Mental Health in the Medical Home: A Longitudinal Curriculum for Pediatric Residents on Behavioral and Mental Health Care

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Abstract

Introduction: Currently, a pediatric mental and behavioral health crisis exists, driven by increasing stressors among children coupled with a paucity of psychiatric providers who treat children. Pediatric primary care providers can play a critical role in filling this gap, yet trainees feel uncomfortable screening for, identifying, and managing mental and behavioral health conditions among their patients. Thus, expanding training for pediatricians in this domain is critical.

Methods: We created a longitudinal integrated mental and behavioral health curriculum for pediatric residents at NewYork-Presbyterian/Columbia University Irving Medical Center with a logic model contextualizing outpatient pediatric care as a framework for the development and planned evaluation. We devised a comprehensive set of materials, with presentations on topics including attention deficit hyperactivity disorder and anxiety disorders. Workflows and escalation pathways promoting collaboration among interdisciplinary providers were implemented. We evaluated residents’ and faculty members’ participation in the curriculum and their perception of curricular gaps.

Results: Approximately 155 pediatric residents participated in the curriculum from 2017 to 2021, reflecting robust curricular exposure. Few residents and no preceptors perceived mental and behavioral health as a curricular gap.

Discussion: Our curriculum is feasible and can be adapted to a variety of educational settings. Its use of a logic model for development, implementation, and ongoing evaluation grounds the curriculum in educational theory and can address curricular gaps. The framework can be adapted to suit the needs of other institutions’ educational and practice settings and equip pediatric trainees with the skills to promote patient mental health and well-being.

Keywords
Community-Based Medicine, Pediatrics, Primary Care, Well-Being/Mental Health, Integrated Behavioral Health

Educational Objectives

After completing this curriculum, learners will be able to:

1. Identify the frequent overlap and interaction between outpatient pediatric care and mental and behavioral health care.
2. Describe methods for capacity building within pediatrics via the delivery of mental and behavioral health care by pediatricians.
3. Demonstrate confidence with mental and behavioral health care as a curricular element of outpatient pediatric primary care.

Introduction

Mental and behavioral health disorders are prevalent among pediatric populations, with approximately one in five children having a diagnosable behavioral or mental health condition.¹ The COVID-19 pandemic has further exacerbated this crisis with its profound psychosocial effects disproportionately impacting children and adolescents.² Among adolescents, emergency department visits related to mental health increased significantly in 2020, along with climbing rates of suicidal ideation and intent.³,⁴ The proportion of visits related to mental health among children ages 5-11 and 12-17 years in 2020 increased 24% and 31%, respectively, as compared to 2019.⁵ These effects are predicted to be long-lasting, necessitating continued support...
for youth as they bear the psychosocial impact of the pandemic for years to come.

Perhaps most concerning are the gaps in care, as approximately half of children with mental health disorders do not receive treatment from a trained professional.¹ Shortages in mental health providers are well documented, with 70% of US counties having no child psychiatrists.² The pandemic has further exacerbated this issue, leading to interruptions in mental health treatment and care. For example, disruption of school routines has impacted many children who typically access mental health resources through educational settings.³ These changes disproportionately impact certain oppressed populations (e.g., racial and ethnic minorities and those with lower family income), which may ultimately contribute to worsening inequity.⁴

Given the prevalence of these diagnoses among children, the shortage of trained providers, and the inequities that continue to abound, it is imperative that pediatricians take ownership of their role in the assessment and treatment of patients' behavioral and mental health needs that present in the primary care setting. It is estimated that one-third of children with mental health disorders are treated solely by their primary care providers.⁵ One of the American Board of Pediatrics' entrustable professional activities (EPAs) is to “assess and manage patients with common behavior/mental health problems.”⁶ Yet recent pediatric residents report significant discomfort in assessing and treating children with mental health conditions.⁷

The integration of mental health resources into pediatric medical care has demonstrated improvements, including improved access to and quality of care, enhanced collaboration between primary care and mental health providers, and increased confidence among pediatric providers in managing mental health issues.⁸ Integrated mental health programs (IMPs) not only emphasize close collaboration between interdisciplinary team members but also contribute to the development of behavioral and mental health curricula and educational materials to share among providers. Curricular models have been developed for a variety of settings and recipients, including internal medicine and family medicine residents.⁹ Isolated educational tools, as well as recommendations for mental health curricula and competencies, have also been proposed for pediatric trainees.¹⁰ However, we failed to find any integrated and longitudinal mental health curricula geared towards pediatric trainees published in the literature. Although the concept of integrated mental health is well studied, our curriculum is novel in that it is a longitudinal and fully integrated curriculum developed for pediatricians-in-training. It has been developed with a deep understanding of the injustices and unique challenges of an underserved patient population.

Methods
A logic model (Appendix A) contextualizing the population served, resources available, and specific outpatient pediatric practice allowed for a clear framework and guide for curricular development, implementation, and planned evaluation of the impact on confidence in providing mental and behavioral health care, actual provision of care, and mental health outcomes for patients.

Inputs
Setting: For the duration of their residency training, approximately 80 pediatric residents had a weekly continuity clinic with patient panels and a primary preceptor at one of four NewYork-Presbyterian community-based ambulatory care network (ACN) practices in northern Manhattan. Between the four ACN sites, there were 20 preceptors who were individually responsible for delivering educational content, via both weekly small-group didactic sessions and longitudinal experiential learning. ACN practices included primary care in pediatrics, internal medicine, and obstetrics and gynecology, as well as specialized outpatient services such as nutrition and pediatric psychiatry. The four pediatric sites served approximately 20,000 pediatric patients per year. These patients came from surrounding communities largely comprising individuals who were publicly insured (∼71%) and had low incomes (∼24% with <$15,000 annual household income). Many parents of pediatric patients were foreign born, were of young age, and had limited English proficiency.¹⁷

IMP at NewYork-Presbyterian/Columbia: Developed collaboratively by primary care pediatric and pediatric psychiatry leadership, the IMP incorporated a colocated psychiatric-mental health nurse practitioner (PMHNP) into the pediatric primary care clinic setting. PMHNPs were available for consultation as well as for direct service to patients in need. We created the model with a public health framework such that the majority of families served were low or medium risk and received short-term services, while the families at the highest level of risk or need were stabilized with short-term services if required and referred to more intensive services either at our children's hospital or in the community.

The IMP supported physician education and patient management through comanagement, experiential learning, and codevelopment of the mental health curriculum described below. The IMP was completely integrated into the primary care setting such that PMHNPs shared physical space, electronic medical
record documentation, and administrative support, including front-desk staff and other ancillary services such as social work.

Technology: All practices and providers worked within the Epic Electronic Medical Record System (Epic Systems Corporation). Team members were able to view schedules and notes and send in-basket messages and chat messages to one another for ease of communication.

Resident education: Residents participated in a weekly continuity clinic, with the first 20-30 minutes of their clinical session devoted to an educational discussion. The preceptor delivered the curriculum during that dedicated educational time. The set of lectures was repeated each year, which ensured that faculty and trainees received repeated exposure to the material. Each preceptor gave continuity talks weekly on various core topics within pediatric outpatient education and was therefore well situated to deliver our sessions. Preceptors did not require recruitment and could teach to the varied levels and experience of resident learners. In addition, residents participated in both the monthlong ambulatory block rotation annually, consisting of additional outpatient care patient sessions and educational sessions, and the ACGME-required developmental and behavioral pediatric rotation during their second year of residency. The elements of the curriculum, as described below, were delivered during these monthlong rotations as well as during residency-wide educational conferences by faculty members.

Activities
Cocreation of pediatric behavioral and mental health curricular content: The curriculum was longitudinal and designed to teach pediatric residents the tenets of behavioral and mental health care. The conceptual frameworks underlying the curriculum were those of integrated care and train-the-trainer, both of which have been used for capacity building within health care.18,19 We based the content areas of the curriculum on American Board of Pediatrics general pediatric core content areas in mental health, including learning differences, attention deficit hyperactivity disorder (ADHD), presentation of anxiety and depression, and medication use. Additionally, EPA 9 (“assess and manage patients with common behavior/mental health problems”)2 included common behavioral and mental health issues such as anxiety, ADHD, depression, management and treatment of common mental health concerns, available community resources, and a focus on interprofessional behavioral health teams. The IMP behavioral health staff (PMHNP5 and social workers), developmental behavioral pediatricians, and general pediatric faculty cocreated all of the content in the curriculum.

The curriculum was progressively incorporated into the program over the past 4 years (2017-2021), with an expanded breadth of sessions each year. The curriculum included several interactive, case-based presentations on a variety of topics related to pediatric behavioral and mental health. As previously outlined, the curriculum was delivered in a variety of settings, including the outpatient continuity clinic, the ambulatory rotation, and the developmental and behavioral pediatrics rotation. The entire curriculum and all resources were available via the internal residency program website for further review and self-directed learning. The Continuity Clinic Curriculum Committee, a group of six faculty evaluating all educational content for the continuity clinic with the added lens of relevance and interactivity, reviewed all curricular content.

Curricular Content
All conferences included facilitator instructions as notes so the content could be delivered by pediatricians, fellows, residents, or IMP team members as needed. Preparation for the session required reviewing the slides and facilitator instructions. Most of the sessions used a slide deck; therefore, equipment needs were a computer for viewing and discussing. For the case-based sessions without accompanying slides, case stems could be printed and handed out to the residents or emailed ahead of time, with the facilitator maintaining the guide. All sessions were interactive, and facilitators followed the guides and prompts to facilitate discussion with residents.

Continuity clinic conferences: The following conferences included an introduction to the IMP as well as several core presentations focusing on the most common conditions encountered in primary care pediatrics. A detailed summary of all sessions can be found in Appendix B. The first session was the introduction to the IMP (Appendix C), while the remainder could be given in any order throughout the year.

- The Pediatric IMP Team (Appendix C): This presentation reviewed the theory behind integrated mental health, introduced the members of the IMP team, and described how to access their resources. This presentation could be modified locally to represent the available team members and referral sources and criteria.
- Maternal Depression (Appendix D): This presentation taught residents the risk factors for postpartum depression, its effects on children and their development, and the pediatrician’s role in identifying and addressing it.
- School Difficulties (Appendices E and F): This case-based activity helped residents identify school difficulties in children. More specifically, it assisted in the differentiation
of ADHD, learning disorders, and anxiety disorders among children.

- ADHD (Appendices G and H): This presentation reviewed standardized screening tools, initiation of treatment, and reasons for expert referral. An accompanying document summarized the main teaching pearls for pediatricians to identify and treat ADHD, which could be used as a reference by residents during actual clinical encounters.

**Rotation-specific and residency-wide teaching:** The following sessions were all designed to be an hour long and could be delivered in small- or large-group settings. Sessions given via residency-wide teaching were repeated yearly, while sessions given during rotation-specific teaching were repeated monthly for the group of residents on that rotation. While these sessions were given by their content experts, a facilitator guide was included with each session. The sessions could therefore be delivered by pediatricians or IMP team members. All sessions could be delivered by one facilitator with minimal prior preparation required. All sessions included slides and accompanying notes for facilitators and therefore required appropriate audiovisual equipment.

- Positive Parenting Training (Appendix I): This presentation discussed the need to use a developmental approach while assessing behavioral challenges in the primary care setting. It reviewed different parenting styles and positive parenting strategies, including nurturing and healthy limit setting. This training complemented self-directed learning completed by residents via the Keystones of Development online curriculum.\(^{20}\)

- Common Childhood Behavioral Problems (Appendix J): This presentation was an overview of common childhood behavioral issues (e.g., bedtime resistance, night wakening, breath-holding spells) and how to modify them.

- Pediatric Anxiety Disorders (Appendices K and L): This presentation reviewed the different types of anxiety disorders, how to screen for them using standardized questionnaires, and treatments that could be initiated in the primary care setting. Similar to the ADHD session, we provided a brief accompanying document for easy reference by residents during clinical encounters.

Major elements of the curriculum as described above are summarized in the Figure.

**Faculty development and modeling:** Approximately 20-25 faculty members were trained in the various topics discussed above during their weekly pediatric division faculty group meetings over the last 5 years. IMP team members and other content experts delivered the training to the general pediatrics faculty in a train-the-trainer approach. Precepting faculty were responsible for delivering this content to the residents they precepted (usually one to two residents in each of the 3 training years per preceptor) during continuity clinic lectures or ambulatory block rotations. In addition, faculty all provided direct patient care for patients in faculty-resident practices and modeled these skills for residents while precepting. Attendance at divisional meetings was approximately 75%, and all curricular content was disseminated via email after each training. During the COVID-19 pandemic, all faculty training transitioned to Zoom meetings, with increased faculty attendance.

In addition to this formal faculty development, pediatric faculty met with the behavioral health staff (PMHNPs and social workers) at weekly practice-based interdisciplinary team meetings. During these meetings, frequent dialogue about cases as well as discussion of and education around treatment (e.g., diagnostic and treatment algorithms) took place, further solidifying the integration of the curriculum via the train-the-trainer model.

**Resident experiential learning:** We designed the curriculum to complement the experiential learning residents received by...
taking care of patients in their continuity clinics while partnering with the IMP team. Residents regularly saw patients in the practice each week and were scheduled for four to seven patients per session based on year of training. Studies in our practices have demonstrated that nearly 30% of patients have behavioral and mental health concerns.\textsuperscript{21}

For pediatric faculty and residents who required additional support related to mental health issues with patients, IMP team members were available for consultation on a regular basis. Behavioral health specialists reviewed and reinforced core principles of mental and behavioral health during consultation and warm handoffs, which occurred regularly during the continuity clinic since these specialists worked alongside the residents and faculty in the integrated practices.

Development of Workflows and Escalation Pathways
We developed workflows for the resident and faculty practices that delineated which patients should be referred to IMP and social work, how to refer, and with what level of urgency (Appendix M). For nonurgent matters, patients could be referred to appointments with behavioral health specialists located on-site or via telehealth. The option of telehealth visits decreased no-show rates and allowed IMP providers to see patients in their home environments.

In addition, we created escalation pathways for situations in which real-time consultations were needed (Appendix N). These workflows used the electronic medical record so that providers working remotely via telehealth and in the practice could utilize them. When real-time consultations were needed, providers either called the behavioral health providers or used messaging within the electronic medical record. Behavioral health group chats staffed by our four practices’ behavioral health specialists at all times ensured coverage during business hours even if individual staff at a particular practice were out of the office. These chats allowed real-time consultation for questions regarding triaging particular patient concerns and were vital during the COVID-19 pandemic, when rates of anxiety and suicidal ideation increased. Chats were typically responded to within 30 minutes; if nonemergent consults arose after business hours, they were responded to the next morning.

Evaluation
A one-time local continuity clinic curriculum evaluation survey was sent to all residents and continuity clinic faculty at the end of the 2021 academic year. The survey assessed perceptions of education within the continuity clinic. Questions centered on delivery of content as well as barriers to learning and teaching in the continuity clinic environment. One free-response question asked residents and faculty, “Are there any gaps in the curriculum that you think should be addressed (i.e., topics that are not part of the curriculum and should be or that are not covered)?” We reviewed results from this question as a secondary analysis to examine for mention of mental and behavioral health as a gap in training from the perspective of preceptors and residents.

Results
Outcomes
Participation and exposure: One hundred fifty-five total residents participated in the curriculum over the 4 years (2017-2021) of its implementation. However, certain classes may have experienced the program differently. For example, third-year residents in 2017-2018 participated in the curriculum for only 1 year, while 2017-2018 interns had the program repeated over 3 years (2017-2018, 2018-2019, and 2019-2020).

Curricular perceptions: Fifty percent of residents (39 of 78) responded to the 2021 survey question regarding perceptions of continuity clinic curricular gaps. Of the 39 respondents, only one identified behavioral and mental health issues as a current gap in the curriculum. Twelve of the 19 preceptors (63%) responded to the 2021 survey question, with zero respondents identifying behavioral and mental health as a current curricular gap.

Discussion
Our curriculum is a longitudinal, pediatrics-focused curriculum that can be adapted to a variety of educational settings. The use of a logic model for development, implementation, and ongoing evaluation of the curriculum both grounds it in educational theory and allows others to adapt it to their own resources and needs.

Compared to other behavioral and mental health curricula developed for residents, our curriculum is unique as it was codeveloped by pediatric and psychiatric team members with the goal of equipping pediatricians with an understanding of integrated care, as well as the skills to promote mental health and well-being, to screen and identify mental health concerns, and to manage mental health issues independently. Both faculty and trainees actively engaged in mental health workflows, including screening, evaluation, management or comanagement, and referral. Because faculty themselves cared for patients in the same environment as residents, they were able to model engaging in longitudinal mental health care provision for their trainees, which has been shown to enhance learning.\textsuperscript{22} The opportunity for residents to engage in experiential learning through a diverse age range of patients in their continuity...
practice linked with the ability to be true longitudinal primary care providers enabled the residents to apply their knowledge and skills to their patient panel. Empowering pediatricians in all career stages to take an active role in their patients’ behavioral and mental health through the expansion of their own knowledge, experience, and skills has the potential to reduce the strain on already limited mental health resources and to increase access to services for patients who may not otherwise be able to obtain psychiatric care. Racial and ethnic disparities in access to and quality of mental health services have existed for years. Initiatives such as ours, especially when serving a particularly disenfranchised patient population, promote a more equitable distribution of valuable behavioral and mental health resources. Finally, it is likely that by providing mental health training in these settings, future specialists may be more equipped to apply these skills in their future practices.

Adaptation
Our curriculum is multifaceted given its successful implementation in a variety of academic settings, including our residents’ development rotation, ambulatory rotation, and continuity clinic. Other institutions can deliver this curriculum as a whole or as stand-alone resources adapted to their own unique residency structures. Based on extensive educational literature, we recommend maintaining the longitudinal aspect of the curriculum in a setting such as resident continuity clinic. However, we recognize the possibility that many institutions may not be able to commit the necessary resources and time to deliver the curriculum in its entirety. The program can also be adapted for use in more diverse educational settings, for example, the inpatient environment, by modifying the cases to reflect more acute scenarios. Many aspects of the curriculum are also applicable to specialties beyond pediatrics (e.g., postpartum depression to obstetrics and gynecology, positive parenting to family medicine).

Limitations
This educational experience has currently been implemented at a single institution and would need to be adapted to suit the unique needs of other sites applying the elements of our logic model. While some short-term outcomes, including implementation and assessment of curricular gaps, have been evaluated, further evaluation is not available for the curriculum. Long-term and objective outcomes have not been evaluated but are included below in our future directions as there is a need to evaluate the impact of the curriculum on residents’ behaviors. The content is also pediatrics specific at this time, which may narrow the applicability of the curriculum; however, the integrated model could likely be modified to serve other specialty areas. Other changes that have occurred within pediatric residency training overall include a greater emphasis on mental health education, as well as increased experiential learning due to climbing number of patients presenting with behavioral and mental health concerns.

Future Directions
Although our currently existing curriculum covers several high-yield topics, there are other areas in behavioral and mental health, such as adolescent depression and suicidality, that must be included in future iterations. This is particularly relevant given the rising rates of suicidal intent throughout the COVID-19 pandemic. A more thorough evaluation of our curriculum as illustrated in the logic model is also necessary; this could be accomplished through the use of direct observation, OSCEs, and chart review in order to assess the impact on cycle time and actual resident behavior. Lastly, further integration of the model could be achieved if PMHNPs and psychiatry faculty become more involved in conducting the curriculum sessions.

Conclusion
The ongoing pediatric mental health crisis warrants thoughtful and impactful responses to challenges faced by primary care providers. Educating pediatric trainees in the areas of integrated mental health care, promotion of mental health and well-being, screening and identification of behavioral and mental health challenges, and treatment of common behavioral and mental health problems is one strategy to increase access and address disparities in care. Our curriculum provides a potential path to implementing mental health training in existing longitudinal resident experiences and selected rotations. Key to implementation are the training of faculty preceptors and the faculty role in modeling mental health workflows. Additionally, robust evaluation of the impact of the curriculum can help in building out further curricular elements and adjusting those that already exist to the needs of learners. Expanding the model and curricular elements to other institutions represents the next step to achieving an even broader impact.

Appendices
A. Logic Model.pdf
B. Summary of Sessions.docx
C. Session 1 - The Pediatric IMP Team.pptx
D. Session 2 - Maternal Depression.pptx
E. Session 3 - School Difficulties Facilitator Guide.docx

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Ethical Approval
Reported as not applicable.

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Received: December 21, 2021
Accepted: June 11, 2022
Published: August 2, 2022