

Maricopa Integrated Health Home Project Frequently Asked Questions (FAQs)

August 2, 2011

- **What is the Maricopa Integrated Health Home (IHH) Project?**
 - This behavioral-health-led program integrates physical and mental health care to foster the whole health of individuals challenged with severe mental illness (SMI) by intervening to improve both their physical and behavioral health outcomes. The IHH Project is led by a partnership that includes Magellan Health Services of Arizona, Maricopa Integrated Health System (MIHS), and central Arizona's four adult SMI provider network organizations: CHOICES Network, Partners in Recovery, People of Color Network and Southwest Network.

- **Who will benefit from IHH services?**
 - This project will focus on the more than 14,000 individuals enrolled in central Arizona who are challenged with SMI. This figure includes close to 2,500 Hispanic individuals.

- **Why is IHH important?**
 - Individuals with SMI die 25 to 30 years earlier than members of the general population, according to the National Association of State Mental Health Program Directors and the National Research Institute. This report cites Arizona's disparity at an even greater 32 years. Behavioral health issues of those with SMI are compounded by chronic physical conditions—heart disease, respiratory problems, diabetes and stroke. Modifiable factors such as smoking, obesity, elevated cholesterol, elevated blood pressure and physical inactivity are major contributors to these diseases. Despite these facts, just one in four individuals in Maricopa County with SMI has a documented primary care physician, and they have limited access to ongoing routine primary care, with stigma keeping many of these individuals from seeking care in a typical physical healthcare setting.

- **Why hasn't IHH been done before?**
 - The concept of total health integration has drawn widespread national attention in recent years, but much of the recent focus has been on integration at the administrative funding level, which does not effectively impact outcomes for the individual. The physical health status of many individuals challenged with SMI has been left largely untreated – as the national health disparity data reveals – leading to costly chronic conditions, and poor outcomes and quality of life.

- **Why not just leave mental healthcare to the primary care physician?**
 - Stigma is still a reality that those with SMI face every day. Primary care physicians are often uneasy about caring for this population due to the

associated symptoms, and they frequently lack the additional time, or training, to address the multiple needs of people challenged with SMI.

- Conversely, many individuals with SMI avoid physical healthcare because they are fearful of, or unfamiliar with, primary care physicians. In addition, homelessness, substance use, lack of transportation, and lack of social supports can prove to be barriers to care as well.
- **What health conditions will IHH address?**
 - Each individual participating in the **IHH Project** will have a person-centered, integrated behavioral healthcare home. The IHH will address serious mental illness as well as health conditions such as asthma, diabetes, heart disease, obesity and other physical conditions. Seventy percent of those with SMI have at least one chronic physical condition in addition to their mental health challenge, and nearly one in three have three or more on top of their severe mental illness.
- **How will individuals be chosen to participate in the project?**
 - Magellan Health Services of Arizona, central Arizona's Regional Behavioral Health Authority, is overseeing the assessment process, the first step in creating the integrated healthcare home. So far, the PNO partners have administered a health risk questionnaire to more than 2,000 individuals with SMI. Many of these individuals have already begun whole health interventions like exercising, observing proper hydration, modifying their diet and quitting smoking.
- **What services will participants receive?**
 - All project participants will receive a health and wellness risk questionnaire and an integrated healthcare home. All of the individuals participating in the project will participate in wellness/prevention programs, receive support and training in self-management, have access to peer-support specialists and receive a range of interventions based upon their unique needs. Enrollees also will have access to community-based case management, featuring group sessions focused on specific co-occurring health conditions, group sessions on whole health and wellness, an integrated health and wellness individual service plan (ISP) and follow-up to divert from higher levels of care.
 - The highest-need group will also have access to a provider network of intensive community support, an integrated care nurse coordinator, a clinical care management team, peer coach, evaluation for remote monitoring and a cell phone outreach support.
- **Where will integrated healthcare homes be located?**
 - Participants will receive care through behavioral health clinics.

- **Are there plans to expand the IHH Project beyond central Arizona?**
 - Efforts in Arizona are beginning with this pilot project, but we believe the outcomes will be positive and that this program can be replicated throughout Arizona in the future.

- **How will the IHH project be funded?**
 - Partners are leveraging current resources. Community reinvestment dollars will also be utilized. Additionally, the IHH Project partners feel the effort aligns with the 2703 Planning Grant Arizona recently received from the Centers for Medicare and Medicaid to explore the creation of Chronic Care Homes for those challenged with SMI, and can become the model for Arizona to implement Chronic Care Homes—allowing the state to take advantage of an enhanced FMAP and relieve the state of 20% of the burden of caring for this vulnerable population.

###