1. **DURATION**: one month PLUS on-going Adolescent experience in Continuity Clinic throughout residency- which residents should be encouraged to staff with Adolescent Medicine Attendings

2. **ELIGIBILITY**: 
   i. PL-1 or PL-2. All the stated competency-based goals and objectives apply to the PL-1 and PL-2 training levels.

3. **POSITIONS**: One resident per block.

4. **FACILITIES/RESOURCES**: 
   i. Adolescent Medical Home, WRNMMC
   ii. USNA Clinic with COL Jeff Hutchinson, M.D.
   iii. Pediatric GYN with Dr. Courtney Yarbrough
   iv. Child and Adolescent Psychiatric Services with Dr. Steve Brasington

5. **TEACHING STAFF**: 
   Core: 
   i. LTC Jean E. Burr, M.D., Chief of Adolescent Medicine Service*
   ii. COL William Adelman, M.D.*
   iii. Kathleen Olson, M.D.
   iv. Harshita Saxena, M.D.*
   v. Richard Ricciardi, NP, COL (ret)
   vi. Wanda Foxx, M.D.

   Expanded: 
   v. COL Jeffrey Hutchinson, M.D.*
   vi. Dr. Cortney Yarbrough- Pediatric Gynecology
   vii. Child and Adolescent Psychiatry Services (CAPS) staff

   *= Adolescent Medicine Subspecialty trained and Boarded.

6. **GENERAL GOALS AND OBJECTIVES**: 

   During the rotation, through instruction and experience, residents will be introduced to the spectrum of problems that affect adolescent patients to include: normal pubertal growth and development and the associated physiologic, anatomic, and behavioral changes; preventive screening, health promotion, disease prevention, and anticipatory guidance; management of common outpatient problems; sports injuries, rehabilitation and preparation; gynecologic examinations and reproductive health, including contraception, STIs, pregnancy related issues, and sex education; psychosocial issues such as school performance, depression, substance abuse, eating disorders, suicide, and peer and family relations. Residents are expected to learn how to approach the complex adolescent patient with chronic problems and coordinate the total evaluation, therapy, and disposition of such patients. They are expected to gain an appreciation for the needs and mechanics of providing health care education to this age group and be able to interact with community resources to this end.
7. COMPETENCY-BASED GOALS AND OBJECTIVES:

1. MEDICAL KNOWLEDGE

<table>
<thead>
<tr>
<th>GOAL: Normal Versus Abnormal (Adolescent). Understand normal adolescent behavior, growth, and development and be able to recognize deviations from the norm.</th>
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OBJECTIVES:

a. Describe normal patterns of physical growth and pubertal development during adolescence and apply this knowledge to evaluation of variations in growth patterns and pubertal changes.
b. Describe normal psychosocial development in adolescents and apply this knowledge to evaluation of "behavior problems" in adolescents.
c. Describe normal musculoskeletal and cardiovascular status in adolescents and apply this knowledge to evaluation of adolescents for participation in a variety of sports activities.

<table>
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<tr>
<th>GOAL: Common Conditions Not Referred (Adolescent). Understand how to diagnose and manage common conditions in adolescents which generally do not require referral.</th>
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OBJECTIVES:

Describe the pathophysiology, clinical features, and evaluation of these conditions:

b. Cardiovascular: risk factors, hyperlipidemia, hypertension, chest pain, syncope.
c. Dermatologic: acne, viral exanthems, dermatoses, eczema.
d. Genitourinary: dysmenorrhea, dysfunctional uterine bleeding, irregular menses, vaginitis, cervicitis, STIs, uncomplicated pelvic inflammatory disease (PID), epididymitis, UTI, pregnancy diagnosis.
e. Musculoskeletal: kyphosis, scoliosis ≤ 20°, Osgood-Schlatter Disease, chondromalacia patella.
f. Neuropsychiatric: headaches, dizziness, school phobia and truancy, attention deficit disorder, depression, anxiety.
g. Pulmonary: asthma, mild and moderate.
h. Other: obesity, breast fibroadenoma, gynecomastia.

<table>
<thead>
<tr>
<th>GOAL: Acne. Understand how to diagnose acne and manage mild and moderate cases.</th>
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OBJECTIVES:

a. Describe the differential diagnosis of acne.
b. List factors which contribute to the development and severity of acne.
c. List topical medications which are effective in acne management (e.g. benzoyl peroxide, retinoids, topical antibiotics) and become comfortable with using them effectively.
d. Explain the role (timing, dose, and duration of treatment recommended) and possible side effects of systemic antibiotics in acne management.
e. Identify indications for referral of acne to an Adolescent Medicine Specialist or Dermatologist.

OBJECTIVES:

a. Describe the recommendations (outlined by the Bright Futures and GAPS guidelines) for the frequency and type of adolescent health care visits, and discuss the rationale behind these recommendations.

b. Discuss how to organize the adolescent visit (e.g., individualization according to the adolescent's developmental level, cultural background, and family characteristics).

GOAL: History and Physical Examination (Adolescence). Understand the process and content of an effective adolescent history and physical examination, including issues related to confidentiality and privacy.

OBJECTIVES:

a. Describe how to use questionnaires (e.g., Initial and Periodic Adolescent Preventive Services Visit Forms developed as an adjunct to GAPS), trigger questions (e.g., from Bright Futures), and organized interview techniques (HEADSSS).

b. Discuss consent and confidentiality and their relationship to treating the adolescent patient as well as involvement of parents in providing care to adolescents.

   1. Understand that variation exists in confidentiality afforded to adolescents under state laws.
   2. Have knowledge of how to locate accurate information on state confidentiality laws. (Guttmacher institute http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf)

   c. Discuss specific times when confidentiality should be abrogated (e.g., life threatening situations, illegal situations, compromise in adolescent's health, danger to the patient, adolescent's inability to handle the problem him/herself).

GOAL: Screening Laboratory (Adolescence). Understand the principles of and be able to perform standard laboratory procedures for adolescent health screening.

OBJECTIVES:

Discuss rationale, timing, office methods, and interpretation of results for the following screening procedures:

a. Sexually transmitted infections (GC, chlamydia, syphilis, HIV, human papilloma virus, trichomonas)

b. Cervical dysplasia

c. Hepatitis

d. Anemia

e. Hyperlipidemia

f. Tuberculosis

g. Hearing screening

h. Vision screening

OBJECTIVES:

Health promotion and disease prevention
a. Describe a healthy adolescent diet.

b. Discuss common deficiencies in the diet of an adolescent (low iron, low calcium) and their consequences.

c. Describe the importance of routine physical activity and suggest the types that should be included in adolescents’ daily activities.

d. Discuss the relationships between adequate weight, overall health, normal physical development, and physiologic functioning.

GOAL: Psychosocial Development (Adolescence). Understand health supervision related to the psychosocial development of adolescents.

OBJECTIVES:

Assessment and screening
a. Discuss the stages of psychosocial development in adolescence and the ages at which they usually occur.

b. Discuss the importance of the covariation of behaviors (e.g., alcohol and sexual behavior) and consider the relationship between individual problems or concerns and other conditions.


OBJECTIVES:

Assessment and screening
a. Describe the routine immunizations needed in this age period and their rationale.

b. Describe risk factors and indications for special vaccines in this age group (e.g., influenza).

c. Describe effective routines for gathering immunization information during visits for illness and health supervision care.

d. Discuss strategies to improve vaccination rates among teens.


OBJECTIVES:

Screening and assessment
a. Describe the importance of including regular physical activity into the routines of adolescents and young adults.

b. Discuss the potential risks from a sedentary life style.

OBJECTIVES:

Assessment and screening
a. List and explain the four major risk factors associated with injuries to adolescents (use of substances, failure to use safety devices, access to firearms, and participation in sports).
b. Describe how developmental and behavioral stages of adolescence and psychosocial factors relate to risks for injury, violence, and abuse.

GOAL: Tobacco Use (Adolescence). Understand health supervision for adolescents related to tobacco use.

OBJECTIVES:

a. Describe strategies to resist tobacco products.
b. Understand how to use motivational interviewing techniques to allow the patient to accept responsibility/internally motivate for changing their substance use patterns.


OBJECTIVES:

a. Discuss physical exam findings usually found in adolescents with substance abuse (e.g., usually normal exam; rarely-fatigue, tachycardia, malnutrition, hepatomegaly, gynecomastia, recurrent skin abscesses, muscle wasting, steroid induced muscle development).
b. Use standardized tools to identify and categorize adolescent substance use patterns (e.g., CRAFFT).
c. Develop capability in counseling on risks of binge alcohol consumption, ideally, utilizing motivational interviewing techniques coupled with factual information.

PATIENT CARE:

Demonstrate a family-centered, compassionate, effective, and age appropriate approach toward the evaluation and management of patients referred to the adolescent medicine service.

GOAL: Common Conditions Not Referred (Adolescent). Understand how to diagnose and manage common conditions in adolescents which generally do not require referral.

OBJECTIVES:

Demonstrate competency in management of these conditions, and understanding of indications to refer to specialty care:

b. Cardiovascular: risk factors, hyperlipidemia, hypertension, chest pain, syncope.
c. Dermatologic: acne, viral exanthems, dermatoses, eczema.
d. Genitourinary: dysmenorrhea, dysfunctional uterine bleeding, irregular menses, vaginitis, cervicitis, STIs, uncomplicated pelvic inflammatory disease (PID), epididymitis, UTI, pregnancy diagnosis.
e. Musculoskeletal: kyphosis, scoliosis ≤ 20°, Osgood-Schlatter Disease, chondromalacia patella.
f. Neuropsychiatric: headaches, dizziness, school phobia and truancy, attention deficit disorder, depression, anxiety.
g. Pulmonary: asthma, mild and moderate.
h. Other: obesity, breast fibroadenoma, gynecomastia.

GOAL: Conditions Generally Referred (Adolescent). Understand how to recognize, manage, and refer adolescent conditions which generally require consultation or referral.

OBJECTIVES:

a. Identify, provide initial evaluation and management of, and refer appropriately these conditions:

1. Cardiovascular: mitral valve prolapse, pathologic heart murmurs.
2. Dermatologic: cystic or nodular acne.
3. Endocrinology: hyper- or hypothyroidism, galactorrhea, unusual hirsutism or virilism, abnormal growth, delayed puberty, unstable diabetes mellitus.
4. Genitourinary: pregnancy, ectopic pregnancy and abortion, primary and secondary amenorrhea of undetermined etiology, severe dysfunctional uterine bleeding, polycystic ovary syndrome, ovarian cysts and tumors, testicular torsion, scrotal mass, varicocele, hydrocele, HIV, GU trauma, Bartholin's abscess, complicated PID.
6. Neuropsychiatric: anorexia nervosa, bulimia, chronic fatigue syndrome, depression, suicidal ideation, learning disabilities, substance abuse including anabolic steroids, psychosis, conduct disorders. [See also GOAL 8.18, Substance Abuse, and Chapter 5, Developmental and Behavioral Pediatrics.]
7. Other: breast masses.

b. Maintain a supportive primary care relationship with adolescents who are referred for management of specific disorders to a specialty consultant.

GOAL: Prevention During Illness/Problem Care (Adolescent). Understand the role of the pediatrician in the prevention of adolescent health problems in the context of delivering adolescent illness or problem care.

OBJECTIVES:

a. In the context of illness and problem care of adolescents, assess risks, and counsel as indicated for the following:

1. Activity (after school and others) and sports.
2. Communication skills and self-esteem building.
3. Education and career/vocational planning.
4. Expected growth and pubertal changes.
5. Injury and violence, particularly related to motor vehicle safety, helmet use, weapon avoidance or safety, and water safety.
6. Nutritional issues, particularly related to prudent diet, anemia risk in menstruating adolescents, vitamin D and calcium nutritional deficits in adolescents, and risks of eating disorders, to include obesity, anorexia, and bulimia.

7. Sexuality, reproductive health to include avoidance of STIs and pregnancy, contraceptive use, and date rape/ sexual assault- both avoidance and treatment after occurrence.

8. Tobacco, alcohol, and other substance avoidance, use, and abuse.

9. Transition to adult health care services.

**GOAL: Acne. Understand how to diagnose acne and manage mild and moderate cases.**

**OBJECTIVES:**

a. Recognize the various clinical features which define mild to severe acne.

b. Demonstrate a step-wise approach to the management of acne, including skin care, and topical and systemic medications.

a. Counsel patients regarding etiology, course, and prognosis of acne and help them deal with the common psychologic ramifications.

**GOAL: History and Physical Examination (Adolescence). Understand the process and content of an effective adolescent history and physical examination, including issues related to confidentiality and privacy.**

**OBJECTIVES:**

a. Obtain and interpret a detailed history from the adolescent assessing current health concerns, social history, and behaviors that may affect health.

b. Obtain and interpret a history from the adolescent's parent(s) including: concerns about the adolescent's health, past medical history, family history, social history, needs for anticipatory guidance, etc.

c. Demonstrate how to approach and perform the physical examination of male and female adolescents and young adults.

d. Perform and interpret screening physical examinations for problems such as:

   1. Cardiovascular disease or risk (hypertension, mitral valve prolapse, cardiac arrhythmia, obesity).
   2. Dental and periodontal disease.
   3. Musculoskeletal problems (e.g., injury, sports fitness, Osgood Schlatter disease, scoliosis,).
   4. Sexual maturity rating/Tanner staging (pubic hair, genital development, breast development).
   5. Skin problems (acne, melanoma, etc.).
   6. Sexually transmitted infections (pelvic exam, male GU exams- including the need to provide patient centered exams and prudent chaperone usage and documentation).

e. Manage these common conditions appropriately:

   1. Variations of timing of puberty, menarche, and growth.
2. Gynecomastia in the adolescent male.
3. Acne
4. Dysmenorrhea

GOAL: Military Relevance (Adolescence). Understand the relationship between Military Medicine and Adolescent Medicine

OBJECTIVES:

Assessment and screening
a. Assess a military member in risk taking behavior similar to assessing an adolescent family member.

b. Documentation considerations in active duty military members.

c. Perform a physical examination pertinent to operational medicine (i.e. musculoskeletal, physical profile).

Health promotion and disease prevention

d. Assess a service member’s knowledge about alcohol, other substance use, and other risk taking behavior.

e. Counsel service members on the benefits of changing a behavior.

f. Provide positive reinforcement to positive behavior choices.

g. Counsel service members on diet and supplement use/ misuse.

Common problems

h. Counsel service members on testing for sexually transmitted infections, both from a force monitoring perspective and based on individual risks.

i. Counsel service members on engaging in appropriate mental health care, at the primary care or specialty care levels, or through other avenues to include Fleet & Family Services and Army Community Services, or the Chaplains.


OBJECTIVES:

Assessment and screening

a. Use screening tools to evaluate growth, measure weight and height, plot on standardized growth charts, and calculate the body mass index (BMI).

b. Obtain a nutritional history to assess dietary patterns; use trigger questions to further assess risk for obesity, poor nutrition, and eating disorders (e.g., assess television watching time, conformity with food fads, adolescent special diets, satisfaction with eating patterns, eating in secret, perception of body image, use of laxatives).

c. Obtain a family medical history and use it with the dietary history to assess risk for obesity and/or other
medical problems (hypertension, hyperlipidemia).

d. Obtain a family psychosocial history and use it with dietary history to assess risk for nutritional problems or eating disorders.

e. Perform a physical examination focusing on findings that could indicate an eating disorder (malnutrition, bradycardia, hypothermia, lanugo-type hair over face/upper trunk, orthostatic pulse and blood pressure changes, etc.).

Health promotion and disease prevention
f. Counsel adolescents to recognize risks for eating disorders and ways to overcome them.

g. Recognize when adolescents cannot resolve diet/eating problems on their own and assist them in finding solutions that may include outside counseling or involving parents.

Common problems
h. Manage these common problems:
   1. A mildly overweight adolescent
   2. An adolescent female with inadequate calcium intake
   3. An adolescent with iron deficiency anemia
   4. An adolescent with iron deficiency without anemia
   5. An adolescent at risk for cardiovascular disease
   6. An adolescent with a tendency to exercise or diet in excess

GOAL: Psychosocial Development (Adolescence). Understand health supervision related to the psychosocial development of adolescents.

OBJECTIVES:

Assessment and screening
a. Explore the adolescent's perspective on relationships with families and peers using organized interview technique (HEADSSS) or trigger questions (Bright Futures, GAPS).

b. Identify the adolescent's concerns regarding appearance, self-esteem, and ability to handle stress.

c. Recognize adolescents at risk for being victims of excessive peer pressure.

d. Recognize adolescents in conflict with their families and parents having serious difficulties parenting their teenager.

e. Recognize the importance of the covariation of behaviors (e.g., alcohol and sexual behavior) and consider the relationship between individual problems or concerns and other conditions.

Health promotion/disease prevention
f. Counsel and work with adolescents to identify:
   1. Old habit(s) they want to change or eliminate
   2. New behavior(s) they want to develop
   3. Steps to begin change
4. Barriers to developing new behaviors
5. People that will help and what they can do
6. A time frame to complete the change

g. Counsel adolescents about physical and emotional changes which are part of normal adolescent development.

h. Counsel families about normal adolescent psychosocial development and provide guidance about ways to help the teen develop appropriate independence, self-esteem, and social competency.

i. Present strategies to both parents and adolescents to assist them in maintaining their positive relationship.

j. Counsel adolescents that peer pressure exists, but should not rule their lives, and present strategies to help them deal with it.

k. Encourage adolescents to accept, manage, and express feelings in a positive way to promote good mental and physical health.

Common problems

1. Recognize and manage or refer these common problems:

   1. Adolescent having disagreements with his/her parents
   2. Adolescent concerned about peer pressure
   3. Adolescent scared of his/her feelings
   4. Adolescent with somatic complaints
   5. Parent(s) in need of additional guidance about raising teens


OBJECTIVES:

Assessment and screening
a. Collect a screening history which includes school performance, school attendance, and parental involvement in education.

b. Identify risk factors for school problems such as learning disabilities, ADHD, psychopathology, lack of parental involvement, cultural barriers, homelessness, gang involvement, etc.

c. Recognize early signs/behaviors of school problems or inappropriate educational placement (e.g., gifted child, child with learning disabilities).

d. Evaluate children who "fail" school screening tests (scoliosis, vision, hearing, etc.).

Health promotion/disease prevention
e. Demonstrate interest in learning about school policy, health screening, and health education programs that affect adolescents in the continuity care practice (e.g., medication policy, scoliosis screening, sex/HIV education, drug abuse counseling).
ADOLESCENT MEDICINE ROTATION
Goals & Objectives
National Capital Consortium Pediatrics Residency
(updated Dec 2015)

f. Discuss with parents and adolescents the importance of:

1. Continuing good habits for school and learning.
2. Completing schooling.
3. Work, vocation, or college plans after high school graduation.
4. Career planning while in college.

Common problems
g. Recognize and manage or refer appropriately:

1. School avoidance and absenteeism syndromes
2. School behavior, performance, or homework problems
3. Learning problems
4. Chronic illness with special school/educational needs
5. Physical safety related to school activities (sports)
6. Teens who drop out of school
7. Educational needs of pregnant teens and teen parents
8. Adolescents pushed or pressured to excel
9. Special needs of gifted children

**GOAL:** Immunizations (Adolescence). Understand health supervision for adolescents related to immunizations.

**OBJECTIVES:**

**Assessment and screening**

a. Identify the immunization status of the adolescent.

b. Identify adolescents with medical conditions requiring special immunizations (e.g., teens with respiratory or cardiac conditions needing influenza vaccine).

**Health promotion/disease prevention**

a. Provide routine immunizations and related counseling on contraindications, common side effects, and informed consent.

**Common problems**

d. Recognize and manage these common conditions:

1. Adolescent behind in his/her immunizations.
2. Common reactions to routine immunizations.
3. Patient or parent refusal of vaccinations either required and recommended.

OBJECTIVES:

Screening and assessment

a. Assess adolescents' physical activity through psychosocial interview (HEADSS), or by using trigger questions from *Bright Futures* or questionnaires from *GAPS*.

b. Identify adolescents at risk from routine participation in physical activities (e.g., those who don't warm up prior to activities, adolescents with chronic disease, physically immature adolescents, teens in contact sports).

Health promotion/disease prevention

c. Recognize and praise involvement in physical activity and praise this positive health behavior by providing information on the benefits of regular physical activity.

d. Counsel adolescents on the importance of warm-up activities and physical conditioning before engaging in sports or other physical activities to minimize risk of injury.

e. Counsel adolescents on the importance of participating in physical activities either daily, or nearly every day, and the psychological benefits of regular physical activity (enjoyment, social experience, time alone, opportunity for family activity, stress control, mood regulation).

f. Counsel adolescents on the risks of excessive exertion (e.g., overuse injuries, rapid weight loss, listlessness, sleeplessness, chronic joint pain, delay of sexual maturation).

Common problems

g. Manage these common problems:

1. Acute “sports” injuries from physical activity.
2. Menstrual irregularities due to physical activity.
3. Athletes who significantly alter their diets during training, or practice unhealthy behaviors to maintain or “cut” weight for competition(s).


OBJECTIVES:

Assessment and screening

a. Use trigger questions to determine the potential risk for intentional and unintentional injury.

Health promotion/disease prevention

b. Provide injury counseling which is tailored to adolescents, based on their particular risks (exposures) and level of development (early, middle, and late adolescence).

c. Recognize adolescents' perceptions of what impresses their peers as a potential barrier to compliance with anticipatory guidance.
d. Counsel adolescents about dangerous behavior in a highly focused manner, including discussion of important factors known to increase risk (e.g., when counseling about safe driving, target: driving while intoxicated or distracted, wearing restraints, speeding, and driving under hazardous conditions).

e. Present anticipatory guidance to adolescents in a manner which enhances their trust and encourages a realistic sense of personal vulnerability (e.g., attach behavior to the occurrence of specific negative outcomes).

f. Counsel effectively on these topics:
   
   1. Firearms.
   2. Substance use/abuse and exposure to others who use.
   3. Use of safety devices (seat belts, helmets, flotation devices for water activities).
   4. Peer/romantic partner violence and abuse

Common problems

g. Manage these common problems:

   1. Simple lacerations, contusions, and musculoskeletal trauma from mild injuries.
   2. Ask about exposure to risk when seeing an adolescent for a minor injury to ensure it is not related to risky behaviors, and counsel appropriately. Provide praise for adolescents who DO use appropriate risk mitigation strategies.


OBJECTIVES:

Assessment and screening

a. Assess the adolescent's knowledge of sexual identity, sexual activity, reproduction, and transmission of disease, and relate this to the three stages of adolescence.

b. Gather information about the adolescent's sexual development and sexuality using organized interview techniques (HEADSS) or trigger questions (GAPS, Bright Futures).

c. Obtain and interpret a sexual history including such topics as menstrual history, abstinence, nocturnal emissions/self-stimulation (masturbation), sexual activity (include what types of contact - e.g. oral-genital, vaginal coitus, and anal coitus; for MSM it is typical to differentiate insertive, receptive, or both), contraception and disease prevention strategies (safer sex), STIs to include HIV/AIDS, sexual orientation and practices (many homosexual teens will engage in sex with opposite gender peers).

d. Perform and interpret an examination for sexual maturity rating, using standard descriptions for rating, and tools such as an orchidometer.

e. Perform and interpret an examination for STIs, cervical dysplasia, pregnancy, and HIV/AIDS, if indicated.

f. Determine adolescents' risks for:

   1. STIs, including HIV/AIDS
   2. Pregnancy
   3. Exploitation (sex trafficking, coercive relationships, trading sex for drugs)
   4. Past or present sexual abuse
Health promotion/disease prevention

g. Counsel adolescents on areas that influence their sexual behavior, such as:
   1. Information about sexual functioning and reproduction
   2. Attitudes about sexual behavior for self and others
   3. Feelings about one's sexuality
   4. Skills for communicating about sexual issues

h. Counsel adolescents about avoiding exploitation, date rape, and other situations where they can be vulnerable.

i. Counsel adolescents to anticipate risky situations in advance (e.g., dating people who are considerably older and more sexually experienced) and present strategies to handle such situations.

j. Counsel adolescents that sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy.

k. Provide demonstrations and instruction on:
   1. Using condoms
   2. Contraception(s)
   3. Prevention of disease transmission

l. Assist the adolescent in developing strategies to promote healthy relationships and safe sexual activity.

Common problems

m. Recognize, manage and know when to refer the following common problems:
   1. Adolescent with a vaginal/urethral discharge
   2. Adolescent with missed or irregular menstrual periods
   3. Adolescent concerned about isosexual attraction
   4. Adolescent with concerns about HIV
   5. Adolescent pregnancy, including options counseling and early prenatal care recommendations.

GOAL: Tobacco Use (Adolescence). Understand health supervision for adolescents related to tobacco use.

OBJECTIVES:

Be aware of smoking prevention programs taught in school.

Assessment and screening

a. Assess the adolescent's use of tobacco - cigarettes, nicotine delivery systems (e-cigarette, hookah, “vaping”), and smokeless tobacco (dip/chew)- and attitudes about starting or quitting.

b. Document other risk factors associated with tobacco use (e.g., family members who smoke, peers or friends who smoke, early sexual involvement, limited coping resources, overestimation of smoking prevalence).

c. Perform a physical examination, looking for physical signs of smoking (e.g., yellow staining on hands) or tobacco effects (exacerbation of asthma, abnormality of gums due to tobacco chewing).
Health promotion and disease prevention

d. Assess the adolescent’s knowledge about the effects on the body of smoking or passive exposure to tobacco.

e. Counsel adolescents on the positive health and social benefits associated with avoidance of tobacco use or passive exposure.

f. Provide positive reinforcement to teens who don’t use tobacco or who quit using it.

g. Counsel adolescents on the risks of tobacco use, including social disadvantages, reduction of athletic ability, staining of teeth, and associated health risks.

Common problems

h. Counsel adolescents who use tobacco products about strategies for quitting, including how to find out about and/or enroll in smoking cessation programs in the community.

i. Recognize and manage adolescents with asthma who experience exacerbations because of tobacco use.


OBJECTIVES:

Assessment and screening

a. Obtain and interpret a history to assess risk factors for substance abuse, including:

   1. Family factors (e.g., alcoholism and other drug use in parents or siblings, genetic factors, cultural factors, inconsistent parental direction or discipline, parental psychopathology).
   2. Peer factors (e.g., friends who smoke, drink, or use other drugs; risk behaviors in peer group; peer group endorsement of use).
   3. Personal factors (e.g., low self-esteem, poor social skills, school problems, early antisocial behavior, lack of bonding to usual social groups).

b. Gather information about the adolescent's attitudes about and use of alcohol and other drugs, including anabolic steroids using organized interview techniques (CRAFFT, HEADSSS) or trigger questions (GAPS, Bright Futures).

c. Carry out additional screening to:

   1. Identify those adolescents who use substances.
   2. Determine the chronicity and severity of risk.
   3. Determine the consequences of alcohol or other drug use.

d. Obtain and interpret a history looking for systemic complaints associated with substance abuse (e.g., fatigue, poor appetite, abdominal pain, vomiting, constipation, cough/wheezing, rhinitis, recurrent epistaxis, tremors, headaches).
**Health promotion/disease prevention**

e. Provide positive reinforcement to adolescents who are not currently using alcohol or other drugs and encourage continued abstinence.

f. Review with the patient the health risks of alcohol and other drugs.

g. Review with the patient health-threatening behaviors associated with substance abuse (e.g., violence and injuries, poor grades, depression, delinquency, unsafe sexual behavior, and risk for HIV infection).

h. Determine the adolescent's knowledge and attitudes towards alcohol and other drugs and refute commonly-held myths.

i. Provide health education and guidance to reinforce healthy decisions and choices.

j. Counsel adolescents to avoid situations where drug and alcohol use is expected of everyone, and have an exit strategy planned if a situation exceeds the adolescent’s comfort (e.g. arrangement to text Mom “911” and have her call back angry about something and pick the teen up).

l. Counsel adolescents to make a commitment not to use alcohol and other drugs and discuss alternatives to drinking and using drugs.

m. Provide anticipatory guidance about planning a designated driver in advance. Many physicians advocate for a “sober friend” to watch the teen’s back when using alcohol. Remind them of other ways of getting a ride if necessary (e.g. cab/ Uber, parent, Metro, staying in place until all are sober).

**Common problems**

n. Counsel adolescents who use alcohol or other substances about quitting and/or using community rehabilitation programs.

o. Recognize and manage or refer appropriately:

   1. Adolescent developing muscles too quickly.
   2. Adolescent with physical findings suggestive of drug abuse (e.g., sudden weight loss, needle tracks, or recurrent skin infections).
   3. Adolescent with a hangover.
   4. Adolescent with injuries (e.g., peer violence, motor vehicle injury) related to the influence of alcohol or other substances.

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**GOAL: Depression and Suicide (Adolescence). Understand health supervision for adolescents related to depression and suicide.**

**OBJECTIVES:**

**Assessment and screening**

a. Perform and interpret screening for depression and risk of suicide, including:

   1. Use and interpretation of standardized screening instruments (e.g. PHQ-2, PHQ-9, SCARED).
2. Review of systems to screen for associated somatic complaints associated with depression (e.g., headache, chest pain, abdominal pain, lethargy, syncope).
2. Behavioral history to screen for behaviors associated with depression (e.g., school failure, truancy, sexual acting out, delinquent acts, substance abuse, other mental health/psychiatric conditions).
3. Social history and family mental health history to assess parental mental health and possible genetic loading.
   b. Use psychosocial history (HEADSSS) or trigger questions (e.g., GAPS, Bright Futures) to identify teens at risk for suicide or at risk for adverse consequences related to depression.
   c. Perform extended assessments on adolescents at risk for depression to determine:
      1. Level of depression
      2. Health and functional consequences of depression
      3. Social support system
   d. Perform extended assessments on adolescents at risk for suicide (e.g., frequent suicidal thoughts, planning suicide, written suicide note).
   e. Recognize different levels of depression and suicide risks and discuss appropriate disposition including supportive therapy, immediate vs. delayed psychiatric evaluation, judicious use of medications, and/or hospitalization with psychiatric management.

Common problems
   f. Recognize and manage or refer the following common problems:
      1. Adolescent who is mildly depressed without suicidal ideation.
      2. Adolescent who has experienced a significant stressor like the recent death of a parent, sibling, neighbor, or classmate.

ii. INTERPERSONAL SKILLS AND COMMUNICATION

Demonstrate effective communication skills with families and patients referred to the adolescent medicine service. Demonstrate effective communication skills during interactions with nurses and other doctors involved in the care of each patient. Maintain comprehensive and concise written consultations and notes on each patient seen.

iii. PROFESSIONALISM

Demonstrate a commitment to patient care and learning by timeliness, responsibility for patients seen on the service, and sensitivity to cultural diversity. Complete documentation within established requirements.

iv. PRACTICE BASED LEARNING AND IMPROVEMENT

Demonstrate the ability to use the medical literature to effectively and cogently evaluate conditions or symptoms seen during adolescence, and modify management plans appropriately based upon the information obtained from the literature. Demonstrate receptiveness to feedback provided during the rotation with appropriate modification of behavior to improve performance.
v. SYSTEMS-BASED PRACTICE

Demonstrate understanding of cost issues related to adolescent medicine, to include lab tests, radiographic studies, and medications. Demonstrate understanding of health care prevention and maintenance related to adolescent medicine.

8. INSTRUCTIONAL PLAN:

1. The resident is expected to attend all didactic conferences and case conference discussions involving adolescent medicine.

2. The resident is expected to attend a minimum of 22 adolescent clinic sessions (22 half-days).

3. A syllabus for the rotation of selected articles on adolescent medicine topics is provided at the start of the rotation - this resource is maintained in the “swag bag” on the share drive for updates prior to graduation. Residents are expected to read the syllabus/articles prior to completion of the rotation. Reference textbooks, pertinent journals, and electronic reference files are kept at the clinic and in the general medical library.

4. Selected adolescent patients are registered and subsequently followed by the resident in continuity clinic throughout the residency training period.

5. A board-style, web-based, test is provided in order to address a greater breadth of clinical scenarios. This will be completed by the resident and reviewed with a staff physician, typically the educational point of contact, prior to the end of the rotation.

6. Pre-rotation self-assessment is completed by the resident at the start of the rotation. This will be compared to a post-rotation self-assessment at the conclusion of the rotation. Subject areas not covered during the course of the rotation are identified for further study during the course of residency.

7. The resident will prepare and formally present to the group on an adolescent medicine topic as a 30 minute didactic lecture or other presentation type. This will typically occur at weekly team conference and should be adolescent focused. Feedback on preparation and presentation will be provided by staff.

8. Participation in Adolescent book club - each resident will choose an Adolescent themed book from the reading list, or suggest an alternate which has particular personal interest (this requires staff approval). The book will be read by the staff as well, and all residents invited to participate, including those not on Adolescent rotation. The group will meet for a discussion, and each resident is expected to turn in a one page review of learning points from the experience, as well as a “out of 5 stars” rating.

9. Residents will precept each patient encounter with staff prior to release of the patient. Immediate oral feedback will be provided. Summative rotation feedback will be provided on the last day, and the written evaluation will be completed in E-values.

9. RESIDENT RESPONSIBILITIES:

The rotators in Adolescent Medicine function as physicians of first contact. Adolescent patients will be interviewed and examined with emphasis on patient confidentiality, informed consent, and cultural/gender sensitivity. Residents are expected to present all patients, discuss physical findings, generate a differential diagnosis, and discuss diagnostic and treatment plans. All patients and charts will be reviewed with the adolescent medicine staff.
Residents are expected to attend the following clinics:

1. Adolescent Clinic (acute care, routine appointments, and continuity clinic)
2. Didactic sessions (3-4 per month)
3. Journal Club
5. Formal, end of month, morning report presentation with discussion.

In addition to outpatient clinic responsibilities, residents are expected to follow hospitalized adolescent continuity patients and provide consultation to adolescent inpatients when requested.

10. **METHOD OF EVALUATION:**

1. Direct observation of selected patient encounters.
2. Oral and written feedback is given to the resident after oral presentations and review of records.
3. Journal club preparedness, understanding and presentation is evaluated by staff in attendance
4. Required oral case presentation with discussion at morning report is evaluated by staff in attendance
5. 100-question board review standardized question test is scored, and anonymous results of the testing are compared for all the rotating residents.
6. A formal written evaluation is completed on every resident at the end of the rotation and reviewed with the resident.

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