January 2011 Vol. 9, No. 1

Residency Program Alert
INNOVATIVE SOLUTIONS FOR GRADUATE MEDICAL EDUCATION

New ACGME requirements will cost $380 million annually, report says

The new year brings a new set of *ACGME Common Program Requirements*. The new standards come with a new challenge for designated institutional officials, program directors, and program coordinators: Figuring out how to cover the high costs of implementing the new duty hour and work environment standards.

"We estimate the total direct annual costs of the new requirements will be $380,766,262 to hospitals nationwide. The total direct annual cost for individual teaching hospitals will be about $785,000," says **Teryl K. Nuckols, MD, MSHS,** lead author of the report and a researcher with the Division of General Internal Medicine and Health Services Research at David Geffen School of Medicine at the University of California, Los Angeles.

The ACGME released the report, *ACGME Common Program Requirements: Potential Cost Implications of Changes to Resident Duty Hours and Related Changes to the Training Environment Announced on September 28, 2010,* on its website *(http://acgme-2010standards.org/pdf/dh-CostAnalysis-for2011CPRs.pdf)* in November 2010.

The cost analysis examines:

- Direct costs of implementing the new duty hour and training environment changes, which include factors such as hiring new labor, implementing new systems, and opportunity costs
- Net costs for teaching hospitals, which include potential savings that may be realized through fewer preventable adverse events

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>
> *—Teryl K. Nuckols, MD, MSHS*

Nuckols based the estimates on recent data in scientific literature pertaining to duty hours and how the ACGME anticipates programs will implement the new duty hour standards, which limit first-year residents to 16-hour shifts.

The ACGME's assumptions are:

- In small programs, 14 or more hours of postgraduate year one (PGY-1) residents' work will be transferred to attending physicians or nurses
- In large programs, PGY-1s will work the same amount of hours as they do now, and schedules will be reorganized so that work does not need to be transferred to others
- Senior residents will transfer two or more hours of work per extended shift to other residents

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New ACGME

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- Subspecialty residents will transfer two or more hours of work per extended shift to other residents

"It's hard to know how programs are going to do this," Nuckols says. "If you change the assumptions, the costs can get much higher."

For example, if all PGY-1 work is transferred to attending physicians or nurses, the costs balloon to $1,187,014,278, according to the analysis.

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Work environment changes

In addition to calculating the cost of implementing the new work hour restrictions, Nuckols also estimates costs associated with complying with new training environment requirements across all ACGME-accredited programs.

The report states that the onetime costs across all programs during the initial year will total $55,676,314. Recurring costs are forecasted to be $190,917,834 annually.

These changes and their onetime and recurring costs across all programs are:

- Faculty and resident education on fatigue is estimated to have an initial onetime cost of $38,834,074 and an annual recurring cost of $18,202,029
- Transportation to post-call residents has no initial onetime cost and an annual recurring cost of $111,001,199
- Implementing structured procedures for handoffs has an initial onetime cost of $16,842,240 and an annual recurring cost of $49,015,169
- Enhancing duty hour and environment oversight, which is the time institutional personnel will spend preparing for and conducting the new annual review by the ACGME, has no initial onetime cost and an annual recurring cost of $12,699,437

ACGME vs. IOM costs

The Institute of Medicine's (IOM) 2008 report outlining recommendations for duty hour and work environment standards projected a cost of $1.7 billion.

"The ACGME's projected costs are much lower because the IOM recommended 16-hour shift limits and five-hour naps for on-call residents. These recommendations applied to all residents, not just PGY-1s," Nuckols explains.

The new standards do not mandate five-hour naps and the 16-hour limits only apply to PGY-1s.

Although the costs associated with the ACGME's 2011 standards aren't as high as those proposed by the IOM, GME professionals will still have to work with hospital administrators to find funding to meet the new requirements before July 2011. ■

Handoff help: A step-by-step guide to identifying barriers and creating a standardized sign-out process

Transitions of care are ripe for improvement in most residency programs. Junior trainees often learn from senior residents how to conduct handoffs during their first year of training.

This model of education leads to variations in practitioners' handoff methods. The lack of standardized processes increases the chance of miscommunication or omissions of crucial patient data, which can lead to adverse events and patient harm.

Program directors and key faculty should review their handoff process and create a uniform method of conducting handoffs within their departments. Doing so has several benefits:

- ➤ Reduces handoff-related patient care errors
- ➤ Provides residents with a template of information that needs to be exchanged
- ➤ Underscores the importance of conducting handoffs
- ➤ Complies with the new *ACGME Common Program Requirements* for transitions of care, which are effective July 2011 (see the sidebar on p. 4 for more on the ACGME requirements)

Creating a more robust handoff process is also critical because the number of handoffs is likely to increase once new ACGME standards reducing first-year residents' work hours take effect.

"As we continue to decrease absolute numbers of hours residents can take call, we're almost by definition going to continue to add additional handoffs into the system," says **Jeffrey Wayne, MD, FACS,** associate professor of surgery in the Division of Gastrointestinal and Oncologic Surgery at Northwestern University Feinberg School of Medicine in Chicago.

Improving the accuracy and completeness of handoffs in your program is a three-step process:

- ➤ Evaluate current practices and identify areas for improvement
- ➤ Create a standardized process for the handoffs
- ➤ Implement the new handoff process

Dig deep into handoff practices

Before implementing a new handoff process, program directors must understand how transitions of care currently happen between residents and attending physicians, says Wayne, who revamped the handoff procedures in 2008 across all 12 services that the surgery residents at his institution rotate through.

Determine which handoff elements you want to assess. For example, Wayne's redesign focused on improving the completeness, accuracy, efficiency, and appropriateness of task delegation of handoffs.

Residents, attending physicians, hospital administrators, and other healthcare providers, such as nurses, can provide insight into how handoffs currently stack up against these four factors.

Use the following methods to get baseline data on how handoffs occur in your program:

➤ **Focus groups.** Focus groups are a relatively low-cost way to get in-depth details about handoff practices. To get honest answers, consider conducting separate focus groups for residents, attending physicians, and others, suggests **Elizabeth Weinshel, MD,** deputy chief of staff at VA New York Harbor Healthcare System and former gastroenterology fellowship program director at the New York University (NYU) Langone School of Medicine in New York City.

While leading a handoff performance improvement project in her program, Weinshel found that focus group participants are more likely to be candid if they are among peers. Similarly, focus group facilitators should be of the same peer category as the participants or an independent third party. Weinshel worked with experts from NYU's Office of Development and Learning to conduct the sessions.

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Handoff help

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Before the focus group, develop open-ended questions that you would like participants to answer. Weinshel created questions that would determine the following:

- How participants define handoffs
- What participants perceive as elements of a good handoff
- How handoffs currently occur
- What improvements can be made

➤ **Direct observation.** Another way of gathering data is to directly observe handoffs and information flow. This method allows program directors to identify inefficiencies and problem areas in the handoff process, says Wayne. The downside to this method is that you most likely need a third party to conduct the observations and analyze the findings. University-based hospitals may be able to save costs by partnering with efficiency or operations experts at their universities' business schools.

"Experts from our business school came in and observed our 12 different services in the hospital, looking at how the residents were conducting handoffs, the quality of the written document exchanged, observed whether the handoff was only verbal or also had written documentation, and whether there was any sign-out at all," Wayne says.

The observers examined how information for patients flows over several 24-hour periods.

New ACGME standards for handoffs

Section VI.B. Transitions of Care of the new *ACGME Common Program Requirements* state:

- ➤ Assignments must be created to minimize the number of transitions of patient care
- ➤ Institutions and programs must ensure and monitor structured handoff processes
- ➤ Programs must ensure that residents are competent in handoffs
- ➤ Institutions must ensure that schedules clearly indicate the attending physician and residents responsible for each patient's care

➤ **Surveys.** Electronic and phone surveys measure the residents' and attending physicians' satisfaction with current processes, confirm practices identified by direct observation or focus groups, and determine elements of good handoffs and items to potentially include on a standardized handoff sheet.

When possible, send electronic surveys. Residents are more likely to complete a quick survey on their smartphones or computers than on paper, Wayne says.

To record residents' perceptions of handoff practices, conduct phone surveys immediately after residents come off call. Ask them about the information they received at the beginning of their shift and the handoff they conducted right before leaving, Wayne says.

Gathering all of this information is time-consuming. Enlist the help of a research assistant if one is available. Program coordinators may also be able to help disseminate and collect surveys. Residents are another option.

"Many programs have chief residents with administrative responsibilities. Delegate data collection for such projects to them," Wayne says.

Make improving handoffs a quality improvement project involving residents. This is a great way to get help and resident buy-in. It also fulfills the practice-based learning competency and ACGME requirements for performance improvement, Weinshel says.

Consistency is king

Standardizing the information transmitted during handoffs helps ensure that residents transfer the most important patient information to their counterparts.

In both Weinshel's and Wayne's programs, focus groups and surveys revealed that residents were using improvised spreadsheets to transfer information.

"These weren't standardized from service to service or even among residents. One resident may design a spreadsheet that works for them and just carries it to the various services they go to," Wayne says.

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Because residents were comfortable with this format for exchanging information, Wayne and Weinshel continued the use of spreadsheets.

"We tried to look for common things that were on all of the sign-off sheets that people were using, and we basically standardized the columns and headings to reflect the data we considered most important, pertinent, and useful to the resident on call," Wayne explains.

Wayne's sign-out sheet lists the following headings:

- Room
- Attending physician
- Postoperative day
- Admit/diagnosis
- Code status
- Allergies
- Medications
- Diets
- Drain/tubes/lines
- Vital/labs/tests/cultures
- Sign out to-dos

Include information that residents and others who were surveyed said was often missing during handoffs. For example, residents in Wayne's program noted that it was often unclear who the on-call supervising physician was for a service. Additionally, nurses said they often did not know what time the transfer of responsibility occurred from one resident to another.

Wayne included a drop-down menu so residents can select an on-call supervising physician and added a date and time stamp so that when the final on-call list was printed, it was clear when the responsibility was transferred to the resident on call.

Scheduling is another key component of standardizing the handoff process. The optimal handoff situation includes a face-to-face meeting between residents to transfer information. Whenever shifts change, try to create a one-hour overlap so residents going off duty and those coming on have time to meet.

Look beyond resident schedules. Weinshel rearranged the program's schedule of conferences, rounds, and journal club to ensure that inpatient care was not interrupted by residents' educational or clinical responsibilities.

"The days have more continuity, and it made it easier for the attending physicians to see patients and round with the team," Weinshel explains.

Tip: As more hospitals convert to electronic medical records (EMR), consider integrating the sign-out sheet and the EMR. Wayne worked with IT staff to design a solution that pulls information from the EMR and autopopulates portions of the handoff document, such as medication, labs, vital signs, and patient name and room number. It saves the residents time and reduces data input errors.

Rollout and follow-up

Education is key to successful implementation of a new handoff process. Consider introducing the new sign-out sheet or system during grand rounds so both residents and attending physicians participate. Most residents are tech-savvy enough to pick up the system quickly, but it may be helpful to make IT staff available to caregivers throughout the rollout phase, Wayne suggests.

However, training residents on the sign-out instrument is not enough. You must also educate residents on the elements of a complete handoff. (See "Improve resident handoffs with 10 best practices" in the January 2010 **RPA** and "Create a toolbox for teaching and assessing handoffs" in the February 2010 issue.)

After rollout, follow up with residents to ensure that the new system is working.

"I brought it up at research conferences every month to ask how it's going, what's working, what's not. It was on people's radar all the time," Weinshel says, adding that she tweaked the system as she received feedback.

Another option is to ask residents to complete an evaluation of the new process. Wayne designed an evaluation in which residents measure the four components of handoffs he set out to improve:

- How many minutes it took to update the handoff sheet (efficiency)

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Handoff help

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- The extent to which inaccuracies appeared on the sheet (accuracy)
- The number of times incomplete information was given on the handoff sheet (completeness)
- Whether it was easier to determine what time patient care responsibilities were transferred to the resident coming on duty (responsibility)
- How the handoff information was communicated—discussions via phone, in-person meeting, or the sheet without discussion (dissemination)

Wayne's evaluations indicated increases in efficiency, accuracy, and completeness and showed that information communication was clearer. ■

Sample handoff policy

A handoff is the transfer of care from one provider (unit, shift, facility, etc.) to another provider. The handoff is a mechanism for transferring information, responsibility, and authority from one caregiver to another.

Hospital handoffs occur upon admission, at shift changes, before and after procedures, upon unit changes, and at discharge. Hospital handoffs are high-risk, high-frequency events in which critical information must be transferred completely and accurately.

Some providers may find it difficult to speak directly with a professional superior or maintain the appropriate assertiveness and tenacity needed in making key points. Different providers may also have different communication styles, which creates the potential for a breakdown of communication.

House staff must comply with the following recommendations, which standardize the handoff process and ensure error-free handoffs:

- Communication between providers must be interactive and allow—even promote—questions between the giver and receiver of information.
- The information must be accurate, complete, and up to date. Residents must include recent or anticipated changes, and there must be an opportunity for the receiving provider to review test results and relevant historical data.
- Interruptions during the handoff should be limited. Conduct handoffs in face-to-face encounters whenever possible, in an atmosphere free of unnecessary noise and interruptions. If patient information is provided electronically or via fax or hard copy form, a follow-up telephone conversation is strongly encouraged to allow for feedback and an opportunity for questions.
- Allow for a verification process, such as write-down/read-backs as appropriate (alarm values, specifically).
- Confirm receipt of patient charts (hospital and outpatient or nursing home setting). Be sure to confirm that the transmission or copy of the chart was received or delivered to the patient's physician.
- Use precise language; avoid terms such as "unstable" or "okay." Refrain from jargon, but define the patient's situation. Adhere to approved abbreviations and keep the handoff free of irrelevant details.
- Use a standardized, consistent reporting format such as SBAR. At a minimum, the format should include a summary of the current medical status, resuscitation status, recent laboratory values, allergies, and both problem and to-do lists. The provider signing out begins by familiarizing him- or herself with the appropriate patient information before initiating the handoff. Report:
  - **S**ituation: Identify yourself, your position, the patient's name, and current situation. Describe what is currently going on with the patient.
  - **B**ackground: State the relevant H&P, physical assessment, treatment and clinical course summary, and any pertinent changes.
  - **A**ssessment: Offer your conclusions—what is the problem in your opinion?
  - **R**ecommendations: What needs to be done?

Source: Adapted from NYU School of Medicine Gastroenterology Fellowship Program.

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Coordinator's corner

Start the year off right with tips from your colleagues

Program coordinators are always looking for ways to streamline processes or improve the way things are done. Unfortunately, coordinators are often too busy to stop and pat themselves on the back for all their efforts to enhance the training program.

The new year is a great chance for program coordinators to reflect on all that they've accomplished. To recognize hard-working, innovative coordinators, **RPA** called on readers to share what they've done this past year to improve their program or resident education.

Borrow your colleagues' all-star ideas, modify them, and implement them in your own program.

Make the switch to e-files

Lainie Franklin, MPA, family medicine residency coordinator at University of Missouri-Kansas City, describes how she successfully transitioned from the paper-based resident file to an electronic format.

As a new coordinator, I have much to learn. However, I entered the profession with 22 years' experience in healthcare, 10 of which were as a certified medical staff coordinator. Paperwork was the name of the game then, but not now.

Coming into the residency program office, I found that the resident files were mostly paper-based, but some were in an electronic format as well. Unfortunately, it was near impossible to decipher the contents of the electronic files without opening the document.

The paper files weren't much easier to sort through. Most were simply a manila folder full of several copies of the same document—all of which were in no particular order.

Locating a document was so time-consuming. I quickly found that it took me less time to create an electronic version with a well-defined naming convention.

I proposed to the residency office team that we create a electronic folder for each resident. All of the residents' folders would include the same information organized into standardized subfolders.

We all agreed on a format, and we tweaked it as we started scanning the paper documents.

The main folder is the resident's name. Currently, we have the following subfolders:

- Contracts
- Credentials verification
- Deferment and forbearance requests
- Exam scores
- Health records
- Interview and match documents
- Leave and rotation requests
- Letters of reference
- License, insurance, DEA
- Life support certificates
- Longitudinal curriculum
- Miscellaneous
- Moonlighting
- Onboarding
- Quarterly and semiannual reports
- Reimbursement requests
- Surgery rotation

Each resident's folder also includes a transcript and photo. We do not put those into subfolders because both are accessed frequently. They are stand-alone items within the main folder.

Each subfolder has defined contents and a naming convention. The name of the document is always the year the document expires, followed by the resident last name and the name of the document. We use the first initial when two residents have the same last name. For example, the naming convention for Michael Brown's license is "2012 Brown M Missouri License."

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Start the year

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We use the electronic file format for the current group of 36 residents. We have not decided whether we will scan the previous years' graduates.

It was labor-intensive to convert these 36 resident folders from print to electronic (approximately 40 hours), but as a new coordinator, the process was invaluable. No longer do we have a combination of paper and electronic files; the files we have are succinct and standardized across the board. I am truly amazed at the time savings this project has afforded us.

There are no more folders and labels to purchase or any more copies to make. When someone needs a document, I simply e-mail it to the person. A bonus that I did not anticipate was that because I scanned and saved all of the documents, I know my residents, their struggles, and their strengths as well as, or better than, anyone else in the office.

Lean and green recruitment

Michelle R. Tuetken, education coordinator for the orthopedics program at Washington University in St. Louis (MO), describes her program's newest way of managing candidate applications.

Gearing up for recruitment is a lot like taking a long trip. The first part is planning the journey, which you start months in advance. As your trip nears, you begin packing and then reevaluating whether everything you brought is really necessary. Finally, you pare down the items so that you can close the suitcase. This is exactly how I manage applications during recruitment.

Each recruitment season, I print an average of 358 files, containing 25 pages per file, and put them into file folders for review. Of these files, our selection committee invites a little more than one-third of the applicants to formally interview with us.

I would then reprint the entire applicant file once the residents uploaded the dean's letter and various other updates into the Electronic Residency Application Service (ERAS). The reprint included approximately 30–40 pages per file, and I made seven copies of each file to distribute for review. This totaled more than 10,000 pages printed using the double-sided option.

This was an excellent opportunity to get lean and green. After reviewing the process, talking it over with the program director and other faculty members, we decided that I should burn the applicant files onto a CD along with a photo sheet containing photos of all of the applicants. I group the candidates' photos by interview day so that the applicants coming on the same day are in the same group.

In order to make this process work, I convert the applicant files to a PDF from ERAS. The only documents that we now reprint are the ones that are absolutely necessary. This year, this totaled approximately 570 pages, double-sided.

All interviewers now receive a single CD containing all applicant files. After the interview day, interviewers return the CDs, which are securely recycled.

This new lean, green process has transformed our recruitment process. The amount of paper savings, both financially and physically, is substantial. The amount of time that staff contributes to this process is truly a remarkable difference than the previous process. For example, it takes two hours to burn 40 CDs versus hours and hours of labor.

The added and most unexpected benefit is that the CDs are a welcome change to everyone involved in recruitment. They fit easily in briefcases and have made a very positive impact on our entire recruitment process!

The 3+1 system

Maria C. DeOliveira, administrative director for medical education in the internal medicine program at Boston University Medical Center, submitted the following description of a new scheduling solution.

In July 2010, we implemented a new schedule format called the "3+1" system. We designed the system to accomplish several goals, including:

- Compliance with ACGME's ambulatory regulations and standards

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- Compliance with duty hours
- Increase resident satisfaction with clinic experiences
- Minimize conflict for the residents, who were struggling with their responsibilities in the inpatient and ambulatory settings

Under the new system, the residents do three weeks of inpatient time. Trainees spend the final week completely devoted to the ambulatory service; hence, the 3+1 schedule. During the ambulatory week, the residents are divided into pods and attend four continuity clinic sessions, four subspecialty clinic sessions, an administrative session, and an academic half day. The academic half days include an expansive curriculum, which faculty members teach at the primary hospital and at our affiliates' health centers and clinics.

Our residents used to be in the inpatient setting and have clinic only once per week. On certain rotations, such as the ICU, the residents often struggled with having to leave a very sick patient to go to clinic. This often left them feeling dissatisfied with the ambulatory setting. The 3+1 system minimizes this conflict.

We are still in the early stages, but initial feedback indicates increased resident satisfaction. They are able to focus on patients in each setting and recharge during their clinic week in preparation for the next three-week inpatient service.

Attending physicians are pleased that, while on service, the team is not constantly being covered by another resident for ambulatory purposes. The system also adheres to duty hour regulations.

In addition to meeting all of our initial goals, we've also found that scheduling for our three-hospital program has become a bit easier. Although there are more components to the schedule, there is less room for error.

There are many creative variations to this type of schedule nationally. We looked into several of these initiatives and designed something that would work out best for our program.

Code drills

LaDonna Epling, RN, program coordinator for the internal medicine residency program at Norton (VA) Community Hospital, describes her program's mock code drills.

To improve our residents' skills and responses when a patient codes, we implemented mock code simulations once per quarter. All resident levels and medical students participate in the exercises.

During the mock code exercise, we assign residents different roles on the team. Residents participate in several scenarios, rotating team member positions. This helps them understand what every code team member experiences during an actual code.

Residents wear badges identifying their role so it's clear to all team members who the primary doctor running the code is, the nurse, recording nurse, etc.

Advanced cardiac life support (ACLS) instructors design the codes and help run the drills. Residents who are certified in advanced trauma life support (ATLS) also help.

The more that the residents participate in these code drills, the more relaxed and confident they become in their skills. Residents are also more comfortable during actual code situations.

We recently purchased a video camera to tape residents during the drills. We hope that they will be able to watch the videos and identify areas for improvement in their code skills. The ACLS instructors and ATLS-certified residents provide feedback to the participants.

A new kind of grade for residents

Molly Ostrowski, general surgery program coordinator at Greenville (SC) Hospital System, explains her program's new grading system designed to enhance resident compliance with administrative tasks.

The newest thing we implemented is a quarterly "administrative grade." Residents receive a grade based on their compliance with completing administrative tasks.

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Start the year

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The grade provides a method for us to track which items residents have completed and recognize those who are timely.

The composite grade is calculated based on residents' compliance in five areas. We weight the areas differently, assigning higher weights to the more important categories. The five areas and weights are:

- End-of-rotation card completion: 30%
- Duty hour compliance: 30%
- Conference attendance: 20%
- Makeup work completion (e.g., missed reading exams): 10%
- Evaluation completion: 10%

There is a spreadsheet for each resident. I write simple formulas that perform the calculations for me. Additionally, I hang a point sheet in the resident work room that lists each resident's score for all to see.

I give the residents two weeks before finalizing their grade to turn in anything they're missing. During the two-week period, paperwork begins to show up on my desk, evaluations are completed, duty hours are approved, and most residents are racing to improve their grade.

I find that most residents are fairly competitive, so some go above and beyond because they like to be the high scorer. To make it even more interesting, I treat the person with the highest grade to coffee.

The residents are aware that I list their administrative grade on their semiannual and final evaluations. When I complete these evaluation forms for the program director, I include a graph chart that shows how well the resident is doing compared to other residents in the same year level. This gives the program director the opportunity to provide feedback based on data-driven comparisons.

For example, if a resident has an administrative grade of D but his peers mostly have Bs, it may indicate the resident needs direction on time management. The program director likes having this feedback because it highlights problem areas.

I find that although collecting the data is time-consuming, the information provided is valuable. The reports and items seem to find things that may otherwise go undetected. ■

Residency Program Alert 2010 index

ACGME core competencies

Book excerpt: *A Practical Guide to Teaching and Assessing the ACGME Core Competencies*, Second Edition. June, p. 8.

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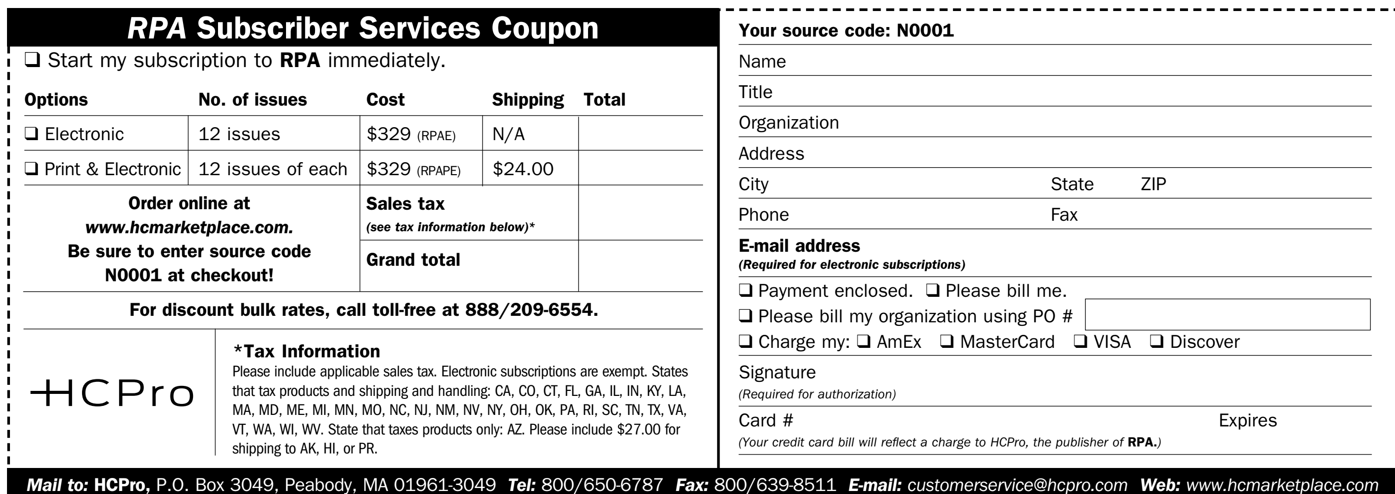

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