



## Ambulatory Pediatrics Curriculum

Family Medicine Faculty Liaison: *Allred, H. MD*

Last review/update: Aug/2017

The Ambulatory Pediatrics training curriculum is a required 8-week experience with 4 weeks completed in the PGY-1 year, 2 weeks in the PGY-2 year, and 2 weeks in the PGY-3 year. Training takes place in private pediatrics offices in Silverdale and Bremerton as well as longitudinally within the NW Washington Family Medicine Residency.

### ACGME Competencies and FM-Specific Milestones Assessed:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health  
✓ **PC-3**
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care;  
✓ **MK-1**
3. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.  
✓ **SBP-3**
4. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;  
✓ **PBLI-2**
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population;  
✓ **PROF-3**
6. **Communication** result in effective information exchange and teaming with patients, their families, and other health professionals;  
✓ **C-2**

### Family Medicine Program Requirements:

**IV.A.6.f):** “Residents must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of children and adolescents in an ambulatory setting.

**IV.A.6.f). (1):** This care must include well-child care, acute care, and chronic care.”

## **Competency-Based Objectives and Instructional Methods**

### **A. Patient Care**

#### **Objectives**

*During supervised clinical practice in the outpatient Pediatric Clinic and in Family Medicine Practice Continuity Clinics, residents must:*

- 1) Perform and document an appropriately-detailed history/physical examination for presenting patients. This includes an appropriate birth history when relevant;
- 2) Approach and deliver care to pediatric patients in a manner which takes into account the developmental age of the patient and the need for parental interaction;
- 3) Determine appropriate type and length of follow-up for patients who have been seen for acute and/or chronic conditions.

#### **Instructional Methods**

- *Direct Instruction:* By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic, and select Academic Conference sessions.
- *Faculty Modeling:* Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- *Guided Research:* Resident presentation of faculty-assigned topics based upon clinical cases.
- *Supervised Clinical Management:* Application of information to individual patient cases in the ambulatory clinic settings.
- *Self-Directed Learning from assigned Texts/Online Resources:*
  - ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in children and Adolescents. Subcommittee on Attention-Deficit/Hyperactivity Disorder. *Pediatrics* 2011;128,1007.
  - Lieberthal, et al. "The Diagnosis and Management of Acute Otitis Media." *Pediatrics* 2013;131:e964.
  - Mackrides, P. "Screening for Developmental Delay." *American Family Physician* 2011. Volume 84, number 5.
  - Roberts, Kenneth. "Revised AAP Guideline on UTI in Febrile Infants and Young Children." *American Family Physician* 2013. Volume 86, number 10.

## B. Medical Knowledge

### Objectives

*During supervised clinical practice in the outpatient Pediatric Clinic and in Family Medicine Practice Continuity Clinics, residents must:*

- 1) Synthesize an appropriate diagnosis, treatment, and/or referral plan for common pediatric conditions in the outpatient setting, including:
  - Asthma, atopy and eczema, allergic rhinitis
  - Immunodeficiency
  - Arthritides including juvenile idiopathic arthritis
  - Vasculitis syndromes including Kawasaki disease, Henoch-Schönlein purpura, and Wegener granulomatosis
  - Rheumatic fever
  - Glomerulonephritis
  - Hematuria and proteinuria
  - Urinary tract infections, including pyelonephritis
  - Vaginitis
  - Enuresis
  - Undescended testis
  - Hydrocele
  - Phimosis and foreskin adhesions
  - Thyroid disorders
  - Diabetes (type 1 and type 2)
  - Obesity
  - Failure to thrive
  - Abnormal growth patterns (short and tall stature)
  - Premature or delayed puberty, the larche, and/or menarche
  - Adrenal disorders
  - Seizure disorders (including non-epileptic seizures)
  - Headache
  - Syncope
  - Psychomotor delay and cerebral palsy
  - Tics and movement disorders
  - Traumatic brain injury, including concussion
  - Macrocephaly and microcephaly
  - Contact and other dermatitides
  - Psoriasis
  - Viral and other exanthems
  - Verruca vulgaris

- Nevi
- Bacterial and fungal skin infections
- Parasites (lice, scabies, and bed bugs)
- Diaper rash
- Acne
- Burns
- Normal newborn and childhood variants
- Clubfoot
- Pes planus and pes cavus
- Developmental dysplasia of the hip
- Genu valgum and genu varum
- Rotational problems and gait abnormalities
- In- and out-toeing
- Metatarsus adductus
- Medial tibial torsion
- Femoral anteversion
- Scoliosis (idiopathic or acquired)
- Aseptic necrosis of the femoral head (Legg-Calvé-Perthes disease)
- Slipped capital femoral epiphysis
- Nursemaid's elbow
- Common sprains, dislocations, and fractures
- Limping differential by age group
- Apophysitis (Osgood-Schlatter disease and Sever disease)
- Preparticipation physical evaluation
- Gastroenteritis (viral, bacterial, and parasitic)
- Dysphagia
- Chronic diarrhea
- Constipation and encopresis
- Gastroesophageal reflux
- Food intolerance and malabsorption, protein-calorie malnutrition
- Pyloric stenosis
- Intussusception
- Volvulus
- Meckel diverticulum
- Recurrent and chronic abdominal pain
- Hernia
- Inflammatory bowel disease (Crohn disease, ulcerative colitis)
- Celiac disease
- Appendicitis
- Hematemesis
- Hematochezia
- Jaundice in the non-neonate

- Congenital heart disease and valvular disease
- Acquired heart disease
- Cardiac dysrhythmias
- Evaluation of heart murmurs
- Chest pain
- Hypertension
- Innocent and pathologic murmurs
- Viral upper respiratory tract infections
- Asthma
- Cystic fibrosis
- Bronchiolitis
- Foreign body aspiration
- Pneumonia
- Pertussis
- Tonsillitis, pharyngitis, sinusitis
- Epiglottitis
- Croup
- Epistaxis
- Obstructive sleep apnea
- Apparent life-threatening events (ALTEs), blue spells
- Otitis media (acute and with effusion)
- Otitis externa
- Hearing loss
- Wax and foreign body in ear canal
- Amblyopia
- Strabismus
- Lacrimal duct stenosis (dacryocystitis)
- Decreased visual acuity
- Conjunctivitis
- Other causes of red eye
- Congenital cataracts
- Hordeolum and chalazion
- Periorbital and orbital cellulitis
- Cleft lip and palate, including feeding strategies
- Dental caries and abscess
- Tooth eruption (normal and abnormal variants)
- Common infections (e.g., thrush, cold sores, herpangina, aphthous stomatitis)
- Ankyloglossia
- Developmental oral lesions (e.g., geographic tongue)
- Fever in children younger than 90 days old
- Fever without source in children 90 days to 3 years old
- Fever of unknown origin

- Sepsis
- Meningitis and encephalitis
- Invasive streptococcal and staphylococcal disease
- Osteomyelitis and septic arthritis
- Reactive lymphadenopathy
- Cervical adenitis
- Lymphoma
- Neuroblastoma
- Wilms tumor
- Leukemia
- Retinoblastoma
- Central nervous system (CNS) tumors
- Anemias
- Hemoglobinopathies, including thalassemia and sickle cell
- Thrombocytopenia
- Bleeding diathesis
- Thrombophilias

2) Procedural competency according to the Longitudinal Procedural Training Curriculum.

The following list of skills are integral to this curriculum and residents should seek opportunities to train in these procedures during rotation.

<u>A<sub>0</sub> Procedures</u> Procedural competence assumed by graduating from the program	<u>A<sub>1</sub> Procedures</u> Procedural Competence is required for graduation	<u>A<sub>2</sub> Procedures</u> Procedural Competence is optional prior to graduation	<u>B Procedures</u> Procedural Competence requires a focused training plan during residency	<u>C Procedures</u> Procedural competence likely requires additional training beyond residency
<ul style="list-style-type: none"> <li>• Anterior nasal packing for epistaxis</li> <li>• Bladder catheterization</li> <li>• Cerumen disimpaction</li> <li>• Corn/callous removal</li> <li>• CXR interpretation</li> <li>• Drain subungual hematoma</li> <li>• EKG performance and interpretation</li> <li>• Fecal disimpaction</li> <li>• Fluorescein examination (without slit-lamp)</li> <li>• Laceration repair with tissue glues or staples</li> <li>• Interpret Spirometry</li> </ul>	<ul style="list-style-type: none"> <li>• Biopsy: excisional (3)</li> <li>• Biopsies: punch/shave including vulvar (3)</li> <li>• Digital Block (1)</li> <li>• Incision and drainage of abscess, including paronychia (3)</li> <li>• Laceration repair with sutures (3)</li> <li>• Newborn circumcision (10)</li> <li>• Toenail removal, partial or full (3)</li> <li>• Upper and lower extremity splints (1 each)</li> <li>• Upper and lower extremity casts (1 each)</li> </ul>	<ul style="list-style-type: none"> <li>• I&amp;D of a perianal abscess (1)</li> <li>• Lingual frenotomy (2)</li> <li>• Lumbar puncture pediatric (3)</li> <li>• Removal of a superficial corneal foreign body (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Hematoma block</li> <li>• IO</li> <li>• I&amp;D of a peritonsillar abscess</li> <li>• Non-obstetrical, point-of-care diagnostic ultrasound (abdominal, cardiac, musculoskeletal, ocular, pelvic, skin/soft tissue, thoracic, vascular, etc.)</li> <li>• Office tympanometry</li> <li>• Peripheral nerve block other than digital</li> </ul>	<ul style="list-style-type: none"> <li>• Allergy skin testing</li> </ul>

<ul style="list-style-type: none"> <li>• Local anesthesia/field block</li> <li>• Peripheral venous cannulation</li> <li>• Phlebotomy</li> <li>• Removal of foreign body from ear or nose</li> <li>• Skin lesion destruction</li> <li>• Skin tag removal</li> <li>• Simple closed reduction of subluxed joint without sedation (e.g. nursemaid elbow or lateral patellar dislocation)</li> <li>• Superficial conjunctival foreign body removal (without slit-lamp)</li> <li>• Topical anesthesia</li> <li>• Urinalysis (dipstick, microscopy)</li> </ul>				
---	--	--	--	--

- For A1 and A2 procedures, the minimum number of procedures that must be logged electronically prior to graduation is listed in parentheses.
- Residents should attempt to complete as many Procedural Competency Assessment Tools as possible during the rotation.

**Instructional Methods**

- 1) *Direct Instruction:* By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic and select Academic Conference sessions.
- 2) *Faculty Modeling:* Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- 3) *Guided Research:* Resident presentation of faculty-assigned topics based upon clinical cases.
- 4) *Supervised Clinical Management:* Application of information to individual patient cases in the ambulatory clinic settings.

## C. Systems Based Practice

*During supervised clinical practice in Family Medicine Practice Continuity Clinics, residents must demonstrate:*

### **Objectives**

1. Appropriate utilization of health care services and professionals within CHI-Franciscan Health Harrison Medical Center while advocating for patient interests; (Examples include: nutritionists, nurse clinicians, podiatrists, physical therapists)
2. Advocacy for patient interests and appropriate utilization of health services and professionals in the local community when such resources are not available within the CHI-Franciscan system;
3. Use of cost effective, evidence-based, medical practices.

*During supervised clinical practice in the outpatient Pediatric Clinic residents must demonstrate:*

1. Appropriate utilization of resources within the private pediatrician's office;
2. Willingness to adapt to the practice style(s) of community pediatric preceptors.

### **Instructional Methods**

- 1) *Direct Instruction:* By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic, and select Academic Conference sessions.
- 2) *Faculty Modeling:* Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- 3) *Supervised Clinical Management:* Application of information to individual patient cases in the ambulatory clinic settings.

## D. Practice Based Learning and Improvement

### **Objectives**

*During supervised clinical practice in the outpatient Pediatric Clinic and in Family Medicine Practice Continuity Clinics, residents must demonstrate:*

- 1) Willingness and ability to incorporate faculty feedback into clinical/academic performance changes;



- 2) Appropriate use of search tools online and in the Harrison Medical Center Library to find references which augment learning from cases seen in the ambulatory setting.

### **Instructional Methods**

- 1) *Direct Instruction*: By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic, and select Academic Conference sessions.
- 2) *Faculty Modeling*: Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- 3) *Guided Research*: Resident presentation of faculty-assigned topics based upon clinical cases.
- 4) *Supervised Clinical Management*: Application of information to individual patient cases in the ambulatory clinic settings.

## **E. Professionalism**

### **Objectives**

*During supervised clinical practice in the outpatient Pediatric Clinic and in Family Medicine Practice Continuity Clinics, residents must demonstrate:*

1. Ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty in all patient/staff interactions;
2. Willingness to acknowledge errors when committed and perform self-analysis to avoid future similar mistakes;
3. Punctuality and reliability at all times, whether in clinic, didactic sessions, or performing inpatient care;
4. A professional appearance at all times.

### **Instructional Methods**

- 1) *Direct Instruction*: By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic, and select Academic Conference sessions.
- 2) *Faculty Modeling*: Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- 3) *Supervised Clinical Management*: Application of information to individual patient cases in the ambulatory clinic settings.

**F. Communication**

**Objectives**

*During supervised clinical practice in the outpatient Pediatric Clinic and in Family Medicine Practice Continuity Clinics, residents must:*

- 1) Present cases clearly and concisely to precepting physicians;
- 2) Develop rapport with the patients and/or family members to promote the patients' welfare, employing active listening techniques to clarify information;
- 3) Demonstrate effective communication with non-physician health-care team members;
- 4) Counselling of patients and/or family members in a compassionate and accurate manner, taking into account the developmental age of the patient and need for parental involvement;
- 5) Construction of appropriately-organized, complete, and timely Health Record documentation.

**Instructional Methods**

- 1) *Direct Instruction:* By pediatric or family medicine physician preceptors during rotation in private pediatric clinics, Family Medicine Practice Continuity Clinic, and select Academic Conference sessions.
- 2) *Faculty Modeling:* Of relevant behaviors and techniques by pediatric and family medicine preceptor(s).
- 3) *Supervised Clinical Management:* Application of information to individual patient cases in the ambulatory clinic settings.

**Points of Contact**

Rotation liaison (R1):  
 Duy Tran, MD  
 Naval Hospital Bremerton  
 One Boone Rd.  
 Bremerton, WA 98312  
 Cell: 215-796-7553  
[Dr.DuyTran@gmail.com](mailto:Dr.DuyTran@gmail.com)

Rotation liaison (R2):  
 Niran Al-Agba, MD  
 9910 Levin Rd NW #200  
 Silverdale, WA  
 (360) 692-8588  
[Niran3@hotmail.com](mailto:Niran3@hotmail.com)

Rotation Liaison (R3):  
 John Corrales-Diaz, MD  
 450 S. Kitsap Blvd #250  
 Port Orchard, WA 98366

**PGY-1 Schedule**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	Clinical Rotation	Clinical Rotation	FM Clinic	Longitudinal Curriculum	Clinical Rotation		
PM	Clinical Rotation	Clinical Rotation	FM Clinic	Academic Conference	Clinical Rotation		

**PGY-2 and PGY-3 Schedule**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	Clinical Rotation	Clinical Rotation	FM Clinic	Longitudinal Curriculum	Clinical Rotation		
PM	Clinical Rotation	Clinical Rotation	FM Clinic	Academic Conference	FM Clinic		

## **Evaluation Activities**

Residents will receive an ***incomplete*** for the rotation and will not be eligible for graduation until the following items are completed.

**1. Resident Evaluation:** *(the resident may be evaluated by several department members)*

- **Mid-rotation feedback:**  
Faculty are encouraged to provide daily verbal feedback; but written feedback is required if resident is failing at mid-rotation or at any other time. Family Medicine Associate Program Director or Program Director should be notified as soon as possible when a resident is in danger of failing the rotation.
- **Final Evaluation**  
Using rotation-specific on-line evaluation form. Evaluations should be completed within two weeks of rotation end to provide timely feedback to the resident.
- **Attendance Verification**  
Documentation of attendance at didactic sessions, procedural clinics, FM continuity clinics and experiential encounters will be maintained in resident training file.

**2. Documentation:** *(resident-completed by end of rotation)*

- Procedures performed must be documented in standard electronic format.
- Appropriate EHR documentation of all encounters must be completed.
- Any provided supplemental readings should be completed and returned to rotation coordinator.

**3. Staff Evaluation:** *(resident-completed)*

- Residents evaluate rotation faculty/staff using standard on-line evaluation form. Evaluation is to be completed within two weeks of rotation end.

**4. Rotation Evaluation:** *(resident-completed)*

- Resident assesses quality of the rotation on the standard rotation evaluation form (same as for rotation faculty evaluation). Evaluation is expected to be completed within two weeks of rotation end.



---

M. Watson, MD  
Program Director

---

8/14/17  
Date

### **Required Reading**

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in children and Adolescents. Subcommittee on Attention-Deficit/Hyperactivity Disorder. *Pediatrics* 2011;128,1007.

Lieberthal, et al. "The Diagnosis and Management of Acute Otitis Media." *Pediatrics* 2013;131:e964.

Mackrides, P. "Screening for Developmental Delay." *American Family Physician* 2011. Volume 84, number 5.

Roberts, Kenneth. "Revised AAP Guideline on UTI in Febrile Infants and Young Children." *American Family Physician* 2013. Volume 86, number 10.

### **Electronic Resources**

Bright Futures/AAP Recommendations for Preventive Pediatric Health Care  
[www.aap.org/periodicityschedule](http://www.aap.org/periodicityschedule)

Immunizations and Developmental Milestones for Your Child  
<https://www.cdc.gov/vaccines/parents/downloads/milestones-tracker.pdf>