MARICOPA INTEGRATED HEALTH HOME (IHH) PROJECT
FACT SHEET

WHAT/WHO:

This groundbreaking total health and wellness integration project is designed to improve the quality of life and lifespan for Arizona's most vulnerable citizens—those individuals challenged with a serious mental illness (SMI). Led by a partnership of healthcare leaders in Maricopa County, this initiative will integrate physical and mental health services to reduce or eliminate health disparities for recipients in the public behavioral health system who live with SMI.

The ***Maricopa Integrated Health Home Project (IHH)*** will feature integrated, behavioral-health-led delivery of care that focuses on measurable outcomes. The **IHH Project** is a partnership among 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.

The IHH Project will achieve its vision of total health integration by:

- ✓ ***Unifying partners*** through a shared governance with Medicaid beneficiaries with SMI and their families, the ADHS/DBHS, the four adult provider network organizations, MIHS, and Magellan Health Services of Arizona;
- ✓ ***Cultivating quality*** through administrative leadership, along with project and care management that addresses funding, policy and regulation, health information exchange and access to medical care challenges; and
- ✓ ***Identifying, monitoring and managing key outcomes*** through transparent reporting of performance and by establishing measurements that reflect service recipients' health and integration into their communities.
- ✓ ***Recognizing and utilizing*** *the proven effectiveness of peer mentoring and family involvement resources to support and motivate recipients on their mental health and physical health improvement journeys.*

WHEN:

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.

The project will focus on the more than 14,000 individuals enrolled in Medicaid in central Arizona who are challenged with SMI.

WHY:

Individuals with a serious mental illness die 25 to 30 years earlier than members of the general population, according to a 2003 report by the National Association of State Mental Health

Program Directors and the National Research Institute. This report cited Arizona's disparity at an even greater 32 years. This is largely because the 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 a serious mental illness 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.

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. Exacerbating this is the reality of stigma. 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 a serious mental illness.

HOW:

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 health 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. All of the individuals engaged 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.

Physical Health Conditions	Modifiable Risk Factors	Behavioral Health Conditions
• Cardiovascular disease • Hypertension • Diabetes • High cholesterol • COPD and/or asthma	• Tobacco use • BMI over 25 • Physical inactivity • Poor nutrition • Non-adherence to treatment plan	• SMI diagnosis • Co-occurring substance use disorder

Success of the project will be measured through a variety of clinical outcomes, ranging from visits to a primary care physician to annual screenings for chronic conditions and adherence to a medication regimen for serious mental illness. Using best-in-class data, individuals will be categorized according to their level of health risk. Participants 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 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.

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