UND School of Medicine & Health Sciences
University of North Dakota

Pediatric Residency Faculty Handbook

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2022-2023 Pediatric Residency Milestones

Patient Care 1: History				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Gathers information strictly following a template	Adapts template to filter and prioritize pertinent positives and negatives based on broad diagnostic categories or possible diagnoses	Filters, prioritizes, and synthesizes the history to develop a differential diagnosis in real-time for uncomplicated or typical presentations	Filters, prioritizes, and synthesizes the history to develop a differential diagnosis in real time for complicated or atypical presentations	Recognizes and probes subtle clues from patients and families; distinguishes nuances among diagnoses to efficiently drive further information gathering

Patient Care 2: Physical Exam				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Performs fundamental physical examination	Performs complete physical examination and identifies variants and abnormal findings	Performs complete or focused physical examination, as indicated, and interprets normal variants and abnormal findings	Performs complete or focused physical examination, as indicated, and selects advanced maneuvers to distinguish between diagnoses	Detects, pursues, and integrates key physical examination findings to distinguish nuances among competing, often similar diagnoses
Performs a routine physical examination using a strict head-to-toe approach	Performs a physical examination considering appropriate adaptation for age and development	Performs a physical examination with consistent use of a developmentally appropriate approach	Performs a physical examination using strategies to maximize patient cooperation and comfort	Performs a physical examination that consistently and positively engages the patient

Patient Care 3: Organize and Prioritize Patient Care				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Completes tasks for an individual patient, when prompted	Organizes patient care responsibilities by focusing on individual (rather than multiple) patients	Organizes and prioritizes the simultaneous care of patients with efficiency	Organizes, prioritizes, and delegates patient care responsibilities even when patient volume approaches the capacity of the individual or facility; anticipates and triages urgent and emergency issues	Serves as a role model and coach for patient care responsibilities

Patient Care 4: Clinical Reasoning				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Presents clinical facts (e.g., history, exam, tests, consultations) in the order they were elicited	Generates an unfocused differential diagnosis based on the clinical facts	Organizes clinical facts to compare and contrast diagnoses being considered, resulting in a prioritized differential diagnosis	Integrates clinical facts into a unifying diagnosis(es); reappraises in real time to avoid diagnostic error	Role models and coaches the organization of clinical facts to develop a prioritized differential diagnosis, including life threatening diagnoses, atypical presentations, and complex clinical presentations

Patient Care 5: Patient Management				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Reports management plans developed by others	Participates in the creation of management plans	Develops an interdisciplinary management plan for common and typical diagnoses	Develops and implements informed management plans for complicated and atypical diagnoses, with the ability to modify plans as necessary	Serves as a role model and coach for development of management plans for complicated and atypical diagnoses, with the ability to modify plans as necessary

Medical Knowledge 1: Clinical Knowledge				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates basic medical knowledge	Links basic medical knowledge to clinical scenarios	Applies medical knowledge to common and typical scenarios to guide patient care	Integrates a breadth of medical knowledge that includes complicated and atypical conditions to guide patient care	Teaches at multiple levels, drawing from a breadth of medical knowledge that spans the continuum of simple to complex problems

Medical Knowledge 2: Diagnostic Evaluation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Lists basic evaluation (e.g., diagnostic testing and consultation) for common diagnoses, with prompting	Recommends broad evaluation based on an unfocused differential diagnosis	Recommends focused evaluation based on prioritized differential diagnosis	Prioritizes and optimizes evaluation based on risks, benefits, indications, and alternatives to clarify the diagnosis(es)	Educates other about risks, benefits, indications, and alternatives to guide diagnostic decision making
Reports results of diagnostic studies	Identifies clinically significant diagnostic study results, with guidance	Interprets clinical significance of diagnostic study results	Interprets clinical significance of diagnostic study results while considering study limitations	Teaches others to interpret clinically significant results and consider study limitations

Systems-Based Practice 1: Patient Safety				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Role models or mentors' others in the disclosure of patient safety events

Systems-Based Practice 2: Quality Improvement				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., community vaccination rate, infection rate, smoking cessation)	Participates in local quality improvement initiatives	Demonstrates the skills required to identify, develop, implement, and analyze a quality improvement project	Creates, implements, and accesses quality improvement initiatives at the institutional or community level

Systems-Based Practice 3: System Navigation for Patient Centered Care – Coordination of care				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Lists the various interprofessional individuals involved in the patient's care coordination	Coordinates care of patients in routine clinical situations, incorporating interprofessional teams with consideration of patient and family needs	Coordinates care of patients in complex clinical situations, effectively utilizing the roles of interprofessional teams, and incorporating patient and family needs and goals.	Coordinates interprofessional, patient-centered care among differed disciplines and specialties, actively assisting families in navigating the healthcare system	Coaches others in interprofessional, patient centered care coordination

Systems-Based Practice 4: System Navigation for Patient Centered Care –Transitions in care				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Uses a standard template for transitions of care/hand-offs	Adapts a standard template, recognizing key elements for safe and effective transitions of care/hand-offs in routine clinical situations	Performs safe and effective transitions of care/hand-offs in complex clinical situations, and ensures closed-loop communication	Performs and advocates for safe and effective transitions of care/hand-offs within and across health care delivery systems, including transitions to adult care	Coaches others in improving transitions of care within and across health care delivery systems to optimize patient outcomes

Systems-Based Practice 5: Population and Community Health				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates awareness of population and community health needs and disparities	Identifies specific population and community health needs and disparities; identifies local resources	Uses local resources effectively to meet the needs and reduce health disparities of a patient population and community	Adapts practice to provide for the needs of and reduce health disparities of a specific population	Advocates at the local, regional, or national level for populations and communities with health care disparities

Systems-Based Practice 6: Physician Role in Health Care Systems				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Engages with patients and other providers in discussions and cost-conscious care and key components of the health care delivery system	Identifies the relationships between the delivery system and cost-conscious care and the impact on the patient care	Discusses the need for changes in clinical approaches based on evidence, outcomes, and cost-effectiveness to improve care for patients and families	Advocates for the promotion of safe, quality, and high-value care	Coaches others to promote safe, quality, and high-value care across health care systems

Practice-Based Learning and Improvement 1: Evidence-Based and Informed Practice				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Develops an answerable clinical question and demonstrated how to access available evidence, with guidance	Independently articulates clinical questions and accesses available evidence	Locates and applies the evidence, integrated with patient preference, to the care of patients	Critically appraises and applies evidence, even in the face of uncertainty and conflicting evidence to guide care tailored to the individual patient	Coaches others to critically appraise and apply evidence for complex patients

Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Participates in feedback sessions	Demonstrated openness to feedback and performance data	Seeks and incorporated feedback and performance data episodically	Seeks and incorporated feedback and performance data consistently	Role models and coaches' others in seeking and incorporating feedback and performance data
Develops personal and professional goals, with assistance	Designs a learning plan based on established goals, feedback, and performance data, with assistance	Designs and implements a learning plan by analyzing and reflecting on the factors which contribute to gap(s) between performance expectations and actual performance	Adapts a learning plan using long-term professional goals, self-reflection, and performance data to measure its effectiveness	Demonstrates continuous self-reflection and coaching of others on reflective practice

Professionalism 1: Professional Behavior				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies expected professional behaviors and potential triggers for lapses	Demonstrates professional behavior with occasional lapses	Maintains professional behavior in increasingly complex or stressful situations	Recognizes situations that may trigger professionalism lapses and intervenes to prevent lapses in self and others	Models professional behavior and coaches' others when their behavior fails to meet professional expectations
Identifies the value and role of pediatrics as a vocation/career	Demonstrates accountability for patient care as a pediatrician, with guidance	Fully engages in patient care and holes oneself accountable	Exhibits a sense of duty to patient care and professional responsibilities	Extends the role of the pediatrician beyond the care of patients by engaging with the community, specialty, and medical profession as a whole

Professionalism 2: Ethical Principles				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates knowledge of the ethical principles underlying informed consent, surrogate decision making, advance directives, confidentiality, error disclosure, stewardship of limited resources, and related topics	Applies ethical principles in common situations	Analyzes complex situations using ethical principles to address conflict/controversy; seeks help when needed to manage and resolve complex ethical situations	Manages and seeks to resolve ethical dilemmas using appropriate resources (e.g., ethics consultations, literature review, risk management/legal consultation)	Called upon by others to consult in cases of complex ethical dilemmas; identifies and seeks to address system-level factors that induce or exacerbate

Professionalism 3: Accountability/Conscientiousness				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Performs tasks and responsibilities, with prompting	Performs tasks and responsibilities in a timely manner in routine situations	Performs tasks and responsibilities in a thorough and timely manner in complex or stressful situations	Coaches others to ensure tasks and responsibilities are completed in a thorough and timely manner in complex or stressful situations	Creates strategies to enhance others; ability to efficiently complete tasks and responsibilities

Professionalism 4: Well-Being				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Recognizes the importance of addressing personal and professional well-being	Describes institutional resources that are meant to promote well-being	Recognizes institutional and personal factors that impact well-being	Describes interactions between institutional and personal factors that impact well-being	Coaches and supports colleagues to optimize well-being at the team, program, or institutional level

Interpersonal and Communication Skills 1: Patient-and Family-Centered Communication				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates respect and attempts to establish rapport	Establishes a therapeutic relationship pin straightforward encounters	Establishes a culturally competent and therapeutic relationship in most encounters	Establishes a therapeutic relationship pin straightforward and complex encounters, including those with ambiguity and/or conflict	Mentors others to develop positive therapeutic relationships
Attempts to adjust communication strategies abase upon patient/family expectations	Adjust communication strategies as needed to mitigate barriers and meet patient/family expectations	Communicates with sensitivity and compassion, elicits patient/family values, and acknowledges uncertainty and conflict	Uses shared decision making with patient/family to make a personalized care plan	Models and coaches others in patient-and family-centered communication

Interpersonal and Communication Skills 2: Interprofessional and Team Communication				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Respectfully requests a consultation, with guidance	Clearly and concisely requests consultation by communications patient information	Formulates a specific question for consultation and tailors communication strategy	Coordinates consultant recommendations to optimize patient care	Maintains a collaborative relationship with referring providers that maximizes adherence to practice recommendations
Identifies the members of the interprofessional team	Participates within the interprofessional team	Uses bi-directional communication within the interprofessional team	Facilitates interprofessional team communication	Coaches others in effective communication within the interprofessional team

Interpersonal and Communication Skills 3: Communication within Health Care Systems				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Records accurate information in the patient record	Records accurate and timely information in the patient record	Concisely documents updated, prioritized, diagnostic and therapeutic reasoning in the patient record	Documents diagnostic and therapeutic reasoning, including anticipatory guidance	Models and coaches others in documenting diagnostic and therapeutic reasoning
Identifies the importance of and responds to multiple forms of communications (e.g., in-person, electronic health record (HER), telephone, email)	Selects appropriate method of communication, with prompting	Aligns type of communication with message to be delivered (e.g., direct and indirect) based on urgency and complexity	Demonstrates exemplary written and verbal communication	Coaches others in written and verbal communication

Pediatrics Entrustable Professional Activities (EPA's)

Entrustable professional activities (EPAs) are observable, routine activities that a general pediatrician or subspecialist should be able to perform safely and effectively to meet the needs of their patients. The ABP has worked with the pediatrics community to develop an EPA framework for general pediatrics and all of the subspecialties. Core EPAs describe the essential activities needed for practice, and supplemental EPAs have also been developed to address a range of issues and inform these core EPAs. This EPA framework can be used for both assessment and curricular development across the entire education continuum and can be found below.

EPA 1: Provide consultation to other health care providers caring for children

- Establishing and maintaining working relationships with the referring providers/agencies, marked by bidirectional communication
- Clarifying and focusing the clinical question to be addressed
- Gathering essential information from referring physician, organization, or health agency, as well as the patient(s) and family
- Communicating findings and recommendations to the patient and family, and the source of the referral (i.e., the requesting provider or health agency)
- Demonstrating content expertise in one's area of pediatrics to provide consultation
- Navigating the relationship with the patient/family to be either supportive or directive (or some combination of the two) as needed over time

EPA 2: Provide recommended pediatric health screening

- Applying knowledge in selection and interpretation of screening tools and tests (e.g., screens for growth and development, special senses, and medical conditions)
- Engaging patients and families in shared decision-making for those screening tests that are not mandated by state law
- Educating patients and families about the implications of the results to their overall health and care plan

EPA 3: Care for the well newborn

- Performing a physical examination to look for normal variations, abnormal signs and congenital anomalies
- Identifying and applying key evidence-based guidelines for care of the newborn
- Providing routine care, as well as addressing common problems that develop within the first 28 days of life
- Using judgment to know when common problems can be handled at home, and arrange for discharge and follow up
- Assessing maternal/family readiness to care for the infant post discharge
- Transitioning care to the community practitioner
- Demonstrating confidence that puts new parents at ease

EPA 4: Manage patients with acute, common diagnoses in an ambulatory, emergency, or inpatient setting

- Assessing the severity of illness and using judgment as to whether immediate or emergency actions, stabilization, or transfer to a higher acuity facility are necessary for treatment of urgent or life-threatening problems
- Gathering essential information through history, physical examination, and initial laboratory evaluation
- Engaging in sound clinical reasoning that drives the development of an appropriate differential diagnosis to allow the indicated diagnostic tests to be performed
- Knowing or acquiring knowledge of the evidence related to the primary problem and applying the evidence to the patient's care in developing a diagnostic work-up and plans for management and follow up
- Placing the patient at the center of all management decisions to provide patient and family centered care by engaging in bidirectional communication with patients and families
- Communicating and documenting the therapeutic plan and clinical reasoning in a manner that is transparent to all members of the health care team

EPA 5: Provide a medical home for well children of all ages

- Demonstrating knowledge of normal physiology, epidemiology, development, and standards of practice for the major age groups including neonates, infants, toddlers, school-age children, adolescents, and individuals transitioning to adult care
- Establishing a highly effective therapeutic relationship with patients and families
- Identifying specific patient and family needs by implementing a comprehensive assessment of patient and family
- Addressing specific patient and family needs by identifying appropriate resources and accessing and coordinating them to ensure optimal patient care
- Optimizing the primary care of the patient by implementing quality standards befitting a medical home

EPA 6: Provide a medical home for patients with complex, chronic, or special health care needs

- Demonstrating knowledge of key community services and agencies, to facilitate appropriate referral of patients with identified needs, and skill to diagnose, refer as needed, counsel and provide health maintenance for medically complex patients
- Facilitating patient and family centered care in a medical home model in order to emphasize collaboration with an interprofessional team that insures optimal care and empowerment of the patient/family
- Engaging in and orchestrating the care coordination of Children with Special Health Care needs (CSHCN)with appropriate specialists, subspecialists, and other healthcare professionals/agencies (physical therapists, occupational therapists, home health care, dieticians, social workers, psychologists, etc.)

EPA 7: Recognize, provide initial management and refer patients presenting with surgical problems

- Recognizing conditions where surgery is primarily indicated or is needed in conjunction with medical management
- Providing initial management and/or stabilization
- Making a referral and communicating directly to the pediatric or subspecialty surgeon
- Assisting with pre- and post-operative medical care of the child (such as nutritional support, pain management, and medication dosing for the pediatric patient)
- Providing continuity of care that ensures mutual understanding of the diagnosis, management and follow up needed

EPA 8: Facilitate the transition from pediatric to adult health care

- Developing a therapeutic relationship with patient and family which foundationally supports recognition and timing of transition to adult care
- Assessing for transition readiness
- Transition planning that includes establishing a care team with an adult primary care provider and medical home, adult subspecialists, as needed and community-based resources
- Transferring care to adult health care providers, and coordinating assistance and ongoing support as needed

EPA 9: Assess and manage patients with common behavior/mental health problems

- Identifying and managing common behavioral and mental health issues, (e.g., low mood, inattention and impulsivity, disruptive behavior and aggression, anxiety, learning difficulty, substance use, and social emotional issues in young children), including the initiation and monitoring of treatment effects for psychosocial interventions and when indicated for certain disorders (ADHD, depression, anxiety), pharmacotherapy
- Referring and co-managing patients with the appropriate specialist(s) when indicated to match the patient's needs, including pharmacotherapy (e.g., cognitive behavior therapist (CBT) for depression, specialist in trauma focused CBT for post-traumatic stress disorder, child psychiatrist for assistance in medication management)
- Knowing the mental health resources available to patients in one's community and utilizing the appropriate resources for each patient's needs
- Knowing the role of each member of the interprofessional team and coordinating and monitoring care provided outside one's practice (e.g., mental health professionals, community social services, support groups, early intervention and school personnel) to optimize patient care
- Providing care that is sensitive to the developmental stage of the patient and the cultural context of the patient and family around issues of mental health

EPA 10: Resuscitate, Initiate Stabilization of the Patient, and Then Triage to Align Care with Severity of Illness

- Recognizing the severely ill patient requiring resuscitation
- Patient care skills reflecting the ability to prioritize and act in rapid sequence, including an assessment, targeted history and physical and initiation of emergency treatment
- Resuscitation of a patient with acute decompensation and potential impending systemic failure requires initiation of medical therapy as well as prescribing or performing invasive procedures. These activities will vary by settings, resources, and the expertise of the practitioner/team
- Demonstrating effective communication skills in managing a severely ill patient
- Embracing the importance of and engaging in reflection after resuscitation
- Knowing when to seek help
- Transitioning care to another provider after initial stabilization

EPA 11: Manage Information from a Variety of Sources for Both Learning and Application to Patient Care

- Evaluating the quality of the information retrieved for informing patient care practice or one's own professional development (e.g., EHR, social networks, the internet, journal articles)
- Accessing relevant information in a timely manner to facilitate patient care in the clinical setting
- Performing queries or searches of appropriate data resources to facilitate timely retrieval of relevant information
- Filtering data gathered by importance based on parameters such as reliability of the source, validity of the data and immediate usefulness for decision-making
- Interpreting and applying information in the context of clinical practice or one's own professional development (e.g., the context of an individual patient or population of patients for whom one is caring, or the context of one's own professional formation)
- Storing and managing information in a manner that optimizes retrieval and ensures protection of patient information
- Maintaining accountability for advancing knowledge and remaining up to date with information pertinent to one's practice
- Recognizing and managing the ambiguity often inherent in data itself or its interpretation
- Developing and maintaining proficiency with technology to facilitate patient care

EPA 12: Refer patients who require consultation

- Making appropriate decisions to refer based on knowledge of referral guidelines
- Making the referral and ensuring its completion
- Appropriately providing post-referral patient care, coordination, and follow up

EPA 13: Contribute to the Fiscally Sound, Equitable, and Collaborative Management of a Health Care Workplace

- Utilizing a working knowledge of current health care payment systems and billing requirements relevant to practice
- Engaging and working with the interprofessional practice team to improve processes to deliver efficient and fiscally sound health care to children
- Demonstrating an awareness of financial practices that affect the workplace

EPA 14: Use Population Health Strategies and Quality Improvement Methods to Promote Health and Address Racism, Discrimination, and Other Contributors to Inequities Among Pediatric Populations

- Recognizing one's professional responsibility to populations, communities, and society at large
- Identifying populations placed at risk for poor health outcomes using statistical, epidemiological, public health, and community outreach measures
- Collaborating with diverse stakeholders in the development and implementation of initiatives to improve health outcomes
- Engaging in quality improvement initiatives to improve patient care delivery, outcomes and healthcare systems
- Utilizing data resources (e.g., electronic health record, patient registries, databases) to advance quality improvement and population health initiatives
- Dismantling processes/systems rooted in racism and/or discrimination to address inequities and achieve optimal health outcomes for all children

EPA 15: Lead an interprofessional health care team

- Establishing a shared vision, goals, expectations, and outcome measures
- Engaging other team members in a way that utilizes their specific roles and capabilities, eliciting and valuing the perspective and contributions of others
- Demonstrating situation awareness by:
    - Monitoring individual team member's performance to enable oversight and management of current and evolving situations
    - Balancing autonomy and supervision of team members by assigning/delegating unsupervised work to team members that aligns with their knowledge, skills, and attitudes (KSA) and supervising work of team members that is designed to expand their KSA
- Monitoring team performance and providing feedback
- Recognizing and managing the social cues, emotional responses as well as the personal and professional needs of team members
- Role modeling as the team leader
- Teaching to the needs of the team members, including patients and families

EPA 16: Facilitate Handovers to Another Health Care Provider Either Within or Across Settings

- Engaging in bidirectional communication of plans and conveying family and patient preferences
- Preparing for a handover by reviewing the medical record and updating the written tool (if applicable) to avoid errors of omission
- Communicating situation awareness, illness severity, patient summary, action planning, and contingency planning to other health care providers, using a standardized template to improve reliability of the information transfer
- Summarizing the information heard, asking questions when needed to clarify information and to fill any perceived gaps
- Asking questions when needed for clarifying information and to fill any perceived gaps
- Restating key action items to ensure understanding
- Providing feedback to the individual initiating the handover on any problems/errors that occurred, including inaccurate information transmission

EPA 17: Demonstrate the Ability to Effectively Perform the Common Procedures of the General Pediatrician

- Knowing and understanding the clinical indications for procedures
- Demonstrating the ability to perform the psychomotor skills necessary to safely and effectively perform the procedure
- Engaging in post-procedure management

Pediatric Residency Requirements

- Complete 36 training months to include the following educational units (unit=4 weeks or 1 month):
  - 6 units minimum of individualized curriculum
  - 10 units minimum of inpatient care including:
    - 5 units inpatient pediatrics
    - 2 units NICU
    - 2 units PICU
    - 1 unit Term Newborn
  - 9 units minimum subspecialty experiences including:
    - 1 unit Adolescent medicine
    - 1 unit Developmental-behavioral pediatrics
  - 4 units of four key subspecialties from the following:
    - Child abuse
    - Medical genetics
    - Mental & behavioral health
    - Pediatric allergy & immunology
    - Pediatric cardiology
    - Pediatric dermatology
    - Pediatric endocrinology
    - Pediatric gastroenterology
    - Pediatric hematology-oncology
    - Pediatric infectious disease
    - Pediatric nephrology
    - Pediatric neurology
    - Pediatric pulmonology; or,
    - Pediatric rheumatology
  - 3 additional units consisting of single subspecialties or combinations of subspecialties from either the list above or from the following list:
    - Child & adolescent psychiatry
    - Hospice & palliative medicine
    - Neurodevelopmental disabilities
    - Pediatric anesthesiology
    - Pediatric dentistry
    - Pediatric ophthalmology
    - Pediatric orthopedic surgery
    - Pediatric otolaryngology
    - Pediatric rehabilitation medicine
    - Pediatric radiology
    - Pediatric surgery
    - Sleep medicine; or
    - Sports medicine
  - 5 units minimum of ambulatory experiences including
    - 2 units community pediatrics & child advocacy
    - 3 units pediatric emergency medicine & acute illness with 2 units in the emergency department
  - 36 half-day sessions per year of a longitudinal outpatient experience not to be scheduled in fewer than 26 weeks per year.

RESPONSIBILITIES OF THE ATTENDING PHYSICIAN

1. Prior to, or at the beginning of each rotation, the attending physician should discuss the learning goals of the experience and the responsibilities of the resident(s) with each assigned resident.

2. The attending physician is the physician-of-record and is ultimately responsible for all patient care provided by the resident(s) under his or her supervision. The attending physician must make management rounds on his or her patients and communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients. The attending physician must document his or her participation in the care of each patient in the medical record in compliance with current governmental and Sanford policies.

3. The attending physician must meet professional standards of behavior and serve as a role model for the residents.

4. The attending physician must delegate portions of patient care to residents based on the needs of the patient and the skills of the resident(s).

5. The attending physician must demonstrate a strong interest in the education of residents; and must devote sufficient time to the residents to fulfill their supervisory and teaching responsibilities.

6. The attending physician should directly observe resident-patient encounters and provide the resident(s) with feedback on their observed skills.

7. The attending physician must evaluate resident(s) performance in a timely manner during each rotation, document this evaluation, and discuss this evaluation with the resident(s) at the completion of the assignment.

CLINICAL EDUCATOR MILESTONES

The Clinician Educator Milestones are not an accreditation requirement and are not intended to become one in the future.

The Clinician Educator Milestones provide a framework for assessment of educational skills of faculty members who teach undergraduate, graduate, or continuing medical education. Faculty members can use these milestones for their own self-assessment as educators, or with a trusted peer to provide feedback and assessment. The ultimate goal of these milestones is to provide faculty members with tools to help them with lifelong growth and development as educators.

Each subcompetency covers a different area of professional development and offers stand-alone assessment of a specific teaching skill or method. Individuals may choose to focus on one or more of the milestones, but do not need to assess against all the milestones.

Competency Statements:

- *Universal Pillars for All Clinician Educators* – Demonstrate the commitment to lifelong learning & enhance one's own behaviors as a clinician educator.
- *Administration* – Demonstrate administrative skills relevant to their professional role, program management, and the learning environment that leads to best health outcomes.
- *Diversity, Equity, & Inclusion in the Learning Environment* – Acknowledge & address the complex intrapersonal, interpersonal, and systemic influences of diversity, power, privilege, and inequity in all settings so all educators and learners can thrive and succeed.
- *Educational Theory & Practice* – Ensure the optimal development of competent learners through the application of the science of teaching and learning to practice.
- *Well-Being* – Apply principles of well-being to develop and model a learning environment that supports behaviors which promote personal & learner psychological, emotional, and physical health

Additional information: https://www.acgme.org/what-we-do/accreditation/milestones/resources/clinician-educator-milestones/

Universal Pillar 1: Reflective Practice & Commitment to Personal Growth				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Accepts responsibility for personal & professional development by establishing goals	Demonstrates openness to performance data (feedback from learners & other input) to inform goals	Filters, prioritizes, and synthesizes the history to develop a differential diagnosis in real-time for uncomplicated or typical presentations	Filters, prioritizes, and synthesizes the history to develop a differential diagnosis in real time for complicated or atypical presentations	Recognizes and probes subtle clues from patients and families; distinguishes nuances among diagnoses to efficiently drive further information gathering
Identifies the factors that contribute to gap(s) between expectations & actual performance	Analyzes and reflects on the factors that contribute to gap(s) between expectations & actual performance	Analyzes, reflects on, & institutes behavioral change(s) to narrow the gap(s) between expectations & actual performance	Challenges personal assumptions & considers alternatives in narrowing the gap(s) between expectations & actual performance	Coaches others on reflective practice
Actively seeks opportunities to improve	Designs & implements a learning plan, with prompting	Independently creates & implements a learning plan	Uses performance data to measure the effectiveness of the learning plan and, when necessary, improves it	Facilitates the design & implementation of learning plans for others

Universal Pillar 2: Well-Being				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Recognizes the importance of addressing personal & professional well-being	Lists resources to support personal & professional well-being	Assesses how personal and professional well-being impact one's own clinical practice & teaching	Proactively responds to the inherent emotional challenges of the clinician educator's work & develops a plan to optimize personal & professional well-being	Role models pursuit of optimal personal & professional well-being

Universal Pillar 3: Recognition and Mitigation of Bias				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies common & complex biases to effective education & patient care (e.g., language, disability, cultural differences, internalized oppression)	Proactively seeks to assess & reflect on one's personal biases, both explicit & implicit	Identifies strategies to mitigate the effects of bias on effective education & patient care	Addresses personal biases & proactively mitigates the effects of personal bias in effective education & patient care	Mentors others on recognition & mitigation of bias

Universal Pillar 4: Commitment to Professional Responsibilities				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Demonstrates the basic standards of the profession & presents "fit for duty"	Is timely in the performance of duties & takes responsibility for follow-up on details	Takes responsibility for errors/professional lapses & initiates corrective action when indicated	Recognizes personal risks to professional behavior & effectively manages those risks to produce the best outcome	Consistently role models professional behaviors in the learning & working environment

Educational Theory and Practice 1: Teaching and Facilitating Learning				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies various techniques for teaching Discusses lessons implicitly learned (e.g., hidden curriculum)	Delivers instruction in unidirectional manner resulting in passive learning Identifies that own behavior (role modeling) is part of the hidden curriculum	Teaches in a way that invites active learning & encourages critical appraisal Intentionally role models desired practice behaviors to aid learners	Uses scholarly teaching methods for varied levels of learners across settings Intentionally role models desired behaviors to aid learners across multiple settings	Serves as a coach to other educators on effective teaching practices Works collaboratively to develop educators' ability to demonstrate evidence-based teaching behaviors

Educational Theory and Practice 2: Professionalism in the Learning Environment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Understands rights, feelings, traditions, and wishes of learners, patients, and team members	Demonstrates respect for learners, patients, and team members through behavior & communication	Recognizes potential obstacles to unbiased & respectful communication, leadership, & educational practice	Applies strategies to mitigate against obstacles to produce outcomes that are always in the learner's best interest	Develops organizational & institutional processes & strategies to facilitate respectful & unbiases communication & problem solving

Educational Theory and Practice 3: Learner Assessment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Discusses the goals & principles of both formative & summative assessment	Uses appropriate methods & tools for assessment in a specific setting	Uses assessment data to identify strengths & opportunities for improvement of learners	Educates others, and when necessary, advises on selection & use of appropriate assessment methods & tools	Designs & implements evidence-based assessment methods & tools

Educational Theory and Practice 4: Feedback				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes timing, content, & approaches to conducting feedback conversations Describes importance of soliciting feedback in developing a growth mindset Describes importance of establishing a learning environment that values feedback	Elicits learners' goals & gives predominantly reinforcing feedback based on goals Reviews feedback about self, manages emotional reactions to feedback, & incorporates relevant items Role models exemplary feedback practices without explicitly setting up the learning environment	Identifies reinforcing & modifying data to give feedback that initiates behavior change Actively solicits general feedback from learners Role models exemplary feedback practices & explicitly states importance of feedback in the learning environment	Consistently engages in challenging feedback conversations that results in desired behavior change Consistently solicits specific feedback from learners that leads to behavior change Supports learning environment in which all learners & faculty engage in actionable feedback	Guides others to conduct effective feedback Guides others to solicit, reflect on, & incorporate feedback Demonstrates expertise in explicitly construction & maintaining learning environment in which all learners give & receive feedback to improve performance

Educational Theory and Practice 5: Performance Improvement and Remediation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies a learner who needs improvement	In conjunction with the learner, identifies factors that contribute to poor performance, identifies helpful resources, & develops individualized learning plans	Implements learning plans & follow-up strategies & successfully guides a learner who is struggling toward a short-term goal, separate from formal remediation	Develops & implements a formal remediation plan with outcome measures	Guides others in remediation recognition & management (in all four remediation domains: identification, clarification, intervention, assessment)

Educational Theory and Practice 6: Programmatic Evaluation				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Contributes to programmatic evaluation as directed by others	Describes the importance & elements of comprehensive programmatic evaluation	Conducts comprehensive programmatic evaluation for curricular areas of responsibility	Uses theory or frameworks to guide programmatic evaluation	Develops & implements multi-site evaluations or meta-evaluations
Carries out an action plan designed by others to address areas identified as needing improvement	Describes how to create an action plan	Creates an action plan to address areas identifies as needing improvement	Uses varied approaches to address programmatic areas of improvement	Disseminates interventions that support programmatic improvement

Educational Theory and Practice 7: Learner Professional Development				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes differences between coaching, sponsoring, advising, and/or mentoring in relationship to continuous professional development of learners	Identifies approaches or strategies (e.g., learning plan) for different learners to provide coaching, sponsoring, advising, and/or mentoring	Employs a variety of approaches or strategies for coaching, sponsoring, advising, and/or mentoring	Implements best practices for coaching, sponsoring, advising, and/or mentoring	Demonstrates expertise (e.g., teaching, researching) for coaching, sponsoring, advising, and/or mentoring

Educational Theory and Practice 8: Science of Learning				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes scholarly approaches for science of learning, teaching fostering intellectual curiosity, & learning preferences	Incorporates theories & strategies for teaching & promoting intellectual curiosity for different learning preferences	Routinely incorporates variety of approaches derived from literature & other high-quality sources to improve teaching practices & promote intellectual curiosity	Role models & coaches for scholarly approach to science of learning, teaching, fostering intellectual curiosity of learners, & incorporation of best practice	Contributes to new knowledge in the science of learning

Educational Theory and Practice 9: Medical Education Scholarship				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Defines scholarship in medical education	Participates in medical education scholarship p& the dissemination of educational approaches, curricula, and/or research	Expands medical education scholarship or evidence through regular dissemination of educational approaches, curricula, and/or research findings	Serves as the principal investigator for medication education scholarship	Demonstrates expertise in the field of medical education scholarship & provides guidance, consultation, & mentoring across medical education

Educational Theory and Practice 10: Learning Environment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Defines learning environment	Describes elements of an effective learning environment	Employs best practices in fostering an effective learning environment	Works collaboratively & leads others to foster effective learning environments	Leads system-level strategic efforts to improve learning environments
Defines different roles & how they contribute to the interprofessional learning environment	Describes the value of an interprofessional team-based approach in the learning environment	Engages effectively in interprofessional learning environments	Creates & manages effective interprofessional learning environments	Coaches others in development of effective interprofessional learning environments

Educational Theory and Practice 11: Curriculum				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies the elements, types & purpose of a curriculum	Participates in developing a curriculum	Adapts a curriculum to meet the needs of the learners	Leads development of a curriculum	Coaches others to develop a curriculum for the needs of their learners

Well-Being : Well-Being of Learning and Colleagues				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes relationship between well-being, burnout, learning, & patient safety	Shares approaches to support well-being	Employs various approaches that support & foster well-being & reduce burnout	Employs system-based approaches that foster well-being & reduce burnout & consistently provides support & resources to foster well-being & reduce burnout	Uses experiences with learners to assess, reimagine, & create new system-based interventions & structures to support well-being
Describes signs of physical, emotional, and/or professional distress	Recognizes learners or colleagues in apparent distress	Intervenes & identifies resources for a specific situation	Guides learners or colleagues in distress & provides on-going support	Guides other in recognizing learners in distress & educates them in available resources

Diversity, Equity, and Inclusion in the Learning Environment				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Defines diversity, equity, including, racism, & oppression (structural, institutional, interpersonal, & internalized) and their impact on the learning environment	Identifies inequities & applies strategies to mitigate racism & oppression & develop a diverse, inclusive, & equitable learning environment	Applies best practices in diversity, equity, inclusion, & anti-oppression in one's own learning environment	Designs learning experiences that engage & support persons from diverse backgrounds, orientations, abilities, experiences, & perspectives	Role models & advocates for best practices in diversity, equity, & inclusion in the learning environment, & work to systemically address inequities

Administration 1: Administration Skills				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes administrative domains of program management Describes components of legal, regulatory, & accreditation functions	Identifies best administrative practices for effective program management Identifies relevant resources for legal, regulatory, & accreditation functions	Employs best administrative practices for effective program management Employs effective approaches to perform legal, regulatory, & accreditation functions	Consistently demonstrates best practices across administrative domains Consistently integrates legal, regulatory, & accreditation functions into practice	Leads & guides others for best administrative practices for effective program management Leads & guides others in legal, regulatory, & accreditation functions

Administration 2: Leadership Skills				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies essential styles, skills & attributes for leadership	Identifies own leadership style & develops leadership skills with guidance	Independently assesses situations & determines which leadership skills are needed to achieve intended outcomes in routine situations	Leads others to achieve intended outcomes in complex & dynamic situations	Leads diverse individuals & teams to achieve program- or system-level outcomes

Administration 3: Change Management				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Describes why change management is important in medical education	Participates in change management initiatives	Facilitates & manages change management initiatives	Implements change & reviews outcomes	Coaches others to create & implement effective change

Residency Rotation Grade Submission Protocol

1. Residency Coordinator office sends out preceptor evaluation forms via MedHub no later than one week **prior** to the end of the rotation with instructions to return within two weeks following the end of the rotation. **(Residency Coordinator responsibility**)

2. If student evaluations are not received by end of Week Two post rotation completion, residency coordinator notifies Associate Program Director for local rotations or the Site Director for away rotations (**Coordinator responsibility**) who then personally communicates with the preceptors. **(Associate Program Director or Site Director Responsibility**).

3. Residency Program Director is notified by either the **Associate Program Director**, **Residency Site Director or Residency Coordinator** if evaluations are not received by end of week three post rotation.

4. **Residency Coordinator is responsible** for ensuring that all student evaluations have been completed and entered into MedHub by end of week four post rotation.

5. **Program Director** informed by **Residency Coordinator** on Monday of week five post rotation if all student evaluations have not been submitted. **Program Director** then takes charge of process to ensure evaluations are submitted that week and students are notified.

Faculty Policies link:
https://med.und.edu/policies/faculty.html
GME Policies link:
https://med.und.edu/policies/medical-residents.html

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES PEDIATRIC RESIDENCY PROGRAM

RESIDENT AND FACULTY MEMBER WELL-BEING POLICY

Purpose of Policy
This policy defines the ways in which residents are supported in their efforts to become competent, caring, and resilient physicians while completing Accreditation Council for Graduate Medical Education (ACGME)-accredited training programs at UND Pediatrics Residency.

Policy Scope
This policy applies to residents, faculty, Program Directors, Program Coordinators, and Graduate Medical Education (GME) staff who participate in the ACGME-Accredited post graduate medical education training program within the UND Pediatrics Residency Program.

Definitions
In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical to development and maintenance of the competent, caring, and resilient physician. Self-care is an important component of professionalism and high-quality patient care; it is also a skill that must be learned and nurtured in the context of other aspects of residency training.

Burnout: Long-term exhaustion and diminished interest in work. Dimensions of burnout include emotional exhaustion, depersonalization, and feelings of lack of competence or success in one's work. Burnout can lead to depression, anxiety, and substance abuse disorders.

Resident: Any physician in an ACGME-accredited graduate medical education program including residents.

Resilience: The ability to withstand and recover quickly from difficult conditions or situations. During training, residents may face difficult patient care, educational or personal events which have the ability to negatively affect their well-being. Decompressing after such situations, through conversation with peers, mentors or family, and self-care activities, can increase resilience.

Well-being: Refers to the state of being healthy, happy, and successful. Well-being may be positively increased by interacting with patients and colleagues at work, being intellectually stimulated and feeling that one is making a difference/helping. In addition, self-care activities, including exercise, getting plenty of rest and connecting with others, is beneficial.

Policy

Residents' physical, psychological and emotional well-being is of vital importance to the UND Pediatrics Residency and our ACGME-accredited training programs. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth. To that end, we provide the following strategies to support trainee health, well-being, and resilience:

Institutional Support:

- UND and Sanford Employee Assistance Programs (EAP): Confidential and free counseling services which include relationship issues, emotional health issues, drug and alcohol issues, workplace issues, financial issues, legal issues, wellness, educational programs, and 24/7 telephonic crisis counseling.
- Occurrence Reporting: Patient and employee safety reporting for actual events and near misses.
- Residents have access to healthy food and beverage options along with sleeping quarters.
- Residents and faculty have security and personal safety measures in parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities.
- Residents and faculty have educational materials to support patient care in the working environment.
- Both faulty and residents have access to multiple well-being activities and resources though the sponsoring and core institutions. UND as the sponsoring institution has a handful of wellness resources available to residents. Sanford Health has a wellness website with a variety of different well-being resources available. Residents are encouraged to access physical fitness activities both off and on site.

Graduate Medical Education Support

- The UND GME and Sanford GME offices are a safe place where residents can ask for and receive help with various needs including academic counseling, coaching, and mentoring.
- The Sanford GME office sponsors an annual resident and faculty appreciation team- based event where residents and faculty can participate in wellness activities and shared meals.
- The UND GME office sponsors a yearly picnic for all residents and faculty and the department has a strong team based back up system to address sick calls and vacations.
- Sanford Physician Recruitment department delivers meals free of charge quarterly to the resident lounges.
- Residents may take advantage of free taxi service to and from the hospital if they are too fatigued to drive home after a clinical shift.
- Assist program directors (PDs) in their initiatives to protect trainee time with patients, minimize non-physician obligations, provide administrative support to trainees, promote progressive autonomy, and enhance professional relationships.
- Provide PDs with resources to educate faculty and trainees about the symptoms of burnout, depression and substance use and their avoidance.
- Identify resources (i.e. Campus Resident Advocate) for trainee burnout, depression and substance use.
- The Sanford GME office has a physician well-being programming offered annually which includes: 1) A pre-session invitation to complete the MBI (22 question work environment assessment) to all the residents and the specialty's faculty doctors. 2) Followed by a 60–90-minute session with the residents and faculty to provide wellbeing material and review the results of the MBI.
- Encourage trainees and faculty members to alert designated personnel when they are concerned about a community member who is displaying signs of burnout, depression, substance use, suicidal ideation, or potential for violence, or who is not proactively engaging in self-care.
- Ensure that programs have sufficient back-up plans to provide patient care if a trainee is unable to perform their patient care responsibilities.
- Provide a way for residents to report unprofessional behavior and a respectful process for reporting,

investigating, and addressing such concerns.

Program Support

- Paying attention to trainee schedules to look at work intensity and compression factors.
- Allowing trainees to attend medical, dental, and mental health care appointments, including those scheduled during work hours.
- Educating trainees and faculty about burnout, depression and substance use, and their avoidance.
- Teaching and nurturing self- care practices, an important component of professionalism and high-quality patient care.
- Providing a respectful, professional, and civil environment that is free from mistreatment, abuse or coercion. There should be education in place about professional behavior and a confidential process for reporting concerns.
- Learning self-care is an important component of professionalism and patient care, and trainees have a responsibility to themselves and to their patients and programs to ensure that they are fit for work through behaviors such as: Proactive self-care, and modeling of healthy lifestyles and behaviors for patients, students, and colleagues.
- Impairment recognition and notification, either from illness, fatigue and substance use in themselves, their peers, and other members of the health care system.
- Time management surrounding clinical assignments
- Lifelong learning
- Performance improvement indicator monitoring
- Reporting duty hours, patient outcomes and clinical experience (such as case logs)

Additional Resources

- UND GME Wellness Resources
  - Assess my Well-Being
  - Burnout Survey
  - Campus Resident Advocates
  - Employee Assistance Program
  - North Dakota Professional Health Program
  - Preventing Suicide
  - Professional Quality of Life (ProQOL)
- UND GME Policies
  - Concerns and Complaints
  - Resident Work Environment
- Sanford Health Wellness Resources
  - Recognizing you
  - Community Support
  - Employee Assistance Program
  - Diversity, Equity, & Inclusion
  - Mind and Body
  - Wellness
  - Food and Fitness
  - Family
  - Financial Well-Being
  - Podcasts
  - Leader Resources
- Sanford Employee Assistance Program (EAP)
- UND GME Employee Assistance Program (EAP)

Created: 12/16/21
Revised:

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES
PEDIATRIC RESIDENCY PROGRAM

PEDIATRIC RESIDENTS SUPERVISION AND ACCOUNTABILITY POLICY

Purpose
The purpose of this policy is to ensure that the program will provide sufficient support, mentorship, and guidance in the supervision and accountability of physicians-in-training to facilitate education and the provision of safe and excellent patient care, while providing sufficient autonomy for residents to develop into independent practitioners.

Application
This policy applies to all residents in the UND pediatrics residency program. Residents who do not comply with the policy are subject to the disciplinary policies of the residency program.

Policy

1. Inpatient Services
   a. Each patient admitted to inpatient teaching services will have an identifiable, appropriately credentialed, and privileged attending physician who is ultimately responsible for the patient's care. The attending physician is expected to personally see and evaluate each patient, to communicate with the responsible resident(s) about the plan of care, and to document the care provided at least daily.
   b. First-year residents (PGY-1) may provide care for patients hospitalized on inpatient services, including initial admission, ongoing hospital care, and discharge, under the supervision of a senior resident (PGY-2 or PGY-3) and/or an attending physician. The minimum level of supervision for a PGY-1 resident during the first 6 months of training is direct supervision by the attending. For first-year residents (PGY-1) who have completed six months of training and have demonstrated ability through the Milestones, the minimum level of supervision that is required is indirect supervision with direct supervision immediately available.
   c. Senior residents (PGY-2 or PGY-3) may provide care for patients hospitalized on inpatient services and may supervise the care provided by PGY-1 residents, under the supervision of an attending physician. The minimum level of supervision of senior residents required is indirect supervision with direct supervision available—the attending physician is not required to be physically present within the hospital, but must be immediately available by means of telephonic and/or electronic modalities and available to provide direct supervision.
   d. When a senior resident is supervising a first-year resident, the senior resident is expected to see and evaluate each patient and to communicate with the first-year resident about the plan of care at least daily.
   e. Any patient scheduled for discharge should be discussed with the attending prior to discharge. Discussion should include the discharge diagnosis, patient's condition at discharge, discharge medications, and follow-up plan.
   f. Residents at all levels of training may perform procedures on their patients with direct supervision—the supervising physician is physically present with the resident and patient—by an attending physician. The supervising attending physician must have privileges for the procedure being performed. Residents may perform minor procedures without direct supervision with agreement of the attending physician who is responsible for judging the resident's competence to perform such procedures without direct supervision. Minor procedures are those that are minimally invasive with a low risk of complications, such as drawing venous blood or insertion of a peripheral intravenous catheter, that are typically performed by non-physicians in the hospital.
   g. Residents at all levels of training may act in the best interests of patients in emergency situations, subject to subsequent review by the attending physician and the medical staff of the hospital.
   h. Any resident may request the physical presence of an on-call attending physician at any time and is never to be refused. An on-call attending physician will be physically present in the hospital and immediately available for direct supervision at all times.
   i. Any significant change in a patient's condition must be reported immediately (within 30 minutes maximum but as soon as possible) to the attending physician by the responsible resident. Situations that require immediate notification of the attending physician include:
      - admission of an unstable patient to the hospital
      - unexpected death
      - need to transfer a patient to an intensive care unit
      - need for endotracheal intubation or ventilator support
      - cardiac arrest or development of hemodynamic instability
      - development of significant neurological changes
      - development of any clinical problem that requires an urgent invasive procedure
      - development of any clinical problem that requires urgent consultation
      - development of any medical error or iatrogenic complication that results in patient harm or requires urgent

intervention
- unanticipated discharge, including a patient leaving against medical advice
- significant changes in the goals of care, such as a decision to withdraw life support or limit care to comfort measures only
- any situation when the resident does not feel comfortable or is unfamiliar with the diagnosis or treatment plan
- signs of excessive stress, fatigue, or other impairment that appears to be impacting the performance of a team member
- uncertainty about the presence of any of the above criteria

2. Pediatrics Resident Continuity Clinic
   a. Each patient evaluated by a resident in the ambulatory setting or emergency department has a member of the medical staff as his/her attending physician who is ultimately responsible for the patient's care. The attending physician is expected to be physically present at the clinical site and readily available during the entire clinical encounter. The attending physician may not be responsible for the supervision of more than four residents, and no more than one resident with less than six months of training. The attending physician must not have responsibilities other than supervision of the residents while the clinic is in session if more than one resident is being supervised.
   b. First-year residents (PGY-1) will provide care for continuity clinic patients under the supervision of an attending physician. During the resident's first six months of training, the minimum level of supervision that is required is direct supervision for the critical or key portions of the services provided by the resident and indirect supervision with direct supervision immediately available at all other times. This means that the supervising attending physician must be physically present in the room for the critical or key portions of the encounter.
   c. For first-year residents (PGY-1) who have completed six months training and for senior residents (PGY-2 or PGY-3) the minimum level of supervision that is required is indirect supervision with direct supervision immediately available. The attending is not required to see patients cared for by the resident provided that all of the following conditions are met (if any of the criteria are not met, the minimum level of supervision required is direct supervision for the critical or key portions of the encounter):
      - the resident has demonstrated the minimum level of competency expected at the completion of six months of training as judged by the attending physician
      - the encounter is relatively uncomplicated
      - The attending must review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); ensure that the care provided is reasonable and necessary; and document the extent of his/her own participation in the review and direction of the services furnished to each patient.
      - The patient considers the center to be their primary location for health care services.
   d. Any resident may request the physical presence of the attending physician at any time and is never to be refused.

3. Other Ambulatory Sites and Emergency Department
   a. Each patient evaluated by a resident in the ambulatory setting or emergency department has an appropriately credentialed physician or licensed independent provider as his/her provider who is ultimately responsible for the patient's care. The supervising clinician is expected to be physically present at the clinical site and readily available during the entire clinical encounter.
   b. For all residents in the emergency department and at ambulatory sites other than the pediatrics continuity clinic, the minimum level of supervision that is required is direct supervision for the critical or key portions of the services provided by the resident and indirect supervision with direct supervision immediately available at all other times. This means that the supervising clinician must be physically present in the room for the critical or key portions of the encounter.

Created: 10/25/21
Revised: 12/8/21

General Pediatrics
Resident Supervision Grid

House Staff Supervision Guidelines **"1" =** An attending physician is physically present while the procedure is being performed. **"2" =** An attending physician, or another house staff member approved to independently perform the procedure ("3" on this supervision grid), is consulted prior to performing the procedure. **"3" =** The procedure may be performed independently while under the general supervision of the residency program. • **This supervision grid is not intended to interfere with the provision of life-saving care.** • **An attending physician will be involved in and responsible for the care of each hospital patient.**	PGY1	PGY2	PGY3	PGY4 CHIEFS
Arterial puncture	1	2	3*	
Bladder catheterization	2	3*	3	
Endotracheal intubation	1	2	3*	
Exchange transfusion	1	2	2	
Foreign body removal	1	2	3	
Gynecologic examination	2	2	3*	
Injections (IM, ID, & subQ)	2	3*	3	
Intraosseous line placement	1	1	1	
Intravenous line placement	3	3	3	
Lumbar puncture	2	3*	3	
Reduction/splinting/casting	1	2	2	
Skin Biopsy	1	1	1	
Suprapubic tap	1	1	1	
Umbilical artery/vein line placement	1	1	1	
Umbilical venous line	1	1	1	
Venipuncture	3	3	3	
Wound care/suturing	1	2	3*	
History and Physical examinations	2	3	3	
Consults	2	2	2	
Sedations	2	3	3	
Thoracentesis		1	1	
Circumcision		1	1	
Code supervision		3	3	
Bone marrow aspiration			1	1
Central Line placement			1	1
Chest tube placement			1	1
Myringotomy			1	1
*Performance of procedure independently under the supervision of the program requires documentation in MedHub of directly observed assessment of competency prior to independently performing.				

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES
PEDIATRIC RESIDENCY PROGRAM

DUTY HOURS POLICY

Principles
Physicians have a professional responsibility to appear for duty appropriately rested and fit to provide the services required by their patients. The program is committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. The learning objectives of the program will be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events and must not be compromised by excessive reliance on residents to fulfill non-physician service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interest of the patient may be served by transitioning that patient's care to another qualified and rested provider.

Application
This policy applies to all UND Pediatrics Residents.

Definitions
Duty hours are defined as time spent in all clinical and academic activities related to the program. Specifically, this includes time spent in patient care (both inpatient and outpatient), administrative duties related to patient care, the provision of transfer of patient care, time spent in-house during call activities, and scheduled educational activities such as conferences.

Duty hours do not include reading and preparation time spent away from the duty site.

Resident Duty Hours
Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Duty
Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents should have 8 hours off between scheduled clinical work and education periods.

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of clinical experience and education. This must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Maximum Duty Period Length
Clinical and educational work periods for residents (PGY1-PGY3) must not exceed twenty-four (24) hours of continuous scheduled clinical assignments.

- Up to four (4) hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
- Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions
In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- To continue to provide care to a single severely ill or unstable patient.
- To provide humanistic attention to the needs of a patient or family.

- To attend unique educational events.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

Moonlighting
Residents (PGY-2 and PGY-3) may be approved if it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety with program director approval documents per policy.

Maximum Frequency of In-House Night Float
Residents must not be scheduled for more than 6 consecutive nights of night float.

Night float must comply with the 80-hour weekly limit.

Maximum In-House On-Call Frequency
Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At Home Call
Time spend on patient care activities by residents on at-home call must county toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.

Implementation
Residents are required to report work hours on a weekly basis in MEDHUB.

Work hours and time off are monitored by the program director who will implement schedule adjustments as necessary to stay within the maximum of 80 hrs./week (Averaged over 4 weeks), and a minimum of 24 consecutive hours off out of 7 days (averaged over 4 weeks).

Residents must notify the director if they or other residents are requested or pressured to work in excess of the duty hour limitations.

The director will immediately notify the DIO of any duty hour violations.

It is the resident's responsibility to ensure that he/she leave work at the assigned time and call for back up in a timely manner if necessary.

Any resident recognizing an issue in adhering to the duty hours limit is to contact the program director or site director immediately before a violation occurs.

Created: 10/25/21
Revised:

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES
PEDIATRIC RESIDENCY PROGRAM

MOONLIGHTING POLICY

Principles
Physicians have a professional responsibility to appear for duty appropriately rested and fit to provide the services required by their patients.

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Moonlighting is a privilege.

Application
This policy applies to all residents in the UND pediatrics residency program.

Definitions
Moonlighting is voluntary, usually compensated, medically-related work (not related with training requirements). Internal moonlighting is moonlighting performed within the institution in which the resident is in training or at any of its related participating sites. External moonlighting is moonlighting performed outside the institution in which the resident is in training or at any of its related participating sites.

Policy
1. PGY-1 residents are not permitted to moonlight.
2. PGY-2 or PGY-3 residents who wish to moonlight must request permission from the program director. The request must be submitted in advance of the proposed moonlighting assignment at least one work day in advance but no more than one month in advance.
3. The privilege of moonlighting is granted at the discretion of the program director. The program director will not grant permission to moonlight to any resident who is not in good standing with the program.
4. Residents must have written approval from their program director in order to moonlight.
5. Moonlighting must not conflict with scheduled duty hours in the residency program.
6. Time spent by residents in internal or external moonlighting must be documents in the resident's duty hours log and will be counted toward the 80-hour maximum weekly hours limit.
7. A regular review by the program director of the privilege of moonlighting will be allowed and the privilege can be revoked if either work hours become a problem or resident performance becomes a problem. Residents should clearly understand this prior to signing any contracts for moonlighting.
8. Failure to comply with this policy may result in disciplinary action, up to and including possible dismissal from the residency program.

Informational
1. Residents must have a regular medical license in the state in which they will moonlight. A resident training license does not allow moonlighting.
2. Residents must obtain their own malpractice insurance or to be covered by moonlighting employer. UND's malpractice does not cover moonlighting activities.
3. Employment in the United States is specifically dependent on visa requirements; residents are responsible for ensuring employment is authorized under their current visa.

Created: 5/18/22
Updated:

American Board of Pediatrics
Core Didactic Topics

General Pediatrics Content Domains
1. Preventive Pediatrics/Well-Child Care
2. Fetal and Neonatal Care
3. Adolescent Care
4. Genetics, Dysmorphology, and Metabolic Disorders
5. Mental and Behavioral Health
6. Child Abuse and Neglect
7. Emergency and Critical Care
8. Infectious Diseases
9. Oncology
10. Hematology
11. Allergy and Immunology
12. Endocrinology
13. Orthopedics and Sports Medicine
14. Rheumatology
15. Neurology
16. Eye, Ear, Nose, and Throat
17. Cardiology
18. Pulmonology
19. Gastroenterology
20. Nephrology, Fluids, and Electrolytes
21. Urology and Genital Disorders
22. Skin/Dermatology
23. Psychosocial Issues
24. Ethics
25. Research Methods, Patient Safety, and Quality Improvement

Universal Tasks for General Pediatrics	
Universal Task	**Description**
1. Basic Science and Pathophysiology	Understanding best practices, clinical guidelines, and foundational pediatric knowledge, including normal and abnormal function of the body and mind in an age-specific development context
2. Epidemiology and Risk Assessment	Recognizing patterns of health and disease and understanding the variables that influence those patterns
3. Diagnosis	Using available information (eg, patient history, physical exam) to formulate differential diagnoses, choose appropriate tests, and interpret test results to reach a likely diagnosis
4. Management and Treatment	Formulating a comprehensive management and/or treatment plan, including reevaluation and long- term follow-up, taking into account multiple options for care

UND Pediatrics Residency Didactics Schedule

Major Teaching Conferences/Topic	Frequency	Responsible for giving the conference	Resident attendance monitored	Location Site #1, 2, 3, 4, Other
Pediatric Grand Rounds	Tuesdays at noon-1pm (except 3rd Tues of the month)	Local and visiting faculty Residents	yes	1 (also video conference)
Journal Club/Chair's Conference	3rd Tuesday at noon-1 pm, 8x per year	Residents, Chair, PD, APD	yes	1
M&M	3rd Tuesday at noon-1pm, quarterly	Pediatric faculty and residents	yes	1
Morning report	Friday AM	Residents	yes	1
Academic Half-Day ABP Core Lectures	Every other Wednesday (noon-5 pm)	Faculty (see topic schedule for details)	yes	1
PEAC Pediatrics Ambulatory Care Curriculum self-study modules	Longitudinally-integrated into Academic Half Day	Resident completes modules individually followed discussion with faculty https://ped.peaconline.org/main-menu	Completion is monitored	Online
Pediatric Fundamental Critical Care Support (PFCCS) self-study modules	4 protected half-days during PICU rotation (PGY-2)	Resident directed https://www.sccm.org/Education-Center/Educational-Programming/Fundamentals/Pediatric-Fundamental-Critical-Care-Support	Completion is monitored	Remote, asynchronous
Pediatric Emergency Medicine	During away PEM rotation at MN Children's (PGY-2)	Faculty (residents participate in on-site didactics as able)	yes	3
Adolescent Medicine	During away AM rotation at U of MN (PGY-2)	Faculty (residents participate in on-site didactics as able)	yes	2,4

Recurring, scheduled didactics (protected time without clinical duties for all residents)

Pediatric Grand Rounds

Tuesdays from noon-1 pm (except the 3rd Tuesday of the month)
Presented by local and visiting faculty and residents

Journal Club/Chair's Conference

Tuesdays from noon-1 pm (3rd Tuesday of the month, 8 times a year)
Case conference format presented by residents to Chair/PD/APD
Residents and faculty present journal articles

Morbidity and Mortality

Tuesdays from noon-1 pm (3rd Tuesday of the month, quarterly)
Pediatric Faculty and Residents

Morning Report

Fridays at 0745-0815
Recently admitted cases discussed by residents with hospitalist faculty/APDs

Academic Half-Day

Every other Wednesday afternoon
Core didactics covering the ABP Core Content presented by faculty

Rotation-specific didactics (protected time without clinical duties while on the rotation)

PICU (PGY-2)

- Completion of the Pediatric Fundamental Critical Care Support (PFCCS) self-study modules during 4 half-days of the rotation

Pediatric Emergency Medicine (Children's of Minnesota) (PGY-2)

- Participation in didactics with faculty and other residents on site

Adolescent Medicine (University of Minnesota) (PGY-2)

- Participation in didactics with faculty and other residents on site

Orientation-specific didactics

Pediatric Advanced Life Support (PALS)
Neonatal Resuscitation Program (NRP)
Basic Life Support (BLS)
AMA Modules

1. Creating an Effective and Respectful Learning Environment
2. Cultural Competency
3. Patient Hand offs
4. Patient Safety
5. Physician Health: Physician Caring for Ourselves
6. Privacy and Confidentiality
7. Quality Improvement Practices
8. Residents as Teachers
9. Resident Intimidation
10. Sleep Deprivation: Your Life and Your Work
11. Thriving Through Residency: The Resilient Resident
12. Working Effectively within an Interprofessional Team

Academic Half-Day ABP Core Lectures Series

- **with additional special topics**
- **assigned PEAC Pediatric Primary Care Curriculum modules**
- **repeats over an 18-month cycle**

Residents will attend all sessions except when they are on vacation, on an away rotation, or on night float. Residents will complete all PEAC modules over 18 months.

Date	ABP Domain
Jul 3, 2024	**2. Fetal and Neonatal Care** • Prenatal screening and maternal conditions • Stabilization and Transition • Routine Care including NB screening and immunization • Common clinical presentations (jaundice, resp distress, SGA, LGA, hypoglycemia) • Congenital anomalies **PEAC modules:** • The Prenatal Pediatric Visit • The Newborn Visit and Newborn care • Breastfeeding
Jul 17	**1. Preventive/Well-Child Care (Session 1)** Birth through 2 yrs • Normal growth and development • Nutrition • Immunizations • Screening and disease prevention • Anticipatory guidance **PEAC modules:** • Neonatal Abstinence in the Outpatient Clinic • Primary Care Follow-up for Premature Infants I • Primary Care Follow-up for Premature Infants II
Jul 31	**1. Preventive/Well-Child Care (Session 2)** Over 2 yrs through teens • Normal growth and development • Nutrition • Immunizations • Screening and disease prevention • Anticipatory guidance • Sports pre-participation **PEAC modules:** • Immunizations I • Immunizations II • Pediatric Primary Care and Health Supervision Guidelines
Aug 14	**7. Emergency & Critical Care (Session 1)** • Resp distress • Shock • Impending organ failure • Concussion, Head Injury • Altered mental status, status epilepticus
Aug 28	**5. Mental & Behavioral Health (Session 1)** • Clinical presentation of developmental delay (cognition, language, learning, social) • ADHD • Autism spectrum **PEAC modules:** • School Issues in Primary Care • ADHD • Language Development • Developmental Screening
Sep 11	**13. Ortho & Sports Med** • Clinical presentations (limp, joint pain, swelling) • Common fractures/trauma • Identified disorders (genetic, congenital, head/neck, spine, upper extremities, hips/lower extremities) **PEAC modules:** • Injury Prevention

Sep 25	**17. Cardiology (Session 1)** • Cyanotic and acyanotic congenital heart disease • Common presentations (HTN, chest pain, syncope) • Dysrhythmias **PEAC modules:** • Heart Murmurs • Hypertension
Oct 9	**18. Pulmonology (Session 1)** • Clinical presentations (cough, wheeze, respiratory distress, tachypnea) • Asthma **PEAC modules:** • Outpatient Asthma Diagnosis and Management • Addressing Tobacco Use
Oct 23	**19. Gastroenterology (Session 1)** • Clinical presentations (pain, nausea/vomiting, diarrhea, constipation) • Hepatology • Gastro-esophageal conditions • Pancreatitis **PEAC modules:** • Constipation • Toilet Training
Nov 6	**20. Nephrology, Fluids & Electrolytes (Session 1)** • Clinical presentations (hematuria, proteinuria, polyuria) • HUS • Inflammatory, genetic, dysfunctional conditions • Acid-base, electrolytes
Nov 20	**21. Urology & Genital Disorders** • Clinical presentations (hematuria, dysuria, incontinence, enuresis) • Abnormalities of collecting system, bladder, urethra, genital system • Infections • Stones **PEAC modules:** • Enuresis
Dec 4	**22. Skin/Dermatology** • Clinical presentations (rash, pruritis, skin pigment abnormalities and changes, hair loss) • Congenital infectious and non-infectious conditions • Acquired conditions (infection, infestation, inflammation, immune, trauma, papules/nodules, vesicles, acne) • Neurocutaneous syndromes • Manifestations of systemic disease **PEAC modules:** • Common Skin Problems: Acne • Common Skin Problems: Eczema
Dec 18	**23. Psychosocial issues** • Stressors/ACEs (divorce, death, adoption, foster care, bullying, violence) • Impact of illness • Social determinants • Cultural differences, immigration • Poverty **PEAC modules:** • Adverse Childhood Experiences (ACEs) • Colic and Temperament
Jan 8, 2025	**24. Ethics** • Medical decision-making (end-of-life care, resource allocation) • Patient-parent-pediatrician relationship • Professionalism • Ethical frameworks **PEAC modules:** • Care of Children with Special Health Care Needs • Telemedicine
Jan 22	**25: Research methods, Safety, & QI** • Research studies (clinical studies, basic statistics) • Patient safety and adverse events (causes, barriers to detecting and reporting, reduction. safety culture) • Quality improvement goals and methods
Feb 5	**16. Eye, Ears, Nose, Throat (Session 1)** • Clinical presentations of eye conditions (red eye, pain, vision change)

	• Common eye conditions (inflammatory/infectious, structural/anatomic, trauma/injury) **Special topics (Session 1)** • Finances • Career planning **PEAC modules:** • Vision Screening • Hearing Screening in Primary Care
Feb 19	**3. Adolescent Care** • Growth and development (puberty, cognitive, emotional) • Sex and sexuality (contraception, pregnancy, orientation and identity) • Menstrual conditions • Clinical presentations (abd pain, vaginal discharge) • Intro to eating disorders **PEAC modules:** • Intimate Partner Violence • Preconception and Interconception Care in Primary Pediatrics
Mar 5	**4. Genetics, Dysmorphology, Metabolic Disorders** • Basic genetics and patterns of inheritance • Clinical presentations (dysmorphology) • Syndromes (chromosomal, genetic, associations) • Inborn errors of metabolism (carbohydrate, lysosomal, amino acids, organic acidemia, urea cycle, fatty acid oxidation)
Mar 19	**8. Infectious Diseases (Session 1)** Common infections (viral, bacterial, fungal, mycobacterial, parasitic) • Respiratory tract infections • CNS infections • Blood stream infections • Bone and joint infections **PEAC modules:** • Fever • Pediatric Tuberculosis in Primary Care
Apr 2	**8. Infectious Diseases (Session 2)** • Toxin-mediated disease • Kawasaki • COVID/MIS-C • Cellulitis, abscess, MRSA
Apr 16	**10. Hematology** • Quantitative disorders of erythrocytes, leukocytes, platelets • Pancytopenia • Coagulation disorders • Transfusions • Immune-mediated disorders **PEAC modules:** • Anemia
Apr 30	**12. Endocrinology (Session 1)** • Clinical presentations (ambiguous genitalia, short and tall stature, abnormal puberty) • Thyroid disorders • Parathyroid disorders • Turner, Klinefelter
May 14	**14. Rheumatology** • Post-infectious/reactive arthritis • Autoimmunity (JIA, Psoriatic arthritis, SLE, connective tissue disorders, dermatomyositis, ankylosing spondylitis) • Sarcoidosis • Fibromyalgia • Rheumatic fever
May 28	**15. Neurology (Session 1)** • Clinical presentations (headache, altered mental status, muscle weakness seizures) • Seizure disorders • Neurocutaneous disorders • Static encephalopathy • Hydrocephalus
Jun 11	**9. Oncology** • Malignancies of childhood (hematologic/lymphatic, CNS and PNS, ocular, renal, reproductive, musculoskeletal/dermal • Complications of cancer treatment • Oncologic emergencies

	• Pain and palliative care
Jun 25	**11. Allergy & Immunology** • Allergic disorders (allergic rhinitis, urticaria and angioedema, anaphylaxis, hypersensitivity reaction, food allergy and oral allergy syndrome) • Disorders of immune function (B cell, T cell, phagocytes, complement) **PEAC modules:** • Allergic Disorders
Jul 9	**6. Child Abuse and Neglect (Session 1)** • Manifestations of abuse (physical and behavioral/psychological) • Provider roles (mandatory reporter, family support) • Physical abuse **PEAC modules:** • Child Maltreatment • Parenting and Discipline
Jul 23	**Special Topics (Session 2): Pediatric Surgical Conditions** • Acute abdomen • Bowel obstruction, malrotation • Pyloric stenosis • Trauma, Burns
Jul 31	**5. Mental & Behavioral Health (Session 2)** • Clinical presentation (suicidal ideas or behaviors, psychosis) • Anxiety, depression • Psychogenic disorders • Substance abuse **PEAC modules:** • Mental Health Issues in Pediatric Primary Care
Aug 6	**17. Cardiology (Session 2)** • Cardiomyopathies • Infection/vasculitis • Connective tissue disease • Lipids **19. Gastroenterology (Session 2)** • Celiac • Inflammatory Bowel Disease • Cystic Fibrosis
Aug 20	**18. Pulmonology (Session 2)** • Cystic fibrosis • Chronic resp failure • Upper airway conditions • Parenchymal conditions • Chronic lung disease of prematurity
Sep 3	**20. Nephrology, Fluids & Electrolytes (Session 2)** • Chronic renal insufficiency • Issues related to renal transplant **Special topics (Session 3)** • Self-care, wellness • Work-life integration
Sep 17	**16. Eye, Ears, Nose, Throat (Session 2)** <u>Ears</u> • Clinical presentations (pain, otorrhea, hearing loss) • Common conditions (inflammatory/infectious, structural/anatomic, trauma/injury) <u>Nose and Sinus</u> • Clinical presentations (pain, rhinitis) • Common conditions (inflammatory/infectious, structural/anatomic, trauma/injury) <u>Mouth, oropharynx, and throat</u> • Clinical presentations (bleeding, ulcers) • Common conditions (inflammatory/infectious, structural/anatomic, trauma/injury) <u>Neck</u> • Clinical presentations-ears (pain, mass) • Common conditions (inflammatory/infectious, structural/anatomic, trauma/injury) **PEAC modules:** • Oral Health • Acute Otitis Media and Acute Otitis Externa
Oct 1	**8. Infectious Diseases (Session 3)** • Prenatally acquired infections

	• Vector-borne infections • Immunocompromised host • STIs • International adoptee • Infection control • International travel
Oct 15	**12. Endocrinology (Session 2)** • Type I DM including DKA • Type II DM • Diabetes insipidus • Other glucose metabolism disorders • Pituitary disorders • PCOS **PEAC modules:** • Pediatric Obesity
Oct 29	**15. Neurology (Session 2)** • Migraine syndromes • Muscular dystrophies, peripheral nervous system disorders, degenerative neurologic disorders • Stroke and vascular anomalies • Brain and spinal cord conditions (inflammatory/infectious, anatomic) • Movement disorders **PEAC modules:** • Motor Development
Nov 12	**18. Pulmonology (Session 3)** • Upper and lower airway conditions • Extrapulmonary conditions and pulmonary hypertension • Sleep disorders including OSA **PEAC modules:** • Sleep and Sleep Problems
Nov 26	**6. Child abuse and neglect (Session 2)** • Sexual abuse • Psychological abuse • Neglect • Caregiver-fabricated illness **Special topics (Session 4)** • Advocacy • Public Health **PEAC modules:** • Child Advocacy in Pediatric Practice • Caring for Patients with Limited English Proficiency
Dec 10	**7. Emergency & Critical Care (Session 2)** • Anaphylaxis • Poisoning/toxin exposure • Foreign body aspiration/exposure • Hypertensive crisis • DKA • Drowning **PEAC modules:** • Neonatal Abstinence in the Outpatient Clinic • Immunizations II