Primary Care – Behavioral Health Integration (PCBHI) at the Cambridge Health Alliance

April 2017

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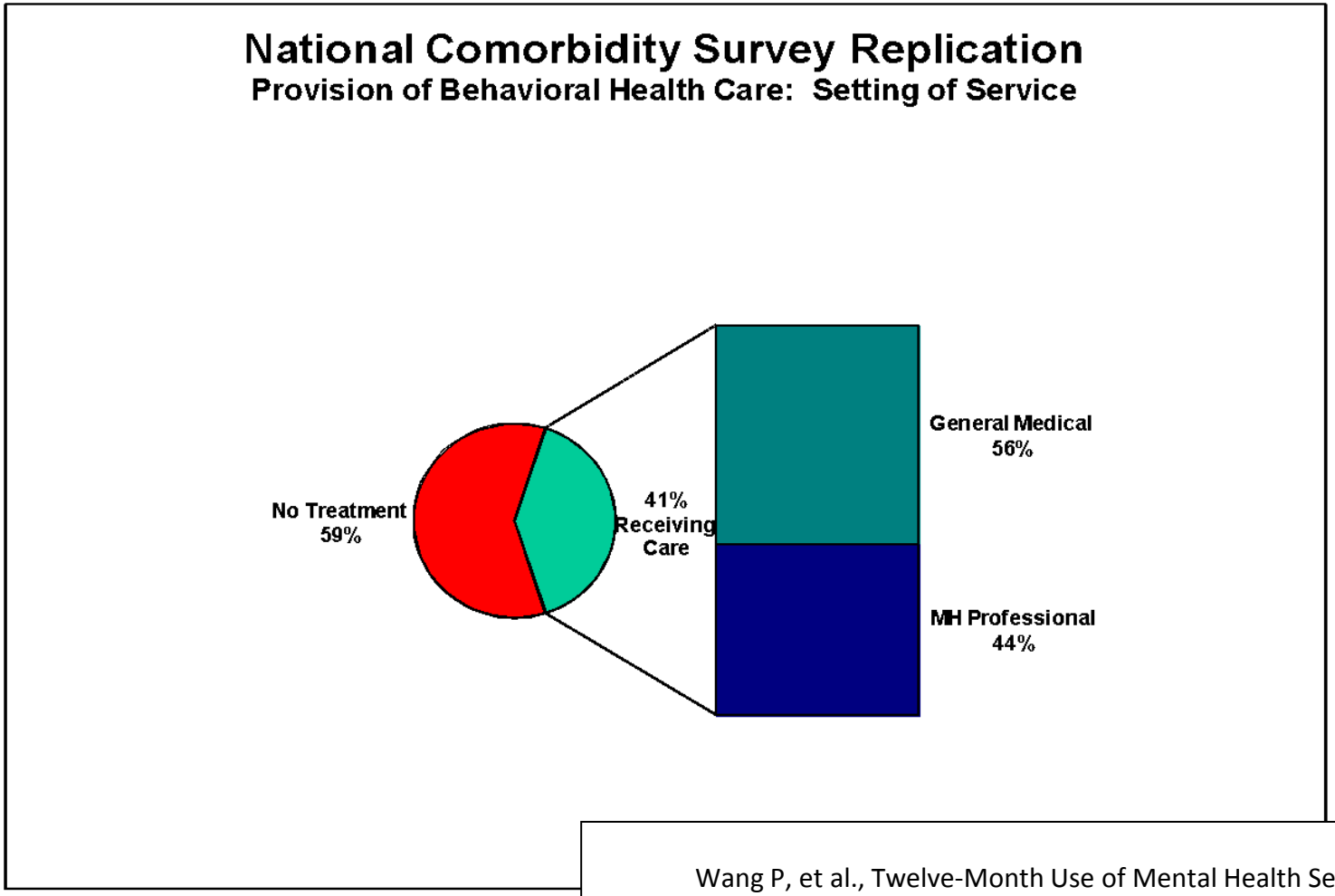
CHA Cambridge Health Alliance

It’s all about the Patients…

Overview

1. **Rationale** for Primary Care Behavioral Health Integration
2. CHA **Model** for Primary Care Behavioral Health Integration
3. **Staffing** to support the model
4. Behavioral Health **Screening**
5. **Targeted high-prevalence diseases**:
    - Depression
    - Unhealthy alcohol use and substance use disorders
    - Reverse Integration Project (HIP)

Primary Care is the 'De Facto' Mental Health System



Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

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Why Integrate?

Rationale for Integration of Mental Health and Addictions

Patient-Centered

- ➢One-stop shopping
- ➢Improves Access
  - ➢More patients willing to be seen by MH provider based at their primary care center
  - ➢Reduces stigma
  - ➢Reduces disparities for minority groups

Consistent w/ New Delivery Systems (CHA Transformation)

- ➢Patient Centered Medical Home
- ➢Chronic Disease Management
- ➢Global Payment/ACO

Improves Outcomes

- ➢Medical/MH often co-morbid
- ➢Leverages primary care relationships
- ➢Reduces total medical expenses (TMEs)

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Telepsychiatry Consultation

Population Screening

Adult Wellbeing Questionnaire
-Depression
-Alcohol
-Drugs

Brief Intervention

Behavioral Activation
Motivational Interviewing
Self-Management Support
Problem Solving Treatment

Referral To Treatment

Outpatient Therapy
More Intensive Level of Care
Community-Based Resources

Primary Care-Behavioral Health Integration Model

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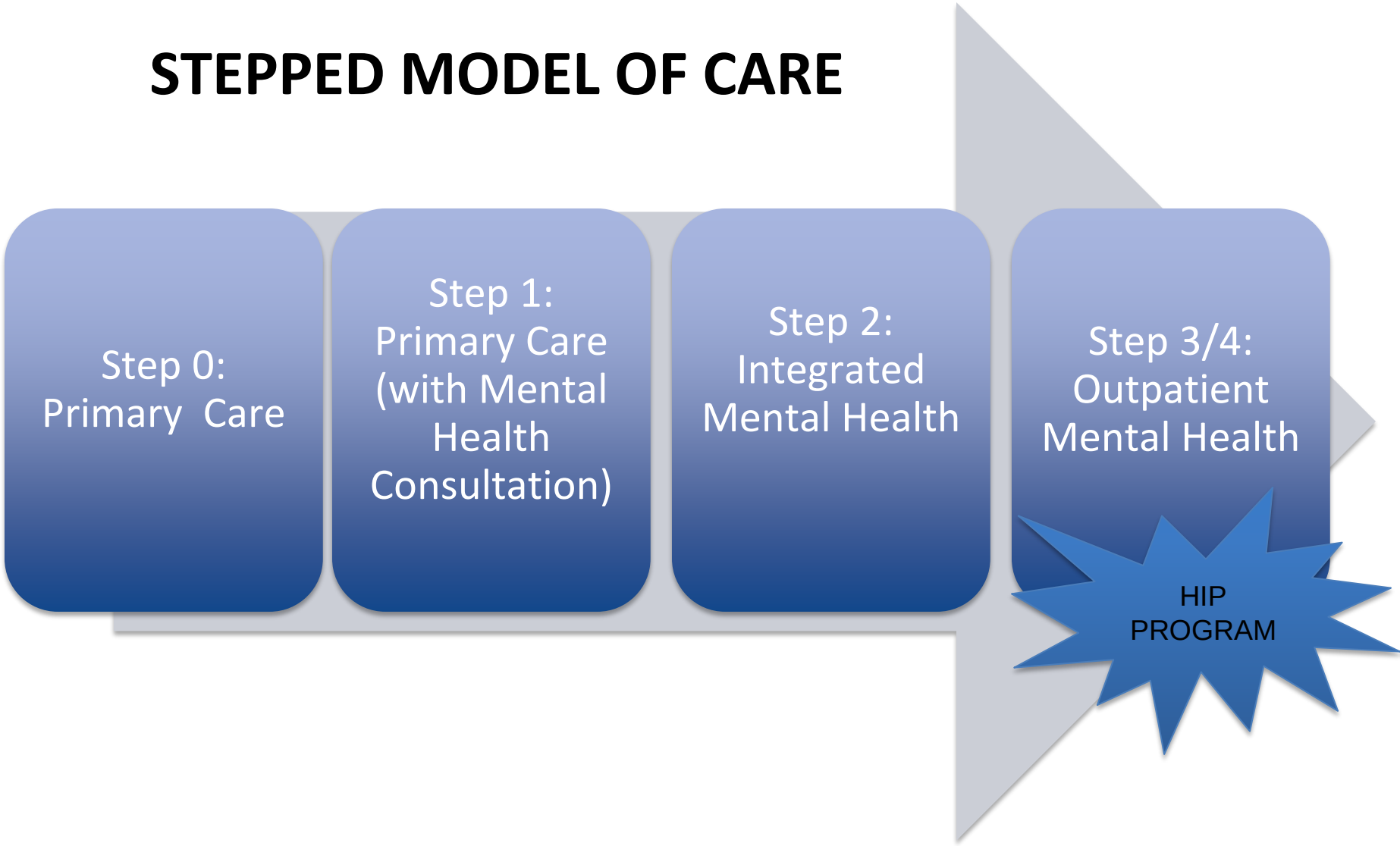
STEPPED MODEL OF CARE



On site Behavioural Health Care Team

Full Time Care Partner – unlicensed mental health resource trained in step 1 and 2 but who can coordinate all of the patients

Full Time Therapist – does warm hand offs and her own schedule of patients for BRIEF therapy interventions (6-8 weeks max, often 1-2 sessions total)

Psychiatry MD – on site one day/week but in continual contact with the team by telepsychiatry and regular meetings to supervise the on site team

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Staffing to Support the Model

Mental Health Care Partner (MHCP)

- Step 0 & 1 Patients
  Positive Screens
- Warm Handoffs
  Team Coordination
  Registry
- Self-Management
  Support &
  Coaching

Integrated Therapist

- Step 2 Patients
- Warm Handoffs
  Team Consultation
  Supports MHCP
- Brief Treatment with
  Evidence-Based
  Therapies

Consult Psychiatrist

- Step 0-2 Patients
- Team Consultation
  Education
  Case review w/MHCP
- Psych Evaluation
  Medication & Diagnostic
  Consultation

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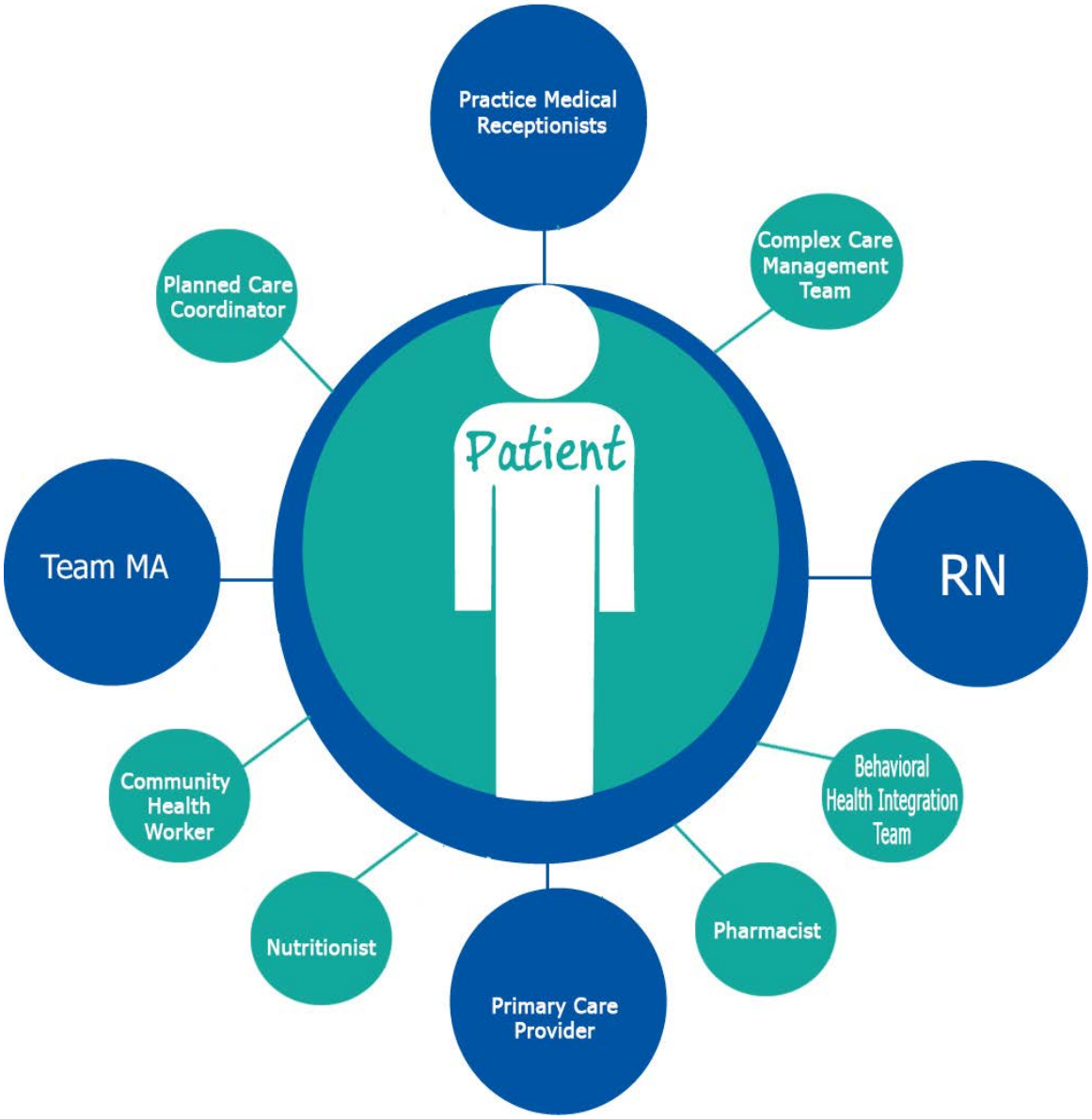
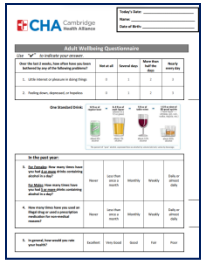
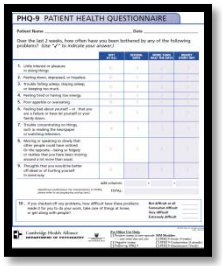
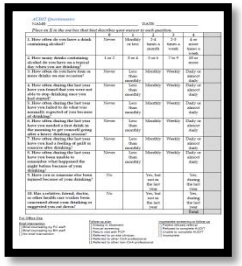


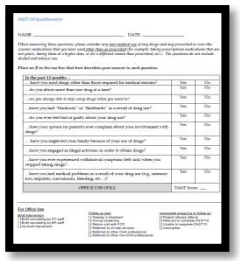
Two-Step Approach to Screening:

Brief Screen and Brief Assessment: everyone has a role









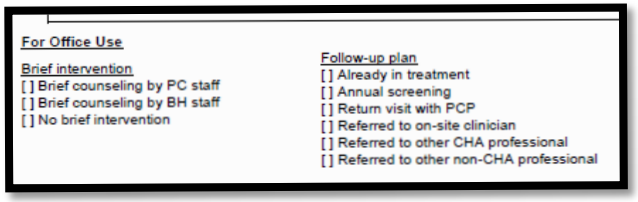
Brief Screen
NIAAA 1-item
NIDA 1-item
PHQ2

Brief Assessments
AUDIT
DAST-10
PHQ9

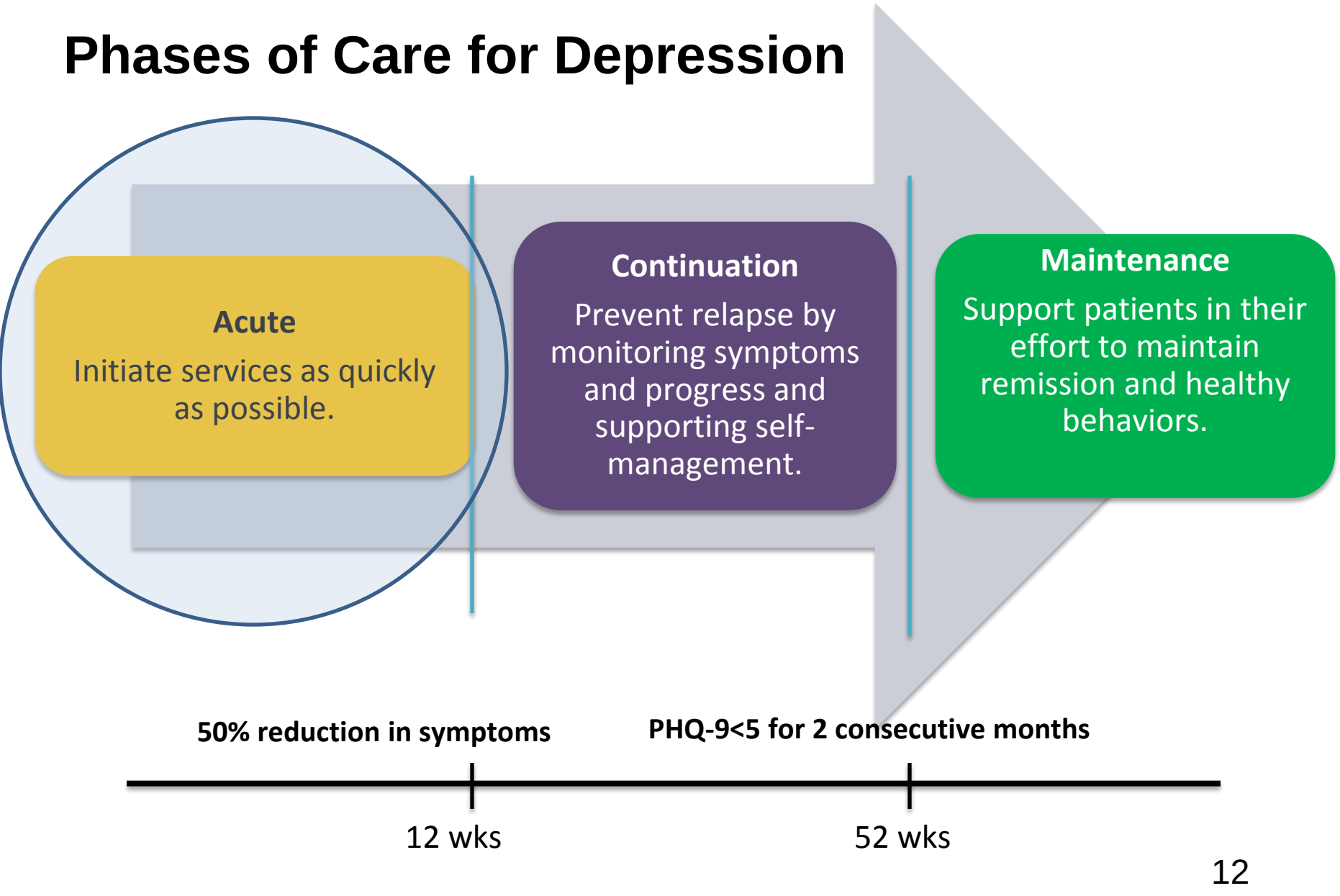
Review results
with patient, recommend intervention

No further action needed

Advise patient of results. Plan for follow-up



Phases of Care for Depression

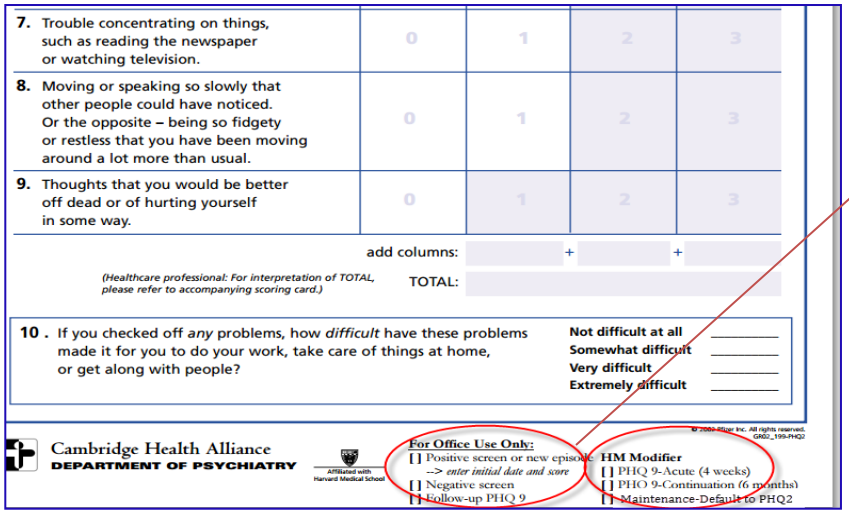


Dual Strategy: In-reach and Outreach

*Integration of **Population Health** into the work adds incredible power
*This strategy is what we use across all of Primary Care now at Cambridge Health Alliance

***Huddles** help organize the work of the day when the team sees patients
***Team Meetings** happen weekly to think about and organize the work around patients who are NOT coming in and make sure they are also getting the care they need
*This is a **paradigm shift**
*This new work needs to be funded and new team roles need to be created

Targeted disease: Depression



7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
	add columns:	+	+	
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10 . If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

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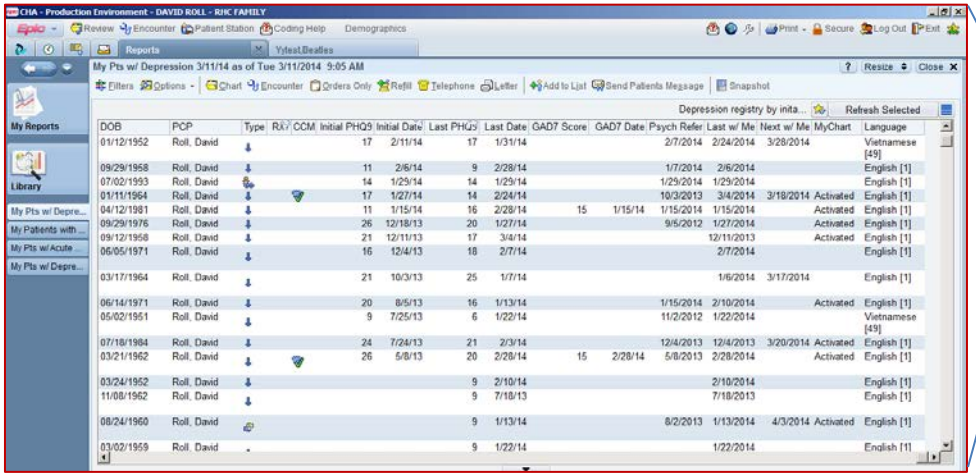
DEPARTMENT OF PSYCHIATRY

Affiliated with Harvard Medical School

For Office Use Only:
[ ] Positive screen or new episode
--> enter initial date and score
[ ] Negative screen
[ ] Follow-up PHQ 9

HM Modifier
[ ] PHQ 9-Acute (4 weeks)
[ ] PHQ 9-Continuation (6 months)
[ ] Maintenance-Default to PHQ2

The "**initial date**" launches the 'acute phase' workflow for intensive follow-up



DOB	PCP	Type	Initial PHQ9	Initial Date	Last PHQ9	Last Date	GAD7 Score	GAD7 Date	Psych Refer	Last w/ Me	Next w/ Me	MyChart	Language
01/12/1952	Roll, David		17	2/11/14	17	1/31/14			2/7/2014	2/24/2014	3/28/2014		Vietnamese [49]
09/29/1958	Roll, David		11	2/6/14	9	2/28/14			1/7/2014	2/6/2014			English [1]
07/02/1993	Roll, David		14	1/29/14	14	1/29/14			1/29/2014	1/29/2014			English [1]
01/11/1964	Roll, David		17	1/27/14	14	2/24/14			10/3/2013	3/4/2014	3/18/2014	Activated	English [1]
04/12/1981	Roll, David		11	1/15/14	16	2/28/14	15	1/15/14	1/15/2014	1/15/2014		Activated	English [1]
09/29/1976	Roll, David		26	12/18/13	20	1/27/14			9/5/2012	1/27/2014		Activated	English [1]
09/12/1958	Roll, David		21	12/11/13	17	3/4/14				12/11/2013		Activated	English [1]
06/05/1971	Roll, David		16	12/4/13	18	2/7/14				2/7/2014			English [1]
03/17/1964	Roll, David		21	10/3/13	25	1/7/14				1/6/2014	3/17/2014		English [1]
06/14/1971	Roll, David		20	8/5/13	16	1/13/14			1/15/2014	2/10/2014		Activated	English [1]
05/02/1951	Roll, David		9	7/25/13	6	1/22/14			11/2/2012	1/22/2014			Vietnamese [49]
07/18/1984	Roll, David		24	7/24/13	21	2/3/14			12/4/2013	12/4/2013	3/20/2014	Activated	English [1]
03/21/1962	Roll, David		26	5/8/13	20	2/28/14	15	2/28/14	5/8/2013	2/28/2014		Activated	English [1]
03/24/1952	Roll, David				9	2/10/14				2/10/2014			English [1]
11/08/1962	Roll, David				9	7/18/13				7/18/2013			English [1]
08/24/1960	Roll, David				9	1/13/14			8/2/2013	1/13/2014	4/3/2014	Activated	English [1]
03/02/1959	Roll, David				9	1/22/14				1/22/2014			English [1]

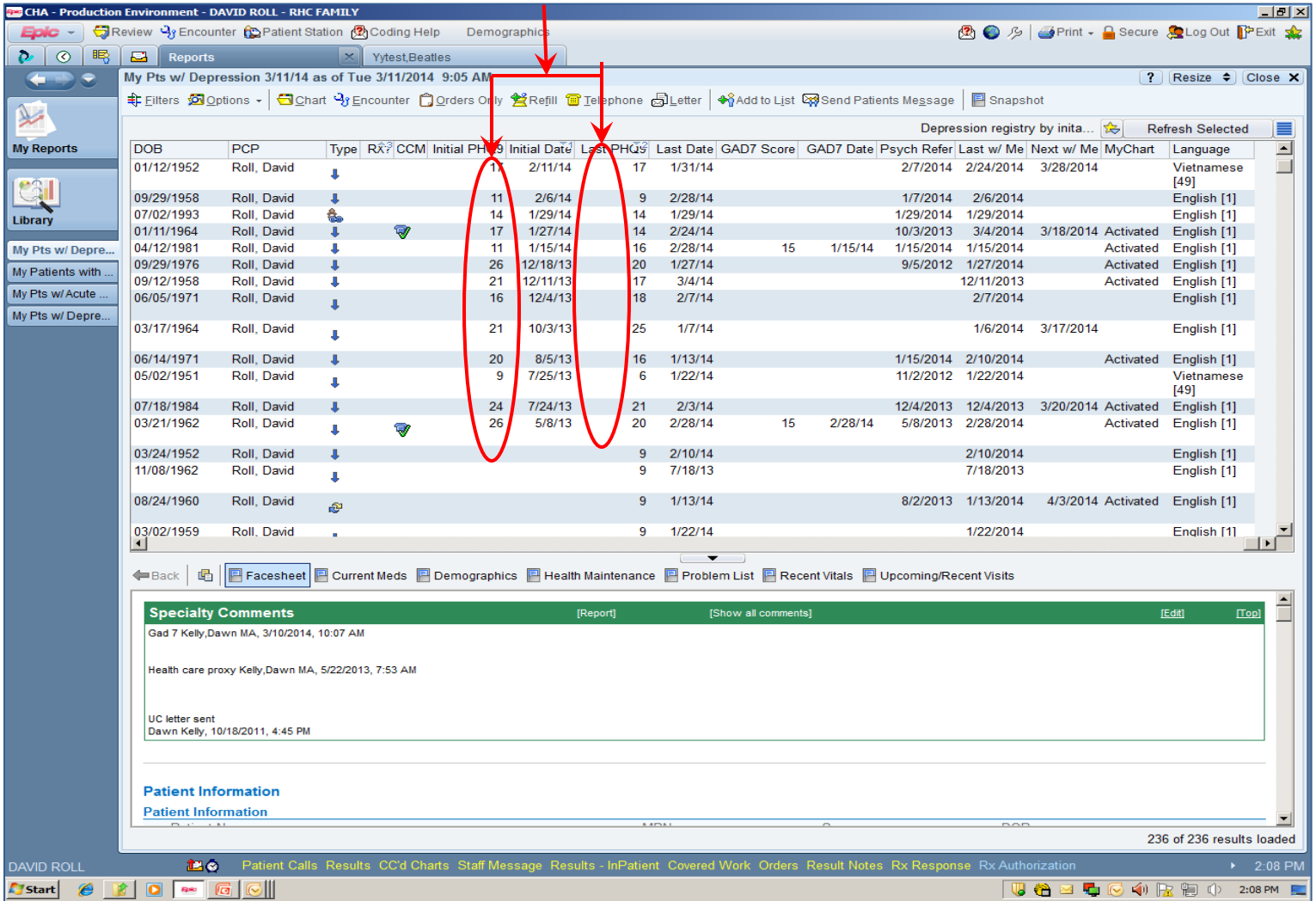
Team meeting supports the follow-up. Care partner plays facilitating role.

Goals: 'Depression Perfect Process' (appropriate follow-up)
'Depression Perfect Outcome' (PHQ9 score reduced by 50%)

Using the Registry Features

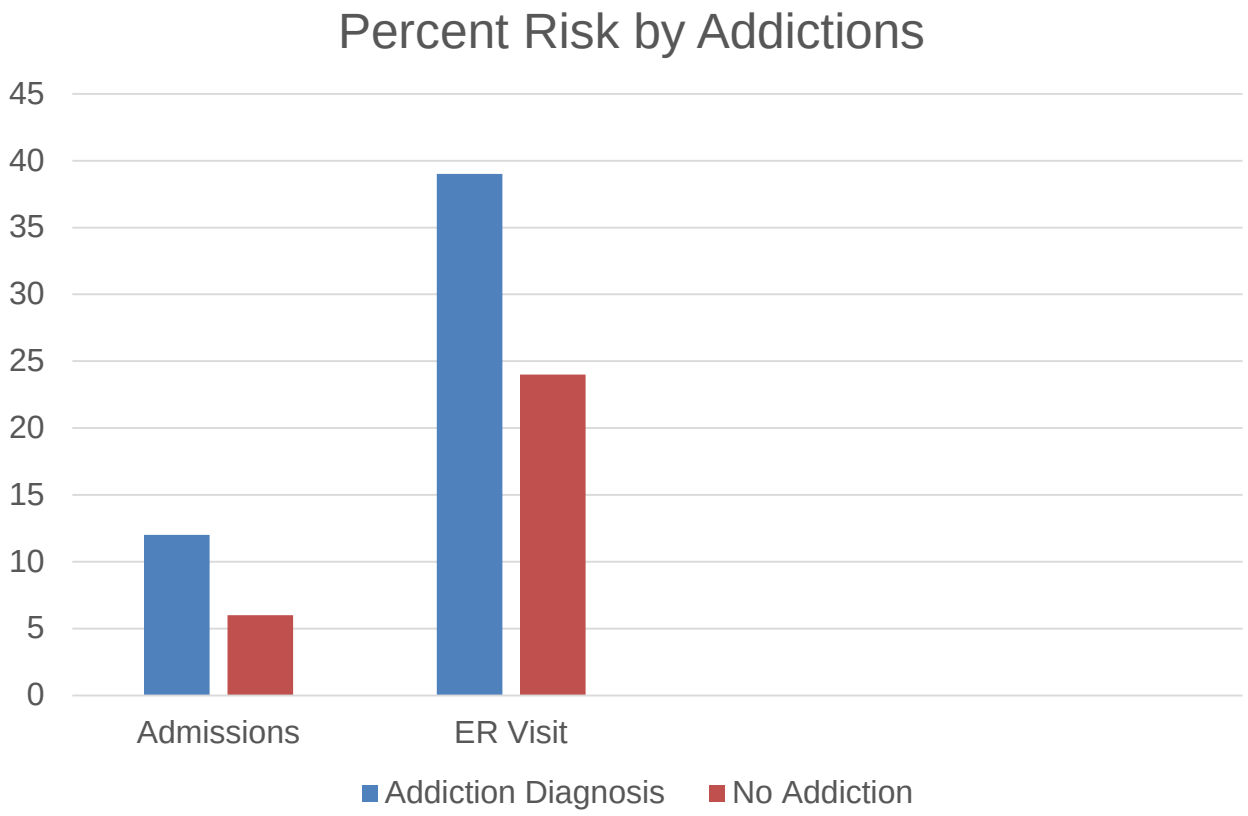
For case review, to bring most recent patients to the top. It is easy to compare the initial and latest PHQ-9 scores shows which patients are improving on treatment

sort by the initial date column



Targeted Disease: Addictions

75,000 patients >=18yo
Current smoker = 15%
8% with an Addiction diagnosis on problem list (not including smoking)



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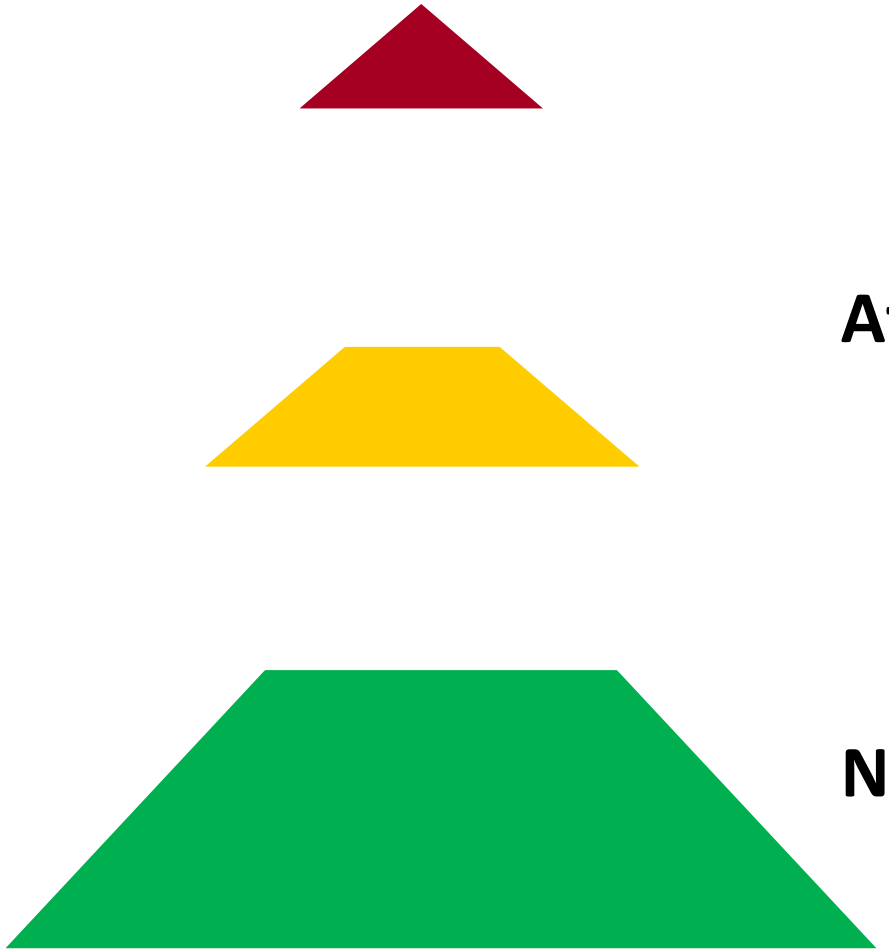
SBIRT Brief Intervention



With Addiction

➔Refer for specialty addiction treatment

At Risk

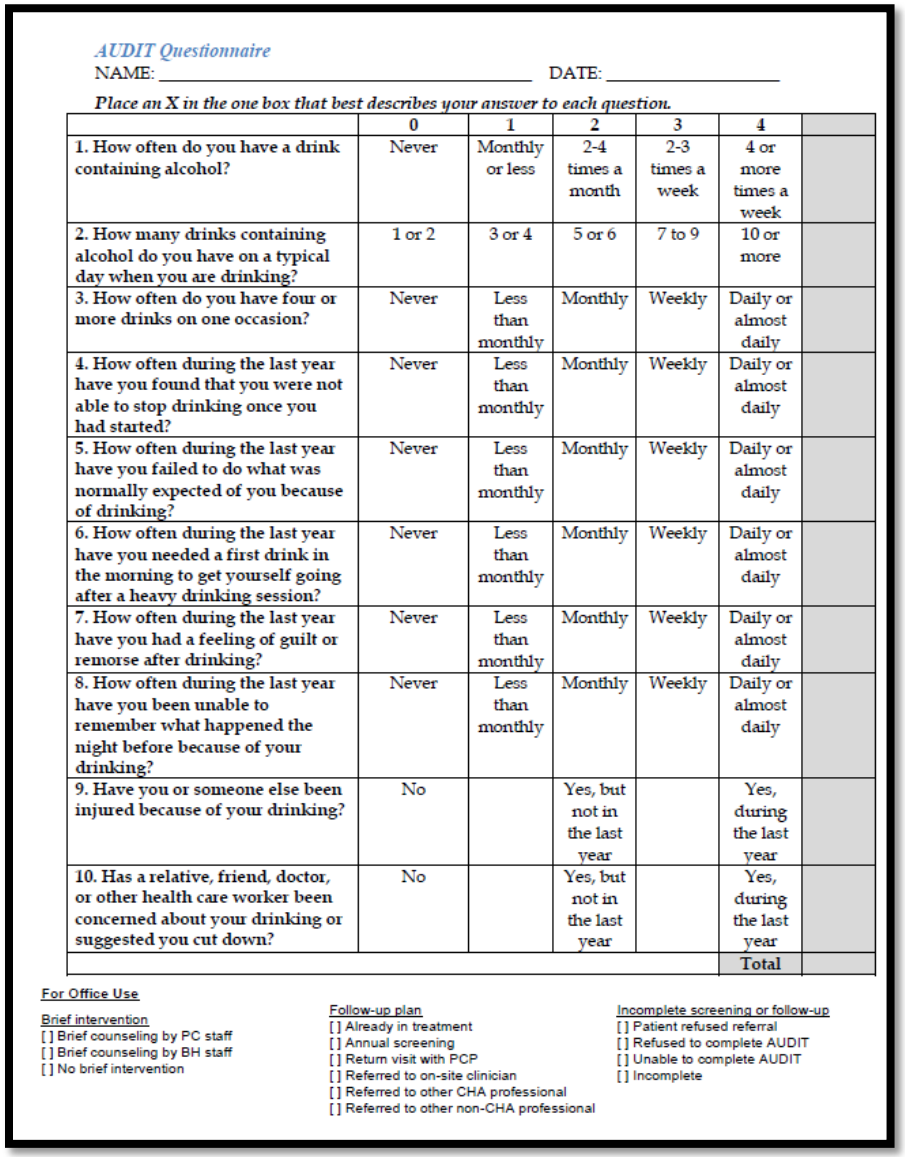
➔Educate about risks

➔Decrease risk for consequences or progression of disease

Not at Risk

➔Educate about risks, promote healthy norms

Targeted disease: Addictions



AUDIT Questionnaire

NAME: _____ DATE: _____

Place an X in the one box that best describes your answer to each question.

	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

For Office Use

Brief intervention
[ ] Brief counseling by PC staff
[ ] Brief counseling by BH staff
[ ] No brief intervention

Follow-up plan
[ ] Already in treatment
[ ] Annual screening
[ ] Return visit with PCP
[ ] Referred to on-site clinician
[ ] Referred to other CHA professional
[ ] Referred to other non-CHA professional

Incomplete screening or follow-up
[ ] Patient refused referral
[ ] Refused to complete AUDIT
[ ] Unable to complete AUDIT
[ ] Incomplete

Brief intervention

[ ] Brief counseling by PC staff
[ ] Brief counseling by BH staff
[ ] No brief intervention

Referred to Treatment

[ ] Referred to onsite clinician
[ ] Referred to other CHA professional
[ ] Referred to other non-CHA prof.

Referred to Peer Support

[ ] Referred to CHA peer support
[ ] Referred to non-CHA peer support

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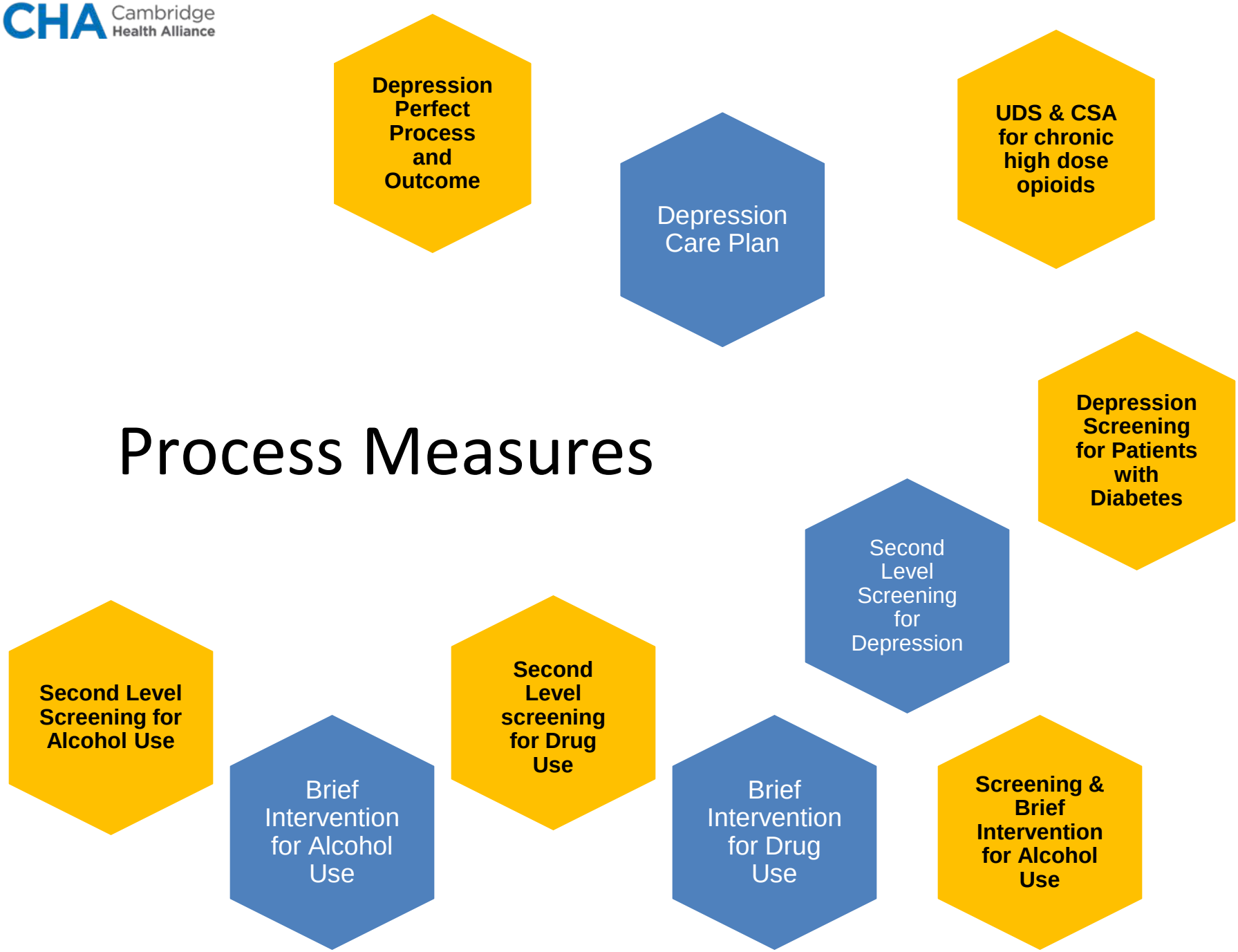
Process Measures



BACKUP
or
How to support the work

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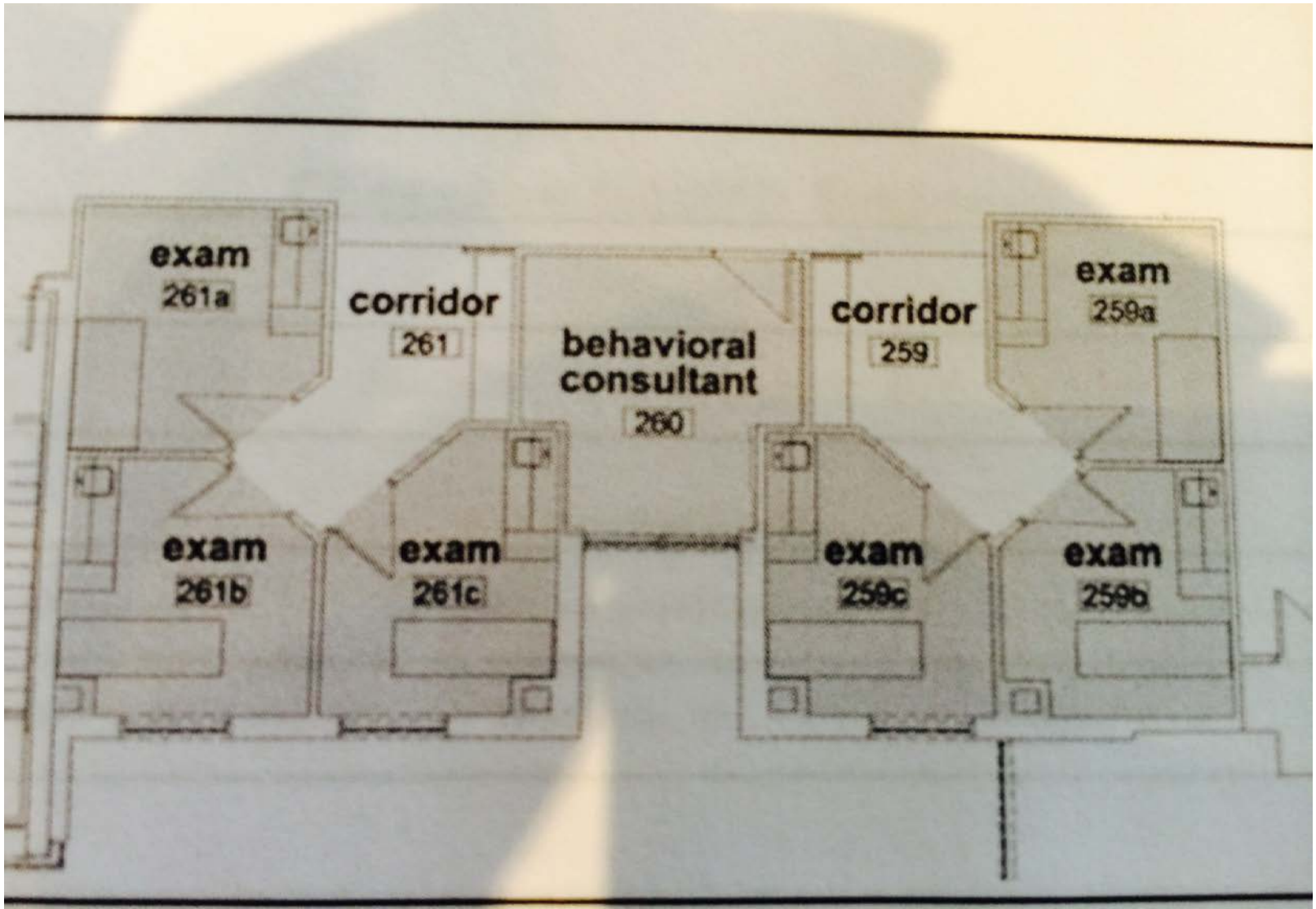
Make your space facilitate the work!



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TELEPSYCHIATRY SERVICE TO SUPPORT PCBHI

PSYCHIATRY CONSULTATION

- Telephone Discussion
- Electronic Case Review

Page service through Staffnet or send message via EPIC

TECH-BASED SELF-HELP:

- Information & Advice Websites
- Mobile Mental Health Apps

Refer patients to Care Partner

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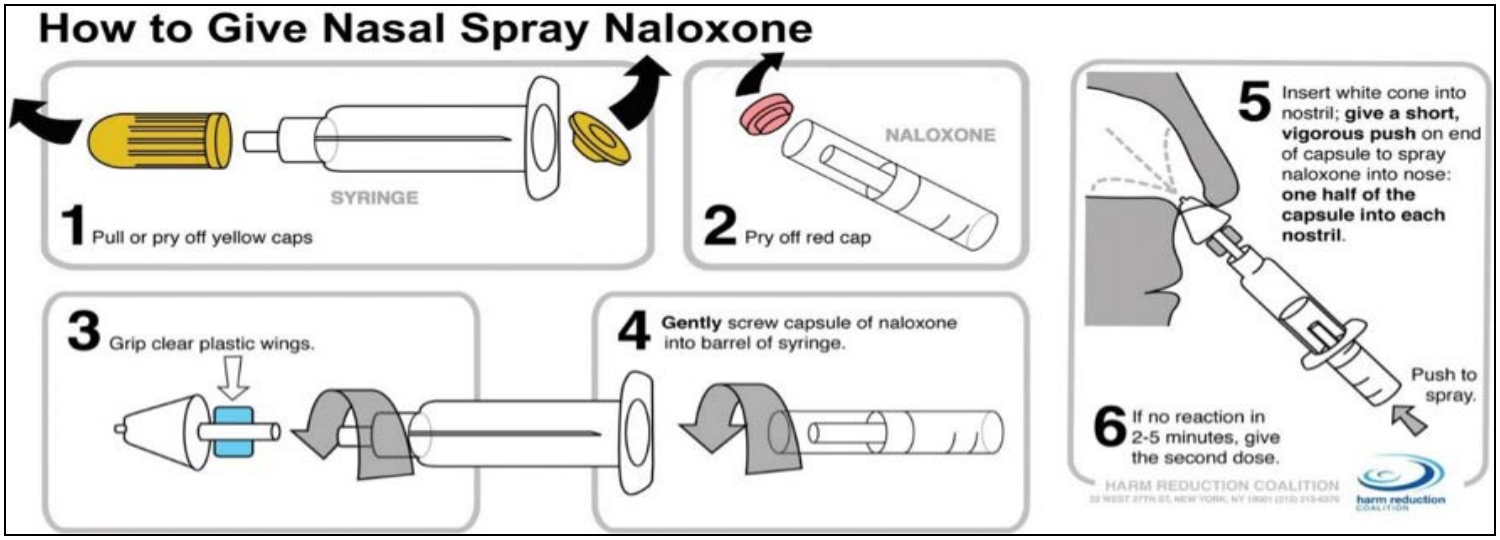
Patient-facing instructions for AVS .naloxone / .narcan



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Health Integration Program (HIP)

A Behavioural Health Home Pilot

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Wait … what is that?

Behavioural Health Home

Clinical program that aims to "improve the overall health status of people with serious mental illness (SMI) through **coordination and integration of primary health care** *with behavioral health (BH) services* **within a community-based, specialty BH clinic**.*"*

- *SAMHSA-HRSA Center for Integrated Health Solutions*

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Mortality Gap

Adults with serious mental illness (SMI) are expected to **die 20-30 years earlier** than general population[1-4]

2015 study of Medicaid adults with schizophrenia:[1]

- Mortality ratio: **3.7 times** > Medicaid population
- Potential life lost: **28.5 years**

Higher SMR for most causes of death[1]

- 85% due to "natural causes" of death (e.g. CV issues, COPD, pneumonia, sepsis, diabetes, cancers)
- Consistent across geographic regions[4]

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Drivers of Early Mortality

- Gaps in detection/treatment of medical needs
- High prevalence of modifiable risk factors (e.g. smoking, diet, exercise, substance use, stress)
- Barriers to treatment adherence
- Iatrogenic effects of antipsychotics
- Biopsychosocial factors related to SMI

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Target Population

Age 16+ with CHA GP and:

- **Schizophrenia** or other psychotic disorder
- **Bipolar disorder** and taking antipsychotic

Would benefit from:

- Integrated, team-based care planning & management
- Health promotion & education
- Close coordination with community service providers

450 currently enrolled

New Team Members

Co-located Medical Nurse Practitioner (0.5 FTE)

- On-site medical and health promotion services
- Integrated team member guiding service design/operations

Care Partner (FTE)

- Care coordination and population management
- Health promotion, pt engagement, behavioral activation
- Referral management

Program Manager (FTE)

- (Re)design systems to enable integrated care delivery
- Collaborate w/ community providers & CHA clinical leaders
- Compliance with 1115 waiver initiative specifications

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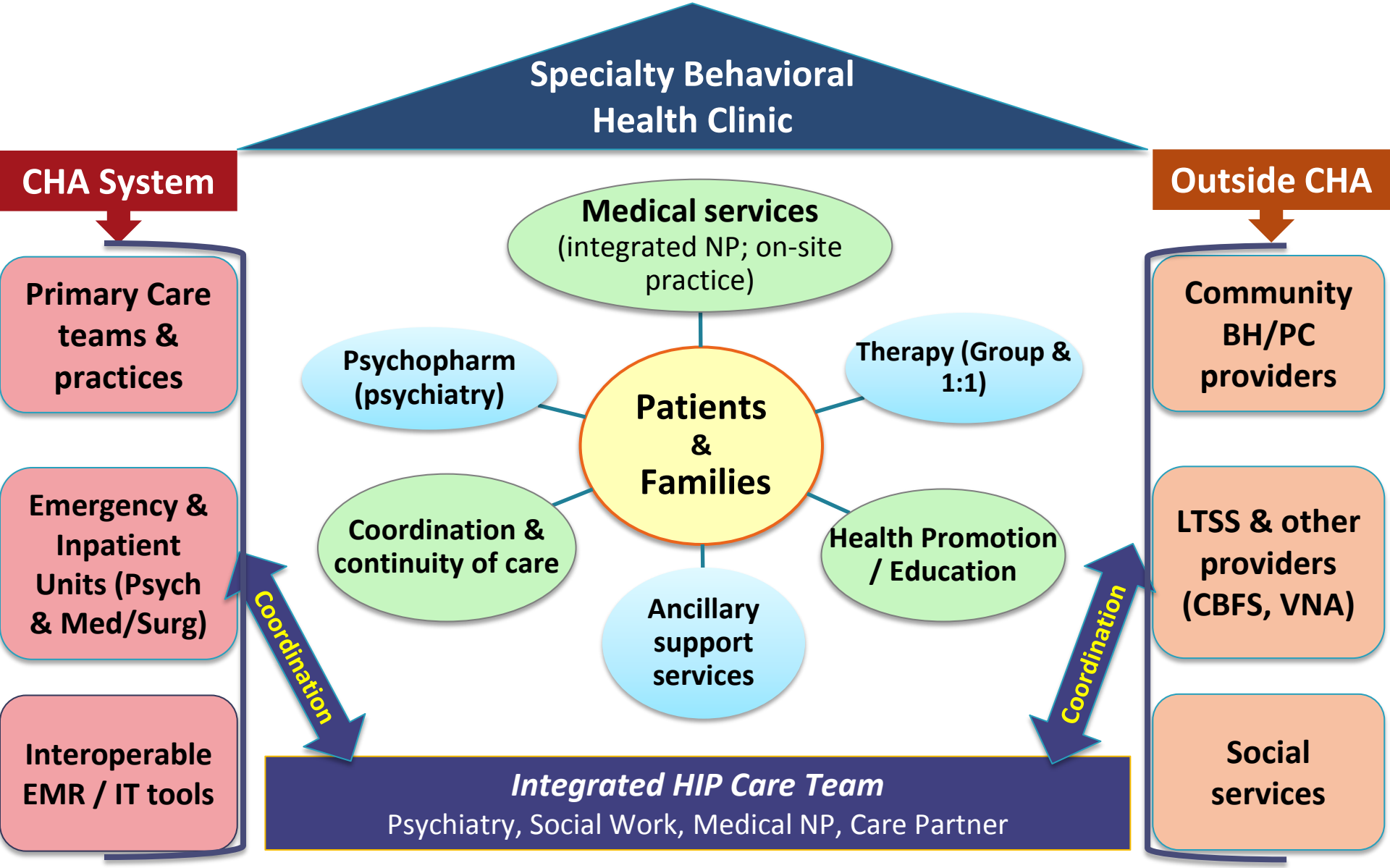
Behavioral Health Home



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BHH Quality Measures

- Annual A1c/LDL screening
- Diabetes monitoring
- BMI screening and preventive care
- Rates of controlled A1c and BP
- Follow-up after BH hospitalization (7- and 30-day)
- Patient-centered care plan up-to-date

Measurement Dashboard

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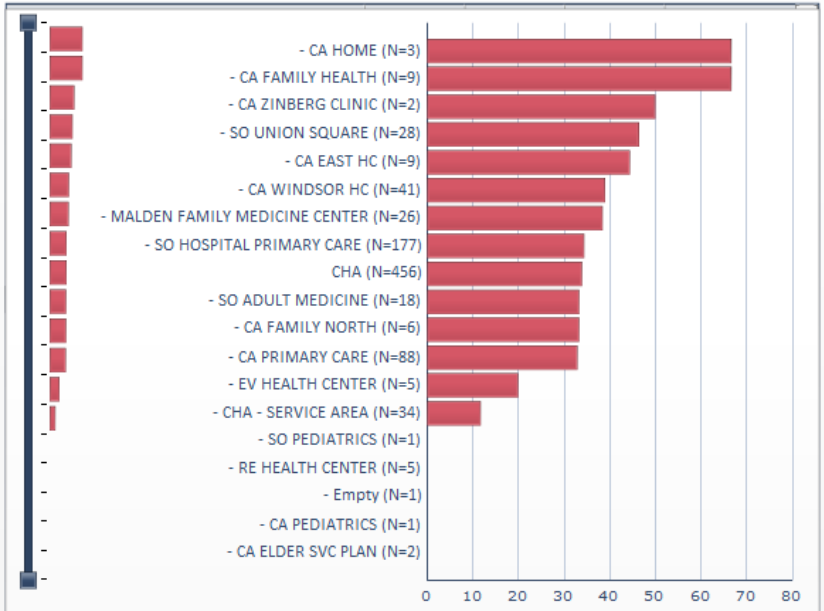
Behavioral Health Home

Default Dates
Custom Dates

	CHA	Actual		Target	Period
	BHH - Target Population with Care Plan	34	%	N/A	Nov-16
	BHH - Integrated Care Encounter	667		N/A	Nov-16
	BHH - Cardiovascular Screening Schizophrenia or Bipc	66	%	N/A	Nov-16
	BHH - Diabetes Screening Schizophrenia or Bipolar Ar	80	%	N/A	Nov-16
	BHH - Followup Hospitalization Mental Illness - 7 Day	44	%	N/A	Nov-16
	BHH - Followup Hospitalization Mental Illness - 30 Da	65	%	N/A	Nov-16
	BHH - Preventative Care and Screening - BMI	34	%	N/A	Nov-16
	BHH - Diabetes Monitoring Diabetes and Schizophrer	76	%	N/A	Nov-16
	BHH - Diabetes Care for Mental Illness - A1c Control	66	%	N/A	Nov-16
	BHH - Controlling High Blood Pressure	67	%	N/A	Nov-16

BHH - Target Population with Care Plan — Navigation — Chart Display

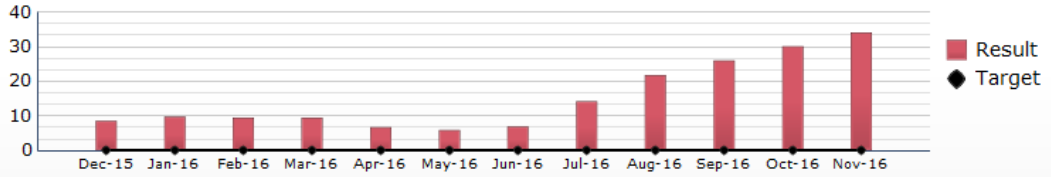


Demographic Analyzer - Patient

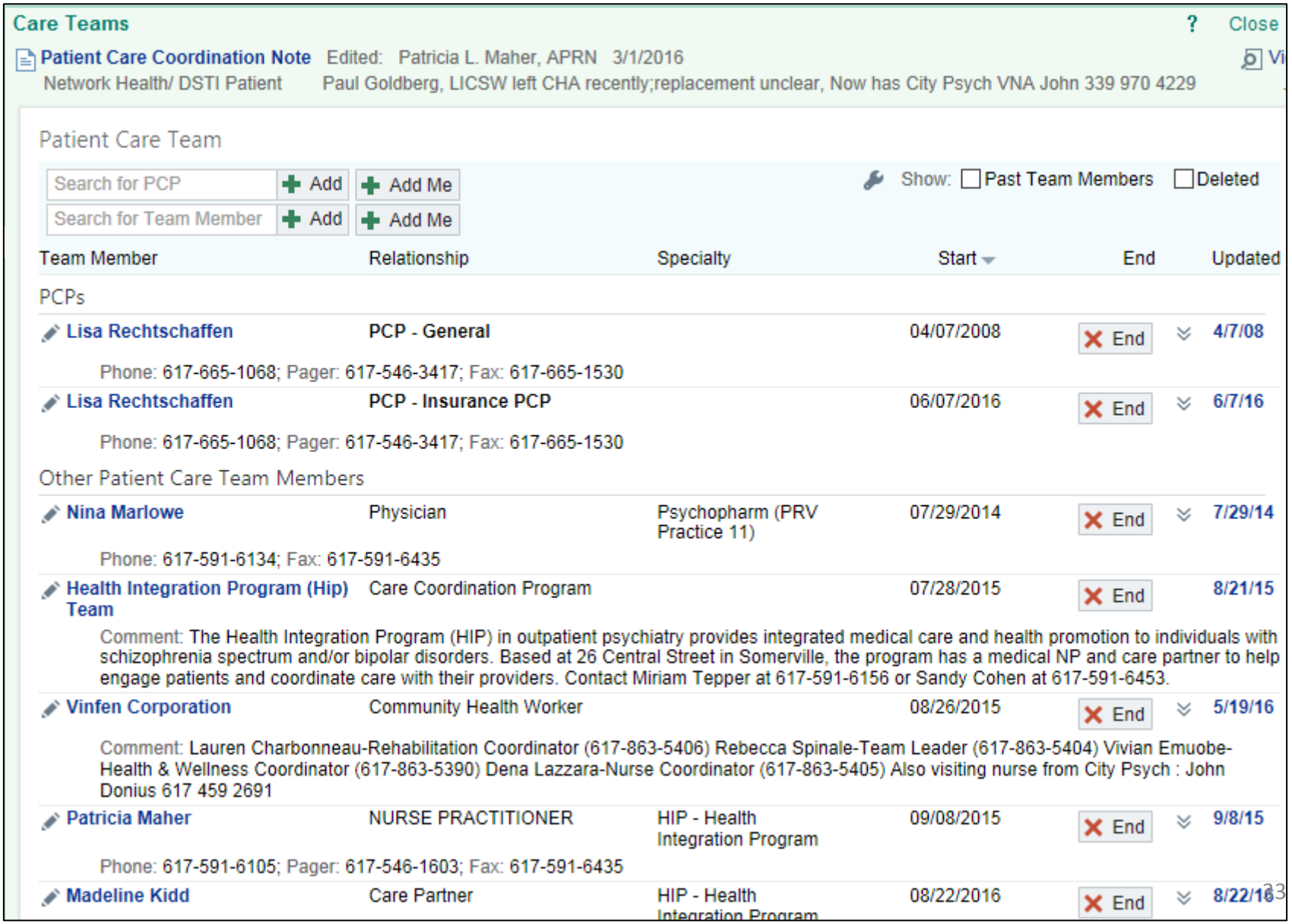
Print Version

Desc: The percentage of Behavioral Health Home target population members with a care plan developed and recently reviewed by a provider from their care team.
Strategic Goals:
Rationale:
Conclusions:

History - BHH - Target Population with Care Plan - CHA



EHR Care Team



Care Teams ? Close

Patient Care Coordination Note Edited: Patricia L. Maher, APRN 3/1/2016 Vi

Network Health/ DSTI Patient Paul Goldberg, LICSW left CHA recently;replacement unclear, Now has City Psych VNA John 339 970 4229

Patient Care Team

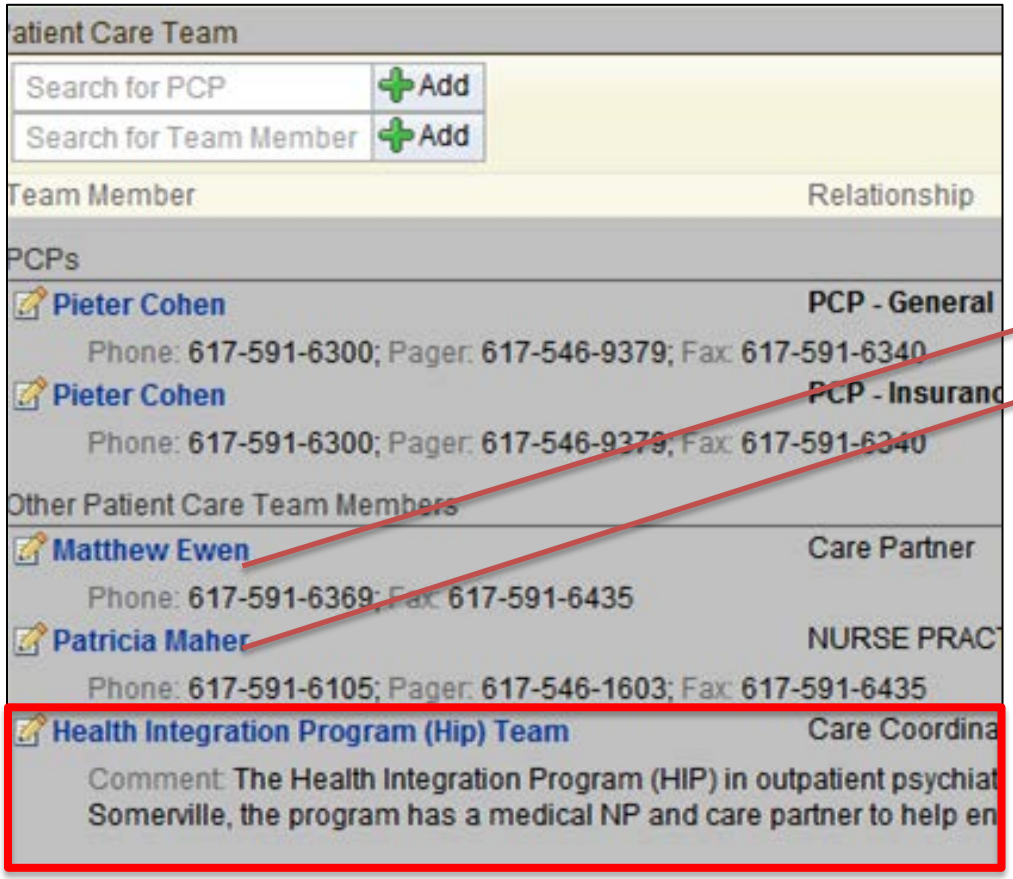
Search for PCP + Add + Add Me

Search for Team Member + Add + Add Me

Show: Past Team Members Deleted

Team Member	Relationship	Specialty	Start	End	Updated
PCPs					
Lisa Rechtschaffen	PCP - General		04/07/2008	End	4/7/08
Phone: 617-665-1068; Pager: 617-546-3417; Fax: 617-665-1530					
Lisa Rechtschaffen	PCP - Insurance PCP		06/07/2016	End	6/7/16
Phone: 617-665-1068; Pager: 617-546-3417; Fax: 617-665-1530					
Other Patient Care Team Members					
Nina Marlowe	Physician	Psychopharm (PRV Practice 11)	07/29/2014	End	7/29/14
Phone: 617-591-6134; Fax: 617-591-6435					
Health Integration Program (Hip) Team	Care Coordination Program		07/28/2015	End	8/21/15
Comment: The Health Integration Program (HIP) in outpatient psychiatry provides integrated medical care and health promotion to individuals with schizophrenia spectrum and/or bipolar disorders. Based at 26 Central Street in Somerville, the program has a medical NP and care partner to help engage patients and coordinate care with their providers. Contact Miriam Tepper at 617-591-6156 or Sandy Cohen at 617-591-6453.					
Vinfen Corporation	Community Health Worker		08/26/2015	End	5/19/16
Comment: Lauren Charbonneau-Rehabilitation Coordinator (617-863-5406) Rebecca Spinale-Team Leader (617-863-5404) Vivian Emuobe-Health & Wellness Coordinator (617-863-5390) Dena Lazzara-Nurse Coordinator (617-863-5405) Also visiting nurse from City Psych : John Donius 617 459 2691					
Patricia Maher	NURSE PRACTITIONER	HIP - Health Integration Program	09/08/2015	End	9/8/15
Phone: 617-591-6105; Pager: 617-546-1603; Fax: 617-591-6435					
Madeline Kidd	Care Partner	HIP - Health Integration Program	08/22/2016	End	8/22/16

Admission & Discharge Alerts



From: Staffnet
Sent: Wednesday, January 20, 2016 1:16 PM
To: Ewen, Matthew; Maher, Patricia
Cc: Staffnet
Subject: ADT Alert Care Team - Patient [redacted] discharged

Discharge of [redacted]
- DOB [redacted]
- MRN [redacted]
- discharged Jan 20 2016 12:53PM
- from PSYCHIATRY service
- at CH in Cahill 4
- discharge disposition HOME
- admitted Jan 12 2016 6:21PM
- LOS 8 days
- attending GILMAN,ROBERT B MD

Hospital Care Transitions

Upon hospitalization, BHH care partner and/or clinician outreaches to inpatient staff for care coordination

Before discharge, IP staff and BHH care partner discuss d/c plan to ensure timely follow-up with established provider(s)

Schedule follow-up with BHH or other specialty BH provider within 7 days, whenever possible; monitor rates of 7- and 30-day follow-up after hospitalization

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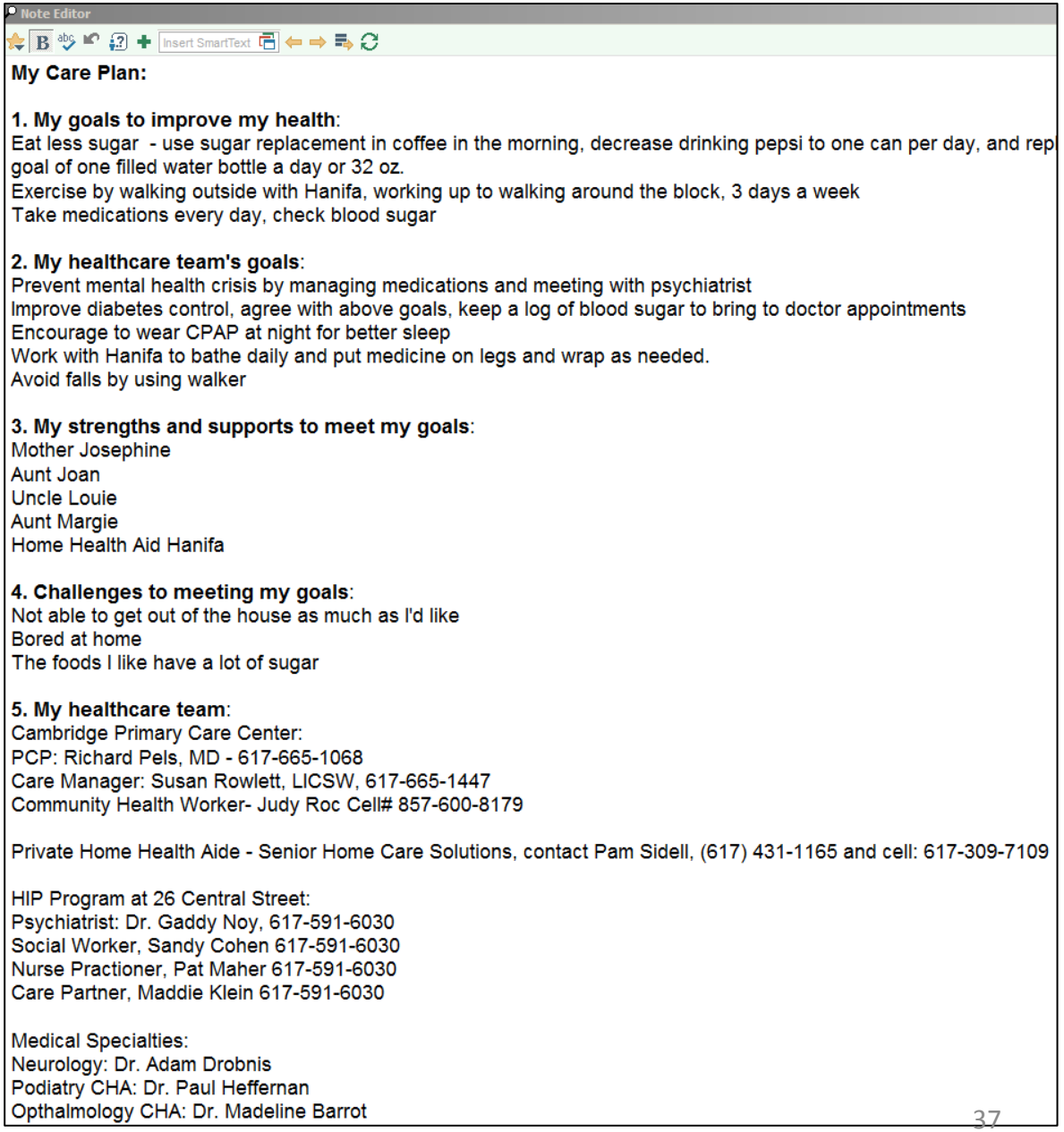
Discharge Follow-up Report

HIP Team Discharge Follow-Up 11/15/2016

Patients from the HIP Registry, 18 years and older, discharged from an inpatient stay or ED visit within the last 30 days, no filters for location or diagnosis. These are patients who have not had a behavioral health follow-up appointment within 30 days of discharge. Those appointments can be a BH Office Visit, BH Medication Inj Visit, BH Refill Enc, or BH INTAKE.

Disch Date	Location	Primary Diagnosis	Discharge Disp	fuh 7day	fuh 30day	Disch Enc 2day	Next BH Visit	Next BH Staff	Next PC Appt	Next P
10/17/2016	EME		HOME			Y	11/23/2016 10:40:00 AM	BOYD, JON WES	10/18/2016 8:40:00 AM	CHEN, JULIA
10/17/2016	EME		HOME			Y	11/28/2016 2:30:00 PM	TANEJA, EKTA	10/18/2016 5:00:00 PM	SOUMERAI, LE
10/23/2016	EME	S09.90XA UNSPECIFIED INJURY OF HEAD	HOME			N	11/16/2016 10:00:00 AM	TEPPER, MIRIAM C	1/17/2017 8:00:00 AM	FARIAS, KRIST
10/28/2016	EME	F25.9 SCHIZOAFFECTIVE DISORDER, UNS	HOME			N				
10/30/2016	EME	F25.0 SCHIZOAFFECTIVE DISORDER, BIP	HOME			N	12/2/2016 3:00:00 PM	HORVITZ-LENNON, MARCELA	11/16/2016 12:00:00 PM	LIN, WOANYIH
10/31/2016	SHEME	S61.216A LAC W/O FB OF R LITTLE FIN	HOME			N	11/17/2016 1:00:00 PM	KLETTER, ESTHER	11/7/2016 2:20:00 PM	DAILEY, SUZAI
10/31/2016	SHEME	F20.0 PARANOID SCHIZOPHRENIA	HOME			N			1/18/2017 2:00:00 PM	DWYER, ERICA
10/31/2016	EME	S76.011A STRAIN OF MUSCLE, FASCIA A	HOME			Y			11/2/2016 3:30:00 PM	ONORATO, AN
10/31/2016	CH4	F25.0 SCHIZOAFFECTIVE DISORDER, BIP	HOME			N				
11/1/2016	WHEME	F10.129 ALCOHOL ABUSE WITH INTOXICA	HOME			N				
11/2/2016	SHEME	S61.412A LACERATION WITHOUT FOREIGN	PSYCH ADM TO OTHER INP PSY FAC			N				
11/4/2016	EME	Z91.14 PATIENT'S OTHER NONCOMPLIANC	HOME			N	11/15/2016 11:00:00 AM	TEPPER, MIRIAM C	11/10/2016 11:20:00 AM	LIPMAN, JAMIE
11/4/2016	EME		HOME			Y			11/7/2016 11:20:00 AM	GREEN, BRIAN
11/5/2016	6N	K59.8 OTHER SPECIFIED FUNCTIONAL IN	HOME			N			11/10/2016 11:00:00 AM	PHILLIPS, CHRI
11/8/2016	WHWEST3		TRANSFER TO BETH ISRAEL DEACON			N			11/18/2016 2:10:00 PM	COHEN, PIETE
11/8/2016	EME	R45.2 UNHAPPINESS	HOME			N	11/16/2016 12:00:00 PM	MARLOWE, NINA	11/9/2016 11:20:00 AM	MAHER, PATRI
11/10/2016	EME		HOME			N	11/16/2016 12:00:00 PM	MARLOWE, NINA	11/9/2016 11:20:00 AM	MAHER, PATRI
11/11/2016	EME					N			11/28/2016 3:30:00 PM	CANNON, NIHA
11/11/2016	EME		HOME			N	11/22/2016 8:00:00 AM	TEPPER, MIRIAM C		
11/13/2016	EME		HOME			N	11/16/2016 12:00:00 PM	MARLOWE, NINA	11/9/2016 11:20:00 AM	MAHER, PATRI
11/14/2016	EME		HOME			N	11/17/2016 11:30:00 AM	KLETTER, ESTHER	12/21/2016 3:00:00 PM	LIN, WOANYIH

Coordinated Care Plan in EHR


Note Editor

Insert SmartText

My Care Plan:

1. My goals to improve my health:
Eat less sugar - use sugar replacement in coffee in the morning, decrease drinking pepsi to one can per day, and rep
goal of one filled water bottle a day or 32 oz.
Exercise by walking outside with Hanifa, working up to walking around the block, 3 days a week
Take medications every day, check blood sugar

2. My healthcare team's goals:
Prevent mental health crisis by managing medications and meeting with psychiatrist
Improve diabetes control, agree with above goals, keep a log of blood sugar to bring to doctor appointments
Encourage to wear CPAP at night for better sleep
Work with Hanifa to bathe daily and put medicine on legs and wrap as needed.
Avoid falls by using walker

3. My strengths and supports to meet my goals:
Mother Josephine
Aunt Joan
Uncle Louie
Aunt Margie
Home Health Aid Hanifa

4. Challenges to meeting my goals:
Not able to get out of the house as much as I'd like
Bored at home
The foods I like have a lot of sugar

5. My healthcare team:
Cambridge Primary Care Center:
PCP: Richard Pels, MD - 617-665-1068
Care Manager: Susan Rowlett, LICSW, 617-665-1447
Community Health Worker- Judy Roc Cell# 857-600-8179

Private Home Health Aide - Senior Home Care Solutions, contact Pam Sidell, (617) 431-1165 and cell: 617-309-7109

HIP Program at 26 Central Street:
Psychiatrist: Dr. Gaddy Noy, 617-591-6030
Social Worker, Sandy Cohen 617-591-6030
Nurse Practioner, Pat Maher 617-591-6030
Care Partner, Maddie Klein 617-591-6030

Medical Specialties:
Neurology: Dr. Adam Drobnis
Podiatry CHA: Dr. Paul Heffernan
Opthalmology CHA: Dr. Madeline Barrot

Training!

CHA Cambridge Health Alliance

Workforce Training Plan

Core Learning Objectives

1. Describe health disparities experienced by people living with SMI
2. Identify primary causes of premature mortality among people with SMI
3. Define the patient population served by the CHA BHH program
4. List general services offered by the CHA BHH program
5. Describe common barriers in to treating patients with SMI in primary care practices

CHA Primary Care

List specific clinical and other criteria for BHH inclusion

Complete EPIC referrals to BHH program

Describe respective roles & responsibilities for care coordination between BHH and primary care teams

CHA Psychiatry

List specific clinical and other criteria for BHH inclusion

Completing referrals to BHH program (EPIC order OR calling Central Intake)

Describe standard of care for effective follow-up after psychiatric hospitalization

Community Partners

Explain how people can get a primary care appointment at CHA

Explain how people can get an appointment for CHA outpatient psychiatry and/or therapy

Describe innovative elements of the BHH program at CHA

Community Connections

- 4 Suicides by young Brazilian immigrant women within one year
- CHA approached by the Brazilian Women's Group, a community agency, to start a community based depression intervention for this population
- CHA GP team and Psychiatry teams work with the BWG – Care Partner is the center of this collaboration!
- Monthly sessions for 2 years open to all around self awareness, empowerment, meditation, mindfulness and yoga

O Meu Bebe Lindo

Parenting group designed to combat immigrant isolation

Creates a community of parents that has been self sustaining

All learn, all teach

Facilitated by the GP team and billing is for routine well baby visits or urgent care

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Behavioural Health Integration: Make the leap

You won't regret it!