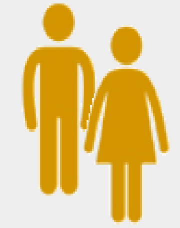
Stony Brook Medicine

Suffolk Care Collaborative PPS

Our Cohort

(Data reflects Jan. '16 to Aug. '16)

Adult Medicaid behavioral health members with a PHQ ≥10

= 76 

Our Actions

Patient Story

Patient presented for PC visit and declined PHQ-9. PC identified that patient was presenting signs of depression and in the moment performed a warm handoff to care coordination to connect patient to SW. Patient was seen by SW within 24 hours who consulted with Psychiatry and NP and connected the patient to the appropriate level of care.

Process Improvements

Patient Identification

- PHQ-9 administered during registration
- If patient scores ≥10 on PHQ the PCP will perform a health assessment and perform warm handoff or refer for Specialty services

Care Planning

- PC and SW collaborate on med. management and therapy intervention
- The SW may administer a psychosocial assessment and connect patient to Care Coordination Team

Management

- Live confirmation calls 24 hours prior to appointment
- PC and SW track patient progress with med. management and PHQ-9 reassessment scores

Follow-Up

- The PCP and SW assess patient progress with treatment plan and by clinical discretion
- Stable patients are transitioned back to PC for monitoring and maintenance

Level of Integrated Practice

LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some Systems Integration	**LEVEL 5 Close Collaboration Approaching an Integrated Practice**	LEVEL 6 Full Collaboration in a Transformed /Merged Integrated Practice

Lessons Learned

- Education and engagement of patients on what therapy is and how it can help is important
- Using data can help identify a disparity in different patient population needs
- Embedding BH providers and Care Coordinators allows for continuity of care

Our Impact

Patient Engagement

32 patients connected to BH

19 patients with improvement in PHQ score

10 patients transitioned back to PC

	Baseline *(Sept. '15 – Dec. '15)*	MAX Program *(Jan. '16 – Aug. '16)*
PHQ Average Screening Rate	N/A	100%
Medication Management	N/A	57%
Patients Connected to BH	N/A	42%
Improvement in PHQ Score	N/A	25%

*Calculations are based on self-reported data from Action Team