable activity such as 4, Estimate and communicate prognosis; 5 Establish goals of care; or 7, Prevent and mediate conflict and distress. Thus, facilitating a family meeting is integrated as a skill component of several EPAs.

Why aren't there more EPAs specifically about communication?

Like other topics considered, communication is ubiquitous to successful medical practice in all fields of medicine, not just HPM. Rather than try to capture "communication" in its many forms and conceptualize it as a discrete and separate EPA, the workgroup favored infusing specific communication skills throughout the EPA set. The current list of EPAs attempts to break down the domain of communication into its measurable parts (eg, 4 Estimate and communicate prognosis; 5, Establish goals of care; and 7, Prevent and mediate conflict and distress). The knowledge, skills, and attitudes required for each EPA typically include communication components.

How do the EPAs relate to ACGME HPM Reporting Milestones?

Through a consensus process with other American Board of Internal Medicine subspecialties, HPM adopted the Internal Medicine Subspecialty Reporting Milestones (RMs), though they are not customized to the specific work of HPM. The HPM EPAs and the upcoming development of HPM Curricular Milestones will be more specific to curricular content and evaluation for HPM. Because the overlap between HPM EPAs and the HPM RMs may be challenging to identify on a practical fellow training level, the workgroup created the attached matrix (Figure) as a suggested guide. The workgroup acknowledges variability in potential interpretation of the HPM EPA-RM relationships. As a result, the matrix denotes two approaches: an expansive/inclusive version (showing most of the RMs that may be relevant for a given EPA) and a narrow/limited view (showing the more relevant RMs for a given EPA). Fellowship programs may wish to modify the matrix further.

Hospice & Palliative Medicine EPA Title: EPA 1. Provide comprehensive pain assessment and management for patients with serious illness.

Detailed Description: HPM physicians lead and collaborate with an interdisciplinary team (IDT) approach to effectively manage complex pain in the context of serious illness using pharmacologic and nonpharmacologic approaches.		
List specific	Knowledge	<ul style="list-style-type: none"> • Explain the pathophysiology of pain across the age spectrum, from pediatrics to geriatrics. • List components of a detailed pain assessment, including developmentally appropriate screening and assessment tools. • Explain the domains of whole-patient assessment and their potential impact on reported physical pain (total pain). • Describe the pharmacokinetics, pharmacodynamics, and potential adverse effects of opioids and nonopioid pain medications to achieve proportionate symptom control. • Describe safe opioid-prescribing practices such as use of the Opioid Risk Tool (ORT), pain contracts, appropriate storage and disposal, risk evaluation and mitigation strategies (REMS), state and local regulations, and aberrant behaviors associated with misuse. • List nonpharmacologic approaches to manage pain. • List procedural approaches (along with referral services) to manage pain. • Describe relative costs of medications and other therapies to treat pain.
	Skills	<ul style="list-style-type: none"> • Perform a comprehensive pain assessment, including all domains of suffering. • Collaborate with the IDT and other providers to optimally manage pain. • Utilize appropriate diagnostic workup and interpretation of diagnostic tests. • Develop and implement plans to provide comprehensive pain management for the full spectrum of pain syndromes. • Recognize and manage adverse effects of medications and other therapies. • Communicate treatment plans clearly to individual patients, their families, and healthcare providers. • Implement safe opioid-prescribing practices. • Demonstrate cost-effective care.
	Attitudes	<ul style="list-style-type: none"> • Appreciate the important, urgent nature of pain management. • Recognize the necessity of managing physical suffering to allow patients to better address other domains of suffering and improve quality of life. • Appreciate the complex interplay between physical and other domains of suffering and the role of the IDT.



11.03.15 HPM EPAs. Developed by HPM Curricular Milestones/EPAs Workgroup (Laura J. Morrison, MD FAAHPM; Lindy H. Landzaat, DO; Michael David Barnett, MD MS; Gary T. Buckholz, MD FAAHPM; Jillian L. Gustin, MD FAAHPM; Jennifer M. Hwang, MD MHS; Stacie K. Levine, MD FAAHPM; Tomasz Okon, MD; Steven “Skip” Radwany, MD FAAHPM; Holly B. Yang, MD MSHPEd HMDC FAAHPM FACP) with funding from AAHPM. ©2015 American Academy of Hospice and Palliative Medicine. All rights reserved.

Hospice & Palliative Medicine EPA Title: EPA 2. Provide comprehensive nonpain symptom assessment and management for patients with serious illness.

Detailed Description: HPM physicians lead and collaborate with an interdisciplinary team (IDT) to effectively manage complex nonpain symptoms, including but not limited to anorexia, constipation and diarrhea, delirium, dyspnea, fatigue, nausea and vomiting, depression, and anxiety using pharmacologic and nonpharmacologic treatments.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe the pathophysiology of common symptoms in serious illness across the age spectrum, from pediatrics to geriatrics. Describe diagnostic methods necessary for optimal symptom assessment. List developmentally appropriate nonpain symptom screening and assessment tools. Identify pharmacologic and nonpharmacologic treatments for nonpain symptoms using the current evidence base in palliative medicine. Recognize the expected benefits, burdens, and relative costs of various treatment modalities and medications.
	Skills	<ul style="list-style-type: none"> Perform a thoughtful, comprehensive, and systematic symptom assessment using validated scales or tools when appropriate. Demonstrate appropriate diagnostic workup and interpretation of test results. Use evidence-based nonpharmacologic and pharmacologic therapies and adjust treatment plan based on results and side effects. Make appropriate referrals to other specialists and members of the IDT to assist with symptom management. Communicate treatment plans clearly to patients, families, and healthcare providers. Demonstrate cost-effective care.
	Attitudes	<ul style="list-style-type: none"> Appreciate the important, urgent nature of nonpain symptom management. Recognize the value of input from multiple disciplines in addressing challenging nonpain symptoms. Appreciate the importance of symptom management in diminishing suffering and improving quality of life. Maintain a supportive presence for the suffering that comes with intractable symptoms.



Hospice & Palliative Medicine EPA Title: EPA 3. Manage palliative care emergencies.

Detailed description: HPM physicians anticipate, prepare for, and respond to palliative care emergencies in partnership with the patient, caregivers, and medical team while taking into account the patient’s goals of care and prognosis.		
List specific	Knowledge	<ul style="list-style-type: none"> Define and list palliative care emergencies characterized by a high symptom burden and decreased quality of life. These may include medical, surgical, psychiatric, and iatrogenic emergencies as well as severe psychosocial crises for patients and/or families/caregivers. Describe the risk factors and pathophysiology of specific palliative care emergencies. Identify various modalities to decrease symptom burden and/or modify underlying pathology that can be implemented in each emergency.
	Skills	<ul style="list-style-type: none"> Anticipate, recognize, and proactively consider risk mitigation strategies for all categories of palliative care emergencies. Use an interdisciplinary approach to identify, prepare for, and provide comprehensive management of palliative care emergencies. Demonstrate judicious and rapid escalation of palliative therapies proportional to the degree of distress and suffering. Provide support to patients and/or families including prognostication and reassessment of goals of care before, during, and after a palliative care emergency. Demonstrate a supportive presence for patients, caregivers, and staff, especially when managing an “unfixable” emergency.
	Attitudes	<ul style="list-style-type: none"> Embrace the responsibility of identifying palliative care emergencies and expeditiously acting on them. Appreciate the emotional impact of preparing for, witnessing, and managing emergencies for patients, families, medical teams, and palliative care providers. Recognize that competent management of palliative care emergencies decreases suffering and may improve quality of life.



Hospice & Palliative Medicine EPA Title: EPA 4. Estimate and communicate prognosis to aid medical decision-making.

Detailed Description: HPM physicians estimate, communicate, and consider prognosis while acknowledging uncertainty as they facilitate shared decision making and delineate goals of care based on patient and/or family values.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe prognostication in serious illness, identifying elements of history, physical exam, and diagnostic testing important to determining prognosis. List current prognostic methods and tools and the strengths and weaknesses of each approach. Describe techniques for communicating prognosis and medical uncertainty across the age spectrum, from pediatrics to geriatrics.
	Skills	<ul style="list-style-type: none"> Perform a thoughtful, comprehensive, and systematic palliative care assessment taking into account disease process, comorbidities, disease trajectory, psychosocial support, and available treatments. Use relevant evidence-based prognostic tools to help create a prognostic estimate when appropriate. Obtain and integrate prognostic estimates from other healthcare providers. Determine hospice eligibility based on a prognostic estimate. Assess patient and/or family interest in knowing prognostic information and explore the specific reasons for preferences, including cultural and/or spiritual influences. Assess and communicate disease trajectory, expected function, and prognosis to patients, families, and other healthcare providers. Acknowledge and express uncertainty. Direct a family meeting when necessary to help communicate prognosis and aid medical decision making.
	Attitudes	<ul style="list-style-type: none"> Appreciate the importance of prognosis in medical decision making and the weight of prognosis for all involved. Appreciate the challenge of uncertainty in prognostication across various patient populations.



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Hospice & Palliative Medicine EPA Title: EPA 5. Establish goals of care based on patient and/or family values and specific medical circumstances.

Detailed Description: HPM physicians elicit patient and/or family values, delineate goals of care based on patient and/or family values in the context of the patient’s medical condition, and make recommendations for an appropriate care plan.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe prognostication in serious illness. Recognize techniques for communicating prognosis and medical uncertainty. Explain and differentiate essential elements of assessing decision-making capacity across the age spectrum. Identify techniques for engaging patients and family members in discussion and conflict resolution. Relate patient- and family-centered communication to delineation of goals of care, particularly in the determination of patient and/or family values. Describe the benefits and burdens of various medical therapies. Differentiate curative versus palliative intent of treatments. Define the concurrent care model which allows for coexisting curative and palliative goals of care in pediatric hospice and other similar settings.
	Skills	<ul style="list-style-type: none"> Perform a thoughtful, comprehensive, and systematic palliative assessment, taking into account disease process, comorbidities, characteristic symptom burden, and disease trajectory, together with input from other healthcare providers. Direct a family meeting to help set goals of care, communicate prognosis, reframe hope, and express uncertainty. Use a framework approach to give serious news or medical information, attending to emotion from the patient, family and other healthcare providers. Establish the patient’s definition and determinants of quality of life. Utilize the interdisciplinary team to explore and clarify patient and/or family values. Provide recommendations for medical care based on patient and/or family values and goals. Discuss withdrawal of medical therapies such as artificial hydration and nutrition, antibiotics, anticoagulation, or other medications based on goals of care. Work toward consensus among patients, families, and healthcare providers. Assist with conflict resolution between patients, families, and other healthcare providers. Guide patients, families, and healthcare providers through the shifting transitions between curative and palliative care. Introduce hospice care when appropriate based on overall prognosis.
	Attitudes	<ul style="list-style-type: none"> Appreciate the importance of determining and communicating prognosis to aid medical decision making. Respect individual patient and/or family differences in hopes and values related to serious illness. Anticipate the full spectrum of patient and family responses to goals of care discussions.



Hospice & Palliative Medicine EPA Title: EPA 6. Participate as a member or leader of an interdisciplinary team.

Detailed Description: HPM physicians manage the medical care provided by interdisciplinary teams (IDTs) and facilitate IDT meetings while sharing the leadership role with other IDT members as appropriate.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe concepts of team processes and development and recognize elements that promote or hinder successful IDT function. Discuss the professional skill set, expertise, role, and potential contribution of each member of the interdisciplinary team.
	Skills	<ul style="list-style-type: none"> Lead and/or facilitate recurring IDT meetings. Evolve one’s own communication style with colleagues to optimize team function within and outside of IDT meetings. Accept and solicit insights from all IDT members in developing a patient care plan. Monitor and facilitate team function including managing distress and supporting resilience. Provide and accept feedback from IDT members. Help to develop the care plan and/or provide care to patients and families as a member of an IDT.
	Attitudes	<ul style="list-style-type: none"> Respect the unique contributions of each member of the IDT and the impact of each member on team function. Recognize the need to address all palliative care domains in the development of an effective care plan. Facilitate openness, receptivity, mutual respect, and trust among IDT members.



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Hospice & Palliative Medicine Title: EPA 7. Prevent and mediate conflict and distress over complex medical decisions.

Detailed Description: HPM physicians prevent and address clinical conflict, uncertainty, emotionally charged encounters, and value-laden suffering through advanced palliative communication techniques.

List specific	Knowledge	<ul style="list-style-type: none"> Describe treatment options and prognosis; indicators and impact of patient, family, provider, and team distress; and ethical and legal implications of decisions. Recall and understand the situations and decisions that lead to clinical conflict.
	Skills	<ul style="list-style-type: none"> Acknowledge and negotiate contentious clinical situations. Identify, recognize sources of, and formulate a differential diagnosis for the conflict, engaging the assistance of the interdisciplinary team as needed. Identify and attend to strongly expressed opinions and emotions; help to de-escalate situations in which conflict intensifies. Attend to the emotional and physical safety of providers, patients, and families in conflict situations. Mediate disagreements regarding care plans using compassion and realistic expectations. Address current or anticipated grief among patients, families, providers, and teams, especially as it pertains to clinical decision making. Elucidate and address the ethical and legal implications of difficult decisions to be made when disagreement exists. Address conflict in a step-wise process (recognition, preparation, identification of involved/violated core concerns, exploration, reframing, alliance, support, and compromise) with the assistance of the team as needed. Direct a family meeting to help address conflict and distress when necessary.
	Attitudes	<ul style="list-style-type: none"> Demonstrate openness to patient and family preferences. Display commitment to meeting patient needs while preserving provider integrity. Exhibit self-awareness of personal values, how they might conflict with others' values, and how they impact conflict mediation. Demonstrate openness to identifying one's own strong positive and/or negative feelings. Reflect on negative emotions in oneself and one's patients over time. Exhibit compassion for all disciplines and specialties involved in difficult patient-care situations. Display humility regarding one's own clinical judgment and openness to other opinions in charged clinical situations.



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Hospice & Palliative Medicine EPA Title: EPA 8. Manage withdrawal of advanced life-sustaining therapies.

<p>Detailed Description: HPM physicians manage the withdrawal of advanced life-sustaining therapies (LSTs), including facilitation of goals of care discussions leading to the decision to withdraw advanced LST, management of symptoms before and after withdrawal of advanced LST, orchestration of withdrawal of LST, and provision of family support for psychosocial and spiritual distress including anticipatory grief and bereavement.</p>		
List specific	Knowledge	<ul style="list-style-type: none"> Describe the federal, state, and local laws that impact the withdrawal of advanced LST. Give examples of ethical principles relevant to the withdrawal of advanced LST. Discuss local institutional policies relevant to the process of withdrawal of advanced LST. Explain the process of withdrawal of various advanced LSTs. Describe the symptom burden and appropriate interventions associated with withdrawal of common advanced LSTs. Discuss the signs and symptoms of impending death after withdrawal of advanced LST. Identify the potential types of psychosocial and spiritual distress around withdrawal of advanced LSTs, including anticipatory grief and bereavement responses from families.
	Skills	<ul style="list-style-type: none"> Facilitate discussions with patients and/or families regarding goals of care and preparation for withdrawal of advanced LST. Diagnose and manage symptom burdens associated with withdrawal of advanced LST. Orchestrate withdrawal of advanced LST. Attend to psychosocial and spiritual distress including anticipatory grief and bereavement responses from families. Utilize the interdisciplinary team (IDT) to support both the patient and family before, during, and after the withdrawal of LST. Demonstrate care that shows respectful attention to sociocultural characteristics of patients and their families. Demonstrate high standards of ethical behavior including utilizing the IDT, maintaining professional boundaries and scope of practice, and collaborating with other involved physicians and healthcare providers.
	Attitudes	<ul style="list-style-type: none"> Appreciate the need to attend to unique characteristics and needs of patients, their families, and healthcare providers. Value the key roles of IDT members, collaboration with colleagues, and maintenance of professional boundaries in withdrawal of LST. Appreciate the potential gravity of decisions to withdraw LST. Accept that personal experiences and the specific microculture of the care setting can contribute to bias, which can impact the recommendation to withdraw LST.



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Hospice & Palliative Medicine EPA Title: EPA 9. Care for imminently dying patients and their families.

Detailed Description: HPM physicians identify signs of the dying process, address multiple areas of suffering for the imminently dying patient and their family and facilitate after-death bereavement support for the family and healthcare providers.

List specific		
	Knowledge	<ul style="list-style-type: none"> Describe the physical signs and symptoms of the dying process and common challenges for symptom management. List medications used to treat symptoms of impending death and explain their mechanisms of action. Describe areas of whole-patient care as it relates to caring for the imminently dying patient. Recognize roles and skills of interdisciplinary team members needed to achieve whole-patient care. Describe communication techniques to provide psychosocial support. Recall and explain the range of potential indications for proportionate symptom control, which could include sedation. Describe ethical principles and how they do or do not apply to end-of-life care. Identify the characteristics of normal and complicated grief and bereavement. List medical conditions that require medical examiner involvement and requisite steps of sensitive death pronouncement and documentation.
	Skills	<ul style="list-style-type: none"> Recognize the imminently dying patient and associated signs and symptoms. Facilitate communication to prepare family and healthcare providers that death is imminent. Utilize an interdisciplinary team approach to provide whole-patient care for the imminently dying patient and their family. Provide psychosocial support to family and healthcare providers regarding common concerns, identify family members at risk for complex bereavement, and have patience and understanding for different coping and grieving styles. Recognize different perspectives of family and healthcare providers regarding the degree of symptom burden during the dying process. Manage physical symptoms of impending death. Inquire if spiritual or cultural rituals are important and provide assistance as appropriate. Make the death pronouncement in a sensitive, respectful way in the presence of family. Document the patient's death and complete the death certificate appropriately.
	Attitudes	<ul style="list-style-type: none"> Appreciate the importance and time sensitivity in providing care for the imminently dying patient and their family. Acknowledge the uniqueness of the dying experience for each patient and family. Value the potential positive impact of effective interdisciplinary care on family bereavement. Recognize the importance of role modeling and teaching sensitive, skilled care of the dying patient to other care providers.



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Hospice & Palliative Medicine EPA Title: EPA 10. Address requests for hastened death.

<p>Detailed Description: HPM physicians address requests for hastened death in accordance with federal, state, and local regulations as well as ethical and professional principles while remaining sensitive to a patient's individual values, preferences, and sources of suffering.</p>		
List specific	Knowledge	<ul style="list-style-type: none"> Identify and summarize the federal and state laws, local regulations, and professional guidelines applicable to requests for hastened death. Demonstrate broad knowledge of epidemiology and etiologies of requests for hastened death. Elucidate a physician's clinical, ethical, and professional responsibilities when faced with requests for hastened death. List and explain bioethical models relevant to requests for hastened death.
	Skills	<ul style="list-style-type: none"> Explore the full range of potential motivations in requests for hastened death using a routine and comprehensive approach. Communicate and counsel the patient about total pain, and provide state-of-the-art palliative therapies to manage total pain by addressing all aspects of suffering with time-limited trials. Explore the patient's fears and expectations and facilitate establishing individual goals when hastened death is requested. Maintain meticulous, interdisciplinary records of requests for hastened death.
	Attitudes	<ul style="list-style-type: none"> Appreciate the importance of the federal and state laws, local regulations, and professional guidelines related to requests for hastened death. Remain mindful of the limits of medicine and a physician's ability to relieve suffering. Seek awareness of and be willing to balance one's own and others' fundamental values regarding requests for hastened death. Be open to consideration of competing claims to safeguard human life and individual autonomy, and be prepared to reconsider previous opinions in light of new evidence or arguments.



11.03.15 HPM EPAs. Developed by HPM Curricular Milestones/EPAs Workgroup (Laura J. Morrison, MD FAAHPM; Lindy H. Landzaat, DO; Michael David Barnett, MD MS; Gary T. Buckholz, MD FAAHPM; Jillian L. Gustin, MD FAAHPM; Jennifer M. Hwang, MD MHS; Stacie K. Levine, MD FAAHPM; Tomasz Okon, MD; Steven "Skip" Radwany, MD FAAHPM; Holly B. Yang, MD MSHPEd HMDC FAAHPM FACP) with funding from AAHPM. ©2015 American Academy of Hospice and Palliative Medicine. All rights reserved.

Hospice & Palliative Medicine EPA Title: EPA 11. Support patients and families in the psychosocial domain.

Detailed Description: HPM physicians address patient and family suffering, coping, and healing within the emotional, psychological, and social domains with focused, developmentally appropriate assessment followed by targeted communication, interventions, and referrals.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe approaches to developmentally appropriate assessment for coping, stressors, grief and bereavement, suffering, and behavioral health comorbidities. Identify techniques for expressing empathy. Describe how issues involving cultural sensitivity and diversity affect access to and utilization of hospice and palliative care. Discuss benefits, burdens, and risks for the caregiver role. Identify specific roles, expertise, and supportive interventions that individual team members, especially psychosocial clinicians, can provide in support of patients and families. List potential referrals and additional resources in various clinical settings.
	Skills	<ul style="list-style-type: none"> Elicit a focused, developmentally appropriate psychosocial history, tailored to each patient and family. Assess for coping, stressors, grief and bereavement, suffering, behavioral health comorbidities, and caregiver burden. Provide basic counseling, empathetic response, and cultural sensitivity in supporting expressions of distress. Develop appropriate patient- and family-centered assessments, communication, and care plans with the interdisciplinary team (IDT), especially psychosocial clinicians when available. Mobilize additional resources, make referrals, and navigate the healthcare system to meet patient and family needs.
	Attitudes	<ul style="list-style-type: none"> Appreciate the contribution of the psychosocial domain to patient and family coping, suffering, resilience, healing, well-being, and bereavement. Value the expertise of IDT members in formulating assessments and care plans for patient and family support. Prioritize developmentally appropriate and culturally sensitive patient and family care.



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Hospice & Palliative Medicine EPA Title: EPA 12. Support patients and families in the spiritual and existential domain.

Detailed Description: HPM physicians address patient and family suffering and identify strengths and needs within the spiritual and existential domain with basic assessment followed by appropriate interventions and referrals.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe approaches to screening and basic history taking of spirituality, religion, existential issues, and issues of meaning and purpose. Discuss types and causes of spiritual distress. Identify interventions the physician and/or interdisciplinary team (IDT) can provide depending on patient, family, and team composition and characteristics. Distinguish expertise that individual team members, especially chaplains, can provide in support of patients and families. List potential referrals and additional resources in various clinical settings.
	Skills	<ul style="list-style-type: none"> Provide compassionate presence and listening. Offer open, empathetic response to spiritual and existential suffering. Take a basic spiritual history tailored to each patient and family. Explore how patient and family spiritual, religious, and existential beliefs and values affect medical decision making and the provision of health care. Inquire about and support patients' and families' end-of-life spiritual and/or religious practices and rituals. Assist the IDT in identifying and promoting a sense of meaning and purpose and creation of legacy. Develop appropriate patient- and family-centered assessments and care plans with the IDT, especially the chaplain when available. Engage community clergy and, when appropriate, mobilize additional resources, make referrals, and navigate through the healthcare system to effectively meet patient and family needs.
	Attitudes	<ul style="list-style-type: none"> Appreciate the contribution of the spiritual and existential domain to patient and family coping, suffering, resilience, healing, well-being, and bereavement. Respect patients' and families' spiritual, religious, and existential beliefs even if these beliefs and values contradict one's own beliefs and values. Value expertise of IDT members in formulating assessments and care plans for patient and family support. Be open to working with spiritual providers of diverse backgrounds and belief systems.



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Hospice & Palliative Medicine EPA Title: EPA 13. Promote self-care and resilience.

Detailed Description: HPM physicians value and promote resilience and personal well-being for themselves and others as a necessary element for professional success and sustainability.

List specific	Knowledge	<ul style="list-style-type: none"> • Discuss the potential impact from personal and professional losses on oneself and others. • Give examples and describe features of burnout, moral distress, compassion fatigue, depersonalization, inefficacy, and vicarious trauma. • Recall factors that predispose individuals and teams to stress and burnout. • Describe strategies to mitigate physical and emotional exhaustion, foster professional and personal growth and identity, promote compassion and equanimity, and strengthen resilience.
	Skills	<ul style="list-style-type: none"> • Develop awareness of one’s own subjective experience and the work environment in order to achieve balance with the needs of patients and their families. • Remain present to suffering of others and maintain resilience when experiencing one’s own distress and/or grief. • Develop practices that promote regular reflections toward growth and self-care. • Recognize risks for and features of excessive stress, impairment, and impending burnout in oneself and others. • Utilize self-care tools and engage in strategies to mitigate physical and emotional exhaustion, cynicism, and inefficacy.
	Attitudes	<ul style="list-style-type: none"> • Appreciate the importance of and professional responsibility to attend to self-care. • Value the need for balance around resilience and grief/bereavement. • Promote highly present, boundary-conscious, empathetic engagement. • Role model and encourage effective self-care for others.



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Hospice & Palliative Medicine EPA Title: EPA 14. Facilitate transitions across the HPM continuum of care.

<p>Detailed Description: HPM physicians care for patients and families across the healthcare continuum (eg, inpatient, long-term care, ambulatory, home) with an understanding of and appreciation for resource availability, care coordination, and transitions support required for effective and high-quality care.</p>		
<p>List specific</p>	<p>Knowledge</p>	<ul style="list-style-type: none"> • Describe various settings in which patients and families may access palliative care. • Discuss common characteristics of interdisciplinary team (IDT) resources and staffing available in different settings to meet patient and family needs around acuity and distress. • Identify the range of diagnostic approaches and therapies that can be maintained in various care settings. • Define systems-based reimbursement and payment structures, eligibility requirements, and key regulations in different care settings. • Recognize potential gaps in care as patients transition between settings, including communication between providers, medication reconciliation, treatments, and emotional support for patients and families.
	<p>Skills</p>	<ul style="list-style-type: none"> • Select and dose medications based on accessibility and availability of route of administration within and across care settings. • Initiate and adjust medical interventions germane to specific care settings. • Communicate with IDT, primary service, consultants, and other providers within and across care settings. • Assess appropriateness of patients for specific care settings, clarifying necessary and available resources, and constructing transition plans that incorporate patient safety while aligning with patient and family goals. • Provide guidance for smooth transitions across settings for patients, families, and providers that address medical, pharmaceutical, social, emotional, and spiritual concerns.
	<p>Attitudes</p>	<ul style="list-style-type: none"> • Recognize challenges to patients, families, and providers in confronting differing formularies and costs of treatments across the continuum. • Appreciate the culture and structure of each care setting and the need to work with their strengths and limitations to best meet patient and family goals. • Recognize that care teams have their own values regarding care settings, which may influence their recommendations. • Appreciate the roles of different healthcare team members in various care settings. • Empathize with patient and family distress surrounding times of transition between care settings.



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Hospice & Palliative Medicine EPA Title: EPA 15. Fulfill the role of a hospice medical director.

Detailed Description: HPM physicians meet the clinical, regulatory, administrative, and supportive responsibilities of a hospice medical director.		
List specific	Knowledge	<ul style="list-style-type: none"> Describe hospice eligibility guidelines for common medical conditions, and pediatric patients, including concurrent care models. Identify specialty-level pain and symptom management expertise specific to the unique settings and requirements for hospice care. Discuss hospice regulatory requirements. Explain how hospice integrates into local, regional, and national health care. Monitor and identify financial issues affecting hospice programs, including public and private reimbursement and payment structures and philanthropy. Outline the appeals process for denied claims.
	Skills	<ul style="list-style-type: none"> Provide hospice care to patients and families across diverse settings: home, long-term care, and inpatient hospice. Facilitate a hospice interdisciplinary team (IDT) meeting. Comply with regulatory requirements and documentation including Certification of Terminal illness, Face to Face, etc. Provide leadership, education, and support to hospice IDT members. Manage medications with formulary restrictions. Work with hospice patients' primary- and specialty-care providers. Engage pediatric palliative care resources to serve pediatric hospice patients. Work telephonically with hospice staff, patients, and families in critical situations. Ensure the safety of oneself and staff when working in challenging environments.
	Attitudes	<ul style="list-style-type: none"> Respect the skills and knowledge of diverse disciplines working to help patients and families. Appreciate the diverse cultural, socioeconomic, and ethnic backgrounds of patients. Display openness to collaboration and teamwork.



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Hospice & Palliative Medicine EPA Title: EPA 16. Provide HPM consultation and team support.

Detailed Description: HPM physicians render patient- and family-centered consultative care in a professional, timely, and effective manner that supports and educates the referring and invested team members.		
List specific	Knowledge	<ul style="list-style-type: none"> • Recognize the roles of different interdisciplinary team members. • Identify appropriate indications for palliative care consultation. • Describe elements of consultation etiquette. • Recognize that comprehensive care of a patient routinely involves attention to physical, emotional, psychosocial, and spiritual elements. • Identify indicators of provider distress. • Recognize the dual and sometimes conflicting roles of patient/family advocate and consultant.
	Skills	<ul style="list-style-type: none"> • Gather and synthesize essential and accurate information relevant to the consult, including clarification of the consultation question when needed. • Introduce and clarify the role of palliative care and hospice. • Perform a palliative medicine-focused history and physical. • Use available evidence to construct a palliative care assessment and management plan. • Seek answers to outstanding patient, family, and clinical questions that arise in the course of consultation. • Seek to understand, maintain rapport, and advocate for patient and family goals when healthcare providers have conflicting views. • Respond to provider distress with empathy. • Communicate recommendations to patients, families, and referring providers and document these in the patient’s medical record in a time-sensitive and effective manner. • Engage the strengths and skills of IDT members. • Support other teams in developing their palliative care skills.
	Attitudes	<ul style="list-style-type: none"> • Exemplify professional and ethical behavior. • Appreciate evidence-based medicine. • Welcome and incorporate feedback from referring teams. • Value patient advocacy. • Show concern for provider and team well-being and needs. • Appreciate the relationship between consultation etiquette and future referrals.



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Hospice & Palliative Medicine EPA Title: EPA 17. Promote and teach hospice and palliative care.

Detailed Description: HPM physicians promote access to high-quality palliative care services across the continuum of care through advocacy and health system improvement as well as by teaching hospice and palliative care to other healthcare providers.

List specific	Knowledge	<ul style="list-style-type: none"> Describe the value and role of palliative and hospice care accounting for diversity of learning needs, backgrounds, learning styles, and education levels among patients, families, community members, and others. Identify educational needs of interprofessional colleagues, administrators, medical staff, peers, and others regarding the basics of hospice and palliative care for all healthcare providers. Describe the key roles of specialty HPM in the healthcare delivery system. Describe how to integrate quality improvement activities into the routine function of palliative and hospice programs.
	Skills	<ul style="list-style-type: none"> Demonstrate the ability to critically appraise, disseminate, and apply palliative care literature. Advocate for palliative care program development within systems. Promote hospice and palliative care education within healthcare systems/organizations. Identify key stakeholders in local and system-level healthcare improvement efforts. Deliver a succinct message to both community and professional audiences about the importance of hospice and palliative care for optimal patient care. Adapt different teaching formats based on the setting, content, and learners. Analyze clinical performance data and actively work to improve performance. Model lifelong learning in palliative care.
	Attitudes	<ul style="list-style-type: none"> Appreciate that basic palliative care skills are an essential competency for all health professionals. Recognize the responsibility to serve as a palliative care educator to patients, families, and the community. Appreciate the need to use meaningful metrics for hospice and palliative care program development. Value advocacy (local, regional, national) as a means to improve quality health care for patients and families. Remain open to feedback at the individual, programmatic, and system level. Value quality improvement as a tool to grow and improve palliative care programs.



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Figure: Matrix of Relevant HPM Reporting Milestones for Each HPM EPA

Matrix developed by the AAHPM HPM Curricular Milestones/EPAs Workgroup

EPAs	Reporting Milestones																						
	PC1	PC2	PC3	PC4b†	PC5	MK1	MK2	MK3	SBP1	SBP2	SBP3	SBP4	PBL1	PBL2	PBL3	PBL4	PROF1	PROF2	PROF3	PROF4	ICS1	ICS2	ICS3
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1 Pain management	*	*	*			*							*										
2 Nonpain symptoms	*	*	*			*	*																
3 Emergencies		*				*			*									*			*		
4 Prognosis	*		*			*													*		*		
5 Goals of care	*		*			*													*		*		
6 Interdisciplinary team		*							*								*	*				*	
7 Mediate Conflict		*			*												*		*		*		
8 Adv. life-sustaining therapies			*			*													*	*		*	
9 Care for imminently dying		*				*			*										*		*		
10 Requests for hastened death	*														*				*	*	*		
11 Psychosocial support		*							*										*		*	*	
12 Spiritual/existential support		*							*								*		*		*		
13 Self-care & resilience													*		*			*		*			
14 Transitions across continuum										*	*	*							*				*
15 Hospice medical director		*							*								*					*	*
16 HPM consultation		*	*			*											*				*		
17 Promote & teach HPM								*	*	*				*		*							

Reporting Milestone Descriptions		
1	PC1	Gathers and synthesizes essential info
2	PC2	Develops comprehensive management plan
3	PC3	Manages with progressive responsibility
4	PC4b	Skill in interpreting non-invasive procedures
5	PC5	Requests and provides consultative care
6	MK1	Possesses clinical knowledge
7	MK2	Knowledge of diagnostic testing & procedures
8	MK3	Scholarship
9	SBP1	Works effectively within interprofessional team
10	SBP2	Recognizes system error/advocates improvement
11	SBP3	Practices cost-efficient care
12	SBP4	Transitions patients within and across systems
13	PBL1	Monitors practice for improvement
14	PBL2	Learns and improves via performance audit
15	PBL3	Learns and improves via feedback
16	PBL4	Learns and improves at the point of care
17	PROF1	Has professional and respectful interactions
18	PROF2	Accepts responsibility and follow through
19	PROF3	Responds to each patient's unique needs
20	PROF4	Exhibits integrity & ethical behavior
21	ICS1	Communicates with patients and caregivers
22	ICS2	Communicates in interprofessional teams
23	ICS3	Appropriate completion of health records

* Narrowed/limited version (showing top 4-5 most relevant RMs for a given EPA by EPA author)

Expansive/inclusive version (showing additional RMs that may be relevant for a given EPA)



† ACGME does not require milestone 4a to be reported for HPM

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