**Collaborative Learning Model: “The Buddy System”**

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**Objective**

This poster describes a novel training model developed by the child and adolescent psychiatry (CAP) residency program and the pediatrics residency program at Maine Medical Center to:

1. develop the skills for multidisciplinary learning
2. increase the skills and efficacy to screen, assess, and care for children and adolescents with mental health concerns by pediatric and med-peds residents (PMP)
3. increase the knowledge and understanding of CAP residents for common childhood illnesses
4. learn the skills to provide consultation by telephone or email, and
5. demystify both the professions and training programs for each profession, thereby increasing likelihood of enduring professional collaborative relationships.

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**Background**

As health care models such as Patient-Centered Medical Homes, Accountable Care Organization, and Medical Neighborhoods develop, we need to train our residents skills of collaboration. Successful collaborative care and mental health integration models exist, yet curricula in primary care or psychiatry residency training programs for collaborative have not been previously described.

Traditionally collaborative contact has occurred in the acute medical setting with the consultation- liaison service to answer a single question for a medically hospitalized individual. Primary care clinicians leave their residency training with little formalized education around mental health and behavioral health concerns and have limited resources to assist them. And child and adolescent psychiatrists may only have six to eight weeks on a pediatric rotation in medical school, yet they will be caring for children their entire professional career.

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**Developing the Model**

Model first envisioned as a component of an AADPRRT workshop in 2012.

Model discussed with pediatric and med/peds training directors at MMC to get “buy-in”, gather other core components, assess level of “hunger”. Pre-surveys developed to learn about prior experiences/exposure to each profession and beliefs about level of knowledge/personal sense of efficacy.

IRB exemption sought and obtained.

**Key components of the model include:**

- Each pairing available to the other for timely telephone consultation or email consultation
- For face-to-face consultations, CAP will attempt to see patient with pedi res in pedi clinic
- Pedri res will have their clinical CAP experience (~ 3 or 4 outpatients clinics, adolescent med month in second year) with the CAP fellow
- CAP fellow will have access to pedi resident for pediatric questions
- Buddies will co-teach together for from each perspective (RAP, headache, chronic illness, FTT, etc)
- Breaking bread together, developing a relationship, and understanding the cultural differences

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**Introducing the Model**

Pre-surveys given July, 2012 to all pediatric, med/peds, and child psychiatry residents (see results below)

September Lunch Meeting to:

- Discuss cultural differences of training
- Meet the buddies
- Establish lines of communication

**Examples of Cultural Differences Discussed:**

- **CAP Fellows**
  - PGY 4-6
  - “Own” patients
  - Autonomous space
  - Boundaries-no hugs
  - Few quick fixes
  - Understanding of parental pathology
  - Referral = sense of mental health concern
  - Non-directive
  - Telephone
  - Supervision
  - Relationships

- **Ped & Med/Ped Residents**
  - PGY 1-3
  - “Cover” clinic
  - Office clinic
  - Hugs
  - Sick kids get well fast
  - Learning about childhood issues only
  - Masked symptoms
  - Non-directive
  - Checking off the boxes
  - Telephone

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**Pre-Survey Results**

- **CAP exposure to Pediatrics**
- **Ped & MP CAP experience in med school**
- **Ped & MP perception of knowledge for mental health dx.**
- **Self-Prescription Level of Knowledge**

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**Buddy Pairings**

- Pedi resident
- Child Fellow
- Med/Peds

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**Lessons Learned to Date**

- Pediatric and med/peds residents find being “buddied with buddy” in ped psychopharm clinic very positive
- The relationships require some effort to develop
- Utilization data and experience data is pending
- The model requires a modest level of faculty/resident check-in to enhance the utilization
- Model is receiving interest at other programs (Arizona and SUNY Upstate considering beginning the model in their training programs)
- Goal of shared teaching experiences still needs to occur
- Initial enthusiasm robustly positive for faculty and residents