AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Hospice and Palliative Medicine

Curricular Milestones

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HPM Curricular Milestones/EPAs Workgroup

Introduction

The Accreditation Council for Graduate Medical Education (ACGME) provided a new framework of competency-based medical education called the Next Accreditation System (NAS) in 2012 that included the introduction of "measurement and reporting of outcomes through the educational milestones."[1] The ACGME has described two different types of milestones[2]: reporting and curricular. Around the same time, the concept of Entrustable Professional Activities (EPAs)[3] spread as a means to help inform faculty's competency-based decisions regarding supervision. The American Academy of Hospice and Palliative Medicine (AAHPM) convened a national workgroup to develop these milestone and EPA elements for our field. The first version of Hospice and Palliative Medicine (HPM) EPAs was completed in 2015 (aahpm.org/uploads/HPM_EPAs_Final_110315.pdf).[4] The following document outlines 22 curricular milestones (CMs) for HPM, which were informed by HPM fellowship program directors' feedback. To clarify terminology, distinctions between the two types of milestones are detailed below.

Curricular Milestones

CMs showcase a potential fellowship curriculum. Unlike reporting milestones (RMs), CMs are optional for programs. They do not require any reporting or have a standard format. The authors have opted to offer them here as an outlined list. HPM has benefited from early development of HPM-specific competencies for adult[5,6] and pediatric training.[7,8] These competencies are specific, detailed, and certainly helped inform the development of this first iteration of CMs and EPAs. The CMs are different from the competencies in that they intentionally are grouped into broad topics and educators may consider them to be "teachable units." Thus, a CM is intended to be more extensive than a solitary teachable moment or lecture, and elements may be taught over multiple points in time during the fellowship year. In this way, CMs may be useful as a repository of shared knowledge and as a guide for educators starting fellowship programs or those reassessing fellowship curricula.

Reporting Milestones

Developed by ACGME stakeholders and clinicians, RMs are designed to be logical trajectories of professional development in essential elements of competency.[9] ACGME-accredited programs submit milestone data on each fellow every 6 months. RMs are an ACGME requirement; first-generation RMs can be found here: acgme.org/Portals/0/PDFs/Milestones/HospiceandPalliativeMedicineMilestones.pdf?ver=2015-11-06-120530-393.

The first-generation milestones sometimes are referred to as the "context-free subspecialty reporting milestones." The second-generation of RMs, which will be HPM specific, are under development with ACGME.

Development of the Curricular Milestones

The AAHPM-convened workgroup comprised 10 HPM physician education leaders who represented a diversity of experience in practice setting, geographic location, size of program, years of practice, and

patient population (ie, adult and pediatric). The workgroup cross-referenced multiple sources to gather curricular content to inform the set of CMs, which included the Entrustable Professional Activities, HPM Core Competencies Version 2.3, Pediatric HPM Core Competencies Version 2.0, and American Board of Internal Medicine HPM Certification Examination Blueprint. Using a modified Delphi process, the workgroup developed 22 CMs with associated subthemes that help interpret the CMs' meaning and provide suggestions for more detailed curricular content. The workgroup solicited input about the draft from HPM fellowship program directors during a live workshop and from attendees at an open vetting session at the 2017 Annual Assembly of Hospice and Palliative Care and then sent an electronic survey to US HPM fellowship program and associate program directors. All feedback data were systematically reviewed and considered for incorporation into the document.

How to Get the Most Out of the Curricular Milestones

Because CMs are not required by ACGME, educators may decide how best to use and adapt them to their specific needs. Moreover, with the evolving nature of healthcare and HPM, educators may view the CMs as dynamic. They will require future iterations to incorporate changes in vocabulary (eg, withdrawal of life-sustaining therapy vs withdrawal of non-beneficial therapy, self-care vs resilience), teaching strategies, and concepts as new developments emerge. The following are helpful hints on how to customize the CMs for the unique character, strengths, and resources of individual programs:

- CMs are organized as thematically based teachable units. You may choose to **use some, all, or none of the CMs** to develop or revise a curriculum.
- Each CM has associated subthemes to help explain its meaning and expand on key curricular elements, and often includes a few examples in parentheses. The subthemes and examples **are not exhaustive.** You may add or subtract subthemes and examples to maximize your teaching.
- **Redundancy in the CMs is expected**. We recognized that much of the content was relevant to more than one CM, and therefore included applicable content in multiple CMs.
- You may **lump, split, reorganize, or expand** the CMs to fit your program. They are designed to help you structure your teaching. Tailor them to your needs.
- A 1-year curriculum based on the CMs is intended to be sufficiently **comprehensive** to include major content areas.
- Although it is **not required** that all CMs will be taught, ACGME program requirements do specify certain educational components. CMs aim to complement the program requirements.
- **The development of assessment tools is not outlined within the CMs.** We encourage innovation in this area.

These 22 CMs are a recommended tool to strengthen your program and support a shared curricular structure across the country. Make them work for you!

Sincerely,

The HPM Curricular Milestones/EPAs Workgroup

FAQs

CM #4C: Why use the term "proportional sedation" and why combine it with the CM #4: Palliative Care Emergencies and Refractory Symptoms?

Many different terms are used to describe sedation as a strategy to manage severe and refractory symptoms (eg, palliative sedation, terminal sedation, proportionate sedation, and sedation for intractable distress, to name a few). The AAHPM position statement on palliative sedation defines it as the "intentional lowering of awareness toward, and including, unconsciousness for patients with … refractory symptoms," in such a way that "the level of sedation is proportionate to the patient's level of distress." We chose to use proportional sedation to underscore the range of approaches required for managing different levels of symptom burden.

Both palliative care emergencies and refractory symptoms easily could be taught with multiple CMs, such as CM #3 (Addressing Suffering/Distress) and CM #17 (Ethics of Serious Illness). We placed proportional sedation in CM #4 to highlight its parallels to palliative care emergencies. Both are infrequent and often significant events that require tremendous skill to adequately manage the distress of patients with severe symptoms.

CM #7: Why are there not more commonly used mnemonics for Fundamental Communication Skills and Attending to Emotion?

Communication with close attention to the emotions of our patients and their families is a fundamental skill in palliative care. The robust literature on how to teach these skills includes mnemonics (eg, SPIKES, NURSE), teaching strategies (eg, role play, checklists), and conceptual models (eg, appreciative inquiry, patient-centered care), to name a few. The examples in this CM are ideas that you may choose to use, modify, or reject in your curriculum on communication skills.

CM #12: Why should fellows demonstrate leadership and facilitation skills within interdisciplinary teamwork? Isn't that a physician-centric view?

HPM requires strong team work. Not all interdisciplinary teams function the same way; some teams are led by nonphysician faculty members, and others may expect that a physician primarily lead. Even if the physician is not the designated leader of a team, there will be times when the physician's facilitation and leadership skills are beneficial. Thus, learning facilitation and leadership skills is a valuable aspect of fellowship training and fellows should have the opportunity during training to develop such skills.

CM #15B: Should managing patients with comorbid substance use disorders be its own CM?

Fellows undoubtedly need to learn how to manage palliative and hospice patients with comorbid substance use disorders. Educators may consider adding context—such as managing complex pain and symptoms in the context of a substance use disorder, appropriate referrals to psychiatry or addiction medicine, etc.—to this subtheme in their particular training program, as appropriate, to make it more robust. We believe that learning to manage palliative and hospice patients with comorbid substance use disorders is an important topic to teach, and this is supported in the HPM program requirements.[10]

Thus, we have included it as a CM subtheme. Although at this time we chose not to elevate this topic to its own CM, we acknowledge that with the evolving landscape of medicine, there is the potential for a change in emphasis in future revisions.

CM #15D: Should fellows have to participate in the investigation of safety events?

ACGME HPM program requirements require fellows to participate "as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, formulation, and implementation of actions … all fellows must receive training and participate in the disclosure of patient safety events, real or simulated."[10] Within palliative care, there are many safety events that should trigger thoughtful analysis and change. An example might be a fellow calculating an opioid conversion incorrectly. Team review of the issue might reveal the need for even simple opioid calculations to always be double-checked by another clinician. Although this example might be a near-miss rather than a true error, it qualifies as a safety-related event and may lead to further evaluation with other disciplines within the healthcare system (eg, pharmacy, bedside nursing, etc.), when appropriate.

CM #15E: How do we promote situational awareness and provider safety in different healthcare settings?

Fellows are required to work in inpatient acute care, long-term care, home care, and ambulatory practice settings. Certain circumstances in each of these settings require a thoughtful approach to maintaining provider and team safety. Examples could include sitting near the door during a family meeting with significant conflict, working with the team to have guns safely stored or removed from a home prior to making visits, using medication lock boxes when needed, and identifying situations where making joint visits with another team member is warranted.

CM #16B: What does it mean to fulfill the role of a hospice team physician?

The terminology around roles can be confusing because individual hospice agencies may use different terms for their lead physician role (eg, hospice medical director, chief medical officer) or any physician working for the hospice. Although graduating fellows 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 team physician. This includes providing expert palliative medicine for hospice patients, fulfilling physician requirements in interdisciplinary group meetings, providing medication review, performing certification and recertification tasks, etc. The EPAs use the term hospice medical director, but given the confusion around terminology,[11] the workgroup elected to use the term "hospice team physician" for the CMs for clarity.

CM #17A: How do we cover fundamentals of bioethics in a 1-year program?

Many fellows will enter fellowship with an existing framework for teaching the fundamentals of bioethics. Some programs may wish to confirm that fellows possess basic medical ethics knowledge and ensure a common understanding of ethical principles; others may wish to teach more detailed content, such as the historic and legal aspects of common ethical issues, in greater depth.

CM #20B: Why use the term "basic" instead of "primary" palliative care?

"Basic" and "primary" are modifiers often used interchangeably to describe a set of palliative care skills required by nonpalliative-care providers to care for their patients. The concept of "primary palliative care" was popularized by von Gunten[12] and Quill and Abernethy[13] to distinguish the fundamental skill-set needed by all providers from the more complex skill-set employed by palliative care specialists. For simplicity, we chose the term "basic" as a more common word to describe the foundational set of palliative competencies that we hope for in our non-HPM providers. With palliative medicine specialist workforce shortages,[14] fellows will need to learn how to help nonpalliative-care colleagues gain or improve their basic palliative care skills to help as many patients as possible.

CM #22: Why is there a CM on Career Preparation?

It commonly is accepted that the acquisition of skills, such as the ability to understand billing fundamentals, cost-conscious care, and lifelong learning, will be expected of a graduating HPM fellow. Educators likely are assessing career goals for their fellows during the fellowship year and offering advice and mentorship. Even if a fellow will not be starting a new program, understanding concepts that are necessary for program growth and sustainability, such as quality metrics,[15] is of educational value.

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Hospice and Palliative Medicine Curricular Milestones
Version 1.1

Number	Curricular Milestones	Category
1	Knowledge of Serious and Complex Illness	Patient Care
2	Comprehensive Whole-Patient Assessment	Patient Care
3	Addressing Suffering/Distress	Patient Care
4	Palliative Care Emergencies and Refractory Symptoms	Patient Care
5	Withholding/Withdrawal of Life-Sustaining Therapies	Patient Care
6	Care of the Imminently Dying	Patient Care
7	Fundamental Communication Skills for Attending to Emotion	Communication
8	Communication to Facilitate Complex Decision-Making	Communication
9	Prognostication	Communication
10	Documentation	Communication
11	Grief, Loss, and Bereavement	Communication
12	Interdisciplinary Teamwork	HPM Processes
13	Consultation	HPM Processes
14	Transitions of Care	HPM Processes
15	Safety and Risk Mitigation	HPM Processes
16	Hospice Regulations and Administration	HPM Processes
17	Ethics of Serious Illness	Professional Development
18	Self-Awareness Within the Training Experience	Professional Development
19	Self-Care and Resilience	Professional Development
20	Teaching	Professional Development
21	Scholarship, Quality Improvement, and Research	Professional Development
22	Career Preparation	Professional Development

Patient Care

CM #1: Knowledge of Serious and Complex Illness
- A. Knowledge of disease trajectories (eg, pathophysiology, differential diagnosis, complications)
- B. Prognostication
- C. Scope of palliative treatments for different serious and complex illnesses (eg, surgery, radiation therapy)
- D. Assessment of benefits and burdens of treatments on the seriously ill patient and family
- E. Pharmacology of essential palliative symptom management
- F. Advance care planning for specific illnesses and potential advanced therapies (eg, mechanical ventilation, implantable defibrillator, ventricular assist device) across the age spectrum

CM #2: Comprehensive Whole-Patient Assessment
- A. Assess pain and nonpain symptoms
- B. Assess decisional capacity and/or developmental stage (eg, cognitive, behavioral, emotional)
- C. Identify cultural values as they relate to care
- D. Identify supports and stressors (eg, psychological, psychiatric, spiritual, social, financial)

CM #3: Addressing Suffering/Distress
- A. Manage pain and nonpain symptoms using pharmacologic strategies
- B. Manage pain and nonpain symptoms using nonpharmacologic strategies (eg, integrative, interventional, surgical)
- C. Manage basic psychosocial/spiritual distress

CM #4: Palliative Care Emergencies and Refractory Symptoms
- A. Identify common palliative care emergencies
- B. Anticipate, triage, assess, and manage palliative care emergencies
- C. Manage proportional sedation for refractory symptoms

CM #5: Withholding/Withdrawal of Life-Sustaining Therapies
- A. Counsel patient, family, and providers about the process of withdrawal (eg, prognosticate, attend to psychosocial, spiritual, cultural needs of patient/families, promote shared decision-making for goals of care, utilize interdisciplinary team)
- B. Manage physical symptoms before, during, and after withdrawal
- C. Orchestrate the technical withdrawal
- D. Consider issues related to withholding/withdrawal of artificial nutrition and hydration that may differ from advanced life-sustaining therapies
- E. Attend to personal, team, and other provider reactions (eg, values, emotions)
- F. Apply ethical and legal standards and institutional culture and policies related to withdrawal of life-sustaining therapies

CM #6: Care of the Imminently Dying
- A. Manage physical symptoms during the dying process
- B. Attend to psychosocial, spiritual, cultural needs of patient/family
- C. Collaborate effectively within own and across other interdisciplinary teams
- D. Communicate around the time of death (eg, empathic presence, preparing family)
- E. Attend to self-awareness and self-care
- F. Attend to post-death care (eg, death pronouncement, note, death certificate, communication with others)

Communication

CM #7: Fundamental Communication Skills for Attending to Emotion
  A. Build rapport
  B. Acknowledge and respond to emotion (eg, listening vs hearing, compassionate presence and strategic silence, intuition around cues and guiding discussion)
  C. Acknowledge one's own emotions and preconceptions (eg, implicit bias)
  D. Address conflict (eg, among patients, families, other care providers)

CM #8: Communication to Facilitate Complex Decision-Making
  A. Deliver medical information (eg, serious news, prognosis)
  B. Elicit patient values and goals
  C. Promote shared decision-making
  D. Facilitate a family meeting
  E. Foster adaptive coping (eg, reframe hope, promote resilience, legacy, humor, affiliation, anticipation)

CM #9: Prognostication
  A. Acknowledge uncertainty and support patients and families facing uncertainty
  B. Possess knowledge of individual illness trajectories and potential responses to therapies
  C. Formulate prognosis (eg, clinical assessment, utilization of tools, input from other healthcare providers, consequences of failure to prognosticate)
  D. Communicate prognosis (eg, function, timeframe, quality of life, challenges of communication prognosis, promote prognostic awareness, acknowledge uncertainty)

CM #10: Documentation
  A. Communicate treatment recommendations professionally and diplomatically to others
  B. Understand the relationship between documentation and billing (eg, CPT requirements and ICD coding, medical complexity and time-based billing)
  C. Document comprehensive hospice and palliative medicine plans (eg, medical decision-making and rationale behind realistic treatment recommendations, patient and treatment goals, ethical and legal implications)

CM #11: Grief, Loss, and Bereavement
  A. Understand risk factors for and types of grief based on age and developmental stage (eg, anticipatory, normal, complicated grief)
  B. Identify and assess individuals for grief and/or bereavement
  C. Provide basic support for anticipatory grief and/or bereavement
  D. Refer for grief and/or bereavement support and therapeutic interventions

Hospice and Palliative Medicine Processes

CM #12: Interdisciplinary Teamwork
- A. Understand and respect role/function of team members
- B. Facilitate interdisciplinary team meetings (eg, understand team dynamics, elicit varied and unexpressed opinions)
- C. Support team members (eg, provide and receive feedback, address conflict, educate)
- D. Develop and demonstrate leadership skills

CM #13: Consultation
- A. Assess and acknowledge institutional/system rules and culture (eg, ethics committee role, religious institution affiliations, medical staff requirements)
- B. Promote professional consultation etiquette (eg, negotiation with other providers around goals, respect for primary team relationships, diplomacy in advocacy)
- C. Demonstrate empathy and respect toward other involved colleagues

CM #14: Transitions of Care
- A. Practice safe handoffs across settings of care
- B. Counsel patient, family, and teams about eligibility, capabilities, payer sources, expectations for next and alternative sites of care (eg, hospital, nursing facility, inpatient hospice, home hospice, long-term acute care facility, home-based palliative care)
- C. Address medication management issues during transitions of care (eg, medication reconciliation, formularies, safety especially with controlled substances, rational de-prescribing)

CM #15: Safety and Risk Mitigation
- A. Practice safe prescribing (eg, polypharmacy, medication reconciliation and disposal, legal and regulatory issues, Risk Evaluation and Mitigation Strategies, Prescription Drug Monitoring Program)
- B. Understand issues around comorbid substance use disorders (eg, diversion risk, addiction treatment)
- C. Understand processes to promote patient safety (eg, screening for safety risk factors, error reporting, handoff procedures, learner supervision, fatigue mitigation)
- D. Identify safety events and participate in their investigation
- E. Promote situational awareness and provider safety in different healthcare settings

CM #16: Hospice Regulations and Administration
- A. Understand hospice regulations (eg, hospice Medicare benefit, non-Medicare hospice coverage, eligibility, evolving business models, levels of care)
- B. Fulfill the role of a hospice team physician
- C. Perform hospice-specific documentation that meets regulatory requirements (eg, physician visits, certification of terminal illness, face-to-face visits, interdisciplinary team input)
- D. Understand the hospice business environment (eg, formularies, contracts, specific resources and policies)

Professional Development

CM #17: Ethics of Serious Illness

    A. Fundamentals of bioethics (eg, historic and ethical-legal context, ethical paradigms)
    B. Ethics of responding to requests for hastened death
    C. Ethics of proportional sedation for refractory symptoms
    D. Ethical aspects of death definition and disorders of consciousness (eg, coma, persistent vegetative state, minimally conscious state)
    E. Ethics of medically assisted nutrition and hydration
    F. Ethics of withholding and withdrawing life-sustaining therapies
    G. Ethics and legal theory of decision-making capacity and confidentiality (eg, assent, consent, dissent, emancipated minors, surrogacy)

CM #18: Self-Awareness Within the Training Experience

    A. Demonstrate personal accountability in clinical duty tasks (eg, timeliness of task completion and attendance, documentation, communication follow up)
    B. Demonstrate personal accountability in administrative tasks (eg, teaching organization and improvement, credentialing activities, assignment completion, committee work tasks and participation)
    C. Identify conflicts of interests (eg, personal, professional, or corporate gains)
    D. Display awareness of one's role, identity, and boundaries in the private, professional, and public domains
    E. Integrate past clinical and personal life experience into a therapeutic patient-provider relationship (eg, cultural, spiritual, emotional, cognitive, and implicit bias)

CM #19: Self-Care and Resilience

    A. Outline characteristics and types of distress (eg, excessive stress, moral or spiritual distress, exhaustion, compassion fatigue, depersonalization)
    B. Identify risk factors for burnout in self, others, and system (eg, high volume, high acuity, misaligned values and incentives, lack of transparency and recognition)
    C. Identify strategies for cultivating self-care and resilience for self and others (eg, medical humanities, healthy boundaries and realistic expectations, physical health, recreation, engagement and receptivity with team and community)
    D. Exhibit evolving self-reflection and conscious personal/professional identity formation (eg, loss and bereavement, insight around actions and consequences, mindfulness, compassion)

CM #20: Teaching

    A. Provide and receive feedback
    B. Teach basic palliative care to other healthcare providers (eg, conducting learner needs assessment; defining learning goals and objectives; adjusting teaching content and methods to the setting and learners; recognizing teaching, coaching, and mentoring opportunities in every hospice and palliative medicine setting)
    C. Share evidence-based hospice and palliative medicine literature with others

Professional Development

CM #21: Scholarship, Quality Improvement, and Research
   A. Appraise and assimilate evidence from hospice and palliative medicine scholarship
   B. Recognize and participate in quality improvement methods and activities (eg, interpret quality data, distinguish between quality improvement and research)
   C. Describe basic approaches and unique aspects of research in hospice and palliative medicine (eg, funding, ethics, vulnerable populations)

CM #22: Career Preparation
   A. Discuss the context of hospice and palliative medicine (eg, history, future trajectory, current regulatory and political issues with need for advocacy, reimbursement, model of interdisciplinary collaboration)
   B. Engage in leadership skill development and planning for career trajectory (eg, lifelong learning, advocacy)
   C. Participate in elements of program development (eg, Program Evaluation Committee participation, quality metric identification)
   D. Demonstrate billing fundamentals and delivery of cost-effective care in hospice and palliative medicine practice

Figure: Matrix of Relevant Hospice and Palliative Medicine Curricular Milestones for Each Hospice and Palliative Medicine Entrustable Professional Activity

EPAs	PC1	PC2	PC3	PC4	PC5	PC6	C1	C2	C3	C4	C5	HPM1	HPM2	HPM3	HPM4	HPM5	PD1	PD2	PD3	PD4	PD5	PD6
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
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												*	*		*	*				*	*	*

Curricular Milestones

#	Code	Description
1	PC1	Knowledge of Serious and Complex Illness
2	PC2	Comprehensive Whole-Patient Assessment
3	PC3	Addressing Suffering/Distress
4	PC4	Palliative Care Emergencies and Refractory Symptoms
5	PC5	Withholding/Withdrawal of Life-Sustaining Therapies
6	PC6	Care of the Imminently Dying
7	C1	Fundamental Communication Skills for Attending to Emotion
8	C2	Communication to Facilitate Complex Decision-Making
9	C3	Prognostication
10	C4	Documentation
11	C5	Grief, Loss, and Bereavement
12	HPM1	Interdisciplinary Teamwork
13	HPM2	Consultation
14	HPM3	Transitions of Care
15	HPM4	Safety and Risk Mitigation
16	HPM5	Hospice Regulations and Administration
17	PD1	Ethics of Serious Illness
18	PD2	Self-Awareness Within the Training Experience
19	PD3	Self-Care and Resilience
20	PD4	Teaching
21	PD5	Scholarship, Quality Improvement, and Research
22	PD6	Career Preparation

The Entrustable Professional Activities (EPAs) describe the work of a hospice and palliative medicine (HPM) physician who has attained sufficient competence to practice without supervision. Curricular milestones (CMs) are "teachable units" that form the conceptual basis of a HPM fellowship curriculum. They typically are taught over multiple points in time during a fellowship year. There is much overlap between CMs and EPAs. The matrix is a guide to identify CMs that may help learners achieve the activities outlined in the EPAs. The workgroup acknowledges variability in the potential interpretation of HPM EPA-CM relationships and invite fellowship programs to modify the matrix as needed.

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