SES043: Review Committee for Radiology Update

J. Mark McKinney, MD, FSIR, FACR – Chair

Felicia Davis, MHA – Executive Director

Conflict of Interest Disclosure

Speaker(s):   J. Mark McKinney, MD

Felicia Davis, MHA

Disclosure

None of the speakers for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

Topics for today…

- The Review Committee

- Radiology Data

- Case Logs

- Review Committee Discussions

- Competency-Based Medical Education (CBME)

- ACGME News and Updates

The
Review
Committee

Member Responsibilities

- Operate under delegated authority from the ACGME Board of Directors

- Exercise fiduciary responsibility
  - Fealty to the ACGME overrides allegiance to sponsoring organizations or specialty associations

- Evaluate program compliance with the published Program Requirements

- Revise and update the Program Requirements as scheduled

- Maintain confidentiality

- Maintain communication with programs and specialty associations

Member Terms

- Members: Six-year term
  Resident member: One two-year term

- Each member evaluated by full Review Committee at end of second year

- Chair and vice chair elected by Review Committee
  - Chair term = Three years
  - Vice-chair term = Two years

Review Committee Composition

- Three members nominated by American College of Radiology (ACR)
- Three members nominated by American Board of Radiology (ABR)
- Three members nominated by American Medical Association (AMA)
- One member nominated by American Osteopathic Association (AOA)
- One public member – open call for nominations
- One resident member – nominations from both ACR and Association of Program Directors in Radiology (APDR)

All members selected by the Review Committee from nominated candidates

Review Committee Staff

Executive Director **Felicia Davis, MHA**	*Associate Executive Director* **Jenny Campbell, MA**
Accreditation Administrator **Bianca Andino**	

Committee Members 2023-2024

Kamran Ali, MD Wesley Medical Center *(Abdominal Radiology)*	**Mollie Meek, MD** University of Arkansas *(Interventional Radiology)*
Teresa Chapman, **MD** (Vice Chair) University of Wisconsin *(Pediatric Radiology)*	**J. Mark McKinney**, **MD** (Chair) Mayo Clinic Florida *(Interventional Radiology)*
Kerri Conner, DO University of Oklahoma *(AOA Member – Interventional Radiology)*	**Bruno Policeni, MD** University of Iowa *(Neuroradiology)*
Lea Gilliland, MD Emory University *(Breast Imaging)*	**Eric Rohren, MD** Baylor College of Medicine *(Nuclear Radiology)*
Toby Gordon, ScD Johns Hopkins *(Public Member)*	**Steven Shankman, MD** Maimonides Medical Center *(Musculoskeletal Radiology)*
Candise Johnson, MD Ohio State University *(Resident Member)*	**David Wymer**, **MD** University of Florida *(Cardiothoracic)*

Radiology Data

Radiology Accredited Programs 2023-2024

Specialty	Programs	Approved	Filled
Diagnostic Radiology	197	5418	4713
Interventional Radiology - Integrated	97	956	787
Interventional Radiology - Independent	91	229	154
Abdominal Radiology	13	62	56
Musculoskeletal Radiology	21	54	39
Neuroendovascular Intervention	5	9	9
Neuroradiology	91	379	322
Nuclear Radiology	19	38	11
Pediatric Radiology	48	132	63

Interventional Radiology 2023-2024

Integrated

- 97 programs
- 956 accredited positions
- 787 filled positions
- Graduates ~150/year

Independent

- 91 programs
- 229 accredited positions
- 154 filled positions
- Graduates ~150/year

- 72 Institutions – Both
- 20 Institutions – Integrated Only
- 16 Institutions – Independent Only

Interventional ⟺ Diagnostic Transfers

	2020-2021	2021-2022	2022-2023
Diagnostic ➡ Interventional Integrated	47	30	23 ⬇
Interventional Integrated ➡ Diagnostic	7	12	19 ⬆
TOTAL	54	42	42

Early Specialization in Interventional Radiology (ESIR) Residents

Academic Year	Total Residents ESIR Specialty Track
2020-2021	171
2021-2022	162
2022-2023	152
2023-2024	115 ⬇

Case Logs
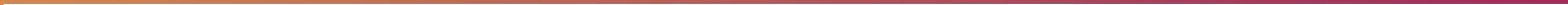
Case Logs: Revisions Coming Soon!

- **The Goal:** A more simplified system that moves away from CPT code-based tracking

- Collaboration with APDR and Association of Program Directors in Interventional Radiology (APDIR)

- All procedures still classified as Diagnostic or Interventional

- Procedures grouped by area: body procedures, musculoskeletal procedures, neurological procedures, drainage procedures, biopsy, arterial interventions, etc.

- Will include I-131 and parenteral therapies, and hands-on ultrasound cases

- Benefits:
  - More consistency in tracking
  - Ease of reference using common terms
  - Easier to maintain

Case Logs

- 25 image-guided biopsy/drainage for diagnostic radiology:
  - The expectation for 25 image-guided biopsy/drainage for diagnostic radiology remains unchanged
  - Added back to the required list posted on the website
  - *Expect these cases to be entered individually in the Case Log System by the residents, not in aggregate by the coordinator*

- The Review Committee expects radiology residents to track all procedures (individually) and imaging studies (aggregate) in the Case Log System
  - This data is essential for the required minimums to be established later for interventional radiology

New Outpatient Interventional Radiology Clinic Encounters

Code	Description	Area	Type	Fav	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter. **Def Cat:** New Outpatient Eval	Patient Evaluation	New Outpatient Clinic Evaluation	★	Add
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter. **Def Cat:** New Outpatient Eval	Patient Evaluation	New Outpatient Clinic Evaluation	★	Add
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. **Def Cat:** New Outpatient Eval	Patient Evaluation	New Outpatient Clinic Evaluation	★	Add

Residents should be tracking all interventional radiology new outpatient clinic encounters in Case Logs

Procedures Expected of a General Radiologist

- Communication from APDR/APDIR Task Force

- Concern about the basic skills of future radiologists

- The Review Committee supports the Task Force recommendation for procedural competencies

- 10 procedural skills identified as the competency areas residents should be able to perform independently after graduation

- These 10 procedures will be tracked in the revised Case Log System for all radiology residents

General Radiology Essential Procedural Skills

10 Essential procedural skills for a general radiologist:

- Paracentesis
- Thoracentesis
- Thyroid fine needle aspiration
- Breast biopsies
- Image-guided core biopsy
- Image-guided abscess drainage
- Catheter exchange, over-wire
- Ultrasound-guided venous access
- Arthrograms/joint aspirations/injections
- Lumbar puncture

Review Committee Discussions

ESIR Challenges

- Working with APDR and APDIR. Concerns expressed about faculty and procedural experience.

- Has the landscape of ESIR programs changed since approval?

- Challenges of ensuring ESIR programs are providing a consistent quality interventional radiology experience with procedural variety and complexity

- New ESIR assessment questions in Accreditation Data System (ADS) being considered

- Case Log data will be helpful for ongoing evaluation of ESIR resident procedural experience

ESIR Interventional Radiology Rotations in PGY-2-4

- ESIR curriculum variation with regard to the number of interventional radiology rotations assigned in the PGY-2-4 (R1-R3)

- ESIR should follow same guidelines as interventional radiology – integrated: three interventional radiology rotations during the PGY-2-4

- This ensures a balanced experience with adequate exposure to all domains of radiology in preparation for the Core Exam

- The Review Committee will allow up to four interventional radiology rotations PGY-2-4
  - Five to six: Area for Improvement (AFI)
  - More than six: Subject to a citation

Nuclear Radiology in Diagnostic and Interventional Radiology

- Each resident must complete **700 hours of training and work** experience under the supervision of an authorized user (AU), including **80 hours of classroom** and **laboratory** training [IV.C.4.b).(5)] and [IV.C.5.e).(2).(e)]

- Residents may count the 80 hours of classroom/laboratory training toward the 700-hour requirement

- *To fulfill the requirement, the Committee will expect the block diagram for both diagnostic and interventional radiology – integrated programs to include at **least 4 rotations in nuclear radiology/nuclear medicine***

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Nuclear Radiology Fellowship
Pediatric Cases

- Volume concerns regarding the number of pediatric nuclear cases available

- Nuclear radiology pediatric requirements:

IV.B.1.b).(2).(b) Fellows must demonstrate competence in performing pediatric nuclear radiology cases. (Core)
IV.B.1.b).(2).(b).(i) This must include the performance of a minimum of **100 pediatric cases**. (Core)

Nuclear Radiology Fellowship
Pediatric Cases

- **Original expectation:** Multiple fellows and students may participate in each case, but, as a general rule, only the fellow who reports the case should record it and take credit for it

- After recent discussions, the Review Committee has revised its position on pediatric cases

***New Interpretation:** As of March 1, 2024, the Review Committee will **no longer enforce the minimum requirement of 100 pediatric cases per fellow**. All fellows must have experience in the performance of pediatric cases in order to develop competence. It is up to the program director to determine the competence of each fellow and how much pediatric experience each fellow needs to achieve a level of competence necessary to enter autonomous practice.

Resident Transfers

Transfer Requirements:

(Interventional Radiology Requirement III.C.1.b))

Resident transfers from ACGME-accredited diagnostic radiology programs into integrated interventional radiology programs must be **limited to transfers from within the same Sponsoring Institution** and must meet the following qualifications for transfer: (Core)

(Diagnostic Radiology Requirement III.C.2.)

Resident transfers from ACGME-accredited integrated interventional radiology programs into diagnostic radiology programs must be **limited to transfers within the same Sponsoring Institution** and must meet the following qualifications for transfer: (Core)

Resident Transfers

- The Review Committee re-evaluated the requirements and determined that it will **not enforce** the transfer limitation from within the same Sponsoring Institution.

Best Practice – *Supervision Policy*

- **Direct Supervision**

- VI.A.2.b).(1).(b).(i)
  - The program must have clear guidelines that delineate **which competencies must be demonstrated to determine when a resident can progress to indirect supervision.** (Core)

- Describe competency evaluation process to move from direct to indirect supervision for specific clinical activities and procedures

Best Practice – *Supervision Policy*

	Competency requirements to perform without direct supervision
Informed consent	Learning module completion, direct supervision four weeks
Procedure A	Always requires direct supervision
Procedure B	Five cases directly supervised, signed off by attending

- **Direct Supervision**

- VI.A.2.b).(1).(b).(ii)
  - The program director must ensure that clear expectations exist and are communicated to the residents, and **that these expectations outline specific situations in which a resident would still require direct supervision.** (Core)

- VI.A.2.c)
  - The program must define when physical presence of a supervising physician is required. (Core)

- Examples:
  - Anaphylactic contrast reaction
  - Simple procedure with unexpected hypotension or acute worsening with respiratory/cardiac compromise

Best Practice – *Supervision Policy*

- VI.A.2.e) List circumstances/events that require immediate communication to supervising faculty

- Supervision policy for **interventional radiology – integrated** should address the diagnostic radiology components of education and training. **Cannot be an interventional radiology-only supervision policy.**

Citation Responses

- Your responses to citations in ADS should be **taken seriously**

- The program's ADS information will be pulled from the system to be evaluated by the Review Committee

- Citation responses should be **robust and clearly delineated**

- Providing abbreviated or "cursory" responses may result in the continuation of a citation or the issuance of a new citation

Major Changes in ADS

- Programs are encouraged to use the "**Major Changes and Other Updates**" section of ADS. Major clinical or administrative changes in your program belong here

- Highlight changes the program implemented to address **AFIs**

- Describe plans implemented to address deficiencies noted on the **Resident/Fellow** and/or **Faculty Surveys**

- This information gives the Committee confidence that the program is engaged and being responsive to potential weaknesses
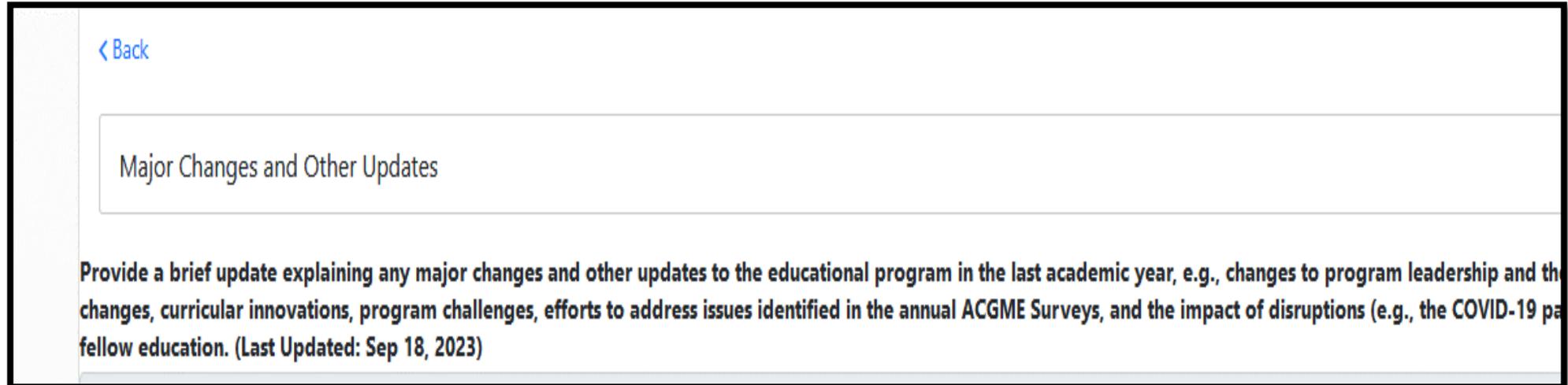
‹ Back

Major Changes and Other Updates

Provide a brief update explaining any major changes and other updates to the educational program in the last academic year, e.g., changes to program leadership and th[e] changes, curricular innovations, program challenges, efforts to address issues identified in the annual ACGME Surveys, and the impact of disruptions (e.g., the COVID-19 pa[ndemic]) fellow education. (Last Updated: Sep 18, 2023)

CBME
COMPETENCY-BASED
MEDICAL EDUCATION

CBME Definition

"Competency-based medical education (CBME) is an approach to medical training that emphasizes the *personalized learning trajectory of each student through the achievement of specific observable skills*. This contrasts with the previous time-based approach, which presumes that learners acquire the same skills at a standardized pace."

Highlights From the Development of CBME

1996
CanMEDS is released. This framework is refreshed in 2005 and 2015.

1998
The Medical School Objectives Project begins. It runs until 2008.

1998 ACGME Outcome Project

1999
The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties endorse a set of six core competencies

2009
The Education in Pediatrics Across the Continuum project is established to build a model for true CBME.

2011
The Interprofessional Education Collaborative releases its initial core competencies for interprofessional collaborative practice. These are updated in 2016.

2012
The Accreditation Council for Graduate Medical Education launches the Next Accreditation System, which incorporates milestones into the core competency framework

2013
The Physician Competency Reference Set is released

2014
A set of 13 Core Entrustable Professional Activities for Entering Residency is developed by a drafting panel convened by the AAMC. A 10-school pilot is established and runs through 2021.

The Coalition for Physician Accountability endorses the six general but essential domains of competence as its common framework.

2017
The AAMC begins its Competencies Across the Continuum Learning Series: New and Emerging Areas

2020
Action Plan 1 of the AAMC Strategic Plan is announced

Timeline: 1996 › 1998 › 1999 › 2009 › 2011 › 2012 › 2013 › 2014 › 2017 › 2020

Competencies

How to evaluate physician competencies?

Medical Knowledge

Patient Care

Interpersonal Communication Skills

Systems-Based Practice

Practice-Based Learning and Improvement
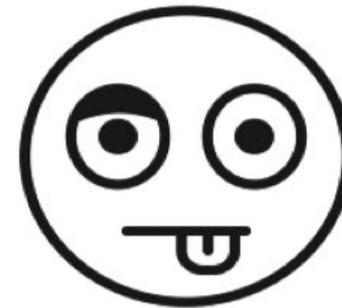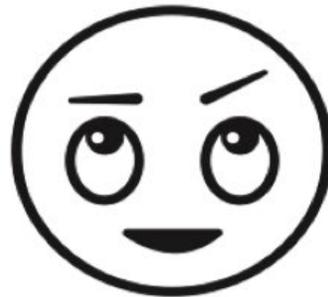
Milestones: From Level 1 to Level 5

- Describe a *stepwise progression* toward achieving mastery

- *Represent a roadmap* for the development of residents and fellows as they advance in clinical skills, knowledge, and values

- Assessed through peer and health professions faculty members' assessments and synthesized by the Clinical Competency Committee

January 2020

First Case of 2019 Novel Coronavirus in the United States

Michelle L. Holshue, M.P.H., Chas DeBolt, M.P.H., Scott Lindquist, M.D.,
Kathy H. Lofy, M.D., John Wiesman, Dr.P.H., Hollianne Bruce, M.P.H.,
Christopher Spitters, M.D., Keith Ericson, P.A.-C., Sara Wilkerson, M.N.,
Ahmet Tural, M.D., George Diaz, M.D., Amanda Cohn, M.D., LeAnne Fox, M.D.,
Anita Patel, Pharm.D., Susan I. Gerber, M.D., Lindsay Kim, M.D.,
Suxiang Tong, Ph.D., Xiaoyan Lu, M.S., Steve Lindstrom, Ph.D.,
Mark A. Pallansch, Ph.D., William C. Weldon, Ph.D.,
Holly M. Biggs, M.D., Timothy M. Uyeki, M.D., and Satish K. Pillai, M.D.,
for the Washington State 2019-nCoV Case Investigation Team*

SUMMARY

An outbreak of novel coronavirus (2019-nCoV) that began in Wuhan, China, has spread rapidly, with cases now confirmed in multiple countries. We report the first case of 2019-nCoV infection confirmed in the United States and describe the identification, diagnosis, clinical course, and management of the case, including the patient's initial mild symptoms at presentation with progression to pneumonia on day 9 of illness. This case highlights the importance of close coordination between clinicians and public health authorities at the local, state, and federal levels, as well as the need for rapid dissemination of clinical information related to the care of patients with this emerging infection.
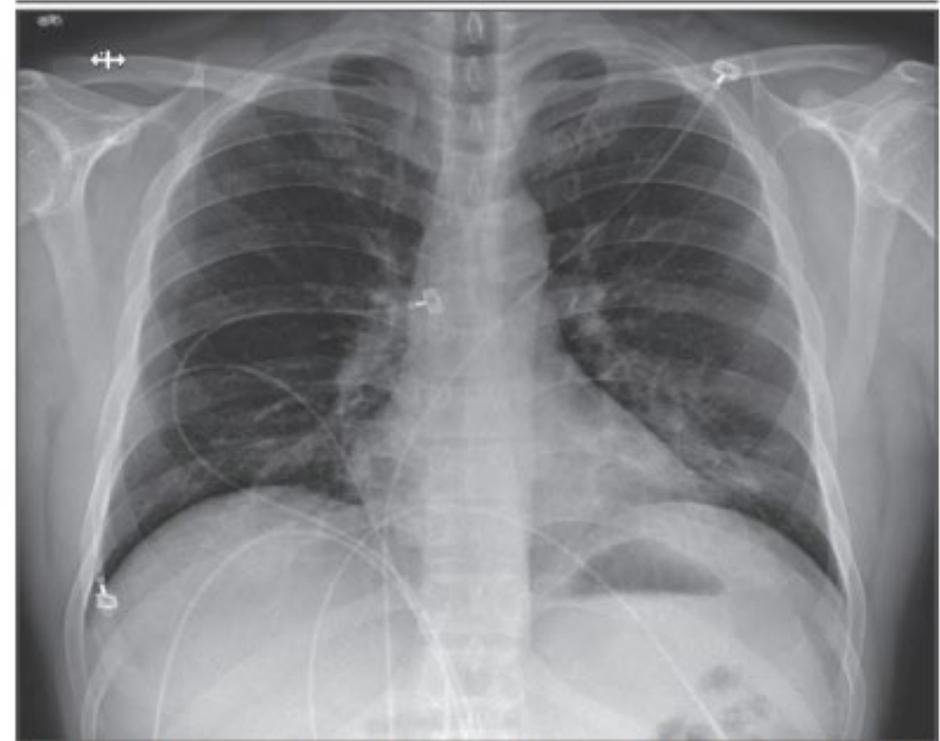
Figure 4. Posteroanterior Chest Radiograph, January 24, 2020 (Illness Day 9, Hospital Day 5).

Increasing left basilar opacity was visible, arousing concern about pneumonia.

What the COVID-19 Pandemic Exposed for GME

- Reliance on time-in-training as proxy for competence untenable
- Usual "proxies" for assessment significantly altered and disrupted:
  - Volume and distribution (e.g., clinical conditions, procedures)
  - Rotations to ensure clinical experiences
    - Removal or redeployment of learners
  - High-stakes examinations
- Highlighted substantial gaps around all transitions
  - UME > GME; GME > GME; GME > practice

Why are *We* Talking About This?

General Surgery Residency Inadequately Prepares Trainees for Fellowship

Results of a Survey of Fellowship Program Directors

Samer G. Mattar, MD,* Adnan A. Alseidi, MD, FACS,† Daniel B. Jones, MD, FACS,‡
D. Rohan Jeyarajah, MD, FACS,§ Lee L. Swanstrom, MD, FACS,‖ Ralph W. Aye, MD, FACS,¶
Steven D. Wexner, MD, FACS, FRCS, FRCS(Edin), PhD (Hon),** José M. Martinez, MD, FACS,††
Sharona B. Ross, MD, FACS,‡‡ Michael M. Awad, MD, FACS,§§ Morris E. Franklin, MD, FACS,‖‖
Maurice E. Arregui, MD, FACS,¶¶ Bruce D. Schirmer, MD, FACS,*** and Rebecca M. Minter, MD, FACS†††

Ann Surg 2013

EDUCATION

Are General Surgery Residents Ready to Practice? A Survey of the American College of Surgeons Board of Governors and Young Fellows Association

Lena M Napolitano, MD, FACS, FCCP, FCCM, Mark Savarise, MD, FACS, Juan C Paramo, MD, FACS,
Laurel C Soot, MD, FACS, S Rob Todd, MD, FACS, Jay Gregory, MD, FACS, Gary L Timmerman, MD, FACS,
William G Cioffi, MD, FACS, Elisabeth Davis, PhD, Ajit K Sachdeva, MD, FRCSC, FACS

JACS 2014

DOCTOR AND PATIENT

Are Today's New Surgeons Unprepared?

By PAULINE W. CHEN, M.D.   DECEMBER 12, 2013, 12:20 PM   159 Comments

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The surgeon had no prestigious named professorship, no N.I.H. grant and no plum administrative position in the hospital's hierarchy. But to the other surgeons-in-training and me, he was exactly who we wanted to be.

DOCTOR AND PATIENT
Dr. Pauline Chen on medical care.

New York Times Dec 12, 2013

Achieving Outcomes: CBME

*"An approach to preparing physicians for practice
that is fundamentally oriented to graduate outcome abilities
and organized around competencies
derived from an analysis of **societal and patient needs**.*

*It de-emphasizes time-based training and promises greater
accountability, flexibility and learner-centeredness."*

"Time" Still Matters

- In outcomes-based medical education (OBME)/CBME, time is viewed as a *resource* and not an *intervention/measure*
  - Time is too often used as a proxy for competence (measure lens)

- Shortening education and training is *not* the primary goal of OBME/CBME

- The core principles of CBME can still advance GME within "fixed" program lengths, designing outcomes-based flexibility within a residency/fellowship

Comparison: Traditional vs. CBME

Variable	Traditional Educational Model	CBME
Driving force for curriculum	Knowledge acquisition	Knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchal	Non-hierarchical
Responsibility of content	Teacher	Teacher and student
Goal of educational encounter	Knowledge and skill acquisition	Knowledge and skill application
Type of assessment tool	Single assessment measure (e.g., test)	Multiple assessment measures (e.g., direct observation)
Assessment tool	Proxy	Authentic (mimics real profession)
Setting for evaluation	Removed	In clinical and professional settings
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

Adapted from Carraccio, 2002

Learning Curves and Developmental Models
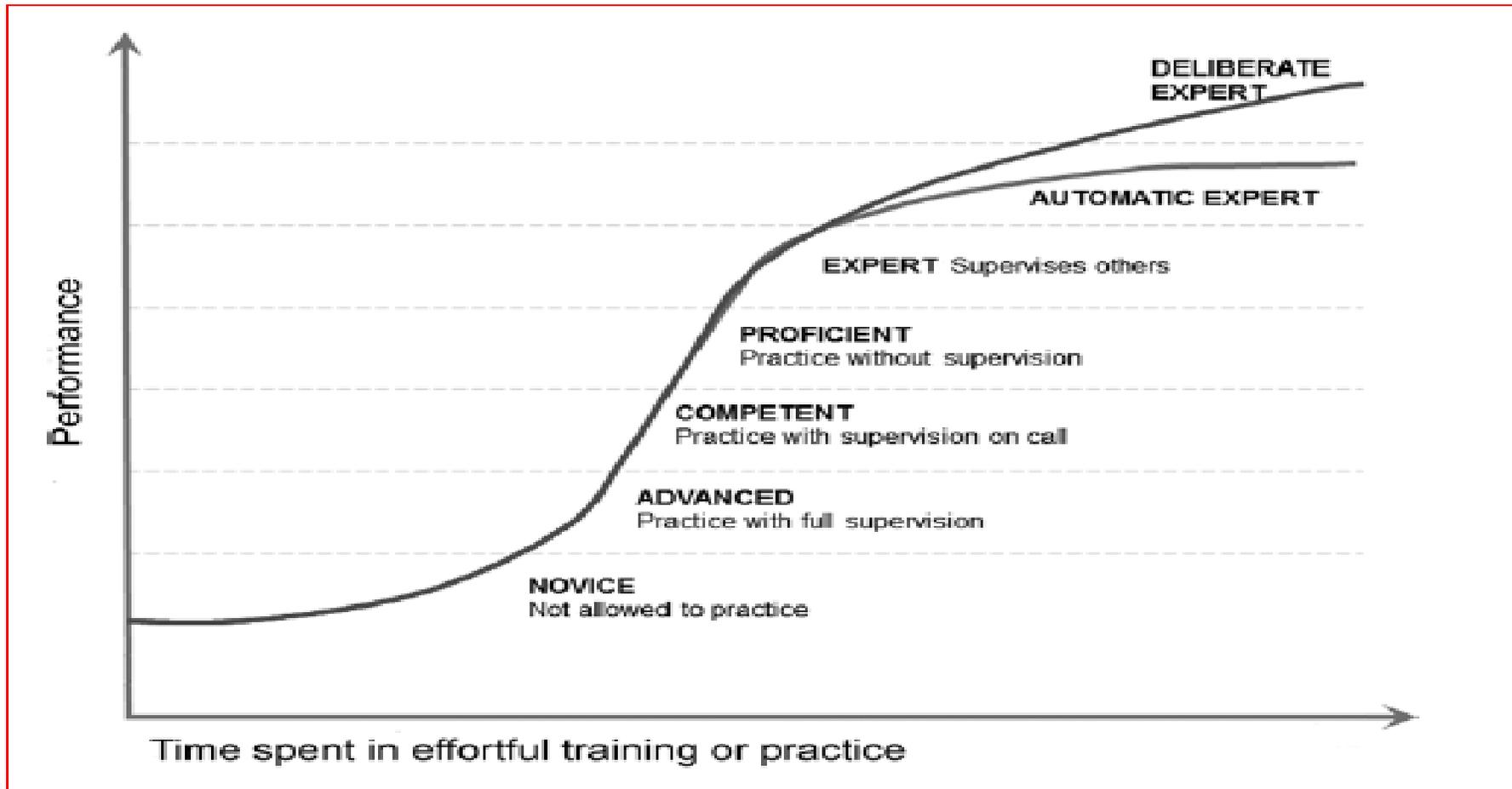
Reading Radiographs: An Example
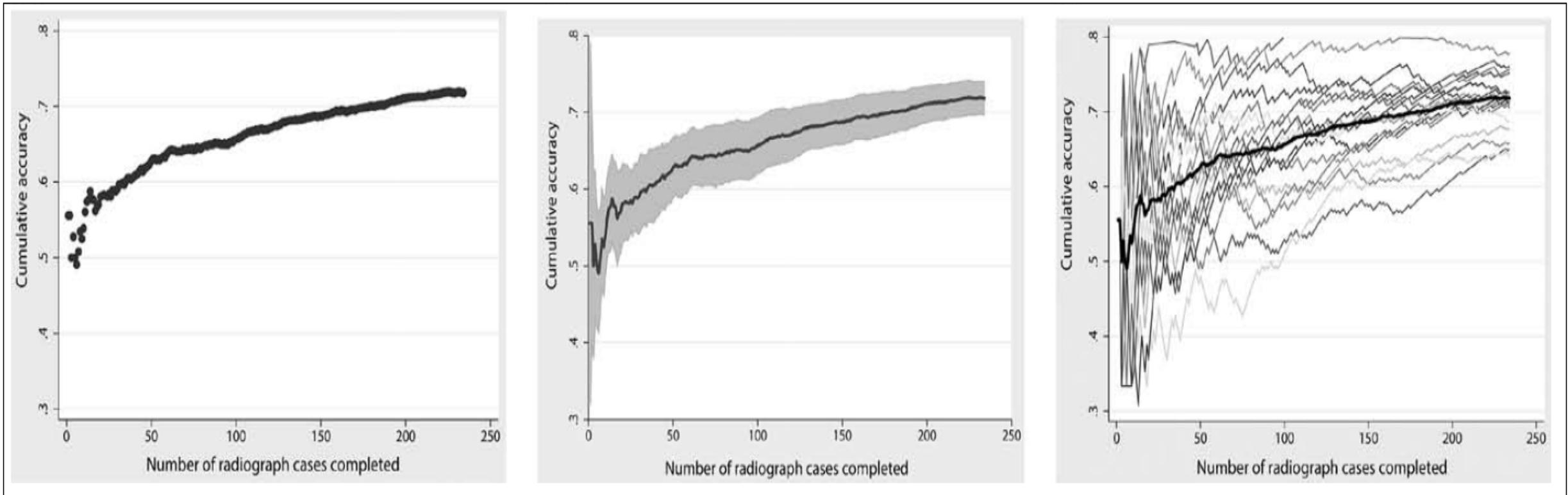
18 residents reading pediatric ankle radiographs

Entrustable Professional Activities (EPA)

What Is an EPA?

- Essential task of a discipline that an individual can be trusted to perform independently in a given context

- "Competencies are descriptors of physicians, EPAs are descriptors of work."

Ten Cate, O. (2005), Entrustability of professional activities and competency-based training. Medical Education, 39: 1176-1177.

Ten Cate, O. Nuts and bolts of entrustable professional activities. J Grad Med Educ. 2013 Mar;5(1):157-8.

EPA Examples in Radiology

- Collaborates as a member of an interprofessional team

- Triages/protocols exams

- Interprets exams and prioritizes a differential diagnosis

- Communicates results of exams

- Recommends appropriate next steps

- Obtains informed consent and performs procedures

- Manages patients after imaging and procedures

- Formulates clinical questions and retrieves evidence to advance patient care

- Behaves professionally

- Identifies system failures and contributes to a culture of safety and improvement

General Surgery EPA Suite

5 + 13 = 18 Total

- Thyroid/Parathyroid Disease
- Cutaneous Neoplasia
- Surgical Consultation
- Trauma
- Breast Disease
- Critically Ill Patient
- Acute Abdomen
- Flexible Endoscopy
- Gallbladder Disease
- Abdominal Wall Hernia
- Necrotizing Pancreatitis
- Small Bowel Obstruction
- Hemodialysis Access
- Appendicitis
- Colon Disease
- Inguinal Hernia
- Anorectal Disease
- Soft Tissue Infection
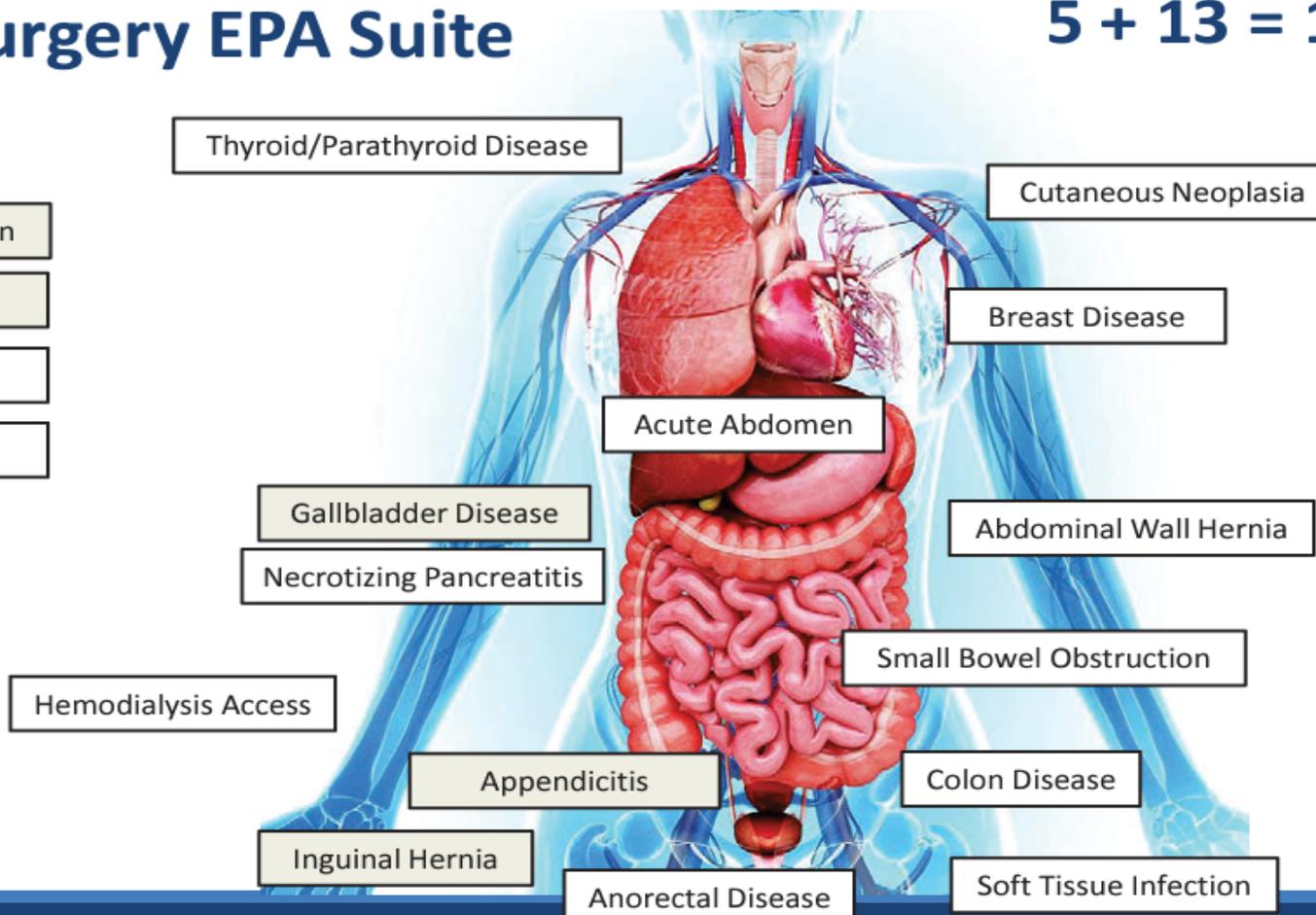
THE AMERICAN BOARD OF SURGERY | www.absurgery.org

General Surgery EPAs
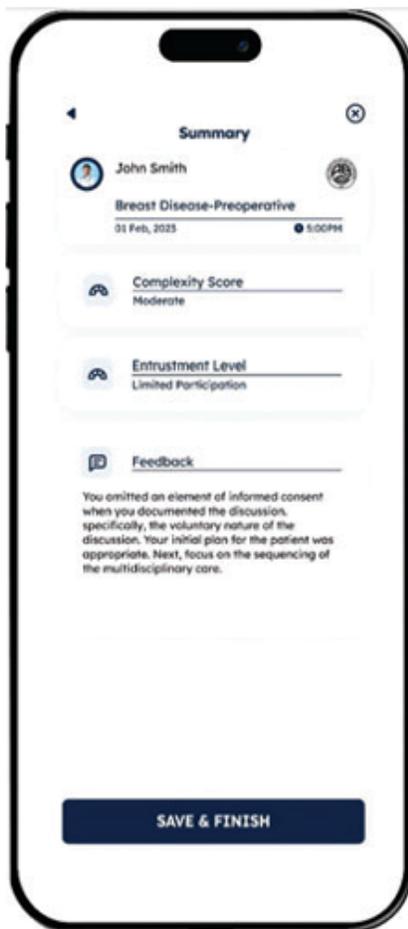
Internal Medicine EPAs

- ## Observable Practice Activities (OPAs)
  - Smaller units than EPAs
  - Learning objectives as activities that must be observed in practice

- ## Entrustable Professional Activities (EPAs)
  - Essential actions and tasks of a discipline that an individual can be trusted to perform independently
  - Shifts assessment focus from the abstract and independent competencies to the work that must be done

Warm EJ, Mathis BR, Held JD, et al. Entrustment and mapping of observable practice activities for resident assessment. *J Gen Intern Med*. 2014;29(8):1177-1182. doi:10.1007/s11606-014-2801-5
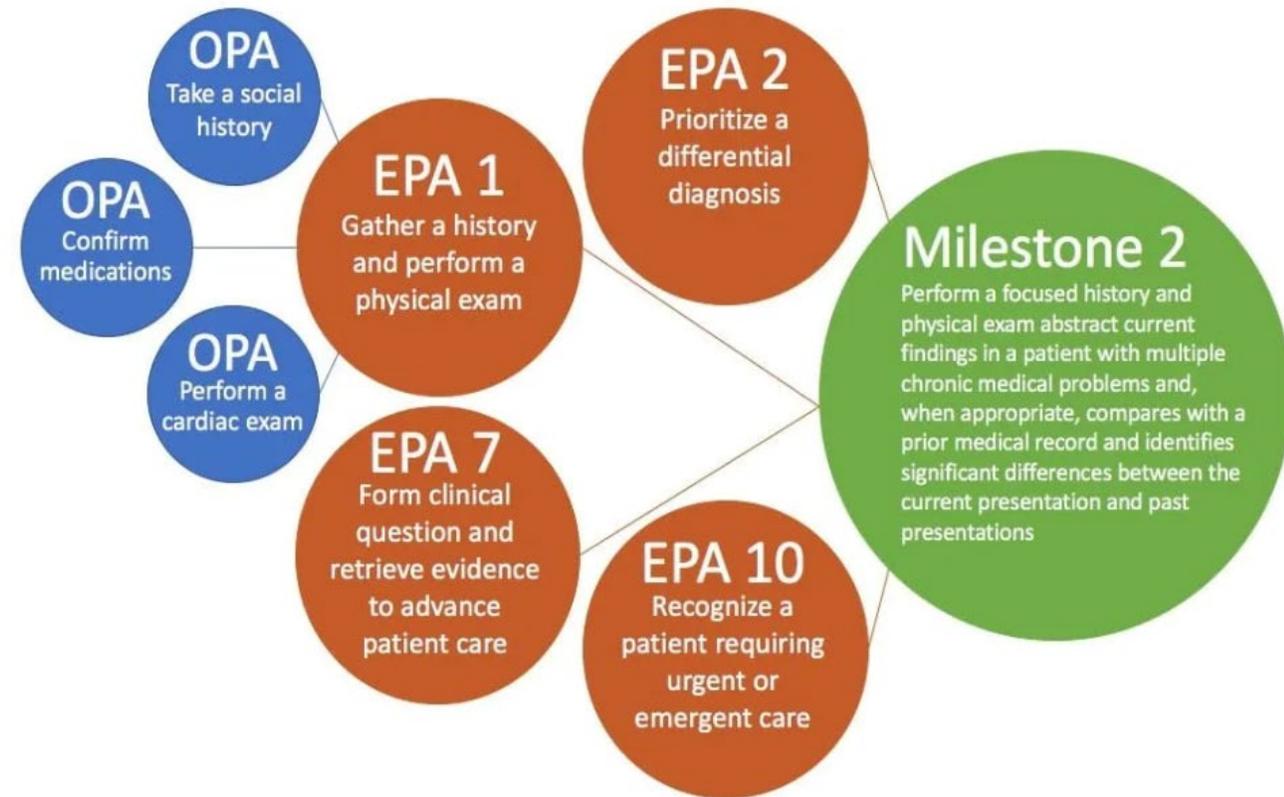
Individual Learning Plans

- ACGME Common Program Requirement V.A.1.d).(2):

The program director or their designee, with input from the Clinical Competency Committee, must: assist residents in developing **individualized learning plans** to capitalize on their strengths and identify areas for growth; (Core)

Challenge: Leadership

- Need for successful leaders who can serve as educational mentors

  - Clinical program redevelopment

  - Resident and faculty subcommittees to provide forums for advocacy and discussion

  - Obtain institutional support

Challenge: Tools

- Phone apps:
  - To easily and rapidly assess and record EPAs and other assessments

Challenges

- Inertia, inertia, inertia
- Change management
- Competence in CBME
  - Faculty, learners, programs, and institutions
  - Implementation knowledge and skills
- Changing rigid curricula
- Faculty resources
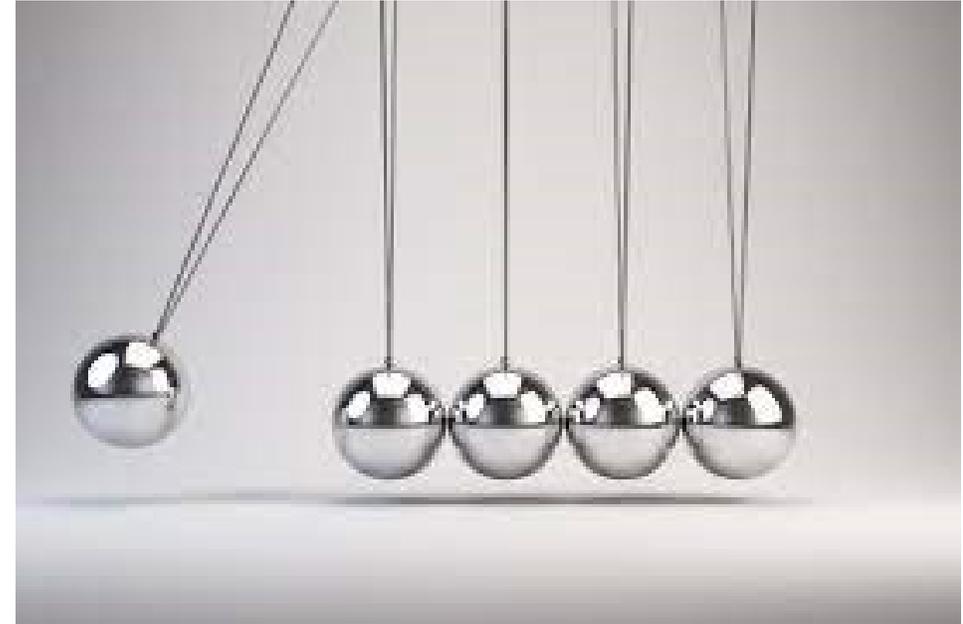
Accelerating CBME will require...

- Better integration of curriculum and assessment
- Rethinking educational design such as rotations
- Advancing effective practices for competency milestones and EPAs
- *Greater engagement of learners as "active agents" (co-production)*
- *Embracing innovation*

ACGME News and Updates

ACGME Site Visits – Continued Accreditation Status

- The program 10-Year Accreditation Site Visit program has been discontinued

- Program Self Study currently paused, but will be reconfigured and no longer linked to a site visit

- All related dates have been removed from all program profiles in ADS

- Starting in 2024, the ACGME will conduct site visits annually for approximately 1-2% of programs on Continued Accreditation that have not had a site visit in approximately 10 years or more

- These site visits will be identified through a sampling process

- All selected programs for 2024 were notified in January of the site visit target date (May-July 2024)

Questions can be directed to accreditation@acgme.org
Site Visit FAQs are located on the ACGME webpage

The ACGME's Online Learning Portal

Learn at ACGME Redesign

Coming Soon!

Visit dl.acgme.org or scan the QR code.

Have a question or need assistance? Contact us!

desupport@acgme.org
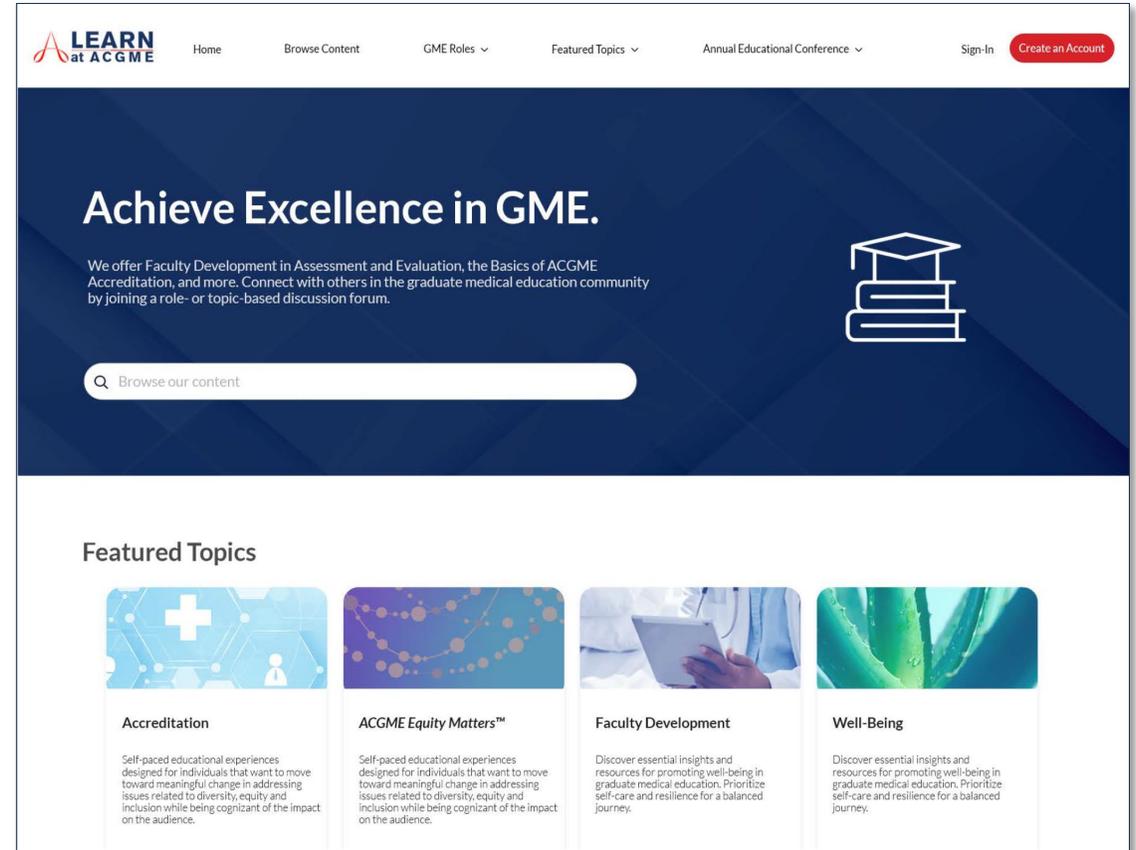
Remediation Toolkit

If You Build It, They Will Come:

Designing a Centralized Remediation Program

Karen M. Warburton, MD, FACP, FASN
Associate Professor of Medicine
Director, Clinician Wellness Program
Director, GME Advancement
University of Virginia School of Medicine

- ➢ 11 modules authored by **renowned experts** in the field

- ➢ Equips participants with tools for **addressing needs of struggling learners**

- ➢ **CME** offered after completion

The ACGME designates this enduring material for a maximum of **5.25 AMA PRA Category 1 Credits** ᵀᴹ

Applying for Program Accreditation Course

➤ Three-part course and **step-by-step guide**

➤ For those **new** to the process, as well as a refresher for **experienced** users

➤ Explanation of key steps, timeline, and the **review process** after submission
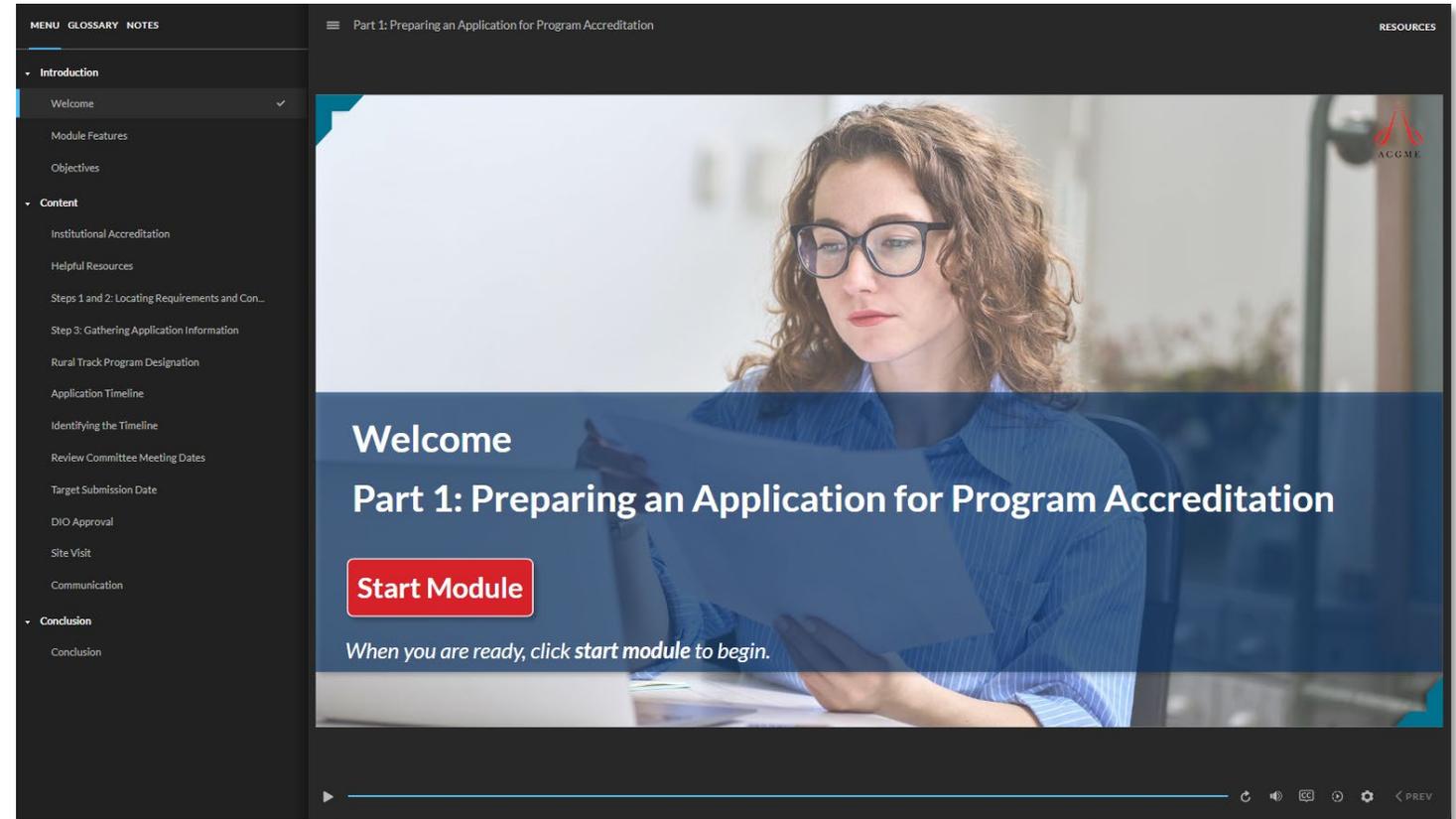
Faculty Development Toolkit:
Improving Assessment Using Direct Observation

- Faculty development materials around **direct observation and feedback**

- Evidence-based **video prompts**

- Answer keys and **facilitator guides**

- **Microlearning** lessons with associated slides and guides

Program Coordinator Course

- For **new and seasoned** coordinators

- Covers a **wide range of topics** important to program coordinators

- **Videos** from working coordinators

- **Summer 2024**

Questions?

Thank You